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Kent and Medway
NHS and Social Care Partnership Trust

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Your reference
My reference HG/366

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Dear Madam

Re: Preventing Future Death; The Inquest in to Natalie Gray's death Response

I joined Kent and Medway NHS and Social Care Partnership Trust (the Trust) in June 2016. Soon after joining I was made aware of the tragic circumstances surrounding Natalie's death on 21st April 2015. I received regular updates in relation to the inquest which concluded on 1st November 2016. Following its conclusion [redacted] (Acute Service Line Director), who attended the entirety of the inquest, briefed myself and the Board on the inquest's findings.

I have carefully considered the three areas you have highlighted as being of particular concern. My response is set out against each of your points.

1. **The approach to discharge planning has been addressed on a general basis but the pathway for those with a diagnosis of personality disorder is currently under review and has not been finalised. It remains a concern that a patient with an emotionally unstable personality disorder will meet the current criteria for discharge but shortly thereafter be at risk particularly where specialist therapies are planned but have not been approved/started.**

   My response in relation to this is twofold. It consists of steps already put in place to support discharge from in-patient services including those with a diagnosis of Personality Disorder in line with NICE guidance. The second part, outlining our longer term plans as part of the ongoing Personality Disorder Review being over seen by our Executive Medical Director.

   Dealing with the former first, the countdown to discharge tool about which I understand you received oral evidence on during the course of the inquest is key to this. In addition to this, links between Community Mental Health teams (CMHT) and the Crisis Resolution Home Treatment (CRHT) team have been strengthened. A daily Crisis Call (Monday to Friday) has been implemented Trust-wide. This allows for a patient focused discussion to occur and for the CMHT to be fully involved in any decision to discharge a patient from either a ward or the CRHT.

The Trust Patient Flow Board provides a further means by which services can closely monitor the input that service users have, by ensuring that once admitted to the inpatient setting a care coordinator is allocated through the process of patient flow meetings, using the Board as a guide and reference point.

The Medical Psychotherapist and Lead Consultant for Personality Disorder unit is providing specialist advice and training to the acute wards on the management and discharge planning for their patients with Personality Disorders. In February 2017, he started training staff at Priority House on a ward by ward basis. This includes risk management formulation and mindfulness. By the end of April all staff at Priority House should have received this training. This will then be rolled out Trust-wide across the Acute Service Line.

A Trust-wide Personality Disorder Panel is being established. Complex and high risk patients will be discussed and support provided to access appropriate interventions. The Panel will consist of a Consultant Medical Psychotherapist/Psychiatrist, Director of Specialist Services, Assistant Director of Acute Service Line, Clinical Lead for specialist psychological practice and Clinical Lead for Community and Recovery services.

The first meeting to establish the panel and approve terms of reference is on 1st May 2017. It is proposed it will meet every two weeks. The Panel will initially focus on our top 50 frequent attenders of acute services to provide support and offer guidance to Care Coordinators in managing these complex cases and assisting with access to the appropriate specialist psychological interventions.

The Trust's Personality Disorder review concludes in May. The issue of safe transition between acute and community services is a central part of this review. A key aim is for all appropriate patients to be able to access specialist psychological therapies. The Trust Board will be presented with plans for a new integrated care pathway for Personality Disorder to consider at the end of May.

As part of the development of the new Personality Disorder pathway we have been considering the stepdown from the acute pathway and into the community and support that is available to patients including psycho-educational groups, service user network support groups which may be provided by voluntary organisations and specialised therapy appropriate for the patients needs, additional training for Care Coordinators and approved care planning for newly admitted Personality Disorder patients.

It is a key component of our suicide prevention strategy (launched in September 2016) and sets out the Trust's strategy over a three year period.

The strategy recognised that those with a diagnosed Personality Disorder are at a higher risk, and therefore require priority due to being in this high risk group. There is work underway in line with this to transform clinical risk assessment and management, both in practice and recording, with new training in place, and new risk assessment documentation about to come onto our electronic clinical record system for general

use. As an organisation we are committing ourselves to achieve greater engagement of patients, families and carers and work jointly with them to achieve effective "safety planning".

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2. **The risk assessment form has not yet been addressed and is under review, there remains an issue as to whether the risk is recorded as a present risk alone or includes chronic risk (particularly for those with personality disorders) as oppose to historic risk. Although risk is discussed at handover and ward rounds there is no evidence that the risk rating is communicated or signed off by the doctor when the record is completed by a nurse/junior doctor.**

   In January 2017 the Trust launched a newly reviewed risk policy and risk summary form, this is currently being implemented Trust-wide.

   We have taken a number of steps to highlight how the points of transition of care are an area of risk for those with a diagnosis of Personality Disorder. Changes have been made to our Clinical Risk Policy to reflect this. There is a flow diagram in the policy providing guidance on when to assess and reassess clinical risk and it highlights transition periods.

   I am aware that its development was informed by learning from Serious Incidents and near misses. Natalie's was a case where the grading of risk was key as there was always a chronic risk which would fluctuate. Updated mandatory training focuses on the critically high risk period as well as other transitions in care. The updated training explains how the period is often referred to as the 'Low Risk Paradox' with risk assessed as low in one environment yet high or escalating in another

   We are using learning from real case examples with our clinicians to ensure that the multidisciplinary teams understand risk, its importance and variability in a more sophisticated sense.

   We have changed our approach to testing practice in relation to risk assessment. As part of the programme for implementation of the new Risk Summary, auditing is focused on quality of the risk assessment rather than just the percentage of risk assessments completed.

   We recognise the importance of the communication of risk both between members of the multidisciplinary team and from shift to shift and this is recognised in training.

   The importance of clearly recording the Consultant's review of risk has been discussed and action taken to ensure this happens. Changes are being made to our electronic patient record to make it easier to record and review.

   Shift patterns and handovers are being reviewed so that they can be structured in such a way as to ensure that the key information is passed onto the next shift. We are considering standardising shift times across all sites and wards and to cost this accordingly. This would be with a view to an extended handover time.

3. Kent Police and Kent & Medway NHS Social Care Partnership Trust have agreed a Missing person Procedure implemented 1st December 2015. There is a concern about the terminology for use in the risk assessment that the Mental Health Trust is required to complete which may lead to an inaccurate risk assessments. There appears to be no explanation as to weather the risk is that formally documented or the risk at the time the 'significant' is highly subjective, is it intended to mean a likely risk of self harm or something more. It is not clear how the Trust should deal with those likely to place themselves in danger and therefore at medium risk of self harm, in terms of the timescales involved and whether 999 should be used or not. By way of example, Natalie's documented risk was inaccurately recorded as low, when it should have been medium and on leaving the facility medium to high, this could lead to an underestimation of the risk of self harm depending on how the form is interpreted by staff.

We have taken a series of steps to resolve this. They include

- Jointly agreed Adverse Incident Process shared by Kent Police and the Trust.
- A compliance bulletin and reminders across the whole Trust, specifying terminology to be used.
- From April 2017 there will be a third specifically designated Police Officer to the acute service line, these are already in situ in North and East and from April this will extend to West Kent, this Officer will be based at Priority House. This supports improvements to communications, joint working, joint learning, and ultimately reduction in risk of harm.
- We continue to work closely with Kent Police on a number of joint projects, including Operation Sotor which has been recognised as an item of good practice nationally.
- Since September 2016 the Trust has established a KMPT and Kent Police Executive Liaison Meeting which takes place quarterly and is attended by KMPT CEO, Exec Lead, Assistant Chief Constable and Strategic Lead Superintendent from Kent Police, Kent Police and Crime Commissioner and the Accountable Officer from West Kent CCG. This is an executive steering group for joint strategic planning and to support the delivery of Crisis Care Concordat. Building on the positive relationships with Kent Police is helping identify and address similar risk to those found in Natalie's case.

As I conclude this letter, I am struck by how much has or is changing since the tragedy of Natalie's death. As Chief Executive I take full and personal responsibility to make sure that we are doing everything we possibly can to avoid such a tragedy being repeated. I offer you as H. M. Senior Coroner my assurance that I believe we are addressing the serious concerns that you raise. I recognise that we have a significant amount of work to do in order to create truly patient focused, high quality services.

I would with your agreement, like to provide you with a further update in the autumn. By then, I believe our service for people with Natalie's diagnosis will be transformed.

Yours sincerely,

Helen Greatorex
Chief Executive