Department of Health

From Jackie Doyle-Price MP
Parliamentary Under Secretary of State for Care and Mental Health

Richmond House
79 Whitehall
London
SW1A 2NS

020 7210 4850

Angela Hodes
HM Assistant Coroner Inner West London
65 Horseferry Road
LONDON
SW1P 2ED

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23rd November 2017

Dear Ms Hodes

Thank you for your Report dated 28 September to the Secretary of State for Health about the death of Mrs Gillian O'Keeffe. I am responding as mental health sits within my portfolio.

I was very saddened to read of the regrettable circumstances surrounding Mrs O'Keeffe's death. Please pass my condolences to her family and loved ones. I appreciate this must be a very difficult time for them.

Your Report details concerns around the decision to discharge Mrs O'Keeffe from mental health services; the lack of communication with Mrs O'Keeffe's GP; the difficulties faced by the family in making their concerns known to mental health services; and the absence of policies in place at the South West London and St George's Mental Health NHS Trust to follow up the GP's subsequent concerns.

The matters raised are operational and relate to the South West London & St George's Mental Health NHS Trust. However, it is important to make clear the national policy expectations in relation to the issues you have raised.

The Mental Health Act 1983 Code of Practice, whilst being statutory guidance for providers of services under the Act should be observed as best practice by all commissioners and providers of services to people who may become subject to the Act. We revised the Code of Practice in 2015 and set out guiding principles to improve the care for patients. The principles include mental health providers involving patients' carers and families in decisions about their care. The Code of Practice also makes it clear that we expect multi-disciplinary teams involved in care

planning and discharge to include all relevant professionals and agencies which may be involved in a person's care.

My officials have made enquiries and I am encouraged that the Trust is taking action to respond to these concerns in your Report, as well as those raised by the family, in addition to learning identified through its own investigations into Mrs O'Keeffe's care and treatment.

While the Trust has explained the rationale for the decision to discharge Mrs O'Keeffe from its services, it acknowledges that more engagement should have taken place with key stakeholders in reaching this decision.

Learning lessons where things have gone wrong is essential to ensuring the NHS provides safe, high quality care. You will know from the response provided by the Trust on 21 November that the Trust has identified actions to take in response to the concerns you have raised. This includes updating the Trust's clinical disengagement/did not attend policy to be more prescriptive in the actions to take and engagement with key stakeholders when taking a decision to discharge a patient.

The Trust advises that it will take action through staff learning mechanisms to promote the importance of the involvement of GPs in pre-discharge multi-disciplinary meetings. Further, the Trust is working to produce guidance for GPs in how they can raise concerns and referrals and is looking to strengthen the engagement of families and carers and liaison with primary care.

My officials also made enquiries with the Wandsworth Clinical Commissioning Group (CCG) and I understand the CCG will review the Trust's action plan for addressing the concerns you have raised.

Wandsworth CCG advises that it is satisfied that the GP Practice took action to raise concerns about Mrs O'Keeffe through the correct processes (i.e., the GP quarterly liaison meeting with the Trust). However, when considering learning points from this case, I am informed that the CCG and Practice have identified other processes and routes the Practice could have used to raise concerns. These include the GP Alert System that enables GP practices and other health professionals to raise concerns about patient care directly to the CCG, and the GP clinical lead for the Trust, who can raise concerns directly at clinical review meetings within the Trust.

I am advised that a learning event will be undertaken to review the system-wide issues that the case has identified and to ensure that the system is able to allow

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families easier access to health professionals should they need to raise care issues about their relatives.

I hope this information provides assurance that there are processes available to families and GPs to raise concerns about patient care in such circumstances. Such processes are the responsibility of individual NHS trusts and you have taken the correct course of action in addressing your concerns to the South West London & St George's Mental Health NHS Trust, and I hope the Trust's response is helpful.

Thank you for bringing the circumstances of Mrs O'Keeffe's death to our attention.

Jackie

JACKIE DOYLE-PRICE