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NHS
Sussex Partnership
NHS Foundation Trust

Sussex Partnership NHS Foundation Trust
Trust HQ
Swandean
Arundel Road
Sussex

Ms Loxton
C/o Sarah Church
Sent by email:
[redacted]

18 June 2021

Our Ref: [redacted]
Your Ref:

Re: The Late Ms Hannah Bampfylde

Dear Ms Loxton

I write in response to your letter of 5 May 2021 in which you raised a concern about follow - up for initial assessment appointments with GP's and patients. Your concern was raised in accordance with Paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and Regulation 28 and 29 of the Coroner's (Investigations) Regulations 2013 following the inquest of Ms Hannah Bampfylde in a Regulation 28 Report.

I would very much like to start by expressing my sincere condolences to Hannah's family for their very sad loss. I have read Hannah's Carenotes and can see the difficulties the Horsham Assessment and Treatment Service had in trying to get Hannah to engage with the service. I have also heard from the audio transcript of the inquest, the proceedings as they occurred in real time. I can confirm the evidence provided to you by [redacted], who spoke to the Trust's SI, was accurate in relation to the measures we have taken as a Trust, since September 2020, to manage routine referrals. Our response to your concern (in bold below) is as follows: -

1. **Appointments are not automatically re-booked when a person has failed to attend an appointment.**

   Our Active Engagement Did Not Attend (DNA) Management Policy (attached) states that where a person fails to attend an appointment, the clinician should make an assessment of any risk posed by reviewing the care and contingency

plans and should decide and document the course of action. This is a clinical risk-based decision.

Our North West Sussex Referral, Triage, Assessment and Allocation Process Map (also attached) states that the assessor is to contact the patient to determine the reasons why the patient did not attend. You will recall that contact was attempted several times in Hannah's case, unfortunately with no response. Following any contact/non-contact made, the assessor will then discuss with the Referrals Coordinator and document the decision and plan on the patients' Carenotes. The assessors name is now updated on the Carenotes if another assessment has been planned/booked.

The above process was discussed in the Horsham Assessment and Treatment Service zoning meeting on 12th May 2020. The Team have been given the direction that after 3 appointments DNA'd/not attended, they will consider discussion with their shift supervisor, a cold call to the patient and/or a letter to be sent to the patient, copying in the patients' GP. The aim is to attempt engagement with the patient. Where the patient repeatedly fails to engage despite the efforts made.

2. **It is not clear who should re-book appointments when a person has failed to attend (administration or assessors)**

   Since September 2020, the Referral Co-ordinator is the person who books any further initial assessment appointments and not the Team Administrator. This measure reduces the risk of a patient not being followed up as highlighted the North West Sussex Referral, Triage, Assessment and Allocation Process Map attached.

3. **GP's are not routinely notified if a person has not attended an appointment with the Horsham ATS, meaning the GP would be unaware the person was not receiving input from the Horsham ATS until they had failed to attend a number of appointments and were discharged back to primary care, potentially many months after being referred**.

   The requirement to notify the GP is stated in our Active Engagement Did Not Attend (DNA) Management Policy. This requirement was outlined in our Serious Incident Report as an action. The action is complete and the practice embedded. Weekly administration support is in place to ensure that all DNA cases have been identified and our Referral Co-ordinator oversees the rebooking of assessments and/or informs the GP of discharge from Horsham ATS due to repeated non-attendance and or engagement.

The safety of patients referred to us is of paramount importance to the Trust. Our service cannot coerce engagement as the desire to engage must come from the patient themselves, particularly when they are capacitous, like Hannah was. However, it is important for our systems to be effective and to ensure that no patient 'falls' between services. I trust this letter demonstrates to you and Hannah's family the action we took to strengthen our systems. I will ensure we audit compliance with this over forthcoming months.

Yours sincerely

[redacted]
Chief Executive