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17 July 2014

**PRIVATE & CONFIDENTIAL**
Mrs P Harding
Her Majesty's Coroner for Mid Kent and Medway
Kent Register Office
The Archbishop's Palace
Palace Gardens
Mill Street
Maidstone
Kent
ME15 6YE

Dear Mrs Harding

**Re: Inquest touching the death of Peter Franklin**
**Report under paragraph 7 Schedule 5 of the Coroner and Justice Act 2009 (prevention of future deaths)**

Further to your report relating to the above matter, I write further to your receipt of the joint action plan formulated by both Maidstone and Tunbridge Wells NHS Trust and Kent and Medway NHS and Social Care Partnership Trust in addressing the issues raised during your enquiry. This action plan was to ensure robust learning and changes in practice to the way both organisations work together to care for patients with mental health issues who may attend our A&E departments.

Firstly I would like to address the issue of confusion in terminology 5(1).The use of a SMART Tool was discussed and agreed at the Emergency Directorate Clinical Governance meeting on 1st July 2014. It is being implemented from an Emergency Department perspective by Dr Bell, Consultant in A&E Medicine and Cliff Evans, Consultant Nurse. Once the design is finalised this will be incorporated into the Junior Doctor Handbook. A copy of the format is attached for your information. This will be used in conjunction with the Mental Health Trust.

5 (3) In the matter of discharge summaries and timely information reaching the patients GPs, the Trust is working towards implementing the Electronic Discharge Summary in line with the rest of the Trust. This is being coordinated by the Head of IT and Information Governance. This will be in place by October 2014. In the meantime all paper discharge summaries are signed and sent by post.

The inaugural frequent attenders' meeting was held within our clinical governance meeting of 1st July. It was agreed that patient who have had high attendance numbers will be highlighted to their GP and mental health team (if necessary). This will take place monthly and will trigger Multidisciplinary Team meetings in many cases. Each quarter these cases will be reviewed within our Governance meetings with a mental health team representative in attendance.

Mental Capacity Act training for doctors and nursing staff is already mandatory training but we have added a 3 hour session to the junior doctor teaching programme dedicated to this topic.

I have attached for your information copies of our Governance Meeting Minutes and the Junior Doctor teaching programme.

As you will be aware from KMPT, there has been investment by West Kent Clinical Commissioning Group to extend the hours of operation of the Liaison Psychiatry Service. At the time of Mr Franklin's death the hours were 9-5 for 5 days a week. The new service is going to be seven days a week 9-5 and 9-midnight Thursday to Sunday once additional recruitment is in place.

In summary I hope we have been able to demonstrate that appropriate measures have been and continue to be put in place to ensure the continued safety of our patients and meet the requirements of your report. The measures will continue to be monitored at Directorate meetings as well as at the Quality and Safety Committee.

Should you require any further information, please do not hesitate in contacting me.

Yours sincerely

[redacted]

[redacted]
**Chief Nurse**