Great Western Hospitals NHS
NHS Foundation Trust

The Great Western Hospital
Marlborough Road
Swindon
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Tel: 01793 60 40 20
[redacted]

8th May 2014

Private and confidential

Mr David W G Ridley
Senior Coroner for Wiltshire and Swindon
Wiltshire and Swindon Coroner's Court
26 Endless Street
Salisbury
Wiltshire
SP1 1DP

Dear Mr Ridley

Re: Regulation 28 Report to prevent future deaths
Andrew Michael Horgan (deceased)

Thank you for your letter of 10th April 2014 summarising the circumstances that led to the sad and untimely death of Mr Horgan. This letter sets out the Trust's response to your report.

Your letter raised concerns about this case, around the lack of understanding by medical staff about the procedure to engage our mental health provider, the Avon and Wiltshire Mental Health Partnership (AWP). Regulation 28 was issued because during the Inquest [redacted] did not provide a clear understanding of the referral procedure needed to initiate an assessment by the community outreach team following Mr Horgan's self-discharge from hospital. You requested that the Trust should review the appropriateness and effectiveness of training currently provided to all staff.

The Deputy Chief Nurse who leads on compliance with the Mental Health Act for the Trust, has reviewed Mr Horgan's case with regards to the referral process and current training

provision. The review of the referral process and actions arising from this was carried out in collaboration with AWP. The findings, recommendations and actions are listed as follows:

Referral to mental health services
The review of the Trust's referral process to mental health services showed that there is a clear referral process in place for patients in the Emergency Department or those admitted into Great Western Hospital (GWH). During 2013/14 staff referred 911 patients to the Adults of Working Age Psychiatry Liaison Service; 321 patients to the Adults of Later Years Psychiatry Service and 94 patients to the out of hours intensive team.

In Mr Horgan's case, there was a miscommunication as to whether the contact with the out of hours intensive team was for advice or referral to mental health community services upon Mr Horgan's self discharge. The Trust and AWP both agreed that this area of practice should be made clearer to all staff. The AWP documentation record has now been updated to include a question making it clear that the telephone call from GWH staff is either for referral, advice or both. In addition, the Trust is advised that community crisis intervention as, in the case of Mr Horgan, is only accessible by the patient contacting the out of hours General Practitioners' service. The patients' General Practitioner will normally be informed about their admission or attendance to hospital through the Trust Patient Electronic Discharge Summary system.

The Trust acknowledges that both staff and patients should be made aware of this and as a result, the information will be included in the patients' information leaflet that will be available at the end of May 2014. In addition, this will be included in the Trust's Mental Health Act training programme and the Trust's intranet site will be updated to reflect this information.

Review of Mental Health Act Training
The Trust provides mandatory training to all clinical staff to support understanding of and application of the Mental Health Act (MHA), the Mental Capacity Act (MCA) and the Deprivation of Liberty Safeguards (DoLS).

In September 2013, the Trust implemented face to face mandatory training as opposed to training via our E-Learning programme. The change was implemented because the Trust strongly acknowledges the value of face-to-face interactive learning, enabling staff to explore issues and learn from case presentation.

A total of 82% of clinical staff had untaken Mental Health Act training and 94% MCA and DoLS during 2013/14. In addition to mandatory training, four one day sessions were held in the autumn of 2013 looking specifically at MCA and DoLS. A total of 91 clinical leaders from across the organisation attended the training that was delivered in collaboration with specialist leads for Wiltshire and Swindon local authorities, as well as the Trust's legal advisors, Bevan Brittan.

Over the last two years the Trust has worked closely with AWP and commissioners to improve the delivery of an effective psychiatric service at GWH. The number of Mental Health Liaison nurses has increased from 2.6 wte nurses to 6.8 nurses, enabling bespoke

training to take place on wards and departments. In addition, the Trust now has a dedicated Consultant Physiatrist who was appointed by AWP and who commenced work with GWH on 4th May 2014. This new position will enable staff, in particular our medical teams, to have greater access to advice, support and training. The Trust is satisfied with the provision and impact of MHA training and also that this is monitored on a regular basis via the Trust's internal governance arrangements.

In conclusion, I hope that this response provides you with assurance that the MHA referral process to AWP and training provision at GWH are working effectively. However, the case has presented gaps in the recording of information by clinical staff and advice given to patients that may require support in the community following their discharge from hospital. Actions have already taken place to address the two issues. If you require any further information please do not hesitate to contact me.

Yours sincerely

Neri Vaughan

Nerissa Vaughan
Chief Executive