Cumbria, Northumberland,
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NHS Foundation Trust

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22nd January 2020

Dr N Shaw
HM Coroner for County of Cumbria
Fairfield
Station Road
Cockermouth
Cumbria
CA13 9PT

Dear Dr Shaw

RE: Inquest into the death of Charlotte Grace
Regulation 28 Report to Prevent Future Deaths Response

I write in response to your Regulation 28 Report dated 29th October 2019 following your investigation into the death of Charlotte Grace. This response has been prepared by Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust ("The Trust") and addresses the concerns as set out by HM Coroner.

As you are aware Mental Health Services at the time of Ms Grace's death were provided by Cumbria Partnership NHSFT. As of 1st October 2019, those services are now provided by Cumbria, Northumberland, Tyne and Wear NHS Foundation Trust.

The issue you raised at the time of the inquest and within your regulation 28 report is as follows:

Agencies to whom a patient is discharged and families or friends (with consent) who will need to be supportive are not routinely involved in the discharge process.

The evidence at the inquest confirmed that it was clearly documented within Ms Grace's records/care plan that her next of kin was to attend discharge planning however, the discharge meeting was changed at short notice and Ms Grace's next of kin did not attend.

The evidence at the inquest confirmed that following the Serious Incident Investigation, a recommendation was made to improve clinical staff attendance at discharge planning meetings, a recommendation that the Home Treatment Team should be involved in discharge planning and where necessary attend meetings. The evidence of [redacted], Consultant Psychiatrist and [redacted], Team Leader, Home Treatment Team, indicated that this recommendation was not being consistently implemented at the time. [redacted] also indicated that whilst he had requested a conference telephone so that meetings could take place, this was not yet available.

Response

The Trust recognises the concerns that have been raised with regards to attendance at discharge meetings. The Trust is committed to ensuring that lessons are learned when any serious incident occurs and therefore following the investigation into Ms Grace's death, and

as a result of matters raised at the inquest, the Trust has put in place a number of measures to ensure optimal attendance at all future discharge meetings. These changes can be summarised as follows:

1. A learning review was carried out following the investigation on 16th November 2018 in which it was discussed that attendance of significant clinicians involved with the patient's care at the time and those responsible for providing future care would be best practice. The learning review suggested that where geographical barriers or workloads prevent face to face attendance at meetings, teleconferencing / videoconferencing could be used as an alternative.

2. Where geographical restrictions exist, teams utilise phone dial in and will move to Skype facilities within the next 3 months as part of the Trust's IT mobilisation planning and roll out.

3. In order to ensure family/next of kin collaboration each admission will detail family/next of kin involvement. The Trust currently holds a weekend family clinic at the Hadrian ward at the Carlton Clinic to work with families in terms of their support and collecting additional supportive information as part of each admission. This clinic is purposely held on a weekend in order to support working families. It is the Trust's intention to extend this process to each inpatient ward as part of the long term family engagement plan. The Trust intend to extend this within a 3 month timescale. This reflects a broader plan to increase and improve family engagement in all aspects of the admission in the service.

4. In order to ensure that the relevant teams/services are invited to discharge meetings, this is monitored as per the Trust's discharge flow chart. This flow chart provides prompts for teams to be invited and indicates that meeting arrangements will be agreed at least 2 days ahead unless urgent. Where attendance is not possible the flow chart states that this should be escalated to team leaders. Although this flow chart was in existence at the time of the incident, it is apparent that it was not being used consistently however, following a safer discharge project staff have been reminded to utilise this. The project includes a commitment to ensure that an agreed follow up is in place within 48 hours of discharge.

5. In addition to the above, weekly interface meetings take place which incorporate all community and inpatient services and ensure that complex cases are discussed alongside discharge meetings. If issues with attendance are identified, this is raised and actioned with clinical leads. Where regular non-attendance is identified, this is now being escalated to the Associate Director of the Clinical Business Unit.

6. In order to monitor the discharge process the Trust use a safer discharge audit. This audit is used on each ward and monitors the following information:

    a. The dated the discharge meeting was held;
    b. Was the Community Mental Health Treatment Team/Home Treatment Team invited;
    c. Did family/carer attend;
    d. Did the care co-ordinator/allocated worked attend the meeting;
    e. Was a discharge 48 hour follow up visit agreed prior to the discharge;
    f. Who has agreed to undertake the 48 hour follow up.

7. As a result of the concerns raised by this case, the audit was amended to ensure that family/carer attendance is also now monitored.

8. This audit is reviewed on a weekly basis at a Clinical Business Unit meeting with the clinical managers and ward managers. This acts as a check to ensure that discharge is not arranged without prior family involvement or communication. The audits have so far shown a consistent compliance with the new safer discharge process and will continue to be reviewed on a weekly basis.

9. The audits are reported through monthly quality standards meeting as a record and audit trail.

I hope that the information provided offers you the necessary assurances that the Trust have invested time, effort and resource into investigating the issues you have highlighted with a view to improving patient care and safety and reducing the risk of any adverse incidents or outcome in the future.

Yours sincerely

JOHN LAWLOR
Chief Executive