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17 December 2015

By email to Leicester.coroner@leicester.gov.uk
Mrs L Brown
Assistant Coroner
Leicester City and South Leicestershire
The Town Hall
Town Hall Square
Leicester LE1 9BG

Dear Mrs Brown

Re: Barry Max Thraves

Further to your report dated 26 October 2015, in accordance with paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, I offer the following response.

We have investigated the matters of concern that have arisen during the course of the inquest of Mr Barry Thraves. Please be assured that Leicestershire Partnership NHS Trust (LPT) has taken these matters very seriously and undertaken a review of the circumstances of the case in response to concerns raised. I trust that you and Mr Thraves' family will be satisfied that we have taken the appropriate measures to reduce the risk of a similar incident occurring.

The Serious Incident investigation was conducted in the immediate period after Mr. Thraves' death. It was signed off by our commissioners in November 2015 and we met with Mr Thraves' sister on 10 December 2015.

We offer specific detail to the responses to the Coroner's concerns below.

1. Psychiatric follow up was planned for 2 months but an appointment was not offered for 4 months; on Barry not attending no action was taken and there was no evidence before the court that any clinical consideration of his risks was undertaken at this time.

Chair: Cathy Ellis Chief Executive: Dr Peter Miller

We agree with the inquest findings. The LPT Did Not Attend (DNA) Policy (attached as appendix 1) is clear that it should be a clinical decision about what action should be taken following a missed outpatient appointment.

This communication with the GP is expected to be recorded by an entry in the medical notes. No such record was found on the occasion of Barry's last appointment. There was no letter evident in the clinical records regarding Barry's non-attendance at his appointment and no letter was sent to the GP which would have indicated when the next appointment was due. It was written in the clinical records by the doctor that the next appointment was to be arranged for 2 months' time.

Actions taken/planned:

All community mental health team staff have been reminded of the requirements of the DNA policy and their duty to follow it. Regular spot checks will be carried out to ensure that compliance is maintained. The Trust DNA policy is in the process of being reviewed and will be available in February 2016 and a clear flow chart of steps to take in case of a patient not attending their appointment is included in the new policy. The Service Manager Adult Mental Health Community Services has circulated an interim version of this flow chart to all Community Mental Health Teams to reinforce awareness of the procedure following a missed appointment while awaiting the release of the new policy. The flow chart is attached as appendix 2.

In the period between completion of the investigation and leading up to the Coroner's inquest LPT has been undertaking a programme of specific work to ensure that the maximum use of clinical appointment slots are available in the Adult Mental Health Outpatients department thereby increasing the availability of appointments to our patients. This will reduce the numbers of people who are not attending appointments.

Specifically our new patients are now being contacted a week before their scheduled appointment to remind them of the appointment date and time. If a patient is unable to attend then the appointment can be offered to someone else. Patients who missed their last appointment are also telephoned to remind them to attend and these patients are also bought to the attention of the clinician so that an assessment can be made as to whether or not any further action is required. A text reminder facility is available to patients who opt into the service and the publicity for this is being reviewed to encourage take up.

LPT is also working towards a 'partial booking' system for outpatient appointments whereby appointments are booked much closer to the scheduled date to be seen allowing for a more flexible use of available appointments and a reduction in cancelled clinics. Cancelling of clinics is sometimes unavoidable but it is subject to Clinical Director approval and an action plan to monitor compliance and improvement is scrutinized for assurance at the LPT Quality Assurance Committee.

Since the beginning of November 2015 what are known as 'open contacts' on the patient electronic record (RiO) are being monitored on a weekly basis. This is where a patient has had an appointment date that has passed but the episode of care has not been closed on the record, either by a record of the appointment having taken place or evidence of a further appointment offered. These will be drawn to the

attention of medical staff for a clinical decision. This will strengthen safeguards to ensure appropriate follow is offered to all patients.

2. Community support did not take place as planned, and the family were not even made aware that this was awaited and Barry was on the list. It was not clear what, if any, information Barry had received apart from a very brief letter of discharge that specifically did not mention the community support.

A referral for community support (community care contact form) was faxed from the Ward requesting support on 11 November 2014 and was noted in the ward notes but not in the discharge letter. This should have been recorded as part of the follow up arrangements in the discharge letter. No information about the delay in assessment by the Local Authority was received by LPT.

Actions taken/planned:

We have written to all adult mental health clinical staff to inform them that they must include all referrals to other agencies in the discharge letter and ensure that this is communicated clearly to patients/carers.

The LPT Discharge Policy is currently under review and the new policy is due to be approved in February 2016.

The current policy attached as appendix 3 states;

Discharging Mental Health service users with severe mental illness from inpatient Mental Health Services will be carefully considered in consultation with all professionals involved and undertaken in consultation with the service user and (where relevant) their carers or parents. Any such decisions must be clearly communicated to the GP, the referrer and all parties involved in the service user's care and the service user themselves.

The new policy will include:

Within 24 hours of the service user's discharge, the doctor must complete the detailed e-discharge letter which is stored within the electronic records system w ithin RiO. This must be sent through to the GP via the ICE electronic system (for surgeries where ICE Is not available, the discharge letter must be sent via either secure email or fax). The service user / carer must be offered a copy. It should contain the following information as a minimum:

- *Initial reason for admission*
- *Investigations carried out and all available results*
- *Clinical summary of treatment*
- *Clear statement of definitive primary diagnosis where confirmed or reason for not being available*
- *Medication commenced and to be continued, including duration*
- *Medication changed or stopped, and reason*
- *Management Plan/Crisis Plan if problems (i.e. who to contact)*
- *Follow up arrangements and referral to other agencies*
- *Information provided to the service user*
- *Infection Prevention and Control status*

- *Functional ability on discharge*

3. The expectation of the Local Authority is that appointments should take place within 28 days, but the unit is significantly under-resourced and delays are common and appear to be tolerated, and have been for some time. Earlier, timely appointments could assist in identifying and intervening with relapsing patients. This opportunity was lost.

This is a question to be answered by our colleagues from the Local Authority as this is regarding the Local Authority's Intensive Support Team, not an LPT service. The LPT Service Manager for Community Mental Health has raised the issue of long waiting times for assessments by the Local Authority Intensive Support team with the Head of Service in the Local Authority (City).

4. Communication between the community mental health team and other stakeholders was poor, with important information that had been identified (that Barry was depressed and not compliant with his medication) not being shared with the GP, nor were the GP or psychiatric team aware that Barry was not receiving any community support.

We agree with the inquest findings that communication between the Community Mental Health Team (CMHT) and wider stakeholders was poor. We agree that LPT did fail to communicate the fact that Barry did not attend his outpatient appointment to his GP and the steps regarding open contacts taken to prevent this happening in the future have been detailed are outlined above.

We have informed our entire medical and nursing staff, in writing dated 1 December 2015 that they MUST write to GPs informing them about patients who Do Not Attend at our outpatient clinics as stated in the LPT DNA policy. In addition we will carry out an audit of the DNA policy to check compliance against the standards in the policy during quarter 2 of 2016/17. The record keeping audit, being scheduled for January 2016 will also include the recording of compliance with the standards within the revised discharge policy as described under point 2.

5. Information was not made readily available for either Barry, or the family who were trying to support him, of who was involved in his care, the extent of their role and who to contact to discuss this further or in case of any deterioration or change in presentation. This made the task of the supportive sister considerably more onerous and difficult and introduced unnecessary further delays in obtaining support for Barry at a time when his mental health was deterioration and he was in need of urgent review.

We agree with the inquest findings that information made available for ether Barry or his family was unsatisfactory and that it is vital that relevant information is available for patients and their families, that this is provided, documented and made part of each individual's assessment and care planning.

Actions taken/planned:

LPT is undertaking a 'Listening into Action' (LiA) programme around the involvement of patients and their carers in their care planning. LiA is a structured approach to

assist service improvement. The first event in the programme is to be held in January 2016. Additionally a Trust Carers' Pack has been developed as part of an established CQUIN (Commissioning for Quality and Innovation) to provide information to carers about processes and services. The availability of the same will be widely publicized by the ward, outpatient staff, and service user and carer organisations. Team managers will be asked to cascade to all staff once it is completed and ready for distribution. It is anticipated that this will be completed by March 2016.

LPT's CMHTs are currently undergoing service redesign. An important part of this redesign is to remove internal barriers between our Outpatients Service and the wider CMHT. Included in this redesign work is a pathfinder project in the North West Leicestershire CMHT to look at a multi- disciplinary team held caseload model with the aim to roll this out across all CMHTs by April next year. We anticipate that this work will help to address the concern about Barry's sister's queries being passed between different parts of the team including the Consultant Psychiatrist and the referral management service

In addition staff have been reminded that where family members are present during an assessment they must be offered the opportunity to give their views, observations and understanding in relation to the crisis and the support they may be able to provide. This information will be documented on the assessment form by the assessing professional and form part of the outcome of assessment. This has been communicated in writing to our CMHTs.

The CMHTs have also been informed in writing that relevant information must be made available for patients and their families, where this is provided it must be documented and made part of each individual's assessment and care planning.

All of the actions outlined in this response will be monitored through the service's clinical governance arrangements.

We hope this reassures you that we have taken appropriate action in response to the issues you have raised under Regulation 28 and that we are committed to provide safe and effective care in order to reduce the risk to our future patients.

Yours sincerely

Dr Peter Miller
Chief Executive