VERITA

IMPROVEMENT THROUGH INVESTIGATION

Independent review of suicides and deaths of mental health patients who attended the Whittington Health emergency department

A report for

Whittington Hospitals NHS Trust

February 2018

1. Executive summary and recommendations

1.1 Between November 2014 and December 2016 seven patients who had contact with the emergency department at the Whittington hospital subsequently died unexpectedly. As well as being treated by emergency department staff, they also received an assessment from the mental health liaison team from the local provider of mental health services Camden & Islington NHS Foundation Trust (the 'mental health trust').

1.2 Whittington Health NHS Trust ('Whittington Health'), with the support of the mental health trust and the local clinical commissioning group asked Verita to carry out an independent review. The aim of the review is to look the trusts' investigation into the deaths and also the processes that are in place to manage patients with mental health needs as part of their commitment to learning and development.

1.3 We interviewed a total of 18 staff across Whittington Health, the mental health trust and the Clinical Commissioning Group (CCG). We reviewed documentation including national guidance, local policies and serious incident reports.

Background

1.4 Whittington Health provides hospital and community care services from 30 community locations as well as from the Whittington hospital ('the Whittington').

1.5 The mental health trust provides care and treatment for patients in the community, in their homes or in hospital. The mental health trust also provides mental health liaison services at hospitals including the Whittington. These services are provided by the integrated liaison assessment team (the liaison team) and include emergency assessment for people with mental health conditions who present to the emergency department. The Whittington liaison team is based at the Highgate Mental Health Centre across the road from the hospital.

1.6 Patients with mental health issues may arrive at the emergency department in a number of ways – by themselves, with friends or family, in an ambulance or accompanied by the police. On arrival at the emergency department, they go through a triage process which is carried out by emergency department nurses with training in triage. The

completion of the triage is usually the point where the triage nurse would make a referral to the mental health team if necessary.

1.7 Patients presenting with mental health concerns are assessed by a nurse using a mental health pro forma which guides them though questions about the patient including issues such as the risk of absconding. The second half of the pro forma is then used by a doctor to carry out further assessment. The pro forma is used for stratifying patents according to risk. Where relevant the patient will be referred to the mental health team.

1.8 The mental health team are required to carry out an assessment of a patient within one hour of the patient being referred to them. Assessments are carried out using the risk assessment model included in CareNotes, the mental health trust's electronic patient record system. If a patient is sectioned under the Mental Health Act and physical restraint of patients is needed, the Whittington security team are contacted as they are responsible for carrying out the restraint.

1.9 In the emergency department interventions are mainly focussed on medication rather than providing therapy as patients are often in a crisis state and the priority is to keep them safe. If the decision is made to admit a mental health patient (either formally or informally), the mental health team will begin the process of finding a bed. Patients waiting for a mental health bed is a major bottleneck in the system.

1.10 The facilities in the Whittington emergency department consist of two rooms (12 and 12a) within the main emergency department area. There is a general agreement that these facilities are not well suited to mental health patients because of their poor physical environment. There are also two secure rooms in the Majors area.

1.11 Everyone that we spoke to described the relationship between the emergency department staff and mental health liaison team as good. Although they are not located on the same site as the emergency department, the mental health team are generally viewed as being accessible and normally meet the one-hour target for seeing patients.

The seven cases

1.12 We considered seven cases that that occurred between November 2014 and December 2016, the last five occurring over three months in late 2016. The cases are summarised in the report, including a reference to the coroner's inquests, where relevant.

Investigations

1.13 We considered the process of the investigations that were carried out as a result of these events. Investigations were carried out by staff in Whittington Health, the mental health trust and, in one case, Barnet, Enfield & Haringey Mental Health Trust. The commissioners, Islington and Haringey CCGs review them. The commissioners told us that they expected the investigations to adhere to the national guidance around reporting. The commissioners want to ensure that the quality of the investigation is high, that the duty of candour requirements with family members are fulfilled and that there is learning from what happened.

Whittington Health investigations

1.14 Whittington Health's serious incident policy is based on national guidance. When an incident has been identified it is escalated and reaches a serious incident panel chaired by the medical director if sufficiently serious. The panel gives a steer on the terms of reference of an investigation, although they are carried out within the relevant directorate, rather than by a central team.

1.15 Some investigators told us that they were commissioned to carry out an investigation by email. The initial steps in an investigation are a crucial part of the process. Face to face meetings with investigators to talk through with them what is expected would be desirable.

1.16 Reports are written using a standard template, based on the national serious incident framework provided by the Clinical Commissioning Group. The investigation template is restrictive and not intuitive. It does not encourage authors to begin by clearly setting out a description of the events leading up to the incident. As a result, there is a tendency for reports to be unclear and repetitive, with the same facts appearing a number of times.

1.17 Whittington Health provides a training programme for investigators. It was not always clear that the investigators had received the training.

Camden and Islington Investigations

1.18 Investigations are carried out jointly by a lead investigator from outside the division where the incident occurred, working alongside a clinical expert from within the division. Investigators are nominated from staff on a central trust rota and tend to carry out investigations every two or three years.

1.19 The question of whether to have a specialist team to carry out investigations, or getting staff throughout the organisation is a dilemma for all trusts. The approach of spreading investigations amongst staff members has benefits in sharing learning. However, having to carry out an investigation is a burden for already busy staff. Providing adequate support is therefore important.

1.20 A central serious incident team carries out a preliminary review of incidents. A decision on what level of investigation is needed is taken by the mortality review group, chaired by the medical director. The terms of reference are decided by the investigator, who involves the family. They are then fed back to the mortality review group. Investigators are usually sent a 72-hour report and a template by email at the start of their investigation.

1.21 We saw plenty of examples of good practice, particularly in relation to family engagement. However, there was a feeling among trust investigators that they were given little guidance and left to 'get on with it'. At times, this made them feel anxious about the process.

1.22 Time pressure was raised as an issue by many investigators. The investigation process described to us was the same for all serious incidents. However, some investigations are more complex and sensitive than others. Extra resources, whether in terms of support

for making time for the investigator should be provided for the most significant investigations.

1.23 Investigators in both trusts told us that they received little feedback after completion of their investigation reports. It would be good to ensure adequate engagement with those who complete reports, to thank them for their work, to get learning for the trust

about the investigation process and to give investigators feedback on learning about the work that they have done.

Joint investigations

1.24 The circumstances of some serious incidents will call for investigations to be undertaken jointly with other NHS trusts, local authorities or other organisations. However, there is no guidance on carrying out joint investigations with other trusts in the Whittington health policy.

1.25 Interviewees had differing views as to who was responsible for managing incidents and therefore investigations - not necessarily a simple question where patients have been involved with multiple organisations. One might argue that it is only possible to be completely certain who is responsible for an incident AFTER the investigation has been completed. Spending a lot of time arguing between NHS organisations about who is responsible beforehand is unlikely to generate any value. Besides, the technical responsibility with regards to serious incident reporting procedures does not necessarily have to determine who actually carries out the investigation - "responsibility" is not necessarily the same as "best placed to input".

Evaluation of serious incident investigation reports

1.26 We evaluated the seven investigation reports supplied to us to establish whether the investigations were robust and whether all relevant learning was identified. The main issues identified were:

- Investigation template – a number of interviewees had concerns about the usability of the template
- Terms of reference – while all the reports included terms of reference and there were some examples of good practice, there was a lack of focus on specific lines of inquiry
- Clinical risk management – there was a lack of analysis of risk management processes
- Benchmarks – none of the reports provided a comprehensive, organised approach to using benchmarks
- Analysis – some reports lacked clarity about the central issues
- Recommendations – some key issues raised in the reports were not carried through into recommendations and some recommendations did not result from the issues highlighted in the report. Many of the

recommendations were not 'SMART'

- Duty of candour – the reports demonstrate in broad terms that duty of candour was adhered to but they could be further improved if the reports were more explicit about when families were told about the incident and when and how an apology was offered. Some of the reports were not as generally accessible as they could be.

1.27 The following common themes emerged from the investigative reports:

- Improving record keeping and handovers, so that accurate information including risks is shared
- The sharing of patient records between emergency department and mental health staff
- Ensuring that risk assessment and risk management plans are up to date and that plans are put in place for when patients leave the emergency department or face long waits to be transferred to non-local mental health trusts
- Improving the physical environment at the Whittington emergency department for patients suffering from mental health problems.

1.28 We were told that the investigation process focusses on learning. However, a pre-requisite for learning is understanding. If the conclusions of investigations are not firmly based on good understanding and analysis of what happened, they are more likely to be prejudices or clichés rather than genuine learning. There is also a danger in focussing on the "quantity" of learning. It may be that there is only one important thing to be learnt from a particular investigation, so having more recommendations weakens, rather than strengthens the report. A report that clearly sets out what happened is a resource which can be used in the future. A report that jumps to conclusions and learning without sufficient analysis may tell the reader little.

1.29 Carrying out investigations is challenging, particularly when authors also have their day jobs to do. While this report focusses on where improvements can be made, this should not be taken as a criticism that the reports we read where particularly sub-standard, or that they were very different from most investigation reports we read from across the country.

1.30 A number of people we spoke to in told us that improvements had been made since the incidents. We were told that there is now much more awareness of the use

of the mental health crisis proformas and that the assessment is now more objective and better focussed on identifying and predicting which patients are at high risk or likely to be at high risk (risk stratification).

1.31 The staffing structure of an emergency department with two providers working so closely together makes it inevitable that in any incident concerning a mental health patient will involve staff from both organisations. Looking from the outside, the case for integrated investigations between acute and mental health trusts is strong. Administrative distinctions within the NHS should not be allowed to get in the way of what is best for the patient or their family. That the medical directors of both organisations share this view and are very closely aligned on this issue, is welcome.

1.32 Formalising the relationship between the two trusts so that it is clear to staff how a joint investigation should work would be welcome as it would avoid most of the issues that arose in these investigations. This approach would be re-enforced by a joint training event to further embed good practice. It is important to note that joint working does not necessarily mean always having to carry out an investigation jointly or agree about all findings. The key issue is dialogue - that the respective investigators and teams meet together at the beginning of the process to agree a way forward. That could result in a single report, two separate reports or some combination of the two.

Themes and issues

Overarching theme

1.33 The conclusion from our review of the seven cases is that while there are a number of underlying factors which lie behind the cases, there is no single factor or issue with the care provided that links together all the cases. We did however identify a number of contributory issues which are relevant.

Contributory issues

1.34 A number of important issues have emerged from our investigation. One issue results from the interaction between three factors – the level of demand for the service, the length of time people have to wait and the physical environment in which they wait. We were told that the number of patients attending the emergency department has grown in recent years due to wider societal issues. The volume of patients creates delays and also increases the length of time that patients have to spend in the emergency department.

Bed availability is the major factor in very long delays for mental health patients as the length of time it takes to find a bed leads to mental health patients having to spend many hours, and sometimes days in the department.

1.35 Emergency departments are generally not good places for people with mental health problems who would ideally be seen in calm, quiet environments. The physical environment for mental health patients in the Whittington in particular is very poor. Whittington Health told us that plans have been developed to improve the rooms used by mental health patients. The news that Whittington have a programme to improve them are welcome.

1.36 Overall it is clear that a rising number of people presenting at the emergency department and the shortage of mental health beds for them to go to will mean that long waits are likely to continue. While this is mainly out of control of the Whittington and Camden & Islington trusts, the best that can be made of this situation is to ensure that the facilities that are provided are as fit for purpose as possible.

Absconding

1.37 For some patients, it is necessary to ensure that they stay in the emergency department even if they do not want to remain. Interviewees told us of their understanding of the balance between allowing patients their dignity and freedom, but also acting to protect them when necessary. Decisions on whether to hold patients against their will are inherently complex. There will never be a simple answer to them, all that trusts can do is ensure that staff are properly trained and that the issues are kept in the forefront of the minds of staff.

1.38 A number of interviewees made reference to the importance of security guards in these issues. They should be included in any training initiatives that are carried out to reinforce awareness of mental health legislation.

Location of the liaison team

1.39 While we were told that the emergency department team work well together with the mental health liaison team, a number of interviewees noted that the liaison team is not based within the emergency department. There are pros and cons to having the mental health liaison team based within the emergency department. The main issues about the

proposal, however, appear to relate to concerns about there being enough space within the emergency department for the needs of the liaison team. If the team is to be moved into the emergency department it will be important to ensure that they have allocated time and space to do the aspects of their job that do not involve interaction with emergency department staff – reviewing patient histories, writing up assessments and making calls to other services.

1.40 The mental health liaison team is nurse-led. There is no settled view amongst those we spoke to about whether or not the level of input into the emergency department by senior psychiatrists (consultants and trainees) is right. However, interviewees report that the highest risk and greatest workload is in the emergency department and that appears to be supported by the data. We think therefore it would sensible for the two trusts to discuss how the time of senior psychiatrists is divided between the emergency department and the wards.

Changes in practice

1.41 There have been a number of changes in practice that have followed the incidents described in this report such as the introduction of a mental health pro-forma and care plan. There remain; however, areas where staff felt further improvements can be made. One of these was around 4-hour observations of patients in the emergency department by the mental health team. The quality of record keeping was an issue that was highlighted in a number of the investigation reports. This continues to be a concern for commissioners.

Overall conclusion

1.42 The treatment of mental health patients within emergency departments of hospitals is a difficult and complex area of practice. Emergency departments, with their noisy and busy atmosphere are not good places for vulnerable people. Ideally there should be adequate facilities in the community to meet their needs. Nevertheless, supporting people in these circumstances is an important role for an emergency department.

1.43 We saw many areas of good practice amongst the staff that we spoke to. They demonstrated a commitment to the welfare of mental health patients and to improving services to them. There was also a commitment from staff to learn from these incidents. Time and again we spoke to front line staff who knew the details of the individual cases and who had spent time thinking about what changes need to be made in the light of them. We

see this as a very encouraging aspect of our investigation.

1.44 We also saw the commitment of the leadership of both the Whittington and Camden & Islington mental health trusts to work together in the best interests of patients, leaving aside the administrative barriers. The staff in the emergency department – from both the Whittington and the mental health trust – also displayed a commitment to working together to deliver the best services possible, despite the issues we identified with past investigations. Joint working on investigations should be cemented through a memorandum of understanding between the two trusts.

1.45 We make a number of recommendations relating to conduct of investigations in the two trusts, including ensuring that there a good template is provided and staff carrying out investigations are properly supported. Everyone who carries out investigations should be fully trained (particularly with challenging issues such as engagement with families). It would be helpful if briefing meetings were held at the outset of investigations and that feedback about the quality of investigations is given to those who have carried them out.

1.46 Training more generally is also a key theme. Staff are expected to make difficult decisions about when to allow patients to go and when to keep them in the department. Both the Mental Capacity and Mental Health Acts are complex and even the most experienced staff find their application difficult. Enhanced training, which could include roleplay using scenarios around which patients are sufficiently 'at risk' so they should be denied their freedom, should be considered. Such training should include the security teams who play and important role in several of the cases we looked at.

1.47 The greater availability of dual qualified nurses – i.e. both Registered General Nurse and Registered Mental Nurse would be of benefit to the department.

1.48 Legal highs appear to be a growing problem. We heard that use of these substances is regularly a causal factor behind people presenting to the emergency department with mental health issues. More information should be provided to staff and patients about the risks.

1.49 The quality of physical facilities is also important, notwithstanding the point we have made about the inherent difficulty of providing mental health services from within an emergency department. Whittington acknowledge that the facilities currently available

within the emergency department are inadequate and we welcome the plans that they have to upgrade them.

1.50 Ensuring that sectioned patients do not abscond is also an important theme. Again, staff are aware of the need to strike a balance. A number told us that they do not see themselves as "jailors" and while it is always an option to lock sectioned patients into a room, their reluctance to do so is understandable. If a non-stigmatising identification system for sectioned patients could be designed, e.g. by putting a flag on the door of rooms 12/12a, that may prove helpful.

1.51 Physical constraints also mean that the mental health liaison team is not currently based on the Whittington site. The closer that they could be located to the emergency department, the better this would be for improving day-to-day communication between the teams. Almost everyone that we spoke to acknowledged the benefits of such a move. Given the nature of their work following an assessment, the team need a properly equipped room.

1.52 The trust may want to consider whether volunteer 'befrienders' working in the emergency department with mental health patients would help alleviate the pressure on professional staff and provide companionship to patients who are waiting.

1.53 Mental health patients in emergency departments is an area where there are few simple solutions. We have found compelling evidence that practice has improved greatly in the Whittington since these incidents occurred. Work should continue until all the lessons are fully incorporated into practice.

Recommendations

R1 Commissioners of investigations should meet with investigators face-to-face at the beginning of the process to discuss what is expected.

R2 The executive team that commissions a serious incident investigation should ensure that members of the investigation team have the appropriate knowledge and skills to undertake the investigation and write the report.

R3 The commissioners of the service should ensure that the investigation report

template meets the needs of the trusts, the commissioners and those affected by an incident i.e. the family, to ensure that investigation reports are sound, accessible and focused.

R4 Those who commission serious incident investigations must ensure that the terms of reference focus on the purpose of the investigation rather than the process and that all relevant lines of enquiry are explicitly stated.

R5 Investigation reports should demonstrate that benchmarks relevant to the incident and surrounding circumstances are identified and these are analysed to find any underlying systems issues so that recommendations can be made to reduce the chances of the same thing happening again.

R6 Both trusts should ensure that recommendations outlined in investigation reports are clearly linked to the issues, contributory factors and evidence so that recommendations can be made that eliminate or reduce risk.

R7 Both trusts should ensure that recommendations are SMART so that there is a clear description of what is required, who is responsible for taking the action and for measuring its effectiveness.

R8 That Whittington Health and Camden & Islington Foundation Trust work together to establish a memorandum of understanding to facilitate joint investigations of serious incidents.