248/2011

Pennine Care NHS
NHS Foundation Trust

25th July 2017

Corporate Governance
Trust Headquarters
225 Old Street
Ashton-under-Lyne
Lancashire
OL6 7SR

Telephone: 0161 716 3000

Our Ref: KB/RC
Department: Trust Headquarters

PRIVATE & CONFIDENTIAL
Ms A Mutch
HM Senior Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Ms Mutch,

Re: David Ian Hamilton (Deceased)

Thank you for your Regulation 28 report dated the 5th June 2017, and for bringing to my attention the concerns you had after hearing all the evidence. Your concerns relevant to Pennine Care have been reviewed, and the Trust's response is outlined below.

Concern 1:

Healthy Minds has no documentation or system of recording the selection process for therapy, including the options given and rationale for the choice of therapy.

Response:

Patients who are referred to the Healthy Minds Service are triaged by the Access Team (Single Point of Entry) and allocated to the appropriate treatment step within the Healthy Minds Service. Where there has been no or limited previous contact with the service (and this is also felt to be clinically appropriate in terms of presentation, history and current risk), patients are invited to attend a 'treatment options' group session where a presentation is given about the service and the treatment options available.

Patients are then asked to identify their preferred treatment modality (from a range of interventions including one to one therapy, Group Interventions and on-line treatment). Patients are asked to endorse this preference on a standard document along with the completion of outcome measures PHQ9 and GAD7. The patients are offered advice and guidance from staff to support with the selection of the appropriate treatment option where required. The forms are then returned to the clinician.

Where a group is requested, patients can select a date and time to attend the group and an appointment is provided during this attendance, which allows the patient to

POSITIVE ABOUT DISABLED PEOPLE

select a date and venue that is most convenient to them. This information is also recorded on the session attendance forms.

The forms are returned to the team administrators who transfer the information from the documents into the clinical records, adding patients to either a treatment waiting list, or the selected group within the electronic record system.

An additional process will be initiated whereby a case note shall clearly state in the patients clinical records that the patient has completed a treatment options session and has chosen 1:1/cCBT/Group Interventions (identifying the treatment selected) and has been allocated to the appropriate treatment pathway.

Concern 2:

There was a lack of clarity of triggers for referrals other than group therapy.

Response:

Patients are triaged and allocated treatment based on the LIFT (least intervention first time) principle within the stepped care model. Patients are referred into the single point of entry for mental health services which sits within the Access Team. The referral is then reviewed and triaged based on current presenting difficulties, previous psychiatric history and risk.

Where a patients difficulties are deemed appropriate to be met at step 2 this is recorded in the triage notes and the information is passed to the Healthy Minds Service who then invite the patient for a treatment options session where a range of interventions including group, online and one to one guided self-help therapy are presented and the patient is supported where necessary to consider their needs and identify their preferred treatment option.

Where a patient presents with a higher level of need (which may include specific exclusion criteria for step 2 for example, complex difficulties or having completed a course of treatment at step 2 which was unsuccessful in the past) the patient may be triaged to Step 3 in the stepped care model. Again the patient would be invited to attend a range of interventions including High Intensity Group provision or one to one therapy in a range of modalities depending on presenting need.

Where a patient is felt to have needs which would not be appropriately met by psychological therapies at step 2 or 3 other options including secondary care or acute care can be considered.

Concern 3:

The system of sharing information between health professionals (GP and Healthy Minds) to identify if the correct services were being accessed or if a referral to a psychiatrist was required was limited and meant that those involved did not have a full picture of his mental health.

POSITIVE ABOUT DISABLED PEOPLE

Response:

The service has a standard method of communicating information to GPs using an electronic document transfer system. This allows information to be delivered to GPs reducing the risk of the loss of information and reducing the time it takes to share information between health professionals. Risk faxes are also used to provide urgent information to GPs where there is a concern about the risk a patient has presented with and how this risk is being supported and managed. This may include requests for support from the GP, for example to review the patient in clinic or consider a review of medication or provide information regarding an ongoing management plan. Where a GP does not have access to this system the information is communicated by fax or post depending on the urgency of the information. Post, fax or email communication is also used for other health professionals and referrers where appropriate.

During the therapy journey a patient may be assessed by the clinician as potentially requiring a review by a psychiatrist. In these instances the case is presented to the secondary care mental health team for consideration including all information gathered during assessment and within the ongoing treatment. Advice may be provided to the GP or an assessment may be offered where it is felt that the patient meets the criteria for secondary care intervention. Where this is not indicated the clinician within Healthy Minds will continue to offer therapy and monitor the progress within treatment.

Should a GP feel that a review with a psychiatrist is required or feel that a patient would benefit from Community Mental Health Team involvement within secondary care a referral to request this can be made via the Access Team. These requests will be triaged and discussed within the secondary care meeting where appropriate.

Concern 4:

Referrals were not made to sleep clinic services to assist with insomnia.

Response:

The patient presented at the emergency department on 30.10.2016. The emergency department practitioner provided a triage assessment with advice being given to the patient regarding support pathways and a request for a referral to a sleep clinic being sent to the GP within the management plan.

The patient self-referred and presented to Healthy Minds with clinical symptoms of depression and anxiety. These can include (amongst others) loss of appetite, loss of motivation to engage in daily routines, lack of concentration and impact on sleep patterns. The patient completed a self-rating measure and endorsed that they had 'trouble falling asleep or staying asleep, or sleeping too much' which is a common difficulty within the context of mild to moderate mental health difficulties. The patient initially identified that this was a problem for more than half the days in a two-week period endorsing 2 out of 3 on the PHQ9 questionnaire for this question. This reduced to several days 1 out of 3 within a two-week period during therapy but fluctuated between these two levels during the course of treatment. The patient did

not score 3 out of 3 (rating this to be a problem nearly every day) at any point within their contact with the service.

A referral to a sleep clinic for insomnia was not considered during the time that the patient engaged with the Healthy Minds Service. The group intervention that the patient elected to attend included (in session 2 of 6) information on sleep hygiene, relaxation and controlled breathing in addition to how food, diet and exercise can improve wellbeing and impact on symptoms of low mood, stress and anxiety.

Concern 5:

There was no evidence of a clear formal escalation process where concerns were held by a health professional.

Response:

The primary care service works within a model of risk enablement, supporting patients, the clinician and other involved individuals (including where possible and appropriate other health and social care professionals, family and any identified care givers) to work collaboratively to understand and manage risk taking into account the interaction between likelihood, harm and imminence. Within group delivery this risk enablement strategy includes providing information regarding crisis care pathways at each contact and offering support for individuals to access at the end of each session should a patient feel that they require support in addition to the weekly group contact.

The health professional involved in the patients care, identified concerns regarding the patients' level of risk during the group sessions. As a result additional support was offered and provided following and in addition to the weekly group sessions. The clinician was STORM trained (a suicide prevention training package) and applied the STORM principles when assessing risk and these principles were also evident in the risk management plan. The clinician sent frequent risk faxes to ensure the GP (as responsible medical officer) was aware of the presenting risk and asked the patient to contact the GP to discuss medication, which they agreed to do. When the patient did not attend the planned appointment with the clinician, they contacted the GP surgery and established that the patient had engaged with this plan and during this contact with the surgery was able to identify that the patient had spoken to the GP on two occasions and had a further review appointment planned. Risk faxes were sent to inform the GP of the patients' non-attendance at the planned appointments with the Healthy Minds practitioner.

The clinician agreed with the patient at each contact that should they feel unable to maintain their own safety, that they would attend the emergency department for support as they had done in the past. The patient is said to have agreed with this plan. Following non-engagement with the planned appointment, attempts to engage by telephone and a further appointment being sent by letter (which was also not attended) a decision was taken in line with service policy and in agreement with the clinicians line manager to discharge the patient to the care of the GP with a risk fax again being provided outlining the concerns and the detail of unsuccessful attempts to contact the patient. The correspondence also requested ongoing monitoring of risk.

POSITIVE ABOUT DISABLED PEOPLE

Should a patient disclose imminent risk and then fail to engage with a management plan, practitioners can request support from the Duty Worker who is a qualified mental health practitioner (RMN or Social worker) for support and may request a welfare check from the emergency services to establish if the patient is able to remain in the community.

During the course of therapy, should a patients clinical presentation indicate a higher level of need than the current step allocated (which is identified at triage) within the stepped care model (for example due to the presenting problem i.e. Trauma), patients can be 'stepped up' to high intensity therapy or be referred for consideration for input from secondary care should there be an indication of a severe mental illness. The clinician involved can request further support and assessment from the teams duty worker (who is a senior mental health practitioner) where needed or can discuss the case with the team managers for presentation at the secondary care meeting.

At any point in the care pathway, the GP can request that a patient is considered for assessment by a Psychiatrist or for provision of care coordination should they have concerns regarding a significant change in presentation when the patient presents to the GP Surgery. This request is made via the Access Team, providing the function of the single point of entry for mental health services. The team would triage the request and where appropriate present the case for consideration at the secondary care referrals meeting.

In cases where there is evidence of immediate risk to self or others a referral can be made to the emergency department to be seen by the RAID team for further assessment where consideration can be given regarding the need for input from the home treatment team, or an acute admission.

I hope this response assures you that the Trust takes seriously any concerns that you raised.

Yours sincerely,

Acting Chief Executive

POSITIVE ABOUT DISABLED PEOPLE