Executive Team
St Mary's Hospital
Parkhurst Road
Newport
Isle of Wight
PO30 5TG

12 February 2019

Mrs C. Sumeray
H.M. Coroner
Isle of Wight Coroners Office
RSKC-XJZG-JKGZ
Seaclose Offices
NEWPORT
Isle of Wight
PO30 2QS

Dear Mrs Sumeray

Please find enclosed the action plan requested in response to the Regulation 28 – Prevention of Future Death touching on the death of Natalie Zara Hunter.

Your report highlighted two main areas of concern; the quality and timeliness of discharge summaries and the Mental Health Services ability to provide a safe and effective "Out of hours – Crisis" service.

I can confirm a meeting was held on the 9 January 2019 to agree the action plan to address both issues raised. The meeting was held with the Head of Nursing and Quality and the Quality Manager for Mental Health and Learning Disabilities Services, Lead for Community Mental Health Services (CMHS) and the Patient Safety Lead. A draft action plan was then provided to me as Director of Mental Health & Learning Disabilities Service and the Director of Quality Governance for final approval.

1. Quality & Timeliness of Discharge Summaries

The Trust fully accepts that there have been issues with discharge summaries across the organisation, and confirms that a work stream lead by the Medical Director is in place to improve the quality and timeliness of the discharge summary.

The action plan sets out the expectation that Mental Health Services will conduct an in depth review of the current situation and include the quality of other communication that is sent to GPs to inform them of patients contact with the services.

The terms of reference of the in depth review will not only focus on the discharge summary as these are only generated from an inpatient episode, but will also consider the wider communication with GPs after Emergency Department attendances and other contacts made with the Community Mental Health Service or out of hours crisis services.

They will also feature the following:

- The individual case of Natalie Zara Hunter will provide the case study for this piece of work.
- The backdrop – process mapping with all staff groups and from this a Standard Operating Procedure (SOP)/flowchart will be developed.
- An audit into quality of discharge summaries to ensure they contain the reason for admission, care and treatment received during the episode of care and detail of any medication review or changes.
- The audit will be led by a Consultant Psychiatrist and will engage Junior Doctors at formal teaching sessions to ensure that learning outcomes are embedded.
- The outcome of the audit will be presented at quality forums across the Trust to share the learning from this evidence

2. Ability to provide a safe and effective "Out of hours – Crisis" service

The second concern raised was related to the provision of Out of hours staffing for Community Mental Health and Out of hours – Crisis. The report focuses on the reduced capacity of staffing and insufficient funding to ensure comprehensive cover out of hours.

The immediate actions which have been taken include:

- Re-instatement of the Mental Health Services within the central hub of the Ambulance Department.
- All staffing vacancies have been filled with bank and agency cover to ensure there is a 24 hour site based service (not deployable).
- The service is constantly evaluating the most effective way to provide safe 24hr cover.
- A Business case has been prepared in collaboration with the CCG and local authority, and has been signed off by the Mental Health Divisional Board and Quality Committee. This will change the model of care for the single point of access, the community mental health team and result in the creation of a new wellbeing service. The aim of the new model is to improve access, responsiveness and quality of 24/7 service provision.

We will of course keep you updated monthly on our progress and should you require any further information please do not hesitate to contact me.

Yours sincerely

[redacted]
Director of Mental Health and Learning Disabilities

[redacted]

c.c. Maggie Oldham, Chief Executive
[redacted], Director of Quality Governance