A member of: Association of UK University Hospitals



Our Ref: CD/cda

15 April 2016

Mr Simon Wickens
HM Area Coroner for Surrey
HM Coroner's Court
Station Approach
Woking
Surrey
GU22 7AP

Dear Sir

Swandean Arundel Road Worthing West Sussex BN13 3EP

Tel: 03003040673



Re: The inquest touching the death of Vanessa Dadswell

Thank you for your letter and report of 17 February 2016, written pursuant Paragraph 7 (1) of Schedule 5 to the Coroners & Justice Act 2009, and for highlighting your concerns.

Firstly, may I offer my sincere condolences to Mr Dadswell. I hope this letter will assure you, and Mr Dadswell, that the matters you have raised have been taken seriously and improvements in Sussex Partnership have been made to enhance the service we provide to service users and their families.

As you heard at the inquest, historically, urgent General Practitioner referrals into West Sussex triage were taken by the triage worker and passed to the Assessment & Treatment team to action. The options available were to be seen within 4 hours or within 5 working days. The system has since been reviewed and improved to allow greater flexibility. The system improvements are as follows:

- Triage Team Leaders now have direct bookable Priority Appointment slots and do not need to pass priority referrals to the Assessment & Treatment Duty Worker for booking.
- There is senior staff oversight of the new system whereby the Triage Team Leader takes ownership and makes contact with the General Practitioner and service user throughout the process. The Team Leader prioritises the incoming work on a daily basis and supports the triage workers.
- Every morning the Triage Team Leader assesses all incoming referrals received out of hours and, if the referrer has requested the service user to be seen within 24 hours but did not consider a 4 hour response was clinically required, appointments within 24 hours are arranged.
- Referrals can be fast track allocated by the Triage Team Leader so they do not wait up to 5 days for a slot; they are given the first available appointment, dependent on assessment of risk, often within 2-3 days.
- If the member of staff taking the referral out of hours has any concerns about the referral or appointment needs, they now immediately escalate the referral to the on call manager.

Chair: Caroline Armitage

Chief Executive: Colm Donaghy

- More home visits are now offered where clinically indicated (as in Mrs Dadswell's case).
- All referrals and referral decisions, including the rationale behind the decision, are documented on our new electronic records system, CareNotes, which all clinical staff Trust wide have access to.

In addition, we are recruiting a full time band 7 member of staff to provide cover to the Team Leaders in times of absence to ensure the system is robust and not reliant on any one individual.

Penny Fenton, General Manager Coastal West Sussex Care Delivery Service (CDS), Nadia Anderson, Service Manager Western, Working Age Mental Health Services, Coastal West Sussex Care Delivery Service (CDS) and Liam Rudden, Service Manager for Adur, Arun & Worthing Assessment and Treatment Service are currently drafting a protocol encompassing the improved system throughout Coastal West Sussex CDS. The checklist and flowchart developed and exhibited at the inquest will be appended so there is a clear user friendly guide for staff. Dr Brian Solts, Divisional Clinical Director – Coastal West Sussex Care Delivery Service (CDS) has confirmed he will present the protocol, together with the learning from Mrs Dadswell's inquest, to the Adult Management Board to maximize learning and embed the improvements introduced.

The Service Specification for the Urgent Care Pathway detailing the 4 hour and 5 day referral options was developed in partnership with our West Sussex Commissioners and is due for renewal. Dr Solts has requested a meeting to be arranged with the West Sussex Mental Health commissioners to review the pathway jointly with us, in light of the improvements we have made, and the greater flexibility we have introduced, so it reflects current practice.

Furthermore, Dr Solts is hosting a ½ day Report and Learn Forum for Coastal West Sussex CDS which will identify learning from incidents and inquests and he will share the learning (anonymously) from Mrs Dadswell's inquest so CDS staff can reflect and take forward the lessons learned.

As a Trust we are committed to learning and improving safety. Lessons from Mrs Dadswell's inquest were shared (anonymously) through the Trust's monthly Report and Learn Bulletin and via the Trust's Quarterly Quality and Safety Report, both are distributed throughout the Trust and externally with our Clinical Commissioning Groups.

The Trust has no objections to this letter being shared or published by the Chief Coroner.

Yours faithfully

Colm Donaghy
Chief Executive