Gender Identity Clinic

Gender Identity Clinic (GIC) Learning from Deaths

12th December 2022

NHS
The Tavistock and Portman
NHS Foundation Trust

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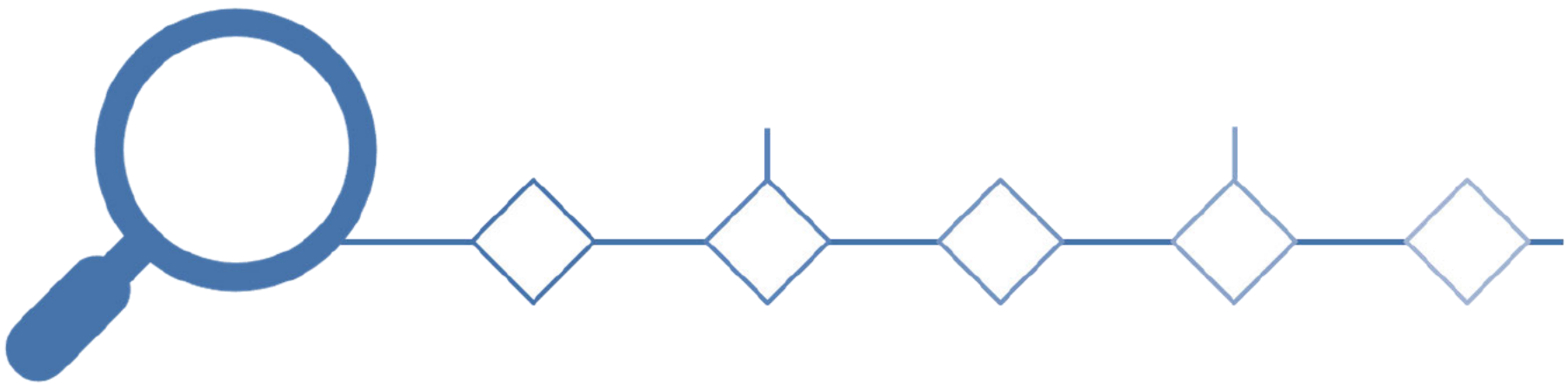
Agenda

Item	Title	Lead	Time
1.	Introduction & context	[redacted]	5mins
2.	Activity 1: Process of patient death	[redacted]	10mins
3.	Activity 1: Group Feedback	All	10mins
4.	Activity 2: Case Vignette	[redacted]	20mins
5.	Activity 2: Group Feedback	All	15mins
6.	Q & A	[redacted]	10mins
7.	Next steps	[redacted]	5mins
8.	Closing	[redacted]	5mins

Context

- Backlog of reportable deaths due to problem with the SPINE
- Outcome of mock CQC inspection
- Single point of failure for recording of incidents and reviewing of incidents and learning
- Develop a learning culture



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Focus for today

Clarify:

- What is an SI?
- Trust responsibility to SIs and deaths

Understand:

- GIC roles and responsibilities to deaths of patients on the waiting list (harm review) and those open at the time of death

Identify:

- Current gaps and areas for improvement
- Solutions to address gaps
- Escalation processes

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Serious Incidents (SIs)

Serious incident reviews are described in the NHSE Serious Incident Framework (March 2015) as those that:

"… include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services."

Patient access to their new (prospective) health information

- Enabling patients to view their GP health record through the NHS App and other online services.
- From 5 Dec 2022 phased rollout to allow new health record entries, including appointment details, test results and clinical letters, to be made visible to patients automatically.
- 16 years and over.
- Does not replace the current practice of communicating and sending letters directly to patients.
- This will include information sent into general practice from secondary care and other providers to be added into the patient record, such as outpatient clinic letters, discharge summaries and other correspondence.

Patient access to their new (prospective) health information

- Exceptional circumstances, GP can redact whole items that should not be disclosed, including “where the disclosure of or access to the information is likely to cause serious harm to the physical or mental health of the individual or another person”.
- If a clinician writing a letter feels a specific piece of correspondence meets this threshold, they should mark the letter clearly and prominently in this way e.g. “not for disclosure to patient”.
- It is not possible to redact parts of letters or other correspondence, only the whole item can be redacted.
- Further info – Comms Bulletin this week.

Activity 1: Process of patient death

1. What do you do when you receive a notification of a patient death?

2. What do you do if you find out your patient has come to harm?

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Activity 1: Group Feedback

1.
2.
3.

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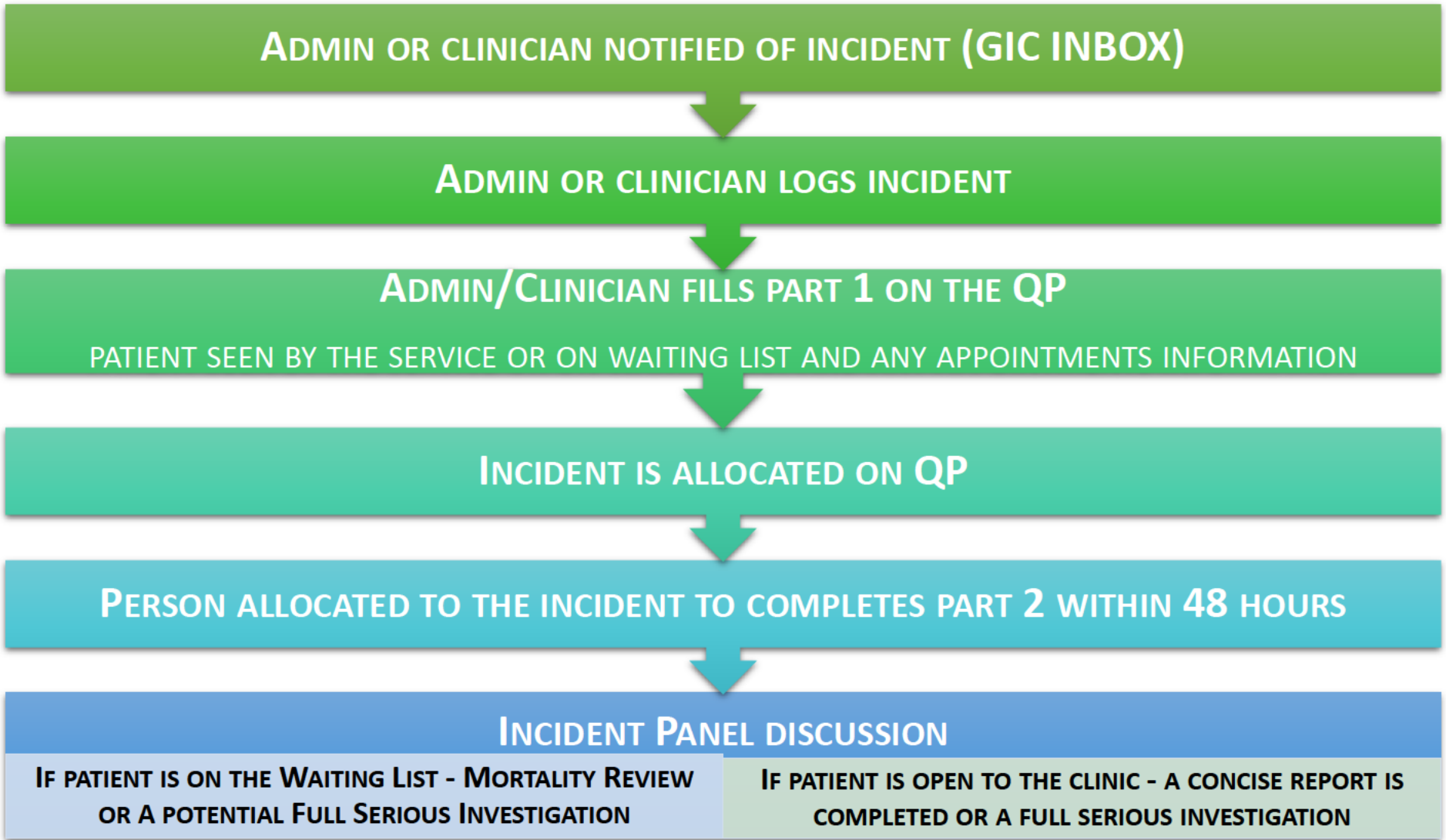
SI Reporting Map



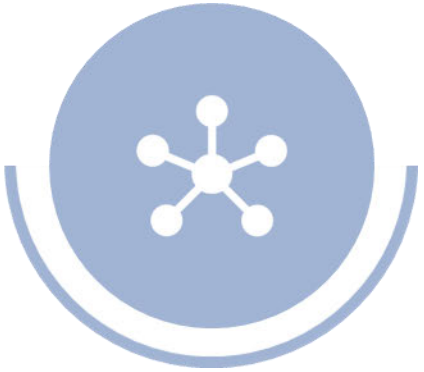
Areas of good practice

Endocrinology Pathway:

- Notes and plans easy to follow with clear instructions
- Evidence that patients understand their treatment plan and management of expectations
- Sign posting when issues arose during sessions and escalation
- Timely documentation

General:

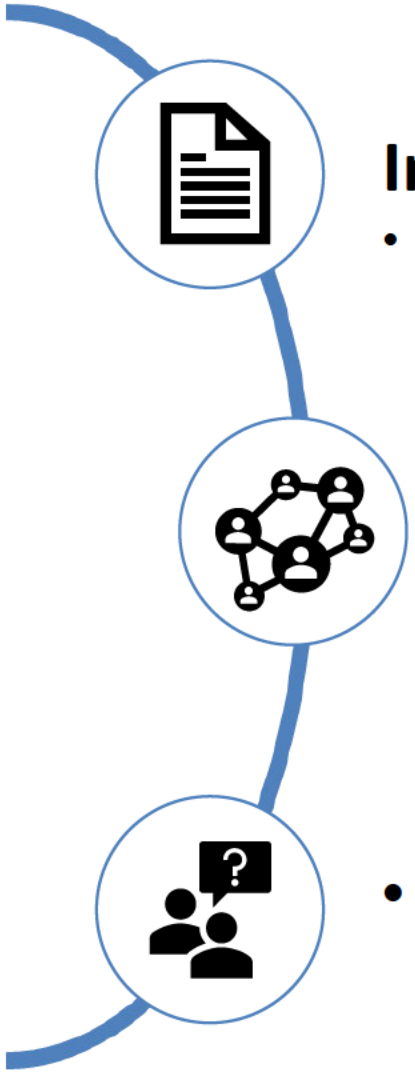
Patient telephone contact to minimise DNA



Process:

- Clear process for hormone endorsement
- Use of assessment template

Areas for learning (1/3)



Interagency communication

- Communication with multiagency network

- Service provision for patients that receive private care and limited information on Care Notes

- Minimal evidence of professional curiosity and further exploration of bio-psycho-social needs

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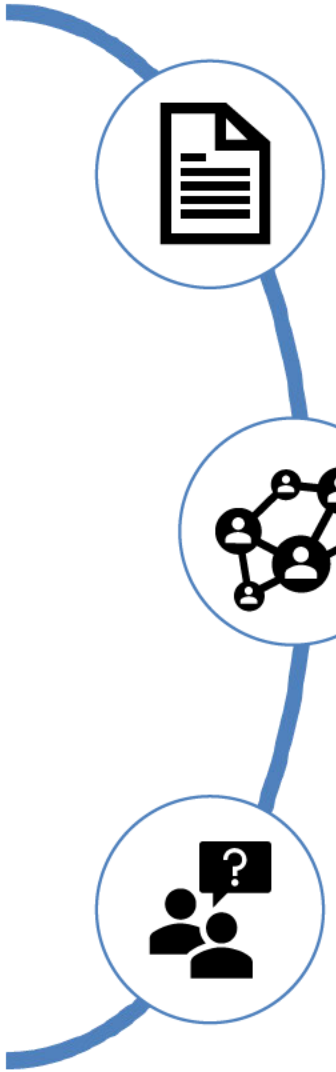
Areas for learning (2/3)



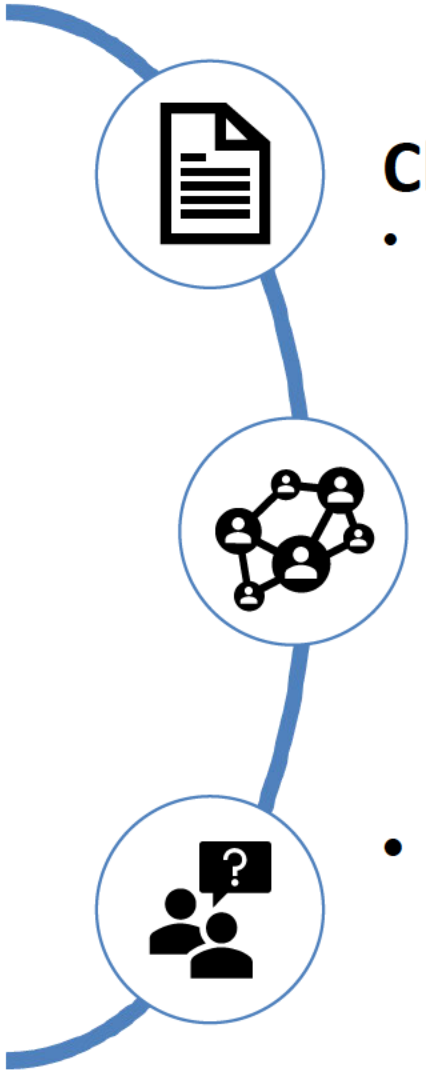
Record Keeping

- Lack of consistency in location of clinical documentation on Care Notes
- Delays in letters being sent out
- Incomplete assessment templates

- Poor quality letters – unfinished sentences and grammatical errors
- Clinical notes section used primarily by admin to note various telephone/email contacts made

- Handwriting not legible
- Delayed notification of patient death leading to continued contact with deceased patients

Areas for learning (3/3)



Clinical Assessment

- Identified risk, e.g. alcohol and mental health not explored even when raised as a risk by referrer

- Minimal evidence of professional curiosity and further exploration of bio-psycho-social needs in a context of long term health conditions

- Where mental health needs apparent limited evidence of mental state examination or consideration of the impact of mental illness on patient's ability to make certain decisions around their health and safety and escalation of these concerns

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Risks

Organisational Risk

- Patient safety concerns
- Reputational damage
- Potential for litigation

Professional Risk

Responsibility
and accountability

Service Risk

- Poor service user outcomes
- Reputational damage
- Potential decommissioning of service
- Increased regulator and commissioning scrutiny

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Activity 2: Case Vignette

• Name: December	•Cause of death: Suicide
• Age at referral: 18 years	• Total number of appointments offered: 16
• Assigned at birth: Female	• Number of attended appointments: 10
•Length of time on the waiting list: 3.5 years	• Cancelled appointments: 4
• Age at time of death: 23	• DNA: 2

Referral Info: Diagnosis of autism, emotionally unstable personality disorder, depression and anxiety, alcohol dependence, historical and current history of self harm. Prescribed antidepressants and anti-psychotic medication, open to local adult mental health team and leaving care team (all information provided). GIC was the most active service involved at the time of death.

Patients' expectation: endorsement for testosterone therapy, bilateral mastectomy and voice exploration therapy

GIC Journey:

- Core Clinician: Three appointments with Consultant Psychiatrists
- Endocrinology: Six appointments
- SLT: three appointments
- Psychology: Attended the full group sessions
- Appointment themes: 1 bottle of vodka a day, low mood, worthless thoughts and issues with disassociation.

A clinician requested asked in their letter that the GP forward the clinic letter to the mental health team.

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Activity 2: Overarching Question

- How do the GIC ensure that patients presenting with this level of complexity are safely cared for and managed in their GIC journey?

Discussion

- How do clinicians hear and manage worrying information in clinical sessions. What do you do with this information afterwards?
- For complex patients that see multiple clinicians in GIC how is the care (information) coordinated to ensure that there is a joined up approach?

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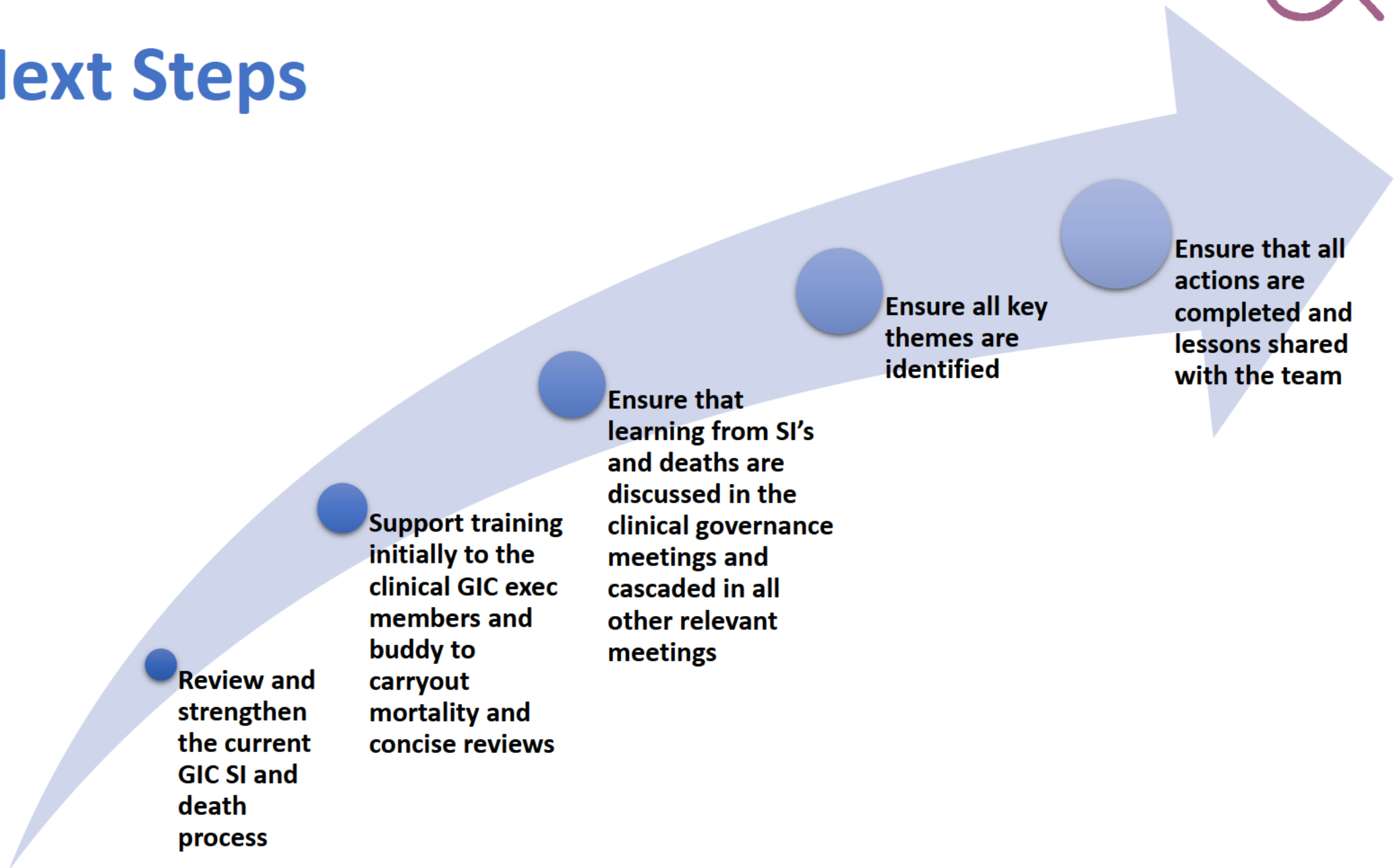
Activity 2: Group Feedback & Next Steps

1.
2.
3.

Next Steps


Review and strengthen the current GIC SI and death process
Support training initially to the clinical GIC exec members and buddy to carryout mortality and concise reviews
Ensure that learning from SI's and deaths are discussed in the clinical governance meetings and cascaded in all other relevant meetings
Ensure all key themes are identified
Ensure that all actions are completed and lessons shared with the team

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THANK YOU!

[redacted]