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Hertfordshire Partnership NHS
University NHS Foundation Trust

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Her Majesty's Coroner
City of London Coroner's Court
78-83 Upper Thames Street
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EC4R 3TD

13th October 2016

Dear Dr Palmer

I am writing in response to your letter, and the Regulation 28 report dated 23 August 2016, which was received in my office on 25 August 2016.

It may first be helpful to explain that this is the first such report that the Trust has received for many years. It has therefore been taken very seriously and has been highlighted to our Commissioners and reported on at Executive Team Committee and our Board of Directors.

The sad death of Nathan Lowe was reported by the Trust as a serious incident to our Commissioners in May 2016 in accordance with the NHS England Serious Incident Framework, March 2015. It has been subject to a robust internal investigation undertaken by a Clinical Director who works as a consultant psychiatrist in our Adult Acute services. The purpose of the review was to establish facts and consider any potential areas of learning for the community team and the wider Trust. It was unfortunate that although the serious incident investigation itself had been completed, the report had not been finalised when the Inquest was heard on 19 August 2016.

I have enclosed a copy of the Trust's serious incident report for your records. As part of the Trust's commitment to the NHS Duty of Candour, a copy of the report has been sent to Mr Lowe's mother, who helpfully contributed to the review process. An offer has also been made by the report author to meet with Mrs Lowe to go through the findings.
You will see from the enclosed report that the investigation did identify a number of areas where practice could have been improved and where there were missed opportunities for more assertive action to have been taken in the follow up of Mr Lowe post discharge. The specific areas of learning identified were as follows:

- The importance of multi-disciplinary working
- The need for clarity about who will take responsibilities for actions arising from multi-disciplinary team discussions and meetings
- Awareness around suicide risk factors
- Potential risks relating to disengagement
- Gathering of information from all available sources to inform the risk management plan

- ❖ Consideration of risk relating to medication non-compliance
- ❖ The importance of medicines reconciliation between primary and secondary care services

An action plan has been put in place to address these areas of learning which has been shared with our local Clinical Commissioning Group. The action plan will continue to be monitored by the Service Line Lead and the Managing Director until the actions taken to address the recommendations are fully implemented into clinical practice. The learning has also been shared more widely across other Trust teams by use of a learning summary.

I am aware that immediately following completion of the serious incident report the Service Line Lead responsible for this Quadrant met with the North West Adult community team members to discuss the learning and take the opportunity to personally review existing processes to look at ways in which the multi-disciplinary ways of working could be strengthened. The following actions have been taken since that time:

1. Improved communication between professionals in the MDT meetings
2. Improved leadership in the team which has created a greater level of oversight around follow up and multi-disciplinary team decision making for service users on the case load who have complex needs
3. Clear actions and timeframes by when these actions will be completed and by whom, are now more clearly recorded in the notes of each MDT meeting. These actions and associated timeframes and leads are also recorded in the service user's electronic record.
4. A reflective practice process has been undertaken with the care coordinator by the community clinical nurse lead.
5. A review of the care coordinators case load is being undertaken to identify if there are any further areas where actions may need to be taken
6. A clinical zoning tool is being piloted in two community teams including the North West. Through training this will assist in identifying those service users in each of the community teams who have high risk factors that require increased monitoring and interventions by the multi-disciplinary members of the clinical team.
7. As part of a quality improvement initiative a specific clinical risk training package around increasing awareness of suicide risk factors to support risk management decision making has been developed and delivered to the community teams in the North West and East and South East Quadrants.
8. A Lead Pharmacist/Medicines Safety Officer has commenced in post; part of this key role will be to identify and implement learning in relation to medication incidents which will include ways in which medicines reconciliation and joint working between GP's and the Trust can be improved.

As part of the Trust's commitment to a zero suicide ambition, on 9 November 2016, the Trust is participating in a Public Health led Hertfordshire Suicide Prevention stakeholder event. The aim of the event is to bring together representatives of the many diverse organisations who together can achieve the vision of making Hertfordshire a county where no one ever gets to a point where they feel suicide is their only option and to develop a Hertfordshire wide suicide prevention strategy. Speakers on the day will include a train driver, a service user with lived experience of surviving a suicide attempt and a family bereaved by suicide.

This builds on work by the Hertfordshire Spot the Signs, Save a Life suicide prevention campaign which was launched in collaboration with Hertfordshire Mind Network, local GP surgeries and the East and North Herts Clinical Commissioning Group building on work undertaken in Detroit on suicide prevention by Dr Ed Coffey. This is one of four 'Zero

Suicide' Programme sites developed across the East of England region. The overarching goals of the project have been to educate the general public on depression and suicide; educate GP's, GP receptionists, district nurses, and community nurses about screening, identifying and managing suicidality effectively in primary care.

Clinical risk training is a mandatory training requirement for staff in clinical roles to attend every three years. The Trust is at present reviewing this training programme to include more serious incident case studies to encourage discussion amongst attendees and inform clinical practice. A Project Lead has been identified.

I do hope you feel that this response provides you with sufficient detail and assurance about actions taken by the Trust in response to the Prevention of Future Death report in respect of the death of Mr Lowe. If you require any further information or clarity about any aspect of this response please do not hesitate to contact my office on the number listed at the top of this letter.

Yours sincerely

T J Cahill

Tom Cahill
Chief Executive Officer

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