A teaching trust of Brighton
and Sussex Medical School

Sussex Partnership NHS
NHS Foundation Trust

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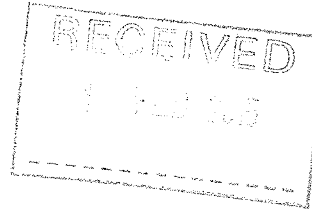

10 February 2015

Miss Veronica Hamilton-Deeley LLB
Her Majesty's Senior Coroner for the City of
Brighton & Hove
The Coroner's Office
Woodvale
Lewes Road
Brighton
BN2 3QB

Dear Miss Hamilton-Deeley

Re: The late Paul Leslie Hyde

Thank you for your letter of 2 December 2014, your report written pursuant to the Coroners & Justice Act 2009 and regulation 28 of the Coroners (Investigations) Regulations 2013, and for drawing your concerns to my attention. I was very sorry to read your concerns in relation to the sad death of Mr Hyde. Firstly, I wish to offer our condolences to Mr Hyde's family.

[redacted], [redacted] and myself have taken the matters you have raised extremely seriously, and seek to reassure you that work has been undertaken, and is on-going, to improve practice in Sussex Partnership NHS Foundation Trust. This letter is a joint response from all recipients. The letter was directed to the City Council and although mental health services in Brighton and Hove are integrated with the Council there was no specific role identified for Adult Social Care & Health in Mr Hyde's care.

Your concerns relate to the Assessment and Treatment Service (ATS) clinical triage service. [redacted] West Assessment and Treatment Service Team Manager confirmed that there was a four day delay in the triage administrators sending Mr Hyde's GP re referral to the West Hove Assessment and Treatment Service.

[redacted] Service Director for Brighton & Hove has confirmed that he is in discussions with the CCG and there is in place a joint Performance Improvement Plan in relation to the 4 Week Wait for routine referrals into the Assessment & Treatment Service. Actions include, a review of the administration triage processes to address triage waiting times. This recognised the need for an additional administrator in Triage and I am pleased to say recruitment to this post has been completed. A further action was a review of the triage function/process to include increased involvement from Consultant Psychiatrists and additional members of ATS. All clinical triage meetings have a Consultant Psychiatrist, lead nurse, and administrator present. Following Mr Hyde's inquest, [redacted] Associate Specialist has been invited to attend the triage meetings on a regular basis.

The use of the Breach Tool has been extended and the system is now more robust. Medical Personal Assistants now complete this for all referrals, regardless of the triage decision. Team leads have oversight of the tool and it is a 'live' record of all pending contacts, whether by telephone or face to face with service users. All actions / outcomes from the clinical triage meetings are now recorded on the Breach Tool and these are closely monitored. The Breach Tool guidance has been reviewed and staff have received clear instruction on how to use the tool.

In his evidence to you, [redacted] said that an appointment with himself would have been appropriate for Mr Hyde. You were understandably very concerned about this, as I was, and our shared concerns have been thoroughly addressed within the Trust. To reduce the likelihood of a similar occurrence in the future, the following improvements to the service have taken place in order to ensure all triage decisions are appropriate and clinically led:

A meeting with the CCG Clinical Lead, Sussex Partnership Clinical Lead for Community Services and Sussex Partnership Managers was held to review the ATS data to ensure all actions relating to referral management are clinically led and appropriate. In addition, [redacted] Service Manager for the Assessment & Treatment Service for Brighton & Hove has agreed to undertake a quarterly audit of the triage outcome decisions, with an independent senior clinician, to ensure our triage decisions are appropriate. We continue to discuss and review our performance against key performance indicators with commissioners on a monthly basis and maintain an updated action plan to ensure this remains a continual focus for quality improvement.

We are always striving to improve the interface between primary care and secondary mental health services. In order to improve relationships between GPs and Consultant Psychiatrists, GPs have been allocated named Consultant Psychiatrists. Meetings between the psychiatrists and GPs have been arranged. [redacted] is leading on this to ensure both GPs and psychiatrists are clear on their roles and the expectations of referrals. Work is on-going to ensure there is a joined-up approach for our service users and their families and there is continual learning and improvement. Mr Hyde's experience has been shared (anonymously) with staff to drive home the lessons to be learned. In addition, to ensure widespread learning, feedback from the case has been given to [redacted], Director of Nursing Standards and Safety. This has guaranteed the issues are high profile and education and understanding is widespread.

Furthermore, in order to educate all staff, lessons learned from Mr Hyde's experience have been included (anonymously) in the Trust's Quarterly Quality & Patient Safety Report.

As you highlighted, we will never know if the outcome would have been different if Mr Hyde had been seen by [redacted] prior to his sad death, however, we can reassure you that systems have been reviewed and improved and staff have carefully reflected on what happened.

Thank you once again for raising your concerns. I hope the actions outlined in this response demonstrate how important these issues are to the Trust, and how seriously we have taken the matters highlighted at Mr Hyde's inquest. I feel sure that future service users will benefit from the lessons we have all learned following Mr Hyde's death and I hope Mr Hyde's family can take some comfort in knowing this.

Yours sincerely

Colm Donaghy
Chief Executive