NA

University of BRISTOL

15.07.19

Regulation 28 response

Thank you for giving us the opportunity to review this sensitive issue as a practice, and to report to you our plans moving forward as an attempt to prevent future deaths from suicide in our patient population.

Background:

The Students Health Service is a GP practice set within the University of Bristol and we serve a population of around 21,000. The majority of our patients are aged 18-25 years and we see a high volume of mental health conditions as part of our daily work as General Practitioners. From our membership of the Student Health Association we are aware that this is in line with the experience of other GP practices serving student populations. Our aim as set out in our Mission Statement is to 'provide a unique and positive healthcare experience for students and their dependents'. We are aware of the increased risk of suicide within our population, and make daily difficult clinical judgements around individual risk and how best to monitor and support our patients.

Inquest case:

Natasha Abrahart was seen by a GP from our practice on 20th April 2018, 10 days prior to her death. She was not at that time expressing suicidal ideation. She was restarted on an SSRI (Selective Serotonin Reuptake Inhibitor - Antidepressant) and given a 14 day supply. There was a plan to review her at 14 days with an option for her to come back sooner if required. She was aware she could be seen as an emergency in a same day appointment if necessary. Natasha was reviewed on 26th April 2018 by the secondary care recovery navigator responsible for her care, who booked further follow up with her on a weekly basis. She ended her life 3 days later.

In response:

NICE review (National Institute for Health and Care Excellence)

We have conducted a review of the guidance from NICE, and advice has been sought from the team at NICE who are involved in writing new draft guidance which is due to be published in 2020. Their response is as follows via [redacted] Communications Executive, National Institute for Health and Care Excellence, email 19/06/2019:

I will respond to your questions in reverse order.

1. The evidence for the potential increased prevalence of suicidal thoughts in the early stages of antidepressant treatment for those younger than 30 years is summarised in section 11.10 of the full guideline (pp.462-465).

Students' Health Service
Hampton House Health Centre, St Michael's Hill, Cotham
Bristol BS6 6AU UK
Tel: +44 (0)117 330 2577 Fax: +44 (0)117 330 2698

[redacted] MB ChB, Head of Service
[redacted] RGN, Nursing Team Manager
[redacted] BA MInstLM, Practice Manager

2. The draft version of the updated guideline on depression in adults: treatment and management that is currently in development (which was made publicly available for consultation last year, but which is now being amended further) has the following very similar recommendation:

'When prescribing antidepressant medication for people with depression who are under 30 years or are thought to be at increased risk of suicide:

· see them 1 week after starting the antidepressant medication

· review them as often as needed, but no later than 4 weeks after the first appointment

· base the frequency of review on their circumstances (for example, the availability of support, break-up of a relationship, loss of employment), and any changes in suicidal ideation or assessed risk of suicide.'

At this stage I cannot say whether this recommendation will be amended further before the final publication of the guideline.

In terms of following NICE guidelines, they have always been guidance and not policy or procedure. The Chair of NICE Sir David Haslam has been quoted as saying "The mantra that I've given in every lecture is that they're guidelines and not tramlines. Doctors have a fundamental responsibility to use guidelines with their experience and with patients' individual needs to get the best possible overlap between patient-centred medicine and evidence-based medicine. It's not either/or."

Local CCG review (Clinical Commissioning Group)

A review of the guidance from the local clinical commissioning group was also undertaken via the medicines management team at BNSSG CCG – their guidance reads: https://www.bnssgformulary.nhs.uk/includes/documents/Prescribing%20for%20Depression%20v2%20May16.pdf

Assessment of suicide risk: Patients considered being at risk of suicide or under 30 years old should be seen after one week and frequently until risk is considered no longer significant. All other patients should be seen after 2 weeks. All patients should be considered for drug and alcohol abuse

Expert opinion

Thank you to the Coroner for asking for clarification from the expert witness in the case, Dr [redacted] around whether the face to face review at 7 days should be done by a General Practitioner or by a member of the practice team. He has advised that the assessment of depressive symptoms and suicide risk at this stage could be undertaken by other suitably trained members of the clinical team e.g nurses, social workers. They could then be supported by prescribing clinicians if a change needed to be made to antidepressants. This advice is

very welcome as it informs how we respond as a service and how we consider future service development and staffing.

QOF

The current QOF (Quality Outcomes Framework) for depression states that a depression interim review should be undertaken at 10-56 days. Having reviewed the guidance around treatment of depression we would suggest that changing the achievement criteria within this QOF domain is a potential area for positive change. A change to this time frame might improve mental health outcomes across primary care, if it were updated at national level to reflect best practice. We intend to feed this back to our local CCG in the near future.

Current position at Student Health Service:

Every patient is considered on an individual basis and clinical treatment plans are put in place according to need and perceived risk of suicide and self harm. This includes the use of safety plans and safety planning apps, both leaflet and text information about emergency numbers/crisis/Samaritans/who to contact.

We have daily dedicated same day mental health appointments with the duty doctor for patients with a mental health problem or crisis. We would also see any patient on the day who felt they needed assessment for their mental or physical health as an emergency. These emergency mental health appointments are 20 minutes rather than the standard GP appointment of 10 minutes, as we appreciate they may require more time in consultation.

Patients are assessed using a mental health template at first presentation and this includes an assessment of their perceived suicide risk at the time. Suicidal ideation and self harm are also routinely asked about at mental health follow up appointments, and at depression medication or other mental health medication reviews. The template has been further amended to include a prompt on follow up after commencing SSRI

Any patient thought to be at high or imminent risk of suicide would be referred as an emergency to Secondary Care Mental Health services using a referral form and a phone call to the AWP (Avon and Wiltshire Partnership) triage team. We make clinical judgements around patient safety in the interim, and if necessary can direct the patient to a place of safety such as the Accident and Emergency department at the hospital.

Patients who 'do not attend' (DNA) for appointments routinely have their notes reviewed and are sent a text with a standard message around missed appointments. If it is clear from the notes that the patient has mental health concerns and therefore may have missed the appointment due to their condition deteriorating, then additional efforts are made to contact the patient – either a tailored text or task sent to the office team to contact the patient to rearrange the appointment. If there is no response to attempts to telephone them then a letter may be sent. If there were significant concerns about the safety of a patient then a welfare check could be requested from local police. If consent was in place to liaise with University support services then we would consider contacting them to express our concern.

Changes made:

Following the inquest touching upon NA's death, we have added an additional field on our first mental health assessment template regarding SSRI and suicidality: "If SSRI newly prescribed: counsel re side effects and risk increase suicidality initially; when is follow up?"

In response to the concerns expressed within your Regulation 28 report, we have moved appointments to review patients when starting an SSRI routinely to 1 week, if this is manageable for the patient, and have this as a 'booked' or 'known' appointment in accordance with NICE guidance.

The clinician ideally books the next appointment with the patient at the end of the consultation. They place a message on the appointment screen under the follow up appointment to alert them that this was a mental health review. If the patient cancels it would be obvious to the reviewing clinician who could follow up appropriately. If the patient DNA's then a review of the notes would be undertaken – see above.

Since the inquest we have requested additional funding from the University to advertise for a permanent Mental Health Nurse to join our team and this has been agreed. We are currently working on an advert and job description. The job plan for this member of the team would include reviewing patients under 30 thought to be at risk of suicide, or starting on SSRI, at 7 days. We are liaising with local partners, mental health advisory service and psychology team to plan how best to utilise this new resource.

As a practice we are committed to adhering to best practice wherever possible, and to ensuring that our procedures are compliant with NICE and local guidelines. The inquest touching Natasha's death has afforded us an opportunity to review systems in place alongside the relevant guidance. We are confident that the changes described above are consistent with local and national guidance. In future we will continue to monitor our systems at the practice to ensure we are providing care to our patients in accordance with these guidelines.