Shared learning bulletin

An independent investigation into the care and treatment of SV

Introduction

This document provides an overview of the findings from an independent review to identify learning from a patient’s mental health care and treatment. Agencies and teams who might benefit from this bulletin include: NHS England, Integrated Care Boards (ICBs), adult community and inpatient mental health services and GP/primary care teams.

Case background

SV had been under the care of a Trust since he was 27 years old, when he was informally admitted to a psychiatric inpatient unit. He was initially diagnosed with a drug induced psychosis and was discharged after his condition improved.

SV was later diagnosed with paranoid schizophrenia and was treated with antipsychotic oral and depot medication. He was readmitted to hospital three years later under Section 2 of the Mental Health Act (MHA), and after discharge remained under the care of secondary mental health services for treatment.

Following a deterioration in his mental health he was cared for by a recovery team. At this time SV was 44 years old and was living with his mother after his relationship broke down and he had become homeless. He was allocated a flat of his own the following year, but the transition to take up residence became problematic. Trust staff were aware of his housing situation and of his mother’s concerns about SV’s behaviour and presentation.

There were times when SV was threatening to his mother and assaulted her on two occasions. SV’s mother had contacted the police to say that he was behaving in a threatening manner and would not leave her house. She said he had been calling her names and threatening to go out and stab someone. She said she was not frightened for herself, but she was worried for the safety of others.

Later that same year, SV telephoned the police to report that his mother had attacked him with a knife. When the police arrived, they found his mother deceased.

After his arrest SV told the treating psychiatrist that he heard voices on the day of the offence, urging him to kill his mother, and that he was suffering from delusions and hallucinations.

Key findings

Care planning

- The care provided to SV was not in accordance with NICE guidance for people with paranoid schizophrenia who were in recovery, especially in the areas of psychoeducation, psychological interventions, medication, and family and carer involvement.
- Care plans were not substantially reviewed for at least two years. There was a lack of detail, purposeful intervention and any sense of service user or carer involvement. The plans did not include early warning signs of deterioration.
- The service approach to his anxiety, his lack of coping skills and to his substance abuse had substantial gaps.
- The issues surrounding his reluctance to move out of his mother’s house were not discussed or examined with SV, by services.
- SV had rarely lived on his own, his ability to function had declined, and he had difficulties managing money. While he was frequently told to use his initiative by moving into a flat, he demonstrated his difficulty with initiative through his inertia and lack of motivation - often features of schizophrenia.
- There were no meaningful time scales set for review and no outcome measures for his care plan or treatment.

Key findings (cont.)

- The relapse prevention strategy relied on the expectation that his mother would monitor how he was presenting.
- SV's medication was an important focus for SV and his mother, and they frequently asked for changes to be made to his prescriptions. There was a lack of focus on the effectiveness of the medication and on the management of side effects.
- In addition to concerns about his risk profile, there were clear problem areas: psychosis (paranoid schizophrenia); anxiety and depression; issues with coping (which some interpreted as personality disorder); harmful substance misuse; and, being homeless. These areas were not systematically addressed during the process of assessment, care planning or review.
- SV and his mother were given access to support from a range of professionals, with the notable exception of a social worker, an advocate or carer support worker. There are concerns about the structuring and coordination of that professional network, and the roles that were undertaken. SV and his mother reported a sense of isolation within the care system, and there was increasing use of emergency service contacts.
- Quality assurance systems in the Trust did not identify the inadequacies of the care plans.

Risk assessment

- The risk assessments completed for SV did not meet policy expectations, were of inadequate quality and did not accurately reflect the risk. Actual risk events were not explored and were not included in the risk assessments.
- There is no evidence that risks were discussed in multidisciplinary team (MDT) meetings. The psychiatrist who saw SV in clinics did not attend the recovery team MDT meetings. This meant that risk incidents involving SV and his mother were not discussed in clinics, and decisions were made by the psychiatrist without knowledge of, or reference to, SV's recent history.
- There was no meaningful assessment of the risks SV posed to his mother. This assessment should have included spending time with his mother to listen to and try to understand her perspective.
- An explanation should have been sought for the decrease in his ability to function, and for what factors might have been preventing his recovery. A systematic recovery-based approach to care would have helped address these issues.
- Safeguarding concerns were identified but were not acted on. Two main areas were identified: it was suspected that SV's mother was controlling him financially and in other ways; and the risks to his mother's safety from SV were known. Both areas of concern should have been referred to safeguarding structures as safety or welfare concerns for SV or his mother. This did not happen.
- Crisis and contingency plans were inadequate and involved SV and his mother calling crisis or out-of-hours services. When frequent calls were made, they were labelled as too frequent and as "inappropriate help seeking".
- We found no evidence that an assessment of the harm SV posed to himself was completed, despite his escalating use of NHS 111 and emergency departments when in crisis. No discernible effort was made to understand the factors that influenced SV to take overdoses or present in a crisis.
- Despite the national evidence base about the potential dynamics and risks from sons with psychosis, no thorough assessment and formulation of the risks inherent in the living arrangements of SV and his mother was carried out. Staff continued to characterise the difficulties as relationship issues between the two.
- Quality assurance systems in the Trust did not identify the inadequacies of the risk assessments and management plans.

Key findings (cont.)

Discharge planning

- The Care Programme Approach policy in place at the time did not provide detailed guidance about the process to follow when discharging someone from community mental health services.
- The recovery team failed to clearly communicate possible discharge plans with SV or his mother. Their views were not sought before, during or after a complex case meeting, which is when the decision to discharge SV was made. There was no formal review of the available outcome measures, namely, the previous Health of the Nation Outcome Scales (HoNOS) scores, to see if treatment was having a positive effect on SV.
- Guidelines for positive risk-taking were not used effectively. This was an opportunity to fully explore the potential risks involved in discharging SV from the recovery team and to discuss the potential pitfalls, early warning signs and safety nets.
- A revised HoNOS was carried out, but there was no documented review of the issues arising in this assessment being used in the discussion about SV's discharge or future plans.
- SV's entitlement to Section 117 MHA aftercare was not discussed either with him or at the complex case meeting. We found no evidence that this entitlement was reviewed or formally discontinued. Therefore, SV should not have been formally discharged from mental health services without due consideration of Section 117 MHA aftercare entitlement.

Interservice liaison and communication

- The links between the mental health care provided by the GP (during depot clinics) and the overall mental health care plan were weak. There was a lack of information sharing about risk and challenges.
- Involving an adult social care perspective from within the MDT could have helped explore the underlying reasons for SV's refusal to move to his new flat.
- Contacts with emergency services led to concerns in the primary care system. However, these concerns were not communicated clearly to mental health services and no interservice approach was in place to address these emerging concerns.

Family involvement

- The recovery team made assumptions about his mother's role in SV's care, which were not clarified or agreed with her. Statements his mother made about not wanting to be treated as his carer were not explored.
- Without considering the possible effects on her own health or their relationship, his mother was included in SV's care plans and in the monitoring of his mental health and medication.
- It was assumed that because SV's mother was present in meetings, she was being consulted. In fact, she was not given time to share her perspective or her concerns about the situation.
- It would have been helpful to have structured patient and carer feedback on SV's progress. This could have been facilitated using a collaborative tool such as the Recovery Star.
- Opportunities to safeguard both SV and his mother were missed. Some of these missed opportunities were serious risk situations.
- The service did not have routine access to carer support or advocacy, so this was not available to SV or his mother.
- Care coordinators were not trained in family engagement, and there was no policy guidance to guide practice.
- The recovery team viewed the situation between SV and his mother through a negative lens. They did not use a family-focused framework to gain a better understanding, nor did they refer to best practice guidance, such as that on expressed emotion.

Key findings (cont.)

- After his mother's death, duty of candour expectations were not met. The Trust also made the decision not to carry out an internal serious incident investigation, because a Domestic Homicide Review (DHR) was commissioned.
- The Trust policy used duty of candour and Being Open interchangeably, which is incorrect.

Current services

- There is now a detailed Patient, Service User and Carer Involvement and Engagement Strategy in place. The Trust has an action plan for implementing and reviewing this strategy, but it is beyond our scope to assess the progress of this implementation.
- Although there is a system of satisfaction measures in place in community mental health services, there are no meaningful outcome measures.
- There are plans for adult inpatient and community mental health services plan to implement the Triangle of Care.
- Current quality audits are not detailed enough to provide proper assurance about the quality of care plans and risk assessments.
- There is no evidence of a system being in place for reviewing the quality of care plans and/or risk assessments for patients on an individual staff member's caseload. The format of MDT meetings and the documentation of the discussions are not standardised across community mental health teams.
- Current assessments of the risk a person poses to others, particularly to family or carers, are limited by the approach outlined in the policy, which is a "tickbox" approach to risk assessment instead of a formulation of risk (see our recommendation for clinical risk assessment, recommendation 4).
- There is an assurance process which shows that the Trust has systems in place and is now meeting the expectations of the duty of candour regulation.
- Approaches to the review and investigation of serious incidents have evolved positively and are now in line with the expectations of the NHS England Patient Safety Incident Review Framework (PSIRF), including training in family engagement.
- The community mental health service transformation is a system-wide change, which is currently in progress. Quality indicators are being embedded into new services and approaches. It is beyond our scope to comment on these, but we would expect feedback on the quality of engagement with families in care to be part of this process.

Recommendations

Integrated Care Board recommendations

Recommendation 1: Information sharing

The links between the mental health care provided by the GP (during depot clinics) and the overall mental health care plan were weak. There was a lack of information sharing about risk and challenges.

The Integrated Care Board, GP practices and the Trust should agree information sharing protocols for risk information when mental health care is provided in primary care. This should include how to respond when someone is identified as frequently attending emergency services and who is also under the care of mental health services.

Trust recommendations

Recommendation 2: Discharge policy

There is no policy guidance about discharge from community mental health services.

The Trust should provide clear policy guidance and protocols for discharge processes. They should include references to the Section 117 MHA aftercare policy.

Recommendation 3: Quality of care plans

Quality assurance systems in the Trust did not identify that care plans were not recovery-focused or outcome-based.

The Trust must develop systems that provide robust oversight of the quality of care plans and interventions. This should include processes which:

- Track care plans against assessed need, and that are developed with both service user and carers.
- Check that care plans are recovery-focused and outcome-based, and include clear evidence-based interventions.
- Ensure outcomes are measured and are used in forward planning.

Recommendation 4: Clinical risk assessment

Quality assurance systems in the Trust did not identify the inadequacies of the risk assessments in this case.

- The Trust must review its approach to clinical risk assessment and management, in particular to ensure that it has set out the appropriate governance oversight of the quality of practice (including audits of quality and clinical supervision arrangements).
- Clinical supervision sessions should give practitioners the opportunity to reflect on recent risk assessments and to share any difficulties they experienced completing them.
- The Trust should examine how easy it is both for staff working remotely and in offices to access historical risk information and incorporate any findings into a new system or guidance. It should identify barriers staff experience when completing them, including any challenges with using electronic patient records and any resource challenges. Learning from this audit should be built into new guidance.
- The Trust should complete its work to introduce an electronic audit system to support monitoring the quality of a range of safety and quality issues, including risk assessment.

Recommendation 5: MDT working practices in community mental health

Approaches to MDT meetings and the documentation of discussions were not standardised across community mental health teams. This meant that key risk information was not readily available at outpatient clinics, and medical staff were not always given the opportunity to discuss patient care in MDT meetings.

The Trust must implement standard approaches to the working practices of community mental health MDTs. They should use the learning from this review.

Recommendation 6: Family/carer involvement

There was a lack of focus on the experiences of family and carers. There was no discussion of what the role of carer meant and a critical lens was used to view interactions.

The Trust must review and clearly set out its strategic approach to engaging and involving patients, service users and carers including:

- How it is agreed who will be a carer, how carer assessments are managed, systems for listening to carers, and clarity and guidance on whether families are expected to monitor progress.
- Training in engagement and an understanding of the effects on family members of people with serious mental illness, including expressed emotion and housing problems.
- Safeguarding and the risk of domestic abuse.
- Psychoeducation, medication, risk to others, discharge planning and understanding a person's right to aftercare under Section 117 MHA.
- Meaningful outcome measures.

Recommendation 7: Duty of candour

The Trust policy uses duty of candour and Being Open interchangeably.

The policy should be revised to clarify that they are distinct and have different accountabilities and responsibilities.

Recommendation 8: NICE guidance for psychosis and schizophrenia

There was no evidence that care provided for a service user with chronic psychosis was in line with the NICE clinical guideline, Psychosis and Schizophrenia in Adults.

The Trust must ensure that best practice guidance for the prevention and management of psychosis and schizophrenia in adults is implemented.

Recommendation 9: Trust developments

We suggest that the Trust reviews the learning from this investigation to ensure that the transformation and the Patient, Service User and Carer Involvement and Engagement Strategy cover the issues highlighted.

Learning Quadrant

Individual/team practice

- Have I/we developed care plans that are recovery-focused and outcome-based with the service user and carers?
- Is there an opportunity to reflect and share any difficulties experienced in clinical supervision sessions?
- When working remotely and in offices, can I/we access historical risk information?
- Have I/we engaged and involved families and carers appropriately and focused on their experiences?
- When involving families and carers, have we considered the possible effects on their own health and their relationship with the patient?
- Have I/we considered whether it is appropriate for families and carers to monitor a patient's mental health and medication?
- Am I/we clear that duty of candour and being open have different accountabilities and responsibilities?
- Do I/we follow best practice guidance for the prevention and management of psychosis and schizophrenia in adults when appropriate?
- Have I/we focused on the effectiveness of a patient’s medication and the management of its side effects?

Governance focused learning

- Are we assured risk information is shared with all professionals involved?
- Is there clear policy guidance for discharge processes that includes references to the Section 117 MHA aftercare policy?
- Are we assured staff access clinical supervision and that it’s effective?
- Are we assured staff working remotely and in offices can access historical risk information? Is there guidance for staff to follow?
- Does policy guidance on risk assessment include the expectation of gathering collateral information from families?
- How are we assured service users, families and carers are engaged and are appropriately involved in care planning?
- Have we provided training on family engagement and understanding the effects on family members of people with serious mental illness?
- Are we assured Trust policy is clear that duty of candour and Being Open have different accountabilities and responsibilities?
- Are we assured NICE guidance for the prevention and management of psychosis and schizophrenia in adults is implemented?

System learning points

- As an ICB, do we have assurance from the Trust Board that there is there an agreed protocol between primary and secondary services for sharing risk information?
- Do we have a strategic approach to engaging and involving patients, service users and carers in mental health services?
- Are we clear on the basis for how patient deaths are investigated alongside safeguarding or domestic violence reviews to ensure that the learning for the NHS is picked up?

Board assurance

- Do we have sufficient quality oversight and monitoring processes to provide assurance that we are undertaking high quality risk assessments and care plans?
- How are we assured that families and carers are engaged and are appropriately involved in care planning?
- How are we assured that discharge processes are robust?
- Are we assured the Patient, Service User and Carer Involvement and Engagement Strategy incorporates the learning from this investigation?