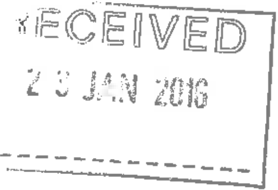

**Medical Director/Consultant Psychiatrist**
[redacted]

B Med Sci, BMBS, MRCPsych
Woodfield House, Tickhill Road, Balby, Doncaster, DN4 8QN

19 January 2017

**PRIVATE AND CONFIDENTIAL**

Ms N Mundy
HM Coroner
Coroner's Court and Office
Doncaster Crown Court
College Road
Doncaster
DN1 3HS

Dear Ms Mundy

**Re: Response to the Regulation 28 Report in relation to JOHN ATKINSON (deceased)**

I write in response to your letter dated 1 December 2016 addressed to Ms Kathryn Singh, Chief Executive Officer of the Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH). I note you have also communicated directly with me in my role as Executive Medical Director of RDaSH regarding this matter. I am writing to you on behalf of the Chief Executive Officer.

Following the death of John Atkinson and the inquest which concluded on 29th November 2016, you issued the Trust with a Regulation 28 Report and outlined your concerns. The matters of concern you noted were as follows:

1. Lack of updated risk assessments when key events occurred or there was a significant deterioration in presentation.
2. Failure of the care coordinator to identify changes in presentation and level of the risk and to seek a doctors input.
3. Absence of an effective and robust system to identify then manage patients under the care of departing staff (for example care co-ordinator).
4. Lack of effective communication between mental health professionals at differing levels and also between those professionals and the patient and the patient's family.
5. Difficulty in consultant psychiatrists accessing Home Treatment Team Services when they indicated a need, (since a change in emphasis in interpreting the guidelines from the end of 2014).

The information outlined below details the Trust's response and actions following Mr Atkinson's death, specifically in relation to points 1-5 above. In addition the Trust developed a rapid improvement plan during October 2016 to support the working practices of the Intensive Community Therapies Team (ICT) and in relation to the increased clinical demand. It has been modified further following your Regulation 28 Report. This plan is enclosed as Appendix A. Also worthy of note is that at the start of October 2016 the Trust completed a management review as part of its transformation programme. Each of the three main geographical areas covered by the Trust (Rotherham, Doncaster and North Lincolnshire) now has its own triumvirate leadership teams consisting of a Care Group Director, an Associate Medical Director and an Associate Nurse Director. This triumvirate is closely monitoring the rapid action plan.

I will respond to each of the specific concerns raised within your Regulation 28 Report.

1. **"Lack of updated risk assessments when key events occurred or there was a significant deterioration in presentation."**

The Trust's 'Clinical risk assessment and management policy' states:

*"Whilst the assessment of risk is a continuous process, a formal assessment of risk must be completed and documented at:*
*- the point of referral*
*- at each subsequent review for all patients (those subject to CPA or otherwise)*
*- when prompted by a change of circumstances e.g. admission, discharge, movement between services, shared care, personal circumstances"*

The policy clearly describes the expectation to review risk following any significant event or clinical change in a patient's presentation. In Mr Atkinson's case this did not occur as expected and therefore the Trust has taken measures in relation to the care coordinator's performance to address this. Furthermore the Trust recognises that staff in the Intensive Community Therapies Team (ICT) require a strengthened approach to risk management given the complexities of their patient group. The Trust has therefore commissioned some tailored STORM training (Skills based Training on Risk Management) due to be delivered during February and March 2017. Furthermore each member of staff in the ICT team will have completed two TED educational sessions during January 2017 (Kevin Briggs- *"The Bridge between suicide and life"*, and *"Overcoming hopelessness")*.

The Trust's internal trainer has assured me that the STORM training package includes the key issues of accelerating risk and risk profiling in order that staff clearly understand the expectation to update risk assessments regularly when there is a change in presentation. In order to understand the impact of these additional measures the Trust is undertaking weekly audits of risk reviews and snap-shot audits via staff supervision. This is also incorporated in the RDaSH Clinical Audit Programme 2017. As an additional measure the Trust has scheduled a Quality Review of the ICT Team during January 2017 (conducted by RDaSH staff who work outside of the ICT Team) to independently monitor the rapid improvement plan.

2. **"Failure of the care co-ordinator to identify changes in presentation and level of the risk and to seek a doctors input"**

The Trust has made sure that the care coordinator is aware of the formal concerns raised by you in your Regulation 28 Report and the concerns raised by the family regarding failures in her practice. She is a reflective practitioner and has already changed her practice in light of the tragic death of Mr Atkinson. This member of staff is formally employed by Rotherham Metropolitan Borough Council (RMBC) but is seconded to the Trust. Therefore the Trust has made her employing organisation aware of the concerns and the management action plan. The care coordinator is an experienced member of staff who has previously identified competencies in relation to risk management. However extra training will be provided for her to ensure her practice is updated and a specific management action plan is in place to facilitate this.

The issues of effective risk management are being addressed throughout the ICT team as described earlier in my response. The team manager, as part of their role, reviews risk assessments and risk management during staff supervision and this is part of the ICT action plan put in place to address any systemic issues.

3. **"Absence of an effective and robust system to identify then manage patients under the care of departing staff (for example care co-ordinator)"**

During 2016 the clinical demands within the ICT Team have increased and the patient flow throughout the mental health system has declined. This in turn has highlighted issues within the ICT Team which relate to patients waiting for care coordination or assessment for therapies. Some immediate actions have been put in place to reduce the risk to patients who are waiting for treatment. The next stage of this work is to assess the impact of these actions which will take place through the Quality Review process. The risk has been identified on the Trust's risk register.

Caseload numbers are starting to reduce within the team and the team manager is now able to review clinical interventions and risk management through staff supervision. All staff have regular booked supervision.

Patient waits are now effectively being monitored and managed on a weekly basis, ensuring no-one is "slipping through the net" and enabling the team manager to prioritise patients who have been waiting longest.

Patients are being reassessed and a tapered discharge process is in place through review clinics where a senior nurse and nurse consultants are focusing their efforts.

The ICT team is presently reviewing an improved system of allocating patients when staff members are unavailable due to sickness, planned leave or resignation. The service manager is working with the team to devise a simple flow chart which clearly identifies the system of allocating patients. As part of this work there is a review of leadership roles within the ICT team, again part of the improvement plan.
Presently the team manager is responsible for oversight of patients when the care coordinator is absent and a process of risk assessing each client is in place pending re-allocation. A "RAG" (red, amber and green) rating system is in place which identifies an individual's risk profile to categorise those patients who need immediate input and those who may require less rigorous oversight. The quality review process in January 2017 will be used to assess the effectiveness of this tool and make suggestions for further improvement in the standard operating procedures.

4. **Lack of effective communication between mental health professionals at different levels and also between the professionals, the patient and the patient's family**

The Trust has attempted to address the issue of communication and coproduction between patients, carers and staff over the last few years and therefore it is particularly disappointing that this issue has again been raised as a concern. For example you may recall from previous formal communications, that the Trust launched the "Triangle of Care" initiative during 2015 which is a National Programme to bridge the gap between professionals and carers. This initiative has been successfully implemented within the Rotherham inpatient wards therefore we have initiated increased awareness sessions to be delivered to the ICT staff group on 24 January and 9 February 2017. The sessions are delivered by carers and have been successful in reducing inpatient carer related complaints.

The Trust has recently reviewed its Patient and Public Engagement Strategy which includes an expectation that staff involve and communicate with carers, a further enhancement of the Triangle of Care work.

The role that families and carers can play in the recovery pathways for patients cannot be under-estimated in my opinion. Not only is it courteous and compassionate, it is clearly supported by evidence that shows it improves patient outcomes. In addition it reduces the stress and anxiety within families and carers who can be profoundly affected by illness in someone for whom they care for.

5. **Difficulty in consultant psychiatrists accessing home treatment when they indicated a need, (since a change in emphasis in interpreting the guidelines from the end of 2014).**

The Trust has reviewed the Home Treatment Team criteria and undertaking a prospective audit in January 2017 to ascertain if any teams perceive a difficulty accessing home treatment. A survey of all referrers to ascertain views on accessibility will be undertaken using a SurveyMonkey® audit. A group of consultant psychiatrists and the Rotherham Associate Nurse Director have been tasked with undertaking this review. As far as we are aware there has been no change of emphasis in the guidance for access to home treatment therefore we are identifying if there is a cultural or perception aspect to this concern. I have attached the current guidance in Appendix B.

A meeting was held in early January 2017 which was attended by the following professionals in Rotherham: Associate Nurse Director, Associate Medical Director, Home Treatment Team Service Manager, Home Treatment Team Consultant Psychiatrist and ICT Consultant Psychiatrist. It was established at that meeting that there was, at times, a lack of clarity amongst consultants and team staff alike as to the role of the Home Treatment Team and the circumstances under which their expertise could be called upon.

However the Home Treatment Team members were clear that they do not reject referrals without very careful consideration. In the case of Mr Atkinson, had they been asked to consider a referral regarding his management (which they were not), they would have accepted him on

the basis that a change in risk profile reflected a change in mental state which required a different treatment approach.

This discussion developed new learning as there was an identification that there are patients who do not require home treatment level input but who may require a level of input beyond that which staffing levels in community teams currently permit . We therefore intend to address this by looking into the possibility of increased capacity to conduct basic out of hours patient reviews where higher risk situations can be managed for patients who do not meet the criteria for home treatment.

Over the coming months as we go through our service transformation process we will be looking closely at the provision for patients such as Mr Atkinson where there is an identified increase in risk but where the suitability for home treatment is unclear or does not quite fit with NICE guidance. We are considering various options to expand out of hours community provision in this direction.

The Trust is perfectly happy to supply you with any final documents and policies being developed should you wish to see them.

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As I have stated before, we believe that the Coronial process is an essential part of continuous health improvement and I hope that this communication is seen as a full, clear and candid response to your Regulation 28 Report.

Please do not hesitate to contact me directly should you wish to clarify any points in my response or should you have any further questions. Alternatively you may prefer to communicate directly with the Chief Executive's office.

Yours sincerely

**Executive Medical Director**