

# VERITA

IMPROVEMENT THROUGH INVESTIGATION

## **An investigation into the care and treatment of Mr A**

A report for  
NHS England, North Region

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Authors:  
Chris Brougham  
Dr Peter Jefferys

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**Verita**  
**53 Frith St**  
**London W1D 4SN**

Telephone **020 7494 5670**  
Fax **020 7734 9325**

E-mail [enquiries@verita.net](mailto:enquiries@verita.net)  
Website [www.verita.net](http://www.verita.net)

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# 1. Introduction

1.1 NHS North of England<sup>1</sup> commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, to carry out an independent investigation into the care and treatment of Mr A, a mental health service-user who killed his wife.

1.2 The independent investigation follows the Department of Health guidance published in HSG (94) 27, *Guidance on the discharge of mentally disordered people and their continuing care in the community*, and the updated paragraphs 33-36 issued in June 2005. The terms of reference for this investigation are given in full in section 2 of this report.

1.3 The purpose of an independent investigation is to discover what led to an adverse event and to audit the standard of care provided to the individual. An independent investigation may not identify root causes or find aspects of the provision of healthcare that directly caused an incident but it will often find things that could have been done better.

## Background to the independent investigation

1.4 Mr A received care and treatment from an older people's community mental health team in Cheshire and Wirral partnership NHS Foundation Trust (the trust) and a social services local independent living team.

1.5 The trust has carried out a joint investigation with Cheshire East Council and Eastern Cheshire Primary Care Trust. The investigation report outlined seven recommendations to improve care and treatment. The trust developed an action plan to take forward the recommendations.

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<sup>1</sup>In April 2013 NHS North of England ceased to exist and its statutory powers transferred to NHS England, North Region. Throughout this report we refer to NHS North of England as they were the original commissioners of the investigation.

## Overview of the trust

**1.6** In July 2007 Cheshire and Wirral Partnership Mental Health Trust became the first mental health trust in the North of England to achieve foundation trust status.

**1.7** The trust serves a million people across Cheshire and Wirral. Its principal activities are to provide services in primary and specialist mental health, learning disabilities, child and adolescent mental health, and drug and alcohol - as well as a range of specialist services connected with eating disorders services and occupational health.

**1.8** Mental health services for adult and older people suffering from complex and serious mental health problems are based mostly in the community, though inpatient beds are available for service-users who need admission.

**1.9** The memory service provides an assessment and monitoring service for people who have suspected or diagnosed cognitive impairment, including problems with forgetfulness, confusion, language, and behaviour. The team is made up of a consultant psychiatrist, clinical nurse specialists, administration and support staff.

**1.10** Mr A received care and treatment under the care of an older people's community mental health team (OPCMHT) in the East Adult Mental Health Clinical Service Line. The OPCMHT is made up of a range of professionals who specialise in older people's mental health problems. The team consists of:

- a consultant psychiatrist
- an associate specialist (psychiatrist)
- a team manager
- community mental health nurses
- a social worker
- an occupational therapist
- a band 4 practitioner.

## 2. Terms of reference

2.1 This independent investigation is commissioned by NHS North West with the full cooperation of Cheshire and Wirral Partnership NHS Foundation Trust (the trust). It is commissioned in accordance with guidance published by the department of health in HSG 94(27) *Guidance on the discharge of mentally disordered people and their continuing care in the community* and the updated paragraphs 33-6 issued in June 2005. It also takes into account the Good Practice Guidance issued by the National Patient Safety Agency in February 2008.

2.2 The independent investigation will:

*Examine:*

- the care and treatment provided to the service user, at the time of the incident (including that from non NHS providers e.g. voluntary/private sector, if appropriate)
- the suitability of that care and treatment in view of the service user's history and assessed health and social care needs
- the extent to which that care and treatment corresponded with statutory obligations, relevant guidance from the Department of Health, and local operational policies
- the adequacy of risk assessments to support care planning and use of the care programme approach in practice
- the exercise of professional judgment and clinical decision making
- the interface, communication and joint working between all those involved in providing care to meet the service user's mental and physical health needs including any safeguarding issues
- the extent of services engagement with carers; use of carer's assessments and the impact of this upon the incident in question
- the quality of the internal investigation conducted by the trust, including any action plans.

*Identify:*

- learning points for improving systems and services
- any development in services since the user's engagement with mental health service and any action taken by services since the incident occurred.

*Make:*

- realistic recommendations for action to address the learning points to improve systems and services.

*Report:*

- findings and recommendations to the NHS North of England board, as required by the SHA.

### **3. Approach and structure**

**3.1** The investigation took the form of a documentary review led by Chris Brougham, an investigator from Verita. Dr Peter Jefferys MA MB BCh FRCPsych FRCP (Lond) SR honorary consultant in psychiatry of old age at Northwick Park Hospital, Harrow provided expert psychiatry advice. Biographies are included in appendix A.

**3.2** Mr A did not have the capacity to give consent to access his medical records. NHS North sought legal advice. The legal advice stated that it was in the public interest for the investigation team to obtain Mr A's clinical records for the purpose of the investigation into his care and treatment and so that the terms of reference were met.

**3.3** Documentary evidence, including policies and procedures from the trust, Mr A's trust and GP clinical records as well as the trust's joint investigation, was examined.

**3.4** The trust investigation report including discussion notes from the trust's interviews with the following professionals:

- social care assessor
- community mental health team secretary
- general practitioners
- speciality doctor in psychiatry
- consultant psychiatrist
- community psychiatric nurse x2
- community mental health team manager
- social worker.

**3.5** The trust's safeguarding lead was interviewed because she had not been interviewed as part of the trust joint investigation.

**3.6** All the evidence received was analysed. Findings and recommendations were made to improve services.

**3.7** This report includes a chronology outlining the care and treatment of Mr A. The analysis appears in section 5 where particular issues and themes are highlighted.



## 4. Executive summary and recommendations

4.1 NHS North of England (previously NHS North West) commissioned Verita, a consultancy specialising in public sector investigations, reviews and inquiries, to carry out an independent investigation into the care and treatment of a mental health service-user (Mr A).

4.2 The independent investigation follows guidance published by the Department of Health in HSG (94) 27, *Guidance on the discharge of mentally disordered people and their continuing care in the community*, and the updated paragraphs 33-36 issued in June 2005. The terms of reference for this investigation are given in full in section 2 of this report.

4.3 The purpose of an independent investigation is to discover what led to the adverse event and to audit the standard of care provided to the individual. While the independent investigation may not identify root causes and may find that nothing in the provision of healthcare directly caused the incident, it might find things that could have been done better.

### The incident

4.4 Mr A attacked his wife on 25 June 2010 resulting in her being admitted to hospital. She died of her injuries on 28 June 2010.

### Overview of care and treatment

4.5 Mr A received an invalidity pension. He was 65 when GP Q referred him to the memory clinic<sup>1</sup> at the trust for assessment. He received outpatient care from the older people's community mental health team in three periods between December 2005 and 24 June 2010. Cheshire East Local Independent Living Team saw him twice for assessment.

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<sup>1</sup> The memory clinic provides an assessment and monitoring service for people who have suspected or diagnosed cognitive impairment, including problems with forgetfulness, confusion, language, and behaviour.

## **Overall conclusions of the independent investigation**

**4.6** This investigation was commissioned and carried out by means of a desktop review because the trust had already carried out a joint investigation into the care and treatment of Mr A with Cheshire East Council and Central and Eastern Primary Care Trust. The reason for the joint investigation was that Mr A had input from the trust, Cheshire East Independent Living Team and his GP.

**4.7** Many of the significant matters raised in this independent investigation were also identified in the trust joint investigation.

**4.8** The significant matters were:

- diagnosis and treatment
- risk assessment and risk management
- involvement and support for carers
- the older person's community mental health team
- Cheshire East Independent Living Team.

**4.9** The trust joint investigation report made eight recommendations. An action plan was developed to take the recommendations forward. All actions from the trust's action plan have been implemented and signed off by the trust.

**4.10** This independent investigation found three other issues not identified in detail by the trust joint investigation.

## **NICE guidelines for dementia**

**4.11** We found that NICE guidelines for dementia were partly followed but the clinical notes contain nothing to show that a differential diagnosis was considered. Such a diagnosis was important given Mr A's presentation. As a consequence, no further relevant investigations were undertaken in a timely manner. We therefore recommend that:

**R1** The trust should ensure that NICE clinical guidance (42) for dementia is fully adhered to, and if necessary negotiate a contract with their commissioners to help achieve this.

### **Safeguarding policy**

**4.12** We also examined whether safeguarding policies were followed. We found no evidence to show that clinical staff fully understood the trigger points for a referral to the safeguarding team. In view of this we recommend that:

**R2** All clinical staff including consultant psychiatrists', specialist registrars and GP's should recognise trigger points for safeguarding referrals and ensure that appropriate referrals are made.

### **First-appointment assessments**

**4.13** Finally, we noted that the Cheshire East Independent Living Team carried out an initial assessment by phone rather than in person. A face-to-face assessment promotes a more comprehensive approach. We therefore recommend that:

**R3** Cheshire East Independent Living Team should ensure that service-users are seen in person on their first referral to reduce any limitations in assessment.

**4.14** As indicated above, we found that there were some aspects of care that could have been better. Despite this, there was no evidence to show that any of these shortfalls caused the victims death or that it could have been predicted.

## 5. Chronology of care and treatment

5.1 Mr A was married and receiving an invalidity pension. He received three episodes of care and treatment from an OPCMHT in Cheshire and Wirral Partnership NHS Foundation Trust (the trust) and a social services local independent living team.

### First episode of care: December 2005 to November 2006

5.2 GP Q referred him to the memory clinic at the trust on 11 November 2005 for assessment. Mr A's GP described a 12-month history of short-term memory problems with more recent episodes of "*forgetting large chunks of conversations he had earlier in day*". Mr A's referral was discussed at the weekly community mental health team (CMHT) allocations meeting and allocated to a community mental health nurse (CMHN T).

5.3 CMHN T assessed Mr A at his home on 1 December 2005. Mr A's wife was present during the assessment. A mini mental state examination<sup>1</sup> (MMSE) was carried out. Mr A scored 29 out of 30, an essentially normal score. Both he and his wife described a recent change in his personality. He had become "*snappy*" and short-tempered as well as frustrated at his apparent memory problems, with possible lowering of mood. A follow-up appointment was arranged for April 2006.

5.4 CMHN S visited Mr A on 25 April 2006 and carried out a further MMSE. Mr A scored 30 out of 30, with no evident change in his presentation. The possibility of Mr A suffering from post-traumatic stress disorder as a result of his former profession as a bomb disposal engineer was subsequently raised in discussion with CMHT colleagues. CMHN S suggested that Mr A should see a psychiatrist and an outpatient appointment was made.

5.5 On 11 May 2006 Mr A attended an outpatient appointment with his wife. Psychiatrist M assessed him and found he had a mild cognitive impairment. An appointment was made for Mr A to be seen again as an outpatient in six months and followed up in the memory clinic in a year.

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<sup>1</sup> A tool widely used for testing memory problems.

**5.6** Mr A went on his own to the outpatient clinic on 9 November 2006 where psychiatrist P saw him. Records show that Mr A's presentation remained unchanged with a normal MMSE score so he was discharged from the memory clinic back to the care of his GP.

#### **Second episode of care: March 2009 to June 2010**

**5.7** On 12 March 2009, GP Q referred Mr A to the memory clinic at the trust because his memory was failing. His wife said he was becoming increasingly confused and that his level of functioning was falling although he scored 29 out of 30 on the MMSE. A CT brain scan showed generalised changes in the cerebral cortex, consistent with normal ageing or early dementia. An antidepressant had also been prescribed (citalopram 20mgs).

**5.8** On 30 April 2009, Mr A saw consultant psychiatrist R at outpatient clinic. Mr A scored 30 out of 30 on the MMSE but he said he was experiencing poor memory, losing track of conversations, having mild difficulty in finding words and in remembering the names of his grandchildren. Mr A was taking citalopram 20mgs. Consultant psychiatrist R changed the antidepressant to mirtazapine 20mgs because the citalopram did not seem to be helping. Consultant psychiatrist R also referred Mr A for an MRI scan and made arrangements to see him again in four months.

**5.9** On 13 August 2009 Mr and Mrs A attended the outpatient clinic. Mrs A told consultant psychiatrist R that her husband continued to experience difficulty recalling names of people, lost track of conversations and forgot what he was saying. Mrs A also said her husband was having trouble working out finances and also could not cope with changes. Mr A denied feeling depressed, but complained that his thinking was slowing down and that he had noticed a tremor in his right hand and that it did not swing when he was walking. Mrs A also said he had difficulty getting out of his chair, shuffled when walking and that his writing had become smaller. Mr A was also suffering lower back pain and had been prescribed gabapentin (licensed for neuropathic pain) 600mgs three times per day. Mr A had also reverted to taking the citalopram because he had been having nightmares, which he attributed to the mirtazapine.

**5.10** The MRI brain scan was reported as showing mild to moderate symmetrical brain atrophy, most marked in the frontal and parietal lobes. There was also widespread mild

cortical white-matter ischaemia. This indicated significant, albeit not severe, loss of brain substance in the front and side of the right and left cerebral hemispheres, which would be consistent with Mr A's mental and behavioural changes. The scan also showed some reduction in the supply of blood, and therefore oxygen, to pathways connecting different parts of the brain's surface.

**5.11** Consultant psychiatrist R observed tension between Mr and Mrs A and therefore referred Mr A to Cheshire East Council's social services so that he could be assessed for day care. Consultant psychiatrist R also suggested to Mr A's GP that a referral for a neurological opinion be considered as some of his symptoms suggested Parkinson's disease.

**5.12** On 7 September 2009 a member of staff from the access team east from social services phoned Mrs A to find out how she was managing. Mrs A said she was the main carer for her husband but she had some support from her sister. Mrs A explained that she helped her husband with his personal care and felt that she was managing well even though she had chronic obstructive pulmonary disease. Mrs A was offered a carer's assessment but she said she wanted to think about this and agreed to call the access team back. The possibility of Mr A attending a day centre was discussed. Mrs A said she would like to speak to her husband because she was not sure whether he would want to go. Mrs A was also provided with the contact details for Age Concern and the access team.

**5.13** On 12 October 2009, a consultant physician assessed Mr A. The physician recorded that Mr A was likely to be suffering from early Parkinson's disease and dementia.

**5.14** The consultant prescribed Co-careldopa 125mgs<sup>1</sup> and a further appointment was made for four months' time.

**5.15** On 3 December 2009 Mr A attended an outpatient appointment with his wife to see Dr R. Mrs A said they had been contacted by social services and offered a care package but they had declined it. Mrs A told the psychiatrist that her husband had been seen by a physician and had been diagnosed with Parkinson's disease. She said Mr A was still having memory problems. Dr R said these were most likely to be related to his Parkinson's disease but they were mild and so, under NICE guidelines for treatment of mild to moderate dementia, acetyl cholinesterase inhibitors<sup>2</sup> were not recommended. Dr R wrote

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<sup>1</sup> Medication used in Parkinson's disease to alter the levels of dopamine in the brain.

<sup>2</sup> Medication aimed at reducing cognitive impairment caused by Alzheimer's disease.

to Mr A's GP advising that a further follow up appointment had not been made but he would be happy to see Mr A again if his presentation changed.

### **Third and final episode of care: February 2010 to June 2010**

**5.16** On 15 February 2010 Mr and Mrs A attended a follow-up outpatient clinic appointment with a consultant physician about Mr A's Parkinson's disease. The physician recorded that Mr A's condition was stable but he scored 7 out of 10 in an abbreviated mental test score (AMTS), suggesting significant deterioration in memory. His wife also described continuing problems with his memory. The consultant physician therefore re-referred Mr A to the memory clinic for a further assessment.

**5.17** The referral was discussed at the community mental health team allocation meeting on 15 March 2010. An outpatient appointment was made for 8 April 2010.

**5.18** Mr and Mrs A attended their GP surgery on 31 March 2010. They were seen by GP U. Records show that Mr and Mrs A had gone to Blackpool, where Mr A had become agitated, demanding his tablets. Mrs A felt at one stage that Mr A was going to hit her with an iron. GP U had a discussion with the team secretary at the community mental health team and an urgent appointment was offered to Mr A. GP U also started Mr A on quetiapine 25mgs twice a day.

**5.19** On 8 April 2010 Mr and Mrs A attended an outpatient clinic at the trust and were seen by a speciality doctor in psychiatry (Dr S) who was under the supervision of consultant psychiatrist R. Mrs A complained about rapid deterioration in Mr A's mental state, cognitive functioning and behaviour. She also said that Mr A was aggressive towards her while they were on holiday in Blackpool. Mrs A reported an improvement in her husband's behaviour since he had started on quetiapine but said he was still abusive towards her. Records show that he experienced occasional visual hallucinations, including seeing a dog in the house or seeing people upstairs when there was nobody there. Dr S recorded that Mr A's cognitive impairment was in the severe range. She was unable to complete a MMSE because he was suspicious and irritable. She also described his comprehension as impaired and his mood as dysphoric, though he denied suicidal thoughts or thoughts of harming himself or others. Dr S could not detect any delusions or hallucinations during the assessment. At the time of this appointment Mr A was taking

gabapentin 300mgs three times a day, Co-Careldopa 125mgs three times a day, citalopram 20mgs once a day and quetiapine 25mgs twice a day. Mrs A said she was struggling to cope with Mr A and she requested urgent respite. The following plan was made:

- a referral to social services due to concern about carer breakdown
- a referral for CT scan.

**5.20** The following day, 9 April 2010, Dr S phoned the Congleton local independent living team at Cheshire East Council and requested an assessment.

**5.21** On 16 April 2010 a social worker visited Mr A at home. The social worker was accompanied by a social care assessor. Mr A's wife and son were also present. The social worker spoke with Mrs A while the social care assessor engaged with Mr A and his son. A community care assessment was completed. The social worker asked Mrs A during this assessment about any mental or physical abuse by Mr A. The social worker said she denied there had been any and described Mr A as "nowty". Mr and Mrs A refused an offer of use of a telecare pendant. The social worker also provided Mrs A with information about the Alzheimer's Society in case she wanted to access help and support for herself. Mrs A also refused an offer of respite care. Arrangements were made for Mr A to attend a day centre on Mondays.

**5.22** Mrs A and her husband attended the GP surgery on 26 April 2010 to discuss Mr A with GP Q. GP Q wrote in a statement that formed part of the trust investigation that Mrs A had noticed an initial improvement in Mr A's agitation, but a marked deterioration in his hallucinations and paranoid ideation since he had started quetiapine. GP Q said Mrs A was having difficulty bringing Mr A to the surgery because of his behaviour and the stress it caused her. GP Q and Mrs A discussed the possibility of the medication aggravating Mr A's confusion and that GP Q had experience of anti-parkinsonian medication causing hallucinations. GP Q and Mrs A agreed to stop both the quetiapine and Co-careldopa (Sinemet) advising that this should be done through downward titration over a few days. GP Q requested that Mrs A contact him to determine how this was progressing.

**5.23** Mrs A went to the GP surgery on 7 May 2010 to discuss Mr A's recent medication change. She said Mr A continued to be obsessive about things, but he was more able to hold a conversation and function better. Mrs A was then keen to stop other medication



with an adverse psycho-active effect, so GP Q advised weaning off the citalopram and gabapentin.

**5.24** Mr and Mrs A went to the GP surgery on 10 June 2010 and were seen by GP Q. The GP records show that Mr A complained of pain in his lower back that was consistent with his previous sciatica. He had poor memory and became frustrated when he could not find the words for what he was trying to say. GP Q increased the dose of Mr A's gabapentin to 600mgs three times a day, which had been his usual dose before the reduction suggested a month earlier. The use of paracetamol was recommended and a prescription for slow release tramadol (an opiate pain killer) was issued.

**5.25** Later the same day Mr A and Mrs A went to Dr R's outpatient clinic. Mrs A said her husband was attending the day centre and that his mental state was better. Dr R was aware that GP Q had discontinued the Co-careldopa, citalopram and quetiapine. Mr A was assessed as being co-operative throughout the interview with no undue anxiety or agitation. His language was significantly impaired, he was euthymic and his affect (mood) was reactive. At the time of the appointment his hallucinations and paranoid ideation were infrequent. Cognitive testing records show evidence of significant deterioration in Mr A's performance. According to Dr R, he was disoriented to time, had marked impairment of recall and impaired attention. Mr A scored 15 out of 30 on the MMSE. This demonstrated that his memory had deteriorated. Dr R discussed the use of anti-dementia drugs and agreed to send some information to Mr and Mrs A.

**5.26** Mrs A phoned a worker at the Congleton independent living team on 24 June 2010 expressing concern about Mr A's behaviour. The social worker advised Mrs A to contact the GP.

**5.27** Mrs A phoned GP Q and said Mr A had become more confused over the past two weeks. She said Mr A was experiencing visual hallucinations, and was reluctant to dress, believing that his clothes and shoes no longer fitted him. He was looking into drains in the street and was verbally aggressive and agitated. Mrs A was concerned that he might strike out at her if she had to cope with him over the weekend. Mr A's son had taken him out for the day, so GP Q could not see him straight away. GP Q advised Mrs A to obtain a urine sample and said he would arrange for an urgent outpatient appointment with the community mental health team.

**5.28** GP Q spoke to the team secretary at the CMHT. She arranged for Mr A to see Dr R the following day. GP Q was satisfied with this response, and he followed this up with a fax describing the current situation. The community mental health team received it later the same day. No further action was pursued that day by the CMHT.

**5.29** GP Q phoned Mrs A and explained that an outpatient appointment had been arranged for Mr A the following morning.

**5.30** The social worker phoned Mrs A and was told about the outpatient appointment. Mrs A confirmed that she was happy with this action.

**5.31** Later the same day Mr A attacked Mrs A with a knife at their home, resulting in her attendance at A&E and admission to hospital.

**5.32** Mrs A died of her injuries on 28 June 2010.

## **6. Issues arising, comment and analysis**

**6.1** In this section of the report we provide our comment and analysis on the issues we have identified as part of our investigation.

**6.2** The themes are:

- diagnosis and treatment
- the Care Programme Approach
- risk assessment and risk management
- involvement and support for carers
- safeguarding adults
- the older person's community mental health team
- Cheshire East Independent Living Team.

### **Diagnosis and treatment**

**6.3** We consider in this section first the NICE Guidance relating to the memory assessment services and assess whether this standard was met. The guidance says primary healthcare staff should consider referring people who show signs of mild cognitive impairment (MCI) for assessment by memory assessment services to aid early identification of dementia.

**6.4** GP Q assessed Mr A in November 2005, diagnosed mild cognitive impairment and promptly referred him to the memory clinic at the trust for further assessment. On 12 March 2009 GP Q re-referred Mr A to the clinic when his memory deteriorated. The NICE guidance standard for referring people with cognitive impairment to a memory clinic was met in both the first and second episode of care.

**6.5** A sound diagnosis is the first step to appropriate treatment. Achieving it relies in the first instance on careful clinical assessment and consideration of alternative diagnoses, including relevant investigation. With time, good clinical care demands re-assessment and diagnostic review with adjustment to treatment and management plans.

6.6 Mr A's first clinical presentation with symptoms of memory loss but a normal score on the MMSE was comparatively unusual. In a presentation of this type, NICE guidance advises that differential diagnoses should be considered. These would include:

- frontal lobe syndrome including Lewy Body Dementia<sup>1</sup>
- alcohol misuse
- the side-effects of medication.

6.7 The clinical notes contain nothing to demonstrate that differential diagnosis was considered. In addition no further relevant investigations were undertaken at this stage, such as a CT<sup>2</sup> or an MRI<sup>3</sup> scan, or seeking psychopharmacological advice. The standard expected regarding the diagnosis of early dementia as outlined in NICE guidance was not met on this occasion, although in practice resource constraints may limit the extent of investigations undertaken.

6.8 Medication was not initially prescribed and a 'wait and see' approach with careful follow-up was taken.

#### *Comment*

***This was appropriate both because the use of anti-dementia drugs would not have been supported by NICE guidance at this stage and because the memory impairment was mild.***

6.9 Mr A attended an outpatient appointment on his own on 11 November 2006. He advised that he was doing well and had only occasional difficulty finding the right words. The psychiatrist discharged Mr A back to the care of his GP.

6.10 The record does not show whether this discharge took place after consultation with Mrs A. It was clear at this point that Mr A's memory problems, albeit minor, persisted. A

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<sup>1</sup> Lewy Body Dementia is a form of dementia that shares characteristics with both Alzheimer's and Parkinson's diseases.

<sup>2</sup> A computerised tomography (CT) scan, uses X-rays and a computer to create detailed images of the inside of the body.

<sup>3</sup> Magnetic resonance imaging (MRI) is a type of scan often used to diagnose health conditions that affect organs, tissue and bone.

clear diagnosis had still not been reached and the only investigation performed at this stage was the MMSE.

*Comment*

***Consultation with Mrs A would have been valuable to see whether she could manage and to check that she had received information and signposting to appropriate support agencies or groups.***

**6.11** In September 2009 during the second episode of care, Dr R appropriately arranged for further investigation (MRI scan), a CT scan having been done previously, and repeated the MMSE. He excluded major depressive illness or psychosis.

*Comment*

***Dr R appropriately identified clinical signs suggestive of Parkinson's disease and triggered an appropriate referral to a physician via Mr A's GP to confirm Mr A's diagnosis and treat it.***

**6.12** However, in spite of an abnormal MRI scan report suggesting frontal lobe atrophy and some atypical features in Mr A's presentation, Dr R did not pursue the frontal lobe diagnostic issue, including Lewy Body Dementia. He did not investigate the possible contribution of alcohol or medication side effects to Mr A's condition.

**6.13** Dr R relied on the information Mr and Mrs A gave him about the diagnosis of Parkinson's disease, which is not uncommonly associated with dementia. Dr R did not seek out the physician's report summarising his opinion about Mr A's diagnosis. If he had, he would have noted that the physician's view was not wholly compatible with Dr R's conclusion that the memory problems were most likely to be related to Parkinson's disease.

6.14 The physician wrote to Mr A's GP:

*"He [Mr A] does not have any significant history of hallucination and it is difficult to pinpoint whether he is having Alzheimer's type dementia or Lewy Body dementia."*

6.15 Dr R decided to discharge Mr A in December 2009 based on the untested assumption that a physician had reached a similar diagnostic conclusion to his on the cause of Mr A's dementia, and was competent and willing to manage Mr A's dementia in future. This was in the absence of any communication between the two doctors and with the knowledge that both Mr A's dementia and his Parkinson's disease were probably progressive.

*Comment*

***This decision was neither wise nor reliable. An opportunity to clarify a complex diagnosis with a possible impact on treatment and management was missed.***

6.16 Home visits by a community mental health nurse are consistently valued by carers of people with dementia, not only to monitor progress but also to offer continuing advice and support to the carer. Dr R could have asked a community mental health nurse to visit Mr A at home. We found no evidence that Dr R considered this while Mr A was attending clinic nor as follow-up after discharge.

6.17 During the third episode of care between April and June 2010 Mr A's condition deteriorated, and he experienced visual hallucinations. Mr A was referred to Leighton Hospital for urgent CT scan. The hospital refused to carry out the scan because one had been done during the last year for a similar presentation. The x-ray medical staff therefore felt that there was no need for it. Other than making this referral, Dr S appears not to have tried to establish why Mr A's condition had deteriorated. Dr S knew that Mr A had been prescribed at least these four drugs in this period: gabapentin, Co-careldoa, citalopram & quetiapine. Visual hallucinations, for example, are fairly common with Co-careldopa, particularly when given simultaneously with other medications.

## *Comment*

*The GP altered Mr A's medication many times in this period, so investigating the possibility that this was the cause of some or all of the recent deterioration and hallucinations would have been important.*

**6.18** No clinical intervention took place on 24 June but the faxed referral from GP Q included the information that a prescription for Tramadol 100mg (60 tabs) had been issued on 10 June. Tramadol is an opiate analgesic with significant psychological side effects, particularly in combination with other drugs. This new information was not drawn to the attention of the psychiatrist. With hindsight it is possible that this information could have assisted in understanding the cause of Mr A's abrupt mental deterioration.

**6.19** At the beginning of the third phase in April 2010, psychiatrist S appropriately recognised the need to rethink Mr A's diagnosis in light of rapid deterioration and a combination of unusual features. However, the focus on clarifying diagnosis appears to have been lost by early June 2010 and the faxed GP referral on 24 June was not reviewed by a psychiatrist before the tragic outcome that night. These were missed opportunities that could have led to a more robust treatment plan for Mr A.

## *Recommendation*

**R1** The trust should ensure that NICE clinical guidance (42) for dementia is fully adhered to, and if necessary negotiate a contract with their commissioners to help achieve this.

## **The Care Programme Approach (CPA)**

**6.20** CPA was introduced in April 1991 as the cornerstone of the government's mental health policy to provide a framework for effective mental health care to all service-users and carers.

**6.21** CPA is a model of assessing, planning, delivering care and then evaluating that care or intervention. It aims to promote effective liaison and communication between agencies, carers and service users, thereby meeting a person's recovery aspirations and ensuring all aspects of safety are addressed by good collaborative risk assessment and management.

**6.22** *Refocusing the Care Programme Approach* was issued by the Department of Health in March 2008. This updated guidance highlights good practice emphasising the need for person centred mental health care, keeping recovery at the heart of the person centred approach, it also sets out how CPA and non CPA, known as standard care, should be used.

**6.23** The trust has developed a CPA and standard care policy to ensure that both are fully implemented.

**6.24** The criteria for CPA include the following:

- severe mental disorder (including personality disorder) with high degree of clinical complexity.

**6.25** The criteria for standard care include the following:

- service-users with more straightforward needs and contact with one agency or no problems with access to other agencies/support.

**6.26** Trust policy outlines that service-users placed on standard care should have their care co-ordinated by a lead professional who should ensure that all those involved in the service-users care have access to the care plan. For service-users who have contact with only a consultant psychiatrist the care plan and risk assessment will be contained in their outpatient letter.

**6.27** Records show that Mr A was assessed and placed on standard care and that he was allocated to a lead professional (Dr R). Mr A's care was outlined in outpatient letters.



## *Comment*

*On balance, standard care was an appropriate decision given Mr A's presentation and involvement with services. Comments on risk assessment are detailed in the next section.*

### **Risk assessment and risk management**

**6.28** National policy outlines that risk assessment and risk management should be at the heart of effective mental health practice. Trust policy says that all service-users should have a risk assessment completed as part of the assessment. Any risks or issues around safety identified should be incorporated into the service-user's care plan and reviewed as appropriate for up to a maximum of 12 months.

**6.29** The trust policy also says risk assessments must include the following aspects as a minimum:

- **risk to self**; including accidental self-harm, risks associated with alcohol, drug or substance misuse and the degree of dependence problems, deliberate self-harm and physical ill health. Risk of falls and impaired capacity must also be considered
- **suicide**; including previous attempts, threats, opportunity, means
- **violence to others**; including access to potential victims, specific threats made, history of violence to family, staff, other service users, the general public and a degree of threat/actual harm, including sexual.

**6.30** Trust policy says all service-users should have a risk assessment completed as part of the assessment process and that any risks should be incorporated into the care plan. The policy also says risk should be reviewed as appropriate for up to a maximum of 12 months.

**6.31** We found evidence that an initial risk assessment took place in December 2005. The conclusion was recorded as 'low risk'.

### *Comment*

*The conclusion of low risk was appropriate given Mr A's presentation and history at the time. Mr A's clinical condition showed no significant change between December 2005 and November 2006. However, a further risk assessment should have been undertaken and recorded in November 2006 before the decision to discharge him.*

**6.32** Mr A was referred back to the memory clinic in March 2009 after his mental state deteriorated. This should have triggered a systematic reassessment of risk as outlined in trust policy. However, nothing in the records suggest this took place or that a structured assessment of risk was undertaken at subsequent appointments or at time of discharge in December 2009.

### *Comment*

*The lack of a systematic risk assessment in episode 2 is serious and clinically significant, not least because Dr R was identified as the lead professional and he became acutely aware of 'tension' between Mr A and his wife in August 2009. He was sufficiently concerned to initiate a social services referral but then failed to follow up any outcome with them when they had not provided feedback from their visit. This meant that critical questions such as whether a safeguarding referral was merited were never discussed with them. We discuss the safeguarding issue in further detail later in the report.*

**6.33** During the final episode of care in April 2010 Mr and Mrs A attended an outpatient clinic at the trust and were seen by a speciality doctor in psychiatry who was part of Dr R's team. Mrs A complained about a rapid deterioration in Mr A's mental state, cognitive functioning and behaviour. She told the doctor that Mr A was physically aggressive towards her while they were on holiday in Blackpool. Mrs A had reported an improvement in his behaviour since starting on quetiapine but he continued to be abusive towards her. It was also noted that he experienced occasional visual hallucinations, including seeing a dog in the house or seeing people upstairs when there was nobody there.

**6.34** The doctor saw Mr A display increasingly abusive behaviour towards Mrs A during the clinic appointment. Dr S recorded that Mr A's cognitive impairment was in the severe range and that she could not complete a MMSE because he was suspicious and irritable. She also described his comprehension as impaired and his mood as dysphoric<sup>1</sup>, though he denied suicidal thoughts or thoughts of harm to self or others. Dr S could not detect any delusions or hallucination during the assessment.

*Comment*

*Such a presentation should have led to a systematic assessment of risk but this did not take place. There is no record that Mrs A was interviewed separately from her husband to help with risk identification. More positively, an urgent phone request to social services in April was made which was appropriate and timely. Social services failed to provide feedback to the trust and the clinical team in the trust did not pursue them.*

**6.35** The trust did not identify the possible contribution of Mr A's complex medications to his mental state and behaviour as a specific risk factor in this period. In addition the GP made a number of changes to Mr A's medication between April and June 2010, stopping or reducing and then restarting or increasing several of them without consulting or informing the trust. Consequently the opportunity to work together on rationalising and monitoring the impact of medication to stabilise him and reduce risk was not taken.

**6.36** GP Q identified a serious and urgent risk and communicated this to the community mental health team on 24 June 10. It made particular reference to Mrs A's alarm over Mr A's behaviour. Clinical staff were unable to triage this information because an effective risk assessment and management process was not in place. The opportunity to make a reliable risk assessment as part of an emergency mental health assessment on the same day was missed. However, an appointment was made for the next day and Mrs A said she was happy with this.

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<sup>1</sup> Generalised feeling of distress

**6.37** Physical aggression was documented in Mr A's clinical record but without detail about its nature and extent. There is no evidence to show that a formal risk assessment took place using the trust's procedure.

*Comment*

*A formal risk assessment might have led to a mutually agreed risk management plan, aimed at clarifying and reducing any identified risks and outlining specific therapeutic strategies.*

**6.38** The trust investigation report also identified the lack of risk assessment and management plans. They recommended that steps should be taken to ensure that a risk assessment is completed for all cases and all information related to risk events is documented in the clinical notes in accordance with the CMHT and CPA policy.

**6.39** The trust has started a clinical peer review of the quality of care plans across community mental health teams measuring the quality of clinical risk assessments. With this in mind, we make no further recommendation in relation to risk assessment.

**Involvement and support for carers**

**6.40** Trust policy outlines that carers are those who support service-users. This might be on a short or long-term basis and may involve direct personal support. Trust policy recognises that carers often hold information that would improve a service-user's treatment and care plan and the trust welcomes appropriate information to ensure they are able to undertake their caring role better.

**6.41** Mrs A clearly met the trust's definition of a carer, as the trust acknowledged. Mr A's clinical records show that Mrs A was generally involved and supported by the trust while her husband attended outpatient clinic attendance. She was present and contributed information at most consultations. There is no indication to suggest that she was ignored or not offered support by medical staff.

**6.42** As highlighted earlier in this report, we found no evidence to suggest that Mrs A was consulted when Mr A was discharged from his first episode of care in November 2006.

*Comment*

***Consultation with Mrs A at this stage would have been important, at the least to see whether Mrs A could manage and check that she had received information and guidance about various support agencies and groups.***

**6.43** Mrs A was offered a carer's assessment during the second episode of care in September 2009 but she declined. The sons of Mr and Mrs A were interviewed as part of the trust investigation. They said Mrs A was worried about being means-tested and about having to sell the house if Mr A had to go into a home. Mrs A therefore was reluctant to receive help.

**6.44** Carers are not obliged to receive a carer's assessment. However, we found no evidence apart from the assessment offered in September 2009 of a continuing, concerted effort to find out Mrs A's needs as a carer. This mirrors the concerns of Mr and Mrs A's sons, who told the trust there was no identified individual the family could contact about their support needs and who would keep them up to date with their father's progress.

**6.45** The trust investigation acknowledges that Mrs A and her family did not receive all the support, advice and information necessary about their entitlements to social care.

**6.46** The trust has demonstrated since this incident that it has developed links with third-sector organisations to ensure that carers have better access to information, support and advice to help them make an informed decision about entitlements, help or support.

**Safeguarding Adults**

**6.47** We examined whether healthcare professions met the expected practice in relation to safeguarding adults policy.

**6.48** The safeguarding adults policy dated November 2009 says:

*“The term abuse/mistreatment is physical, sexual, psychological or financial. It may be intentional, unintentional that causes harm temporarily or over a period of time.”*

**6.49** The policy goes on:

*“Incidents of abuse should be reported on the same day to a line manager and the lead nurse for adult safeguarding.”*

**6.50** Mr and Mrs A went to see GP U in March 2010. Mr A became agitated and demanded his tablets. Mrs A was worried that he was going to hit her. The GP requested an urgent outpatient appointment. This was an appropriate response. There is no evidence though to show whether GP U considered talking to Mrs A alone to discuss her concerns or whether he considered making a safeguarding referral.

**6.51** Old-age psychiatrists should be familiar with the possibility of relationship breakdown where either party can lose self-control when one has dementia. Mrs A told Dr S in April 2010 that Mr A had been physically aggressive to her during a holiday in Blackpool. Arrangements should have been made to meet Mrs A on her own so that her concerns could be clarified and discussed in more detail. If she was subject to abuse she would have been unlikely to mention it in the presence of her husband. Once the details were clarified, this should have been reported to the lead nurse for safeguarding so she could consider whether the degree of aggression justified a referral and/or any intervention. Dr S did make a referral to social services though which was appropriate in these circumstances.

**6.52** A social worker and a social care assessor visited Mr A at home on 16 April 2010. The social worker spoke to Mrs A alone about any mental or physical abuse by Mr A. The social worker said Mrs A denied any abuse and described Mr A as “nowty”. Social services carried out the visit in a timely manner but they did not tell Dr S, who in turn failed to chase them up for feedback.

**6.53** The trust’s joint investigation highlighted that medical staff may not have been aware of the trigger points for a referral to the safeguarding team. The report outlined

that any suspicions of abuse should be reported. Although this issue is raised there is no recommendation in the report to ensure that this issue is taken forward.

**6.54** As part of this investigation the trust's safeguarding lead was interviewed. She told us she had responsibility for safeguarding across the health community. She explained that mandatory safeguarding training including refreshers was now in place. All clinical staff attended the training and received a refresher every three years.

### *Recommendation*

**R2** All clinical staff including consultant psychiatrists' specialist registrars and GP's should recognise trigger points for safeguarding referrals and ensure that appropriate referrals are made.

### **The older person's community mental health team**

**6.55** The trust's operational policy for older adults says:

*"When a referral to the community mental health team takes place, the team manager or a nominated other should ensure that all necessary information including risk factors, are gathered from the referring agent and others who may be involved in the service users care, prior to allocating to a team member for assessment"*

**6.56** The policy also outlines that if an urgent referral is made, face-to-face contact with the service-user should be made within 48 hours.

**6.57** GP U phoned the community mental health team on 31 March 2010 after Mrs A had told him about Mr A's aggression while on holiday in Blackpool. GP U spoke to the team secretary and asked for an urgent appointment. There is no record in the clinical notes showing that the team secretary referred the case to the team manager or duty worker so that they could gather any risk factors and all other necessary information as outlined in trust policy. The team secretary made an outpatient appointment for Mr A to see Dr S the speciality doctor on 8 April 2010.

## *Comment*

***This date does not meet the response timescale of a face-to-face contact within 48 hours as outlined in trust policy.***

**6.58** GP Q spoke to the team secretary at the community mental health team on 24 June 2010 and asked for an urgent review of Mr A. The team secretary arranged for Mr A to see Dr R the next day. There is no evidence in the clinical records though to demonstrate that other members of the team such as the team manager or the duty worker were involved or that anyone from the team gathered all the necessary information about Mr A before he was scheduled to be seen.

**6.59** The trust's joint investigation concluded that roles and responsibilities in the older person's community mental health team were not clearly understood by all members of the team. The investigation report included a recommendation that all CMHT workers should receive a flow chart of the referral pathway. A further recommendation was made for team managers to undertake an audit of referrals to determine whether the correct pathway had been followed. More recently, further development has taken place and the trust is in the process of redesigning community mental health teams and the care-pathways. The transitional arrangements outline the need to make sure that clear roles and responsibilities are key during this period of change. Documentary evidence states that the trust has a robust impact assessment, evaluation and monitoring process as part of the service redesign, which is reported to the trust's board of directors.

## **Cheshire East Independent Living Team**

**6.60** Dr R referred Mr A to the Cheshire East independent living team during the second episode of care. The independent living team phoned Mrs A. They offered her a carer's assessment but she decided not to have one. They discussed the possibility of Mr A attending day centre. Mrs A was also given contact details for Age Concern. The independent living team did not provide feedback of this contact to the referrer.



### *Comment*

***This was the first referral to the independent living team and therefore face-to-face contact should be standard practice.***

**6.61** A social worker and a social care assessor visited Mr A at home during the last episode of care. They carried out a community care assessment and Mrs A was interviewed. She denied any abuse. She was offered the use of a Telecare Pendant and Information about the Alzheimer's Society. Respite care was also offered, but Mrs A refused it. Arrangements were made for Mr A to attend a day centre.

### *Comment*

***The independent living team responded appropriately to this referral but did not provide feedback to the lead professional (Dr R) or the community mental health team on this occasion either.***

**6.62** The trust investigation recommended that all community mental health teams and local authority community teams should establish mechanisms for providing feedback after a referral to either organisation/service. Team managers have met with local authority team managers to establish the agreed forms of communication.

**6.63** An audit of case files has been undertaken to monitor feedback mechanisms. As indicated previously, the trust is redesigning community mental health teams and the care-pathways. This issue is being monitored throughout the service redesign.

### *Recommendation*

**R3** Cheshire East independent living team should ensure that service-users are seen in person on their first referral to reduce any limitations in assessment.

## 7. The trust's internal investigation and progress made against the recommendations

7.1 The terms of reference for this investigation include assessing the quality of the internal investigation and reviewing the trust's progress in implementing the action plan.

7.2 In this section we examine the trust's incident policy and whether its investigation into the care and treatment of Mr A complied with it.

### Reporting of serious incidents

7.3 The trust's incident reporting policy (April 2007) says:

*“Following some incidents, for example a homicide, it may be necessary to hold an internal inquiry. These will have an inquiry team, appointed by the Executive team and will include an executive director. No members of the inquiry team should be directly involved with the service in which the incident occurred. The Terms of Reference need to be agreed with the Director of Nursing, Therapies and Patient Partnership and the Strategic Health Authority. The Inquiry Report will be approved by the Trust Board.”*

7.4 Documents the trust provided show it commissioned and led a joint investigation into the care and treatment of Mr A with Cheshire East Council and Central and Eastern Primary Care Trust.

### Terms of reference

- *“Examine all circumstances surrounding the treatment and care of Patient A up to and including 24.06.2010.*
- *“Examine the extent to which care complied with the statutory obligations, national guidelines and local policies which will include the following processes;*

*referral, assessment, care planning, communication and the links between statutory services and professionals.*

- *“To determine whether individuals were acting within their areas of responsibility and competency.*
- *“To review the standard of note keeping against professional and local guidelines.*
- *“To consider any relevant issues that emerge as part of the analysis including any specific issues raised by family, if appropriate.*
- *“To examine the risk assessments completed and determine whether the response to identified risks (including risks to self and others) was appropriate and in line with statutory obligation, medical guidelines and local policies.*
- *“To review the management of Mr A’s medication in line with NICE guidelines, BNF and clinical best practice.*
- *“To establish whether there are lessons to be learned from the circumstances of the case about the way in which local professionals and agencies work together to safeguard vulnerable adults.*
- *“Identify areas of good practice and shared learning across all agencies.*
- *“Prepare a report and make recommendations for the trust and partner organisations of any changes to local policies or procedures that are required to reduce the risk of future incidents.”*

**7.5** The terms of reference were shared with Mr A’s sons to ensure that the investigation took into account any matters they wanted addressed.

**7.6** The trust commissioned a joint investigation into the care and treatment of Mr A. The terms of reference were clear and an executive lead was appointed. These actions met the requirements of the trust’s incident reporting policy.

## Recommendations and action plans arising from the trust's internal investigation

**7.7** In this section we look at the trust's progress in implementing the action plan resulting from the internal investigation report.

**7.8** The report identified several areas that needed improvement and made seven recommendations:

1. *"The role and responsibilities of the duty worker should be understood by all members of the Community Mental Health Team.*
2. *"The agreed template for outpatient clinic letters should be used by all medical staff to ensure that all areas are explored and communicated to GP's and others involved in the care.*
3. *"All CMHTs and Local Authority Community Teams should establish mechanisms for providing feedback following a referral to either organisation/service.*
4. *"All authorised prescribers have a responsibility to ensure they are aware of all medications that an individual may be taking and seek advice from an appropriate qualified individual if further clarification is required.*
5. *"All staff working with older people and their carers should consider the cultural beliefs and understandings of this generation in relation to the welfare state, benefits and social care entitlements. Where appropriate staff should draw on the expertise of third sector and voluntary organisations to achieve this.*
6. *"All information related to risk events must be documented within the clinical notes and in accordance with the CMHT and CPA policy.*
7. *"Carenotes4 should have the facility of "shut down" following an incident to ensure that clinical notes are not entered post incident."*

**7.9** The trust developed an action plan to take forward the recommendations. We asked for evidence to show it had followed them through.

**7.10** Appendix B shows a table outlining the progress that the trust has made against each recommendation.

**7.11** The trust carried out a joint investigation in line with trust procedure. The report highlighted eight recommendations. An updated action plan was provided as part of our

investigation, this shows that as of January 2013 all eight recommendations have been implemented. The action plan is included in full in appendix B.

*Comment*

*The trust carried out a joint investigation into the care and treatment of Mr A in line with policy and procedure.*

*The trust has provided evidence that all the recommendations have been put in place.*

### Team biographies

#### Chris Brougham

Chris is one of Verita's most experienced investigators and has conducted some of its most high-profile mental health reviews. In addition to her investigative work, Chris regularly advises trusts on patient safety and supports them in carrying out their own systematic internal incident investigations. As head of training, Chris has developed and delivered courses on different aspects of systematic incident investigation. She has held senior positions at regional and local level in the NHS, including director of mental health services for older people. Chris heads Verita's office in Leeds.

#### Peter Jefferys

Peter is an experienced consultant old age psychiatrist and former trust medical director. He is currently a non-executive director for Norfolk & Suffolk NHS Foundation Trust. He has investigated unexpected mental health deaths for district and regional health authorities, the Mental Health Act Commission and CQC as well as conducting extensive suicide audits. He is a former advisor to the Parliamentary and Health Services Ombudsman, chairs MPTS (GMC) Fitness to Practice Panels and serves on mental health review tribunals.

## Appendix B

### Progress made by the trust on the recommendations from the trust internal investigation report

Recommendation	Actions	Implementation by:	Target date for completion and progress of action	Progress as of January 2013
The role and responsibilities of the duty worker should be understood by all members of the Community Mental Health Team.	All CMHT workers will be presented with the flow chart as part of supervision. Team managers to undertake an audit of referrals to determine whether they have followed the correct pathway.	General Managers  Community Mental Health Team Clinical Network	July 2011 <b>Action completed 19/04/2011</b>	The Trust is in the process of redesigning CMHT and the care-pathways. Having clear roles and responsibilities outlined is a key part of the transitional process. There is a robust impact assessment, evaluation and monitoring process put in place as part of the service redesign, which will report to the Board of Directors.
The agreed template for outpatient clinic letters should be used by all medical staff to ensure that all areas are explored and communicated to GP's and others involved in the care.	An audit of the out patient clinic letters to be undertaken. Individual's performance that falls short of the expected standards will be addressed via supervision.	Clinical Director for Adult Mental Health Clinical Service Unit	Dec 2011 <b>Action completed 08/02/2012</b>	This has been identified as a re-audit and therefore continues to be part of the clinical audit programme. Re-audit is in progress and will also review quality of content as well as the use of the agreed template.

Recommendation	Actions	Implementation by:	Target date for completion and progress of action	Progress as of January 2013
All CMHTs and Local Authority Community Teams should establish mechanisms for providing feedback following a referral to either organisation/service	<p>Team managers to meet with Local Authority team managers to establish the agreed forms of communication.</p> <p>Undertake an audit of case files that have involvement from both agencies to check that this has been embedded in practice.</p>	Community Mental Health Team Clinical Network Team Managers	April 2011 <b>Action completed 17/05/2011</b>	The Trust is in the process of redesigning CMHT and the care-pathways. Having clear roles and responsibilities outlined is a key part of the transitional process. There is a robust impact assessment, evaluation and monitoring process put in place as part of the service redesign, which will report to the Trust Board.
All authorised prescribers have a responsibility to ensure they are aware of all medications that an individual may be taking and seek advice from an appropriate qualified individual if further clarification is required.	<p>To develop a standardised clinic leaflet for service users this will include a request to bring an up to date list of medication that they are taking to their appointment.</p> <p>Clinical appointment letters to include a request for service users to bring their current medication with them to the appointment.</p>	Associate Medical Director of Quality, Compliance and Assurance.	May 2011 <b>Action completed 23/04/2012</b>	The Trust has developed a series of Medicines Management Always Events, which are quality standards which should always happen. This includes standards around patient information. This is in addition to checks as part of a medicines management clinical audit programme and an annual Trust-wide clinical audit of medicines management as part of the clinical audit programme.
All staff working with older people and their carers should consider the cultural beliefs and understandings of this generation in	Community Mental Health Teams to develop links with third sector organisations to ensure service users and carers have access to support, advice and information when deciding about input from either health and/or social care.	General Managers	July 2011 <b>Action completed 17/05/2011</b>	The Trust is in the process of redesigning CMHT and the care-pathways. Having clear roles and responsibilities outlined is a key part of the transitional process. Key to this is how teams link to other health and social care and



Recommendation	Actions	Implementation by:	Target date for completion and progress of action	Progress as of January 2013
<p>relation to the welfare state, benefits and social care entitlements. Where appropriate staff should draw on the expertise of third sector organisations.</p>				<p>third sector organisations.</p>
<p>All information related to risk events must be documented within the clinical notes and in accordance with the CMHT and CPA policy.</p>	<p>To confirm via the results of the annual Care Programme Approach audit and Care Plan audit.</p> <p>Team Managers/Clinical Directors must review practitioners' case notes as part of clinical supervision</p>	<p>General Managers</p> <p>Clinical Service Managers</p>	<p>January 2011 <b>Action completed 20/03/2012</b></p>	<p>CPA performance targets are monitored internally and via commissioners.</p> <p>The Trust has commenced a Community Safety Metrics programme which is a clinical peer review of the quality of care plans across community mental health and learning disability teams measuring the quality of clinical risk assessments and care planning, and ensuring that care planning reflects risk.</p> <p>Supervision is also monitored on a regular basis.</p> <p>All of the above is reported to the Board and the Trust's Quality Committee as a component of quality governance monitoring.</p>

Recommendation	Actions	Implementation by:	Target date for completion and progress of action	Progress as of January 2013
Carenotes4 should have the facility of “shut down” following an incident to ensure that clinical notes are not entered post incident.	Raise with the associate Director of Informatics as part of Carenotes version 4 developments.	Information Governance Committee	March 2011 <b>Action completed 21/03/2011</b>	This was addressed as part on ongoing clinical systems reviews, which continue.

### Criteria for CPA and non CPA (standard) taken from trust CPA policy

#### CPA criteria

Characteristics to consider when deciding if support under the Care Programme Approach (CPA) is needed.

The list is not exhaustive and there is no minimum or critical number of items on the list that should indicate the need for CPA:

1. Severe mental disorder (including personality disorder) with high degree of clinical complexity;
2. Current or potential risk(s), including:
  - Suicide, self harm, harm to others (including history of offending);
  - Relapse history requiring urgent response;
  - Self neglect/non concordance with treatment plan;
  - Vulnerable adult; adult / child protection e.g.:
  - Exploitation e.g. financial / sexual;
  - Financial difficulties related to mental illness;
  - Disinhibition;
  - Physical/emotional abuse;
  - Cognitive impairment;
  - Child protection issues.
3. Current or significant history of severe distress / instability or disengagement
4. Presence of non-physical co-morbidity e.g. substance / alcohol / prescription drugs misuse
5. Multiple service provision from different agencies, including: housing, physical care, employment, criminal justice, voluntary agencies.
6. Currently / recently detained under Mental Health Act or referred to crisis / home treatment team. Subject to Community Treatment Order or Guardianship.

7. Significant reliance on carer(s) or has own significant caring responsibilities
8. Experiencing disadvantage or difficulty as a result of:
  - Parenting responsibilities;
  - Physical health problems / disability;
  - Unsettled accommodation / housing issues;
  - Employment issues when mentally ill;
  - Significant impairment of function due to mental illness;
  - Ethnicity (e.g. immigration status; race / cultural issues; language difficulties, religious practices)
  - Sexuality or gender issues.

#### **Non - CPA / standard care**

For those service users who do not require the support of the CPA they will be covered under standard care. These service users will have more straightforward needs and contact with one agency or no problems with access to other agencies / support.

They will be allocated a lead professional who will support them.

The service user will require a full assessment of their health and social care needs, including a trust recognised risk assessment.

They will have a plan of care that is recovery focused and has been developed with the service user and their carer.

The care plan will be reviewed as and when required, up to a maximum of annually.

For service users who only have contact with a consultant psychiatrist their care plan and risk assessment will be contained in their outpatient letter.

The documentation of the plan of care may be a clinical / practice note, or a letter. Good practice still requires a copy to be given to the service user and the GP, and should provide a clear understanding how care and treatment will be carried out and by whom.

A care review document must be completed on CareNotes for each review and a new care review must be commenced to plan the next review.

For service users on standard care there should be on-going consideration of need for CPA if risk / safety issues or circumstances change.

### Documents reviewed

#### Internal reports

- Internal investigation into the care and treatment of Mr A
- Transcripts of internal interviews
- Action Plan following internal report
- Reflective review
- Internal investigation report

#### Medical records

- Mr A's clinical records
- Mr A's GP records

#### Policies and procedures

- Older Peoples CMHT duty rota - July 2010
- Older People CMHT operational procedure - July 2007
- Safeguarding adults policy - May 2009
- CPA policy - January 2009