Leeds and York Partnership NHS Foundation Trust

Leeds Teaching Hospitals NHS Trust

Assurance Statement

In response to recommendations from IODEM Independent investigation report into the care and treatment of MS

Reference No: 2015/13271

Introduction

NHS England commissioned an independent investigation report to elicit learning from a serious incident which occurred in April 2015, which led to the death of MS. The final recommendations from this review were received by the Trust in September 2018.

MS was able to gain control of the ambulance being used to transport him between separate NHS services pursuant to his treatment plan on 10 April 2015. Having taken the vehicle mid-transfer, owing to the fact that the keys were left in the ignition of the vehicle by the ambulance personnel, MS left the two ambulance technicians by the side of the road, and then drove approximately 15 miles before colliding with a bus. MS died at the scene of the collision.

Significant learning points have been identified through both the internal Serious Incident review and the external review, which made a number of recommendations made to improve future practice and service delivery. Due to the passage of time and other developments in the commissioning and funding of Psychiatric Liaison services, a number of significant changes have already occurred to the services over the 3 year period following this serious incident. The oversight of the delivery and the development of the Psychiatric Liaison Service – including delivery against the agreed action plans in relation to this incident – is managed and overseen by a joint delivery group of LYPFT and LTHT clinical and operational staff.

Following a meeting in September 2018 between NHS England and the various agencies involved in the care and treatment of MS, it was agreed that an assurance statement would be submitted to the Clinical Commissioning Group outlining how the Trust have developed working arrangements and practice in response to the recommendations of the external report. This assurance statement is supported by an evidence file.

Recommendation 1 – LTHT: training

The Independent Investigation Team recommends that:

In accordance with the Recommendations made in Mental Health in General Hospitals: Treat as One (Date of publication: 26th January 2017) all hospital staff who have interaction with patients (including clerical and security staff), should receive training in mental health conditions in general hospitals. Training should be developed and offered across the entire career pathway, from undergraduate, to workplace-based continued professional

development.

LYPFT/LTHT Response:

Leeds and York Partnership NHS Foundation Trust has worked with Leeds Teaching Hospital to develop a joint training package that is now regularly delivered to LTHT staff. 'An introduction to the care of adults with mental health problems in an acute setting' is a full day of training delivered by mental health specialists and includes the following topics:

- Mental Health in Older People
- Identifying and managing distress
- Managing patients who are withdrawing from alcohol and/or illicit substances
- Identifying and responding to risk
- Consent, Capacity, Restraint and Deprivation: Use of MCA and MHA on hospital wards

This training is open to all hospital staff, with a focus on Registered Professionals, that has interactions with patients and the facilitators have received positive feedback on the programme.

LTHT also provided assurance on the training and education workplace based professional development, the undergraduate registered nurse training will be discussed with the universities and in house training departments for other non-registered groups. In addition Leeds Health and Care Academy is supporting work across the Leeds system that both LTHT and LYPFT support to identify opportunities in learning and development where physical and mental health expertise in different areas of the system can work collaboratively across organisational boundaries to share learning and development and promote parity of esteem.

Recommendation 2 – LYPFT: Integration of physical and mental healthcare

The Independent Investigation Team recommends that:

Following the care of MS, the Independent Investigation Team understands that a review has been undertaken by LYPFT and LTHT which has addressed a number of the concerns highlighted in this report. The review has resulted in significant changes to the model of liaison services and has been supported by significant additional income from commissioners.

In order to establish the success of the review conducted by LYPFT referred to in paragraph 5.1 above and to confirm that the recommendations in the NCEPOD report 'Treat as One' report have become embedded in current practice, it is recommended that an audit is conducted by LYPFT.

> The audit should seek to establish the nature and extent of multi-disciplinary working involving professionals and clinicians when caring for mental health patients being treated on general wards following the introduction of the new model of working.

As a minimum, the audit should cover the following areas;

a. The nature of the problem (diagnosis or formulation);
b. The legal status of the patient and their mental capacity in the event that a decision might need to be made, if relevant;
c. A clear documentation of the mental health risk assessment – immediate and medium term;
d. Whether the patient requires any additional risk management e.g. observation level;
e. A management plan, including medication or therapeutic intervention;
f. Advice regarding contingencies, e.g. 'if the patient wishes to self-discharge please do the following….'
g. A clear discharge plan in terms of mental health follow-up;
h. Mental health involvement in transfer process from acute setting;
i. Risk assessment relating to discharge process including any transfer arrangements.
j. Such an audit should seek to establish the involvement of organisations or individuals without specialist knowledge such as transport providers in the MDT process.

Having completed the audit any deficiencies identified should be rectified and the audit repeated to confirm effectiveness thus completing the audit cycle.

LYPFT Response:

LYPFT's Liaison Psychiatric Service is accredited by the Psychiatric Liaison Accreditation Network (PLAN) until March 2019. PLAN is a national network run by the Royal College of Psychiatrists' Centre for Quality Improvement (CCQI) in collaboration with the Royal College of Emergency Medicine, the Royal College of Nursing, MIND and the Royal College of Physicians.

Its purpose is to facilitate quality improvement and development of liaison psychiatry services through applying national standards and a peer review network.

The accreditation process involves being measured and peer reviewed against a set of national quality standards across 5 Domains. Within Domain 1, referral procedures, mental health assessments, care planning, risk assessments/management plans, discharge planning, documentation, audit and governance are all identified as being core standards for liaison psychiatry services. Similarly, the NCEPOD Report sets out these recommendations as being essential.

As LYPFT is currently accredited as meeting the PLAN national quality standards, we consider that we have completed recommendation 2. This will be re-audited in March 2019 when we re-engage in the accreditation process.

Additionally, LYPFT and LTHT have reviewed and developed a Standard Operating Procedure for the safe conveying of patients with mental health needs from Leeds Teaching Hospitals NHS Trust (LTHT) to a mental health in patient unit.

The key principles of this document are

1. A comprehensive risk assessment, identifying factors that present a risk to the patient's health and safety or to other people, must be carried out for all mental health patients; detained or informal, prior to transfer to a mental health placement. The risk assessment and subsequent management plan will be communicated to all relevant parties prior to transfer.
2. Patients should always be conveyed in the manner which is most likely to promote their dignity and privacy whilst consistent with managing risk and safety.
3. The individual arranging the transport should have a full understanding of the transport options available and the details of what they provide (e.g. RMN escorts, escorts trained in appropriate restraint techniques etc.) and be able to consider them in the context of the individual patients' risk assessment

This procedure has been embedded into practice across both trusts and will be added to the liaison psychiatry audit cycle to ensure compliance.

Recommendation 3 – integrating liaison psychiatry services

The Independent Investigation Team recommends that:

In order to overcome the divide between mental and physical healthcare, liaison psychiatry services should be fully integrated into general hospitals. The structure and staffing of the liaison psychiatry service should be based on the clinical demand, both within working hours, and out-of-hours, so that they can participate as part of the multidisciplinary team.

LYPFT Response:

Significant changes have been made to the liaison psychiatry service since the tragic events leading to the death of MS in April 2015. Since that time, a review of the service has been undertaken and the Trust has implemented a Core 24 Liaison Psychiatry model consisting of a multidisciplinary team working across LTHT twenty four hours a day, seven days a week. Our service has an appropriate skill mix of health professionals including psychiatrists, mental health nurses and social workers and we are accredited by the Psychiatric Liaison Accreditation Network (PLAN) as mentioned in the previous recommendation.

In order to make sustainable changes and improvements to the liaison psychiatry service, robust governance arrangements between the LYPFT and LTHT have been established and there is a regular partnership board between the 2 trusts.

Additionally, we have teams based within LTHT in order to provide a responsive and integrated approach to meet the needs of those who present with mental health problems in the acute trust. Further discussion is underway regarding the strengthening of these arrangements through further co-location in LTHT sites.

Recommendation 4 - Information sharing

The Independent Investigation Team recommends that:

A discharge summary dated 15 April 20015 was dictated but not typed until after the death of MS.

LYPFT is required to undertake an audit to establish whether the delay in issuing a comprehensive discharge summary is a Trust wide issue and if so, to formulate a strategy in order to address any issues which are identified.

LYPFT Response:

Some work has been undertaken by the Trust between 2015 and the current day to improve the quality, consistency and timeliness of communication with GPs (including completion of discharge summaries).

An outcome of one audit in early 2018 was for the trust to implement a new system using BigHand technology to automatically ensure timely communication with GPs. We are currently in the final stages of rolling out electronic inpatient discharges and outpatient communications trust wide, although this has been somewhat delayed due to initial system and supplier issues. We are currently implementing the new system and – in parallel with a CQUIN scheme overseen by the CCG which focusses on improving communication with primary care - this will include the introduction of a new KPI to monitor completion of the discharge summary within 48 hours of discharge from inpatient services. The Trust will monitor and audit compliance against an agreed improvement trajectory.

Recommendation 5 - consolidating/fully reviewing medical records

The Independent Investigation Team recommends that:

LYPFT is required to adopt a strategic response in relation to its consolidation of patient records, i.e. the migration of the paper and digital notes system into one system. The Independent Investigation Team is of the view that ideally, this should be the unification of records within an electronic system, capable of allowing a care professional at any given stage of treatment to retrieve information relating to the patient and in particular, the status of their risk assessments, at a glance, in order to ensure that they have all requisite and relevant clinical information necessary to make an informed decision on the appropriate next step.

For instance, in relation to the facts of MS's case specifically, a significant issue identified by the Independent Investigation Team related to the fact that key information, of considerable clinical significance to Trainee Psychiatrist 2's decision to discharge MS from LYPFT, was 'lost' in the paper notes and therefore not readily available. A successfully 'consolidated' patient record or comprehensive risk assessment, (preferably electronic) could, in this instance, have provided the relevant clinician with information that could have resulted in a significantly different direction in MS's care, at the time that clinician needed it.

A strategic response at LYPFT Board level is therefore required in order to address the practical difficulties faced by their clinicians when presented with the challenge of accessing a service user's historical records over multiple systems. The loss of information when migrating to electronic service user records is also a risk which must be addressed.

New database packages allow a Care Professional to retrieve from their (consolidated) electronic patient record to show the service users under a team member's care, and the update status of risk assessments for the last 6 months. This does not address the needs of a patient who has had previous admissions over a period of time. Consequently, a protocol should be developed to ensure a review of paper and electronic records held for service users who have experienced a number of episodes of care, such as MS.

LYPFT Response:

LYPFT and LTHT have jointly worked to devise and implement a new digital solution to support liaison psychiatry working across 2 electronic patient recording systems.

The Liaison Psychiatry Teams are now able to make their clinical notes visible in real time to all clinicians involved in the patients' care regardless of their employing Trust or location. This means that important clinical information will always be highly visible; it will reduce time and effort from clinicians duplicating information, and will ensure that historical and current risks and plans are documented accurately and consistently.

Using this information has improved patient-centred care by enabling a more coordinated and joined-up approach for patients with both physical and mental healthcare needs.

Patient care will consequently improve through more efficient working practices and the provision of up to date information on LTHT and LYPFT systems.

END