South London and Maudsley NHS
NHS Foundation Trust

Inquest touching on the death of Christopher Ajayi:

Ms Ormond-Walshe, HM Coroner

Southwark Coroner's Court, 1 Tennis Street, London SW1 1YD

South London and Maudsley NHS FT response to Preventing Future Death (PFD) report

December 22nd 2014

1. Introduction

The following statement has been written in response to the Coroner's regulation 28 report to prevent future deaths (dated 30.10.14), which detailed failures identified in CA's care, together with a number of related concerns.

These failures related primarily around discharge planning and discharge follow up (9 in total, 6 'gross'). The Coroner judged that on the balance of probabilities one or more of the identified gross failures were linked with CA's death by uncontrolled diabetes.

The Trust accepts the Coroner's duty to report (under Section 5, paragraph 7) and this statement seeks to respond to the failures identified, together with addressing the concerns raised.

The Trust had invited the Coroner to write her PFD report specifically to our Trust in order that we may further clarify matters of concern as lead provider for CA's integrated health and social care.

This response elaborates on [redacted] witness statement (17.07.14) and oral evidence to the Inquest, given on behalf of the Trust. This evidence covered the Trust's expected standards of clinical communication about collaborative discharge care planning around mental and physical health needs, together with all the changes that have taken place in the Trust and the learning that has arisen from this incident.

Although requested as a sole response from the Trust, this response has been discussed with the London Borough of Southwark, as our Local Authority partners in delivering integrated health and social care.

2. Inquest Evidence, Summing Up and Conclusions (determination)

In considering the failures and concerns raised, the Trust was reassured that the Coroner, in her summing up, was comforted by the internal Trust Serious Incident (SI) Investigation and action plans, together with the senior level interest and attendance throughout the evidence.

The Trust is grateful that the Coroner acknowledged that lessons have been learnt through this incident, both internally within the Trust and across interface partnership working.

The lessons are being taken forward in very positive collaborations with our Southwark Clinical Commissioners, together with Acute, Primary and Third sector providers, particularly with regards to supporting patients, like CA, with severe and enduring mental illness and co-morbid physical health problems.

3. Cause of Death

The Trust agrees with the Coroner's verdict that on the balance of probabilities the cause of CA's death was found 1(a) Hyperosmolar Non-Ketotic Coma (HONK), 1(b) Diabetes Mellitis type II (Insulin dependent), Schizoaffective disorder.

4. Neglect (rider)

The Trust also accepts that the Coroner has reached a Part 4 (Conclusion) conclusion that the death was due to natural causes to which Neglect contributed.

5. Concerns raised in the Regulation 28 report and Trust response

5.1 Discharge Planning and Discharge Follow Up

The Trust acknowledges and agrees with the Coroner that in this specific case discharge planning and discharge follow up fell below expected standards.

Mental and Physical Health

CA was known to have complex mental and physical health needs, with a long history of not complying with his treatment.

As a result, his mental health after care was appropriately discharged under a Community Treatment Order with a condition of remaining adherent with depot antipsychotic medication.

However it was also established, but not effectively communicated, that his physical health status and treatment had changed significantly before discharge and that an appropriate after care package should have been put in place to reflect this.

An appropriate physical health care plan that had been instigated on the in-patient unit was not translated into an effective and robust community physical health care plan covering appropriate support and supervision.

Social Care and Accommodation

CA was known by both The Trust and Local Authority providers to have complex social housing needs.

An In-Patient ADL assessment identified that CA was able to live and function independently, assuming his mental health was stable.

However, there was a lack of effective communication and clarification between the care co-ordinator and in-patient unit and Local Authority Housing providers regarding the exact nature of the support and supervision any post discharge accommodation would require, and as such CA was discharged to unsupported accommodation with no assertive community supervision.

Action taken:

- The breakdown in effective clinical communication and collaborative care planning was noted in the Trust's SI investigation report (together with action plans) and further acknowledged and discussed in supporting evidence given at Inquest.

- All Trust and London Borough of Southwark (LBS) staff involved in this specific case gave evidence, learnt lessons and have been de-briefed on the Coroner's conclusions.

- All Trust and LBS staff involved have been given reminders about the Trust Policy guidance on effective discharge planning, clinical documentation and physical health which are all pertinent to this case.

- Prior to the Inquest, the Trust SI Investigators had met with the In-Patient and Community Teams (March 2014) to feedback findings of the investigation.

- Progress has been made from the updated action plans following the Trust internal SI investigation, resulting in more robust systems and structures being in place between the Southwark in-patient and community teams.

- GP registration: this is a National MHMDS quality requirement, monitored for all Trust patients; ordinarily administrative staff within the In-Patient ward concerned are extremely vigilant in checking all patients have a registered GP; these GP checks, including cross reference to the NHS Spine and ensuring GP email enablement are under constant internal monitoring.

- Pre-discharge meetings: community teams are sent dates for these meetings in advance from the in-patient team (via email) and consider these in daily team planning meetings.

- Minimum standards of contact between community and in-patient teams: this currently takes place on average once a week, with improvement noted in overall communication between inpatient, community and other services.

- Discharge proforma (discharge notification): this is now routinely completed and copies sent to community team/team manager on the day of discharge (compliance is monitored through ongoing audit).

- Discharge summaries: the Trust has an expectation that all patients discharged have a summary record to their in-patient mental and physical health care, treatments and risks (compliance in monitored through ongoing audit).

- Multidisciplinary team discussions: daily review meetings, 'zoning' systems and more structured weekly clinical team review meetings have been developed ensuring effective team-based case load reviews and to improve oversight and monitoring or individual Care Co-ordinators work.

- The community team involved have undertaken two specific audits; (a) Team 7 day follow-up performance (Oct-Dec 2014) showed no missed reviews; (b) Discharge of two patients with unstable diabetes (Dec 2014) demonstrated extensive communication and forward planning prior to discharge, appropriately involving all partners.

- Audit processes, addressed in 1:1 supervision as well as monthly Performance meeting with Director for Community services, and Borough Community Service Leads, including (a) 7 day follow up, (b) discharge notifications, (c) physical health checks, (d) supervision and appraisal.

- Community Treatment Order (CTO) initiation at discharge: the Trust issued policy guidance (Sept 2013) clarifying that the In-Patient Responsible Clinician (RC) undertakes the CTO initiation, together with an Approved Mental Health Practioner (AMHP) from the receiving community team, setting CTO conditions that have previously been discussed with the receiving community RC.

- Trust Board Level feedback: Senior Trust staff have been extensively briefed both in preparation, during and after this Inquest; concerns raised have been acknowledged and taken forward, particularly around the area of planning, instigating and joint working partnership arrangements for patients with severe mental health problems and co-morbid (serious) physical health problems.

5.2 Care Co-Ordinator: Roles and responsibilities

The Trust acknowledges that the Care Co-ordinators role supporting patients suffering from severe and enduring mental health problems is a challenging and vital role in effective delivery of integrated health and social care.

Staff are required to be highly qualified (Band 6 grade and above), trained and supported to undertake their duties; all Care Co-ordinators have comprehensive induction to the role, including the statutory expectations for both health and social care and additional training is offered, tailored to their specific needs.

All care co-ordinators within Trust community teams work within a Multidisciplinary (MDT) setting; 1:1 clinical and performance supervision is provided by the community Team Leader (average monthly; more frequent as required), with the expectation that Care Co-ordinators additionally update other team members on important developments for individual patients at both morning handover meetings, weekly clinical MDT clinical reviews and regular CPA community reviews.

Team Leaders within community teams have a Co-Leadership role with the Consultant Psychiatrist in overseeing the clinical care for all patients under the teams care; their role is also to allocate patients to individual Care Co-ordinators, delegating responsibility to closely manage those individuals under the Care Programme Approach (CPA) framework and monitoring this process under 1:1 supervision.

All staff employed by the Trust are professionally accountable to the Trust and their Professional regulators; they have a responsibility to escalate any concerns through the supervision process and MDT structures and are made aware of this at induction and through the supervision process.

Actions taken:

- Trust revised Supervision policy (Sept 2014); this recent policy update which covers Trust and LBS staff, has been sent out to all staff and available on the Trust intranet for reference, sets out clear expectations of staff supervision, recognising effective supervision as an integral aspect of the working lives of all NHS clinical and social work staff to support them to deliver the best care to patients and their carers, provide opportunity to develop as competent parishioners and to develop their skills.

- Trust expectations of Band 6 Mental Health Practitioners and Social Workers are consistently raised through supervision, and regular supervision for all staff is constantly monitored.

- Staff mandatory annual training is centrally monitored.

- Performance concerns are managed through regular supervision, increasing the frequency of supervision as required; annual appraisals of competencies, training and support needs are closely monitored for compliance with Trust expectations

- Individual failings identified in this case are being robustly managed under the Trust's performance management framework.

- Case load management: Southwark community psychosis teams have active case-loads between 250-300 patients, resulting in average Care Co-ordinator case-loads of 25-30; the Trust continues to work with stakeholders in Primary care and the Third sector to develop capacity within the active case load, aiming ideally to reduce the average Care Co-ordinator case load to facilitate enhanced delivery of evidence based interventions; case loads are monitored on an ongoing basis, both within 1:1 supervision, and across the community as a whole.

5.3 Trust Safety Net beyond supervision

The Trust has clear Policy guidance (acknowledged by the Coroner) around standards of clinical communication (verbal/written) between (a) In-patient to Community (handover of secondary care mental health responsibilities), (b) In-patient to Acute (KCH) to ensure effective interface working around Physical Health care, (c) In-patient to Primary Care (GP: Practice & District Nurses) in appropriately transferring for physical health clinical responsibilities and (d) the Trust and Local Authority (under S75 responsibilities) for delivering integrated health and social care.

Actions in process:

- Clinical Commissioning: the Trust is currently involved in discussions with Southwark Clinical Commissioners with respect to changing the emphasis of services commissioned, embedding principles of the Trust Adult Mental Health model (recently introduced in Lambeth and Lewisham boroughs) including teams undertaking more structured clinical reviews and developing robust systems to improve collaborative interface working with in-patient services, crisis services, local

authority and the third sector; the Trust expects to hear from the Southwark CCG in early 2015 about their intentions.

- King's Health Partners Physical Health developments; the Trust has an appointed Physical Head Lead who is actively engaged in King's Health partnership discussions and developing service level agreements (SLAs) with our Acute and Primary sector partners.

- ICT harmony: there have been significant developments in increasing mutual access between the Trust and Acute electronic patient record systems, with the development of an ICT 'Portal' to review key clinical information; further developments are underway to link these secondary care systems with Primary care ICT (EMIS) systems; this work is further being supported by the Southwark CCG.

- MDT Physical Health leads within community MDTs: teams are being encouraged to identify and support individual team staff members to lead on developing support for patients to engage with the assessment, treatment and support around their physical health.

- Commissioning intentions (2015/16); appropriately supporting community patients to manage their physical health are being prioritised in the next round of CQUINs; there is a range of collaborative initiatives including consideration of pilots with GPs undertaking outreach clinics in community team bases to increase the numbers of patients receiving appropriate physical health assessments, investigations and interventions.

- Southwark Diabetic services; discussions are underway to scale up the award winning Diabetic Liaison service currently running at KCH to assist patients with severe mental health disorders, with additional training being developed for community mental health staff.

- Community District Nurses: the Trust is working with our partners to ensure District Nurse provision to ensure safe community diabetes management.

- Partnership working around social care and support: discussions are currently underway reviewing housing and community support needs for patients to appropriately address physical health care once living independently in the community

- Additionally, there is a further Serious Case Review underway, managed through the Safeguarding Adult Partnership Board, which will further understand the issues raised by this case and develop our learning.

6. Governance

Robust discharge planning and follow up and support to care coordinators are supported by the actions outlined in this report. However, the Trust will undertake an audit in March 2015 to assure itself and partners that implementation has been effective.

The audit results will be reported and reviewed by the Trust Adult Safeguarding Committee and the London Borough of Southwark's Safeguarding Adults Partnership Board, and with final review and sign off by the Trust Board's Quality Subcommittee.

7. Conclusion

This report has set out a range of actions already under taken by the Trust and further action proposed that seeks to address the concerns raised by Coroner's conclusions issued in her PFD report.

The Trust acknowledges that important lessons have been learnt from this specific case that are being taken forward in improving integrated working; the Trust is otherwise confident that there is no systemic problems with regard to discharge and community follow up of similar patients with complex mental and physical health problems.

22.12.2014