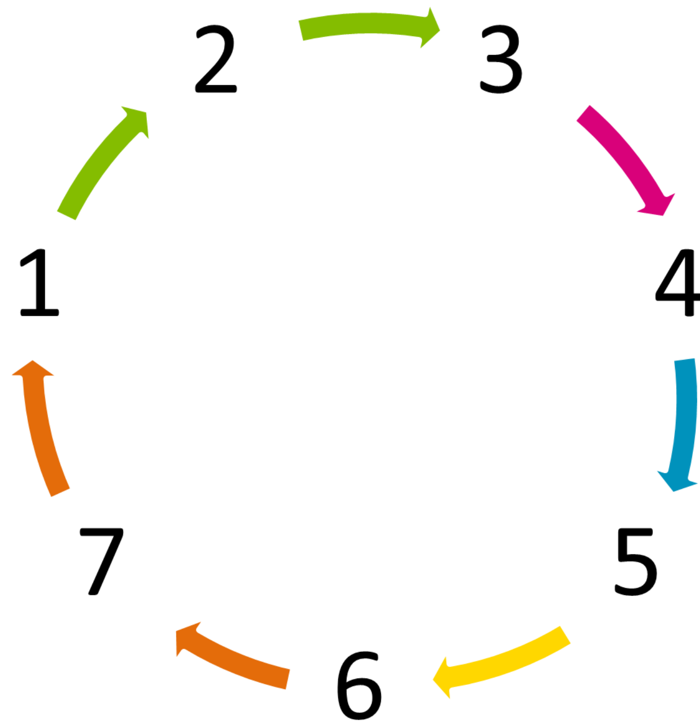

7 Minute Briefing: Brett

Safeguarding Adult Review (SAR): Brett

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Methodology

The Adult's Independent Chair is consulted on the methodology utilised in any given SAR and mandates the approach.

The WSAB used a 'Systems Learning' approach in the review of Brett. This is a model that was introduced by the Social Care Institute for Excellence following the Munro Review of Child Protection published in 2011. This approach sets out to study the whole system and look closely at what influenced professional practice. It does this by taking account of the many factors that interact and influence individual worker’s practice in a more in-depth way. The process seeks to be a collaborative process with professionals being actively involved in the review from the outset. The approach promotes reflective thinking as a system to identify the causal factors that influenced practice for which improvements can be made upon.

Background

Brett was described as always being a “sensitive lad” by his parents. He began to struggle with his mental health in his early 20’s and was given a diagnosis of schizophrenia. Following two periods of inpatient care under mental health, sadly Brett took his own life in Spring 2018.

The main themes within the case are:

- Mental Health
- Suicide

The main learning themes from the review are captured within Key Lines of Enquiry and in this case include:

1. Mental Health Care Coordination and Case Management
2. Access to Psychological Services
3. Accurate Record Keeping
4. Mental Health Crisis Intervention
5. Good Practice

Learning points were identified through the case review, highlighting areas of learning and improvement.

1. Mental Health Care Coordination and Case Management

Brett's father reported that by the age of 19, Brett had developed "quite severe anxiety". Over a three-year period he was a patient under the care of the early intervention team (was seen as having first episode psychosis and treated with anti-psychotic medication). In 2018, Brett suffered a relapse. The family described it had been stressful and quite difficult to get Brett re-engaged with services. He was readmitted to hospital in on an informal basis. He was discharged home within a few weeks but was not allocated a care coordinator. Brett was again admitted to hospital two months later following an attempted ligature and was seen as suffering from negative effects of schizophrenia. Following discharge, Brett had regular appointments with a care coordinator, however, he was not allocated an adult social worker on this discharge. This led to the input from Making Space not being discussed as part of his ongoing care (professionals wanted this input to be increased). Additionally, Brett had been referred to psychology but the waiting times for an appointment were very long. As a result of this the family pursued psychological therapy on a private basis.

Making a difference:

> GMMH have provided assurance through the introduction of weekly reviews of open cases via MDTs to ensure appropriate allocation of staff has occurred as well as routine audit of the system to quality assure Care Planning Approach (CPA), including staff allocation, risk assessment and multi-agency working

> GMMH have a policy for care coordinator cover and transfers out of borough within the Recovery Standard Operating Procedure (SOP) document

> Care Coordinators to include parents and carers in the CPA planning meetings to be developed through the Mental Health Transformation plans in the borough, work ongoing between the Local Authority Service Manager for Carers and the GMMH Carers Lead

> GMMH clinicians to undertake risk assessment and management training in respect to core competencies, and compliance to be monitored

> Care Coordinators to include multi-agency involvement within the CPA plan to ensure services and families/carers are certain of what services are being offered/provided to service users. The exact nature of the input should be documented in the CPA plans: GMMH care/safety plans include key contact names and numbers of those included in the patients support structure, and should contain triggers and coping strategies for relapse. These elements are quality assured by GMMH Quality Assurance Framework

2. Access to Psychological Services

The long waiting times to access psychological services were a result of staff vacancies at the time.

Making a difference:

> CCG to incorporate for assurance purposes within quality assurance and safeguarding contract meetings with GMMH

> Difficulties accessing psychological therapies (including waiting times) are being addressed by GMMH. CCG to provide WSAB with assurance from QSSG that there are actions addressing the availability of psychological services, including the following:

- Waiting lists

- Vacant posts have been filled with appropriately skilled and experienced professionals

> Think Wellbeing aims to achieve triage to assessment in 2-weeks. There are weekly meetings regarding the waiting lists for psychology, with those waiting longest receiving a review from an identified lead

3. Accurate Record Keeping

Mental Health case records did not document the conversations had with Brett in relation to the presence or absence of symptoms and suicide ideation, therefore it is not known what degree this was or wasn't explored by mental health services.

The independent reviewer concluded that "a core role of mental health professionals is to assess patients for the risk of self-harm or suicide". This highlights the importance of practitioners' confidence in having difficult conversations, recognising the signs and symptoms and accurately documenting and reporting the outcomes.

Making a difference:

> Case note entries should be meaningful and not open to question: explicit recording in case notes that documents the practitioners' discussions with the patient regarding the presence or absence of

symptoms and suicide ideation. GMMH quality assure through routine audit the quality of risk assessment in relation to self-harm and suicide, as well as the quality of the narrative recorded within the case records

> Ensure the issue of difficult conversations is included in WSAB Training

4. Mental Health Crisis Intervention

The family experienced difficulties accessing mental health services at times of relapse and deterioration following discharge, resulting in Brett having to re-present at the front door point of contact with mental health services, meaning repeating initial assessment and telling his story again, either by self-referral to mental health services or via presenting at A&E.

Self-referral to mental health services did not have out of hours provision, and consent was a barrier to assessment.

Facilities at A&E were unsuitable for patients in mental health crisis due to the busy and noisy environment of the department as this can exacerbate mental health difficulties, such as anxiety and paranoia.

Making a difference:

> WSAB to be assured via the CCG through QSSG and the Mental Health Programme Board that patients and their families/carers are provided with clear information about what actions to take in the event of a relapse in their mental illness after they have been discharged from services

> The Mental Health Transformation Plans for the borough includes developments for appropriate settings and/or reasonable adjustments in existing settings to ensure patients suffering from mental illness have access to appropriate facilities at point of crisis, including review of current crisis care alternatives and exploring options for crisis pads

> The Mental Health Transformation Plans for the borough includes a review of service provision and accessibility in the community with aspirations to improve the service offer through an integrated approach

5. Good Practice

- When the Care Coordinator became involved, there was good involvement of Brett's family throughout the Care Programme Approach (CPA) framework
- Trauma informed practice was observed in:
  - mental health practitioner liaison with RAID team regarding assessment
  - face to face handover of care between the inpatient psychologist and the care coordinator
- Consent was appropriately sought by Brett's Care Coordinator to share his information, including his Crisis Plan
- Consent was appropriately sought by Brett's Private Psychologist to liaise with other agencies involved in his care
- The family were offered bereavement support following the death of Brett by:
  - The private psychologist
  - The Care Coordinator
- The communication between the Adult Mental Health Team and the General Practitioner was noted as being very comprehensive and exemplary
- A comprehensive and detailed assessment of suicidality was completed and well documented by the duty doctor in early 2018
- The inpatient Psychologist met with the Care Co-Ordinator to provide a handover of Brett

Practitioner Questions to Consider

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1. ***What processes and procedures are in place to allow service continuity in the best interest of service users and their families, this includes management of waiting lists?***

2. ***Are you aware of the wider services that your service user is in receipt of? And what processes are in place to understand this and promote multi-disciplinary working?***

3. ***Is your service aware of the impact of accurate and descriptive recording, how is this promoted?***

4. ***How does your service promote a think family approach to service provision, are you able to express and promote consideration of concerns raised by the people that know the service user best?***

5. ***Do you have clarity regarding the lived experiences of individuals you work with outside of their presenting issues? Do you have a trauma informed practice approach?***

6. ***Do you feel confident in directly asking a service user about their current mental health, and recording and responding to what you hear? (Connect 5 Training - see link in next section)***

Want to learn more?

Wigan and Leigh Carers Centre:

Wigan and Leigh Carers Centre (wlcccarers.com)

Bereavement Support:

bereavementsupport@wigan.gov.uk

Connect 5 Training:

Connect_5_Briefing.pdf (nwppn.nhs.uk)

Wigan contact: Jo Norton - jo.norton@wigan.gov.uk

Trauma and Resilience Training:

WSAB Training Brochure 2021 (wigan.gov.uk)

Evidence Led Practice:

Suicide prevention toolkit - Social Care Online (scie-socialcareonline.org.uk)

WSAB Training:

WSAB Training Brochure 2021 (wigan.gov.uk)