SM/PR/65
20 March 2015

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Mr Tom Osborne LL.B
HM Senior Coroner Bedfordshire and Luton
HM Coroner's Office
The Court House
Woburn Street
Ampthill
Bedfordshire MK45 2HX

Dear Mr Osborne

I am writing to set out the Trust's formal response to the Regulation 28 Report to Prevent Future Deaths, dated 19 January 2015 and received by my office on 29 January 2015. I am grateful to you for extending the response deadline to 23 March 2015 as a result.

I would like to begin by extending our condolences to the family and friends of Mr SA. I hope this response provides them and you with robust assurance that the Trust has taken this situation very seriously and is taking robust action to address the issues promptly.

The Trust's process is that every patient accepted by the Crisis Resolution and Home Treatment team is medically reviewed. The decision to transfer a patient from the care of the Crisis Resolution and Home Treatment team is taken by the team's Consultant Psychiatrist (or his/ her deputy) in a multi-disciplinary team setting and takes into consideration the patient's current presentation, future needs and identifies any risks.

The procedure for patient handover between community teams requires agreement between the teams and any issues of concern to be discussed fully and solutions agreed before the transfer of the patient is completed. The Trust's discharge summary sheet records the decision to discharge and information about the patient's current mental state and presentation, any medication or other therapeutic interventions and the patient's treatment plan.

The Trust regrets deeply that the process was not followed in this case. As a result, the Trust's Executive Director of Clinical Governance and Quality and the Trust's Executive Medical Director instructed senior clinicians from the Trust to carry out a comprehensive and robust Root Cause Analysis investigation of Mr SA's care. The investigation also took into account the matters of concern raised by the Coroner. This investigation was completed on 19 March 2015.

The investigation used a variety of methods to establish the facts. These included tabular timelines, accessing health care records, establishing a chronology of events, interviews with Crisis Resolution and Home Treatment team staff, identification of care and service delivery issues and the establishment of contributory factors and root causes.

The report and recommendations of the Root Cause Analysis investigation have been accepted in full by the Trust's Executive Medical Director, Executive Director of Clinical Governance and Quality and the Trust's Executive Director of Integrated Services – Bedfordshire.

The actions recommended by the Root Cause Analysis investigation which will be implemented to address the concern that a patient with a long mental health history was discharged from the Crisis Resolution and Home Treatment team without a formal hand over are:

- Crisis team joint handovers should be facilitated as planned and that discharge should not take place from the crisis teams until this has been discussed and agreed with the Care Coordinator, or nominated other, who will take on responsibility for care in the community. Crisis teams should provide written evidence of their active input at the point of handover.

- When patients are discharged from a service a letter must be written to the patient and their GP advising them of the reasons for discharge and the suggested follow up plan. This letter must include a summary of the interventions and the progress made since the patient has been known to the service and recommendations for the patient to follow in the event of a change in circumstances leading to a relapse in symptoms.

The actions recommended by the Root Cause Analysis investigation which will be implemented to address the concern that a patient was discharged from the Crisis Resolution and Home Treatment team when the Community Team still considered that he needed support are:

- That all members of the multidisciplinary team contribute to risk assessment and care planning of complex high risk cases. This should be extended to include professionals who hold responsibility for physical health treatments and the Police, if necessary, thereby supporting Care Coordinators in management of complex high risk cases.

- Care Coordinators should facilitate a full multidisciplinary Care Programme Approach review on identification of a complex high risk case and when known risks begin to escalate.

- Anyone identified as being subject to Mental Health Act Section 117 aftercare should not be considered for discharge from the full Care Programme Approach process, even if their needs and risks have reduced , until such time as they are deemed not to require support under Section 117, thus ensuring that a full review takes place.

- All patients who present with a complex mental health diagnosis and poly-substance misuse must be discussed with the drug and alcohol service for advice and guidance on their management plans. In addition, consideration must be given to referring patients routinely who present as such to the drug and alcohol service for regular follow up and monitoring.

- Patients who are prescribed Clozapine must be subject to enhanced monitoring due to the contraindications of this particular medication therapy. Where patients are identified as non-concordant, the care coordinator must arrange for screening during an outpatients appointment in order to assess this risk of non-compliance further.

- Patients with complex personal issues may experience higher levels of stress leading to an increased risk of harm to self or suicide. Care Coordinators must ensure that they are routinely assessing personal circumstances of patients when updating risk assessments and care plans and discussing patients with increased risks as a result of complex personal issues within the multidisciplinary team.

The action recommended by the Root Cause Analysis investigation which will be implemented to address the concern that the reason for discharge from the Crisis Resolution and Home Treatment team was never recorded is:

- When patients are discharged from a service, a letter must be written to the patient and their GP advising them of the reasons for discharge and the suggested follow up plan. This letter must include a summary of the interventions and the progress made since being known to the service and recommendations for the patient to follow in the event of a change in circumstances leading to a relapse in symptoms.

In making the decision to identify a patient's death as a Serious Incident for investigation, the Trust's policy follows the NHS East of England Serious Incident reporting criteria.

In response to the matter of concern in relation to the Trust's Serious Incident reporting response to Mr SA's death, this issue has been reviewed by the Trust's Executive Director of Clinical Governance and Quality and the Trust's Executive Medical Director. As a result, it has come to light that, in this case, insufficient information was provided to the senior managers making the decision whether to report the death as a Serious Incident.

The Trust has subsequently decided that the default position is always to report such deaths as Serious Incidents. If further information then comes to light which would put the death outside of the Serious Incident reporting criteria, the reporting decision can be amended with clear reasons recorded for the revision.

Additionally, the Trust has taken steps to strengthen the internal processes in relation to Serious Incident reporting overall:

- Increased clinical information is made available by the Serious Incidents team to the senior staff making the decision about Serious Incident reporting.

- Decisions for reporting of serious incidents are taken by Executive Directors, following review of the information available at the time and use of a decision monitoring tool.
- The Trust's process no longer requires confirmation of the Cause of Death before a death is considered for reporting as a Serious Incident.
- A weekly Serious Incident review meeting is held – chaired by the Trust's Executive Director of Clinical Governance and Quality - to monitor investigations, confirm incidents reported and review potential incidents.
- A monthly meeting to review reported deaths – chaired by the Trust's Executive Director of Clinical Governance and Quality - is held to monitor updates awaiting toxicology reports and to ensure all serious incidents reported as per revised criteria.

In line with the agreed process for Root Cause Analysis investigations, a detailed plan and timetable for implementing all these actions will be provided by the Trust to the lead NHS commissioner in Bedfordshire by 06 April 2015. The Clinical Commissioning Group will review and agree the action plan. This plan will be audited after three months to assure robust action to address the areas of concern has been taken or is on target for completion.

As you may be aware, NHS Luton Clinical Commissioning Group and NHS Bedfordshire Clinical Commissioning Group have undertaken procurement processes in relation to the local mental health services. The outcome of these processes is that the local mental health services will be transferred from the Trust to a new provider from 1 April 2015. This Regulation 28 Report to Prevent Future Deaths, the Trust's response and the Root Cause Analysis investigation report has been shared with the new provider, who has undertaken to review and ensure that appropriate actions are taken.

Yours sincerely

Sally Morris
Chief Executive