



**Central and
North West London**
NHS Foundation Trust

23rd May 2019

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To be opened by Addressee only

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Dear Professor Wilcox

Re: CNWLCOM59279

Dear Professor Wilcox,

Re: Georgia Sylvia Nelson, Prevention of Future Deaths Notice

I am writing in response to your correspondence to Robyn Doran, Chief Operating Officer CNWL NHS Foundation Trust, dated 29th April 2019.

As a Trust, we are very saddened by Miss Nelson's death and take an incident of this severity very seriously. Through our investigative and learning lessons process we will ensure that changes are embedded at both a local and Trust wide level, providing the level of reassurance that is expected of the Trust.

In your Report, you set out the following concerns:

1. That there is no suitable housing specifically for young patients with severe and enduring mental illness in RBKC
2. There are no long term placements, potentially life long, for any patients requiring supported housing in RBKC with such mental illness
3. There is a severe shortage of rehabilitation housing placements in RBKC for patients who require them
4. That there should be a system to ensure that there is proper discharge planning and referral on for all patients discharged after admission with mental illness
5. That whilst mental health patients are in hospital all opportunities are used to improve their care and treatment and that where possible, they are not discharged before these have been appropriately addressed, rather than discharging them as soon as they are deemed no longer at active risk to themselves or others
6. That rehabilitation should be more actively considered as a discharge option for patients especially where there are pre-admission concerns about their housing.

Concerns 1, 2 and 3 are within the domain of the Royal Borough of Kensington & Chelsea, who develop and commission housing provision, including a range of supported accommodation. Whilst the Trust does not commission these services, as the major provider of NHS mental health care within the Borough, we do work closely with the local authority to inform and assist them in developing new services. We think however, they will want to respond to these 3 points separately as the responsible organisation, and we are aware they are currently in the process of responding to you in this respect.

Points 4, 5 and 6 are areas over which we have responsibility, and I will address these points below:

4: That there should be a system to ensure that there is proper discharge planning and referral on for all patients discharged after admission with mental illness.

The Trust has specific policies (CPA Policy 2015 and the Discharge and Transfer of Patients, 2015) in place that set out the expectations and requirements of discharge planning and referral for patients leaving hospital are completed. These policies underpin the important principle of the need for community teams work to closely with inpatient teams to ensure that planning is carried out to ensure as seamless a transition as possible from our inpatient services to the community in recognition of the well-known vulnerability of this period.

Practice currently in place at ward level to ensure these policies actually impact on practice includes the following:

- At the point of admission immediately plan for discharge through daily use of a discharge tool to anticipate needs post discharge.
- Rapid notification of the care coordinator and family members of the admission and invite to attend the ward for pre-discharge meetings

To further support this critical point in the pathway we will:

- The Crisis and Home Treatment Teams now attend the daily handover meeting on each ward to ensure they are aware of any planned discharges and contribute to discharge planning for all patients on the wards.
- Ensure we deliver on the National CQUIN that people leaving hospital have face to face contact within 72 hours of discharge by an identified worker
- That all patients leave hospital with a clear plan of who to contact in crisis and where to get help if they need it as well as the details of the above appointment This will help this critical period of adjustment and support longer term ongoing care and communication.
- Ensure the learning from this case is shared across all in-patient, crisis and community teams

5. That whilst mental health patients are in hospital all opportunities are used to improve their care and treatment and that where possible, they are not discharged before these have been appropriately addressed, rather than discharging them as soon as they are deemed no longer at active risk to themselves or others

We agree that patients should not be discharged simply by virtue of presenting no risk to self or others. The emphasis from mental health legislation and policy is that the aim of inpatient treatment is to optimise their recovery time and allow patients to return to their life and engage in treatment outside of hospital as soon as possible. However we recognise that this must be supported through a holistic assessment during the admission to inform the ongoing

care needs after discharge effective and that robust discharge processes are in place to deliver this safely.

To ensure that this is the case we will:

- We have successfully piloted a new trauma-informed approach to in-patient care delivery in one of our units and this is being implemented across all sites. This will support the development of a more personalised approach to in-patient care
- The Crisis and Home Treatment Teams attending the handover meeting on each ward daily will ensure they are aware of any planned discharges and contribute to discharge planning for all patients on the wards
- Every community team has a daily 'zoning' meeting and we will ensure that all inpatients are discussed in the relevant team so community teams are aware of all current in-patients and their progress and can contribute meaningfully to the intended aim of the admission
- Community team leads will attend the daily bed management meeting huddles where forthcoming discharges are discussed to ensure they are sighted on these and can support better communication
- We have a range of support and interventions for patients outside hospital settings which we will ensure are maximised in the discharge planning process. For example the Recovery College offers a range of person-centred interventions and the Trust has a well-developed Vocational service, offering Employment Support using the Individual Placement and Support Model, a User Employment Programme and a strong programme of Peer Support.

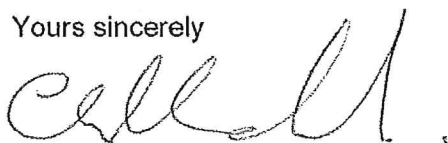
6. That rehabilitation should be more actively considered as a discharge option for patients especially where there are pre-admission concerns about their housing.

We acknowledge your concern about rehabilitation needing to be actively considered as a discharge option. Rehabilitation can take place in a wide range of settings and modalities, such as that described in Point 5 above.

NICE are due to produce guidelines on Rehabilitation in adults with complex psychosis and related severe mental health conditions that we know are likely to propose a wider range of options to provide patients with rehabilitation not just in an inpatient setting. This is the national direction of travel, with patients being brought back from out of area placements to their local community and rehabilitation being provided in high supported accommodation or even in patients' independent accommodation. We are working with our commissioner and local authority to ensure that services are commissioned for our patients that give the widest choice of rehabilitation options and keep up to date with modern ways of working. This will mean that as discharge planning starts at admission, we will follow the new NICE guidance on considering rehabilitation as appropriate.

I do hope I have been able to address the areas of clarification that you have asked for and that I have given you sufficient assurance that our services do thrive to provide the best possible care, taking into consideration the legal framework in which we work, local and national policy and the views of our service users when planning care and aftercare from hospital.

Yours sincerely



Claire Murdoch
CEO