mentalwelfare commission for scotland

dignity & rights ethical tre respect ca & equality

INVESTIGATION

The care and treatment of Ms FG

Our aim

We aim to ensure that care, treatment and support are lawful and respect the rights and promote the welfare of individuals with mental illness, learning disability and related conditions. We do this by empowering individuals and their carers and influencing and challenging service providers and policy makers.

Why we do this

Individuals may be vulnerable because they are less able at times to safeguard their own interests. They can have restrictions placed on them in order to receive care and treatment. When this happens, we make sure it is legal and ethical.

Who we are

We are an independent organisation set up by Parliament with a range of duties under mental health and incapacity law. We draw on our experience as health and social care staff, service users and carers.

Our values

We believe individuals with mental illness, learning disability and related conditions should be treated with the same respect for their equality and human rights as all other citizens. They have the right to:

- be treated with dignity and respect
- ethical and lawful treatment and to live free from abuse, neglect or discrimination
- care and treatment that best suit their needs
- recovery from mental illness
- lead as fulfilling a life as possible

What we do

Much of our work is at the complex interface between the individual's rights, the law and ethics and the care the person is receiving. We work across the continuum of health and social care.

- We find out whether individual care and treatment is in line with the law and good practice
- We challenge service providers to deliver best practice in mental health and learning disability care
- We follow up on individual cases where we have concerns and may investigate further
- We provide information, advice and guidance to individuals, carers and service providers
- We have a strong and influential voice in service policy and development
- We promote best practice in applying mental health and incapacity law to individuals' care and treatment

Introduction

This short report explains our serious concerns about the way an NHS mental health service dealt with an urgent referral. There are important learning points for all services.

The Commission became aware of Ms FG following contact from the Scottish Government, advising us of a serious incident which resulted in Ms FG receiving care in a secure setting.

We were aware that Ms FG had not been assessed by psychiatric services prior to the incident despite her parents contacting health services (NHS 24 and local GP) in the 36 hours preceding the incident, due to their concerns about her mental health.

We contacted the Health Board involved to confirm that it had undertaken a Critical Incident Review and received a copy of its report and the action plan resulting from the recommendations. We also received further information at a later date on progress in addressing the recommendations

We contacted the GP practice involved and received a copy of its records relating to Ms FG

From the Critical Incident Review we noted that NHS 24 had been contacted by the family of Ms FG in the 2 days prior to the incident.

We contacted NHS 24 to confirm that it had undertaken a Critical Incident Review and received a copy of its report along with information on the actions taken as a result of its findings.

Background

Ms FG was a 22year old student living away from home where she was registered with a GP, but had returned to her parents' home at the time of the incident.

She had one brief contact with psychiatric services 2 years prior to the incident.

Her father reported that Ms FG had a couple of episodes prior to the incident when she had become distressed and smashed things up in the house

Summary sequence of events

Day 1.

Ms FG's parents were due to fly out on holiday, but returned from the airport, following a call from Ms FG who was in some distress and threatening to harm herself.

En route home to deal with the situation her father called NHS 24 for some advice, but was unable to provide details of his daughter's address and GP details. The call handler asked to speak to Ms FG. Her father made it clear that his daughter was not with him, and he didn't want to give his daughter's mobile number in case an unexpected call to her further exacerbated the situation. The call handler advised Ms FG's father to call when he was with his daughter or to contact her GP. She declined to put him through to a practitioner and failed to open a file or make a record of the call.

On arriving home Ms FG arranged an appointment with the family GP for 4pm that afternoon. Following this appointment the GP's conclusion was that urgent psychiatric assessment was required, although Ms FG was not detainable at that time.

The GP contacted the local intensive home treatment team (IHTT) requesting assessment. However, when asked if Ms FG required admission, the GP said no. This resulted in her being told to contact the sector psychiatrist for an urgent outpatient appointment.

The GP then contacted the local community mental health team (CMHT) at 17.30. The call went to answer phone.

Day 2

The GP contacted the local consultant psychiatrist and advised him of Ms FG's presentation and her conclusion that urgent psychiatric assessment was required. The psychiatrist advised that IHTT referral would be more suitable.

The GP again called the IHTT and informed them that the psychiatrist had advised that IHTT referral would be more appropriate. The GP terminated this call, due to frustration at the difficulty in having a referral accepted.

Following a failed attempt to obtain an urgent appointment outwith the NHS the GP again contacted the CMHT to speak to the psychiatrist. The psychiatrist was with a patient and did not return the GP's call.

Shortly thereafter Ms FG committed a very serious offence. Since then, she has been receiving care and treatment in a secure hospital.

Our Analysis

We had concerns about the NHS 24 response to Ms FG's Fathers call. Her father was not provided with any support or advice, nor was he signposted to other services other than his GP. Further, when we contacted NHS 24, it became apparent that a call record had not been made. We would have expected NHS 24 to have provided access to a mental health advisor, or to have acted as a gateway to other services.

We noted that the GP responded appropriately by offering an appointment within 2 hours of Ms FG's father's call, and spent some time assessing Ms FG before attempting to refer her for a psychiatric assessment. When this was not successful immediately, the GP attended the surgery, despite not being on duty, and continued over the following day to attempt to access services for Ms FG.

The difficulty which the GP experienced in making a referral was unacceptable. There was clearly a lack of knowledge of the current criteria for IHTT referral both within the mental health services and primary care, and the GP was not given information about availability of same day assessment either by the IHTT or the Psychiatrist. This resulted in the GP effectively being "bounced" between services, with no-one within mental health services taking responsibility for arranging an urgent assessment.

The main findings from the Critical Incident Reviews carried out by the Mental Health Services and by NHS 24 were as follows:-

Findings from NHS Board CIR

1. Updated information should be provided to referrers highlighting that same day emergency assessment can be requested for patients who are assessed as not requiring admission to hospital. This should also highlight that the referral process involves a dialogue and that the referrer can override the recommendation of the IHTT if he/she considers that the patient requires assessment that day
2. A wider review of acute access by General Practitioners to the psychiatric service should be undertaken to obtain information about any areas where changes require to be made to the service. This should include a review of the referral process.
3. It is noted that there is ongoing work to develop a single point of access to specialist mental health services. This should be progressed and should take account of feedback from referrers
4. The timescales for emergency, urgent and routine referrals to acute mental health services should be clarified and steps taken to monitor that these are being achieved. Steps should be taken to ensure that all staff understand these and a consistent response is provided. The process for referral should also be clearly articulated to General Practitioners and Community Mental Health Teams.
5. The Community Mental Health Team should review the process for taking and recording telephone messages and the learning should be widely shared across other services. All calls should be logged.
6. Steps should be taken to review the completion of the IHTT screening form to ensure that all information is recorded. This should include ensuring that any additions to the document are clearly dated and signed to make it clear who has completed the information.

Action taken by NHS Board

1. IHTT remit includes same day emergency referrals, even if not seeking admission. A new protocol for single point of access for the new psychiatric emergency hub has been implemented in November 2013. This includes a single telephone number for all same day referrals in and out of hours. The services incorporated are IHTT, Liaison and Duty psychiatrist. The changes to the service have been widely communicated via face to face meetings and email, an engagement event was held for GPs. Arrangements are in place to seek feedback and monitor the effectiveness of this.
2. Referral pathway developed and launched with emergency access protocol. This offers clarification re emergency urgent and routine referral process. Phased introduction of electronic referral pathways to the CMHT Service is being rolled out.
3. The importance of logging telephone messages has been raised with the CMHT. There is wider learning for all NHS services. This will be taken forward via the board Risk Network
4. IHTT staff had integral role in developing the revised pathway and emergency psychiatric hub. There has been an internal awareness raising initiative for

mental health staff and a formal communication to GPs and acute colleagues. This has included junior Drs. Information will continue to be included in induction process.

5. The process for completing IHTT screening form has been re-iterated to all staff ensuring that all parts of form are completed. Should further referral be made regarding the same individual this will be considered a new referral with new screening form.

Findings from NHS 24 Review

1. When Ms FG's father could not provide the call handler with all the details required, the call handler did not follow process to find out the location of the patient.
2. The call handler did not take team leader advice before advising the father to go home and either call the GP or NHS 24. When the caller asked to speak to a specialist in mental health for urgent advice, the call handler should have reverted to a team leader.
3. The call handler failed to make a record of the call as Ms FG had not given permission.
4. NHS 24 found that, taking account of the circumstances, if the call handler had followed the processes in place, Ms FG's father should have been put through to a team leader/nurse practitioner at the time of his call. This has been addressed with the individual involved.

Actions taken by NHS 24.

NHS 24 reviewed its processes to ensure these were fit for purpose. It highlighted learning points and amended its internal education programme to address this. It is undertaking an audit of its third party processes, which will be informed by the outcome of this review. The issue of failure to follow processes has been addressed appropriately,

Conclusion

We had serious concerns that an individual who needed urgent mental health specialist assessment did not receive this. We are aware that families and referrers can experience similar delays and difficulties in accessing urgent psychiatric assessment. Therefore, we believe there is merit in sharing these findings and the actions taken as learning points for other services.

It was **totally unacceptable** for the referring GP to be "bounced" between services. We are pleased that the NHS Board has taken action to address this. Other NHS mental health services should ensure that they have procedures in place to prevent a similar situation occurring.

We therefore recommend that all mental health services in Scotland have a single point of access for emergency referrals.

It is not possible to comment on whether the outcome would have been different if Ms FG had been assessed by a psychiatrist. The mental health service and NHS 24 undertook robust critical incident reviews which identified a number of systems and process issues which impeded Ms FG's access to services.

The services involved each took prompt action to address the issues highlighted. As a result we did not feel there was a role for the Commission in undertaking a further investigation, but the issues identified are not unique to the service in question.

One of the key elements of the mental health services response is the development of the 24 hour single point of entry for urgent referrals and the reviewed and clarified referral pathway which provides a more accessible service to referrers. They have plans to seek feedback from stakeholders and audit the effectiveness of this. We feel the service should be commended on this development.

However, we must emphasise that the service should have responded much better to a request for urgent assessment. It was tragic that it took a serious incident to highlight this.

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