PE1604/N

NHS Dumfries and Galloway Letter of 28 October 2016

The following is the response of NHS Dumfries and Galloway to the questions you have raised in considering the above petition.

Question 1. What measures are in place to provide protection for the health and safety of patients released under CTO?

The Mental Health Directorate has a number of measures in place to ensure effective communication between inpatient and community based teams, and ultimately provide a smooth and structured transition from hospital to community care.

We have a specific Admission Discharge and Transfer Policy, which guides our discharge planning. This helps to ensure best practice around discharge processes. The Policy is currently under review and an updated version is due for release soon.
No patient should be discharged from in-patient care without a multidisciplinary discharge planning process having been undertaken. The occasional exception to this rule may include patients who self-discharge against medical advice, and who are not deemed suitable for detention, however, even in these cases, a post-hoc discharge management discussion with relevant parties should take place. It is certainly the case that all patients detained under a Compulsory Treatment Order (CTO) should have been involved in an extensive multidisciplinary discussion. This discussion will normally have involved the patient's inpatient nursing team, medical team, psychologists and other relevant allied health professionals; the patient's Mental Health Officer and other relevant members of the social care team; the patient's community mental health team; housing and other support services; and most importantly, the patient himself or herself and appropriate members of the patient's family. During this discussion discharge objectives, timing, and follow up arrangements are agreed.

It is increasingly the case that patients requiring community based CTOs will be supported through the Care Program Approach (CPA). At present, the decision to include the patient in CPA case management is a clinical one, based on complexity of need, but the revision to our CPA policy is likely to require that all patients on a Community based CTO will be case managed through the Care Program Approach. The CPA system has the advantage that it requires structured follow up, care planning, and risk management through a multidisciplinary case review and standardised process. Our CPA documentation currently uses a traffic light system which gives the opportunity to provide more detail and planning into how to identify and manage a period of deterioration or crisis.
Those patients detained under a CTO, but who are not managed through the Care Program Approach will still receive regular multidisciplinary case reviews following discharge. This will monitor the patient's progress and review the Risk Assessment and other aspects of manangement.

The patient will have been included in care and treatment planning. This inclusive care planning is commenced at the onset of the inpatient stay, and continues in the lead up to, and following discharge. The care plan will identify who is involved in the persons care and treatment and will be written in a recovery focused way. It allows the patient to be involved in setting the objectives and guiding the delivery of care in a patient centered way. It also forces clarity and transparency in the way our care is planned and delivered.

The use of Immediate Discharge Summaries (IDS) and an electronic case records system (eCasenote (eCN)) also ensure timely communication about discharge. As a result of the introduction of electronic Immediate Discharge Summaries, a notification of the basic details of the admission, and the patient's discharge arrangements are immediately available to the patient's primary care providers, and also the patient's community mental health team at the time of discharge. This has effectively stopped the previous concerns regarding community based care providers being unaware that their patient had been discharged because of a delay in receiving written notification. The electronic record system that is used in inpatient care (eCasenote (eCN)) is now instantly available to the community team and acute care services. Unfortunately, primary care services continue to use a different electronic system, and do not yet have 'read access' to our eCN records.

Following discharge, the patient's day-to-day support and follow up is normally carried out, and coordinated through the community mental health nursing service in conjunction with the patient's RMO consultant psychiatrist, and Mental Health Officer social worker. These three professionals form the core of the multidisciplinary team managing those patients discharged while detained on a CTO.

During the patient's admission, a Community Mental Health Nurse (CMHN) will be allocated and will work to establish a rapport with the patient in the lead up to discharge, and will largely coordinate care following discharge. This will include tailored community contact, social support and the administration of medications if necessary. The CMHN will also communicate with the RMO about the progress of the patient and will often support the patient in attending mental health out-patient medical appointments.

Risk is reviewed at each contact, in both both in- and out- patient settings, but if there are no identified changes to risk the risk assessment document is updated at a maximum interval of 6 months. Directorate risk assessment policy and procedures are currently being updated. Regular reviews will be scheduled (frequency determined by patient need) and the named person, family and carers will usually be invited to participate and contribute.

Medication is prescribed as per policy and treatment decisions are discussed with the person. There are different systems in place to provide safety monitoring for patients on specific medications or on high dose safety monitoring. Some teams are working towards a clinic model while others are monitoring on an individual basis.

Patients will have opportunity to discuss health and lifestyle issues and may be given support, dependent on need, to schedule or even attend GP/dental/ hospital appointments. Patients are often referred or signposted to Smoking cessation services and this should always be considered if smoking is known to impact on treatment efficacy (e.g. Clozapine). Patients have been supported in the past to attend for ECGs, smear tests etc. Patients are given health information dependent on identified need (e.g. diabetes or other long term conditions) but teams have also been looking at how to build physical health awareness, information and monitoring into routine visits to ensure inclusion in care plan before physical health deteriorates.

Housing needs are usually identified before discharge and patients are discharged to a 'stable' address but it is recognised that many other factors can impact on housing and community staff (including the patient's MHO) may involve housing or other support agencies to maintain housing stability. Patients are often given information about benefits/ budgeting or debt and regularly use local agencies to work alongside patients to ensure financial 'health checks' or debt advice.

At times when the patient may be experiencing a relapse in symptoms, the level of contact with the community nursing team will increase, and there may be a requirement to engage our crisis team, the Crisis Assessment and Treatment Service (CATS). CATS can provide a short term intensive out-patient or home based support to patients experiencing significant relapse in mental health symptoms, and where hospital admission may be otherwise necessary.

2. The following is an explanation of the process of investigation that is carried out for any patient who commits suicide while receiving care from mental health services, or having recently received care from mental health services.

Upon receiving notification of the suicide of any person who has been receiving care within NHS Dumfries and Galloway Mental Health Services the case is brought to the attention of Dr David Hall, in his role as Associate Medical Director for Mental Health Services, or Dr Fraser Gibb in his role as Chair of the Healthcare Quality Clinical Governance Committee. A review of the patient's care is then carried out in order to determine whether a formal Critical Incident Review process should be carried out. A full Critical Incident Review (CIR) will take place for any patient who has committed suicide, or possible suicide while under the care of Dumfries and Galloway NHS Mental Health Services, or who had been receiving care at any time during the preceding 12 month period. A Critical Incident Review can also be triggered if the above test is not met, but where there are any other concerns about the care that the person may have received that could have contributed to the person's suicide.

As well as deciding to trigger a Critical Incident Review, the initially reviewing clinician will consider who should be invited to attend the review and whether

the circumstances around the person's care warrant additional external oversight of the review processes. In cases where the person committed suicide whilst receiving closely supervised care, such as whilst an inpatient, or while under detention, then an external review of our own process by an independent psychiatrist is normally sought. In such a case, the external psychiatrist will receive a copy of our review report prior to its publication, and will comment on the quality, robustness, findings and recommendations. In most CIRs, however, the review team consists of a chair and co-chair who are senior members of the medical, nursing or managerial services within NHS Dumfries and Galloway, and who were not directly involved in the patient's care.

Following the decision being made that the patient does fulfill the criteria for a CIR then a number of initial stages take place.

The patient's treating consultant will write to Health Improvement Scotland (HIS) to notify them of the patient's death, and to inform them that a review will take place. HIS ultimately receive the report from each review and ensure that the quality of the process is of an adequate standard, and they also try to learn from and disseminate learning from reviews carried out across the whole of Scotland

The chair of the review will request that those professionals involved in the patient's care provide a written report and also attend the review in person.

The administrator, who co-ordinates the review process, will contact the procurator fiscal to inform the PF of the review and to request information about the Post Mortem and any other relevant investigation.

Our reviews are carried out using a framework provided by Health Improvement Scotland (HIS) and all of our reviews follow this framework. This is as follows:

1. General demographic details.

2. Inpatient/outpatient contact with mental health services or crisis services.

3. Legal status.

4. Format of the review including details of those attending.

5. Scope and remit of the review and what information was considered.

6. Level of review.

7. Who was involved in the care given and any relevant agencies not represented at the review.

8. Health and social history including
    - Date and detail of last Risk Assessment;

- Brief social history;
- Psychiatric and relevant medical history;
- Any relevant information established after the review;
- Circumstances of the suicide and cause of death.

9. Family and carer involvement.
   This includes care for the family provided during the patient's contact with services and the support provided subsequent to the suicide itself.

10. Support for staff.

11. Support for relevant others.

12. Findings.

13. Learning points.

14. Recommendations for action.

Following the review a detailed report is prepared. This is normally some 7 to 10 pages in length. Prior to the publication reports are approved by those who attended the review and then they are anonymised and disseminated.

There are 3 main bodies that scrutinise the review process. These are Health Improvement Scotland (HIS), the Healthcare Quality Committee, and the Quality and Patient Safety Leadership Group (QPSLG).

HIS receive a copy of all Critical Incident Reviews in Scotland. When the receive our review they consider it in relation to its thoroughness and rigour, and also consider the findings and learning points within the review.

A copy of the report is also sent to the local Healthcare Quality Committee, which is an operational group within mental health services that is responsible for overseeing and implementing matters pertaining to Clinical Governance and promoting safe and standardised practices. The Healthcare Quality Committee considers each Critical Incident Review to ensure that they are of an adequate standard, and they follow each review until all the recommendations have been addressed or implemented.

A further scrutinising committee is the Quality Patient Safety Leadership Group, which is a Dumfries and Galloway NHS Board level management and governance committee. This committee looks at each Critical Incident Review from a more strategic perspective to ensure that there is adequate learning and dissemination of the findings of a Critical Incident Review from an NHS Dumfries and Galloway Board perspective.

As well as these 3 levels of scrutiny, a copy of each Critical Incident Review is forwarded to the Mental Welfare Commission, who utilise the information therein to follow themes and trends within mental health services.

On the completion of the review contact is made with representatives of the patient's family. They are invited to meet with the chair of the review, the patient's treating psychiatrist, or both, to discuss the findings of the review and the recommendations for action, and also how these recommendations are going to be implemented. The family members are also offered a non-redacted copy of the review. If the family member has any comments or issues around the content of the report then the report will be modified to incorporate the changes and the family member will receive a copy of the modified version.

In relation to the question about families being involved in the review process itself, we have involved families at the actual review meeting in a minority of cases. These occasions have broadly been successful, and have been a positive experiences for those involved. We do not, however, routinely invite families to attend our suicide review meetings. This is in an attempt to try to ensure that the review meeting is a safe forum for open discussion about the factors that led to the person's suicide, and to prevent a move to an adversarial experience where the onus changes from the learning of lessons and improvement of service, to the apportion of blame. It is our opinion that the current arrangement where families are involved in the process after the initial review meeting, with them being given the opportunity to highlight their concerns and modify the report is a method which works well. It balances a focus on quality improvement, with transparency and involvement of the families of those who have committed suicide. This approach appears to be well received within our service.

With a specific focus on your question about patients who commit suicide while detained under a Compulsory Treatment Order, we have reviewed our records and we do not have much experience of these events, as they fortunately happen very rarely.

We have looked at all suicide reviews since January 2010.
In the nearly seven years since then there have been 42 critical incident reviews carried out to investigate a suicide or possible suicide.
Of these there were two people detained under a Compulsory Treatment Order (CTO) at the time of their death. One of these patients was detained and being looked after by a different NHS Board the time of death, and the main review was therefore carried out by that Board. There has therefore only been one suicide of a patient while under the direct care of our Board and subject to a CTO. This was in 2011.

In addition, there was one patient that was detained under a Short Term Detention Certificate (STDC) at the time of death. This was in 2015. In this case an external review of the report into the patient's suicide was carried out by an independent consultant psychiatrist employed by a different NHS Trust. Recommendations were received from that psychiatrist and some subtle modifications were made to the report before its publication.