Kent and Medway NHS
NHS and Social Care Partnership Trust

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Chairman: Andrew Ling
Chief Executive: Angela McNab

24th March 2016
Your ref:
Our ref:

Patricia Harding
Senior Coroner for Mid Kent and Medway
Archbishops Palace
Maidstone

By post and email

Dear Ms Harding,

Joanna Bowring deceased
Regulation 28 – Prevention of Future Deaths Report

I refer to your letter of 27th January 2016 enclosing the Prevention of Future Deaths Report arising out of the inquest into the Death of Joanna Bowring. I have been briefed on the details of this case and would like to reassure you that the issues you raise are ones that the Trust had already identified and which it takes extremely seriously. A number of changes were already in chain at the time the inquest was heard but had not yet been completed. The Trust fully understands why you therefore thought it important to outline the following concerns to me in your letter which I will deal with in turn. I enclose a number of documents including the Trust's action plan summarizing the steps in progress.

1. **The patient and carer left an initial assessment on 4 April 2015 without a clear understanding of the service available and without a care plan (or written indication of what would be happening next apart from a post-it note and leaflet).**

   I am aware that you heard oral evidence from [redacted], Acting Assistant Director that it is the Trust's expectation that patients will be provided with written information upon leaving the Psychiatric Liaison Assessment as to these issues, and that information should encompass more than just a leaflet and telephone number and that the patient will be given a copy of their care plan (which can be shared with their family with consent) in due course.

   However, as I understand it your key concern is that really patients and / or their carers should have something in writing which says what the outcome of the Psychiatric Assessment is immediately following that assessment (ie on this occasion that the patient is recommended for Crisis and Home Treatment),

where that will take place, what next steps or assessments need to take place, when, where and for what purpose and so on.

This is something the Liaison Psychiatry they have been working on since last year. As of the beginning of February 2016 after every assessment an Initial Action Plan is required to be completed at the end of an assessment each service user will have a written outcome so it is clear to both themselves and their carers what the next steps will be. I attach the Initial Action Plan Proforma (IAPP) that is completed for your information. The IAPP has been shared with staff through a newsletter, team meetings and supervision as well as shared with all GP surgeries. The IAPP is currently in the middle of its 12-week trial period with the intention of all feedback being reviewed at the end of the trial.

2. **Carers were not routinely included in the risk assessment process and their views about the patient and knowledge of the patient were not routinely sought.**

This is an important issue and one that had been identified by the Trust's internal investigation and which I believe [redacted] presented evidence of Trust changes in this regard outlining the following steps that had been taken prior to the inquest itself:

- That the Trust has met with all clinicians as part of its learning process to emphasize the importance of engaging with the patient and carers separately,
- That this issue has also been separately discussed by the Trust at its Patient Safety Meetings, with the outcome that the Trust is commissioning a senior psychotherapist with expertise in family therapy to provide bespoke training to the Crisis and Community Mental Health Teams. I am pleased to confirm that Nigel Jacobs, Family Inclusion Project Lead, has started to provide training across the Service Line to all front-line staff on working with Families with the intention that it assists staff in engaging with carers
- The Trust has also embarked on taking forward Open Dialogue Training where the focus will be on working with the individual and their family as equal partners in care. Medway is one of the two areas where this is being piloted. This is being taken forward currently, with the intention that selected individual will need to attend a 4 week residential course, and that it is envisaged that they will train others in what they have learned. It was accepted that this was the start of a longer term process.
- The Trust has re-launched its carers protocol in February 2016 across the service which includes an outline of possible "red flags", and what behaviours carers may look out for. A copy of the Protocol is attached. A review and audit will be undertaken in June to ensure that it is being implemented appropriately.
- The Trust has met with Joanna Bowring's family on a number of occasions with the intention of using their experiences to feed into this process.
- The learning had been embedded by the Trust in face to face meetings, patient safety meetings, and individual written guidance (including by way of policy update)
- In February an Audit was carried out of care plans and risk assessments for evidence of Carer involvement. This has been carried out and a report of it provided to the Leadership Forum. I enclose recent slides

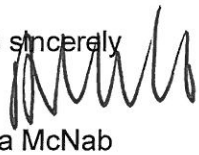
setting out the findings of the audit and the steps being put in places to increase compliance.

- The Service Line is to commission an external Risk Assessment Training company (STORM) to deliver Nationally Recommended Risk Assessment Training Trainors to key individuals

3. **Carers were not advised about the behaviours which might indicate an increased risk of suicide.**

It is hoped that the steps outlined in number 2 above will help address point 3. As explained in evidence this is however a very difficult and case specific point. I have liaised with the Medical Director and with other clinical staff who have indicated the difficulty as there is no one "red flag" marker which indicates an increased risk of suicide generally, it is dependent on the patient; but there has been a recognition that this could be useful (in line with the changes indicated above).

Yours sincerely



Angela McNab
Chief Executive

Enclosures:

Acute Service Line Carers Protocol
Action plan in response to PFD
Powerpoint presentation to the Leadership Forum on action plan