NHS
Cornwall Partnership
NHS Foundation Trust

8th December 2021

Interim Medical Director
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Dear Mr Cox

Regulation 28 - Prevention of Future Deaths report following the inquest into the death of Mrs Kirtsy Doodes (concluded 14 October 2021)

Thank you for your Regulation 28 Report, issued following the Inquest into the death of Mrs Doodes. I am replying as the Medical Director for Cornwall Partnership NHS Foundation Trust.

I would first like to offer my sincere condolences to Mrs Doodes' family and to say that I am truly sorry for their devastating loss. Every death in such circumstances is a tragedy and the implementation of learning from this is my absolute priority.

I have discussed the concerns raised with our Director for Mental Health Services, our Nurse Consultant for Mental Health Inpatients and Targeted Services (MH&TS), and the Care Quality Lead for MH&TS. We considered the circumstances around Mrs Doodes' discharge and the experience of Mr Doodes, and I set out below the response to the matters you have raised.

Discharge Process
I am aware of ' concerns regarding Mrs Doodes discharge from hospital and the care provided following her discharge. Having reflected on these concerns, and the concerns you outlined in the Regulation 28 report, I feel it is important to highlight a number of general points:

We would firstly like to identify that the general length of stay on our hospital wards for the full range of patients is not short - we currently have an average length of stay that is significantly greater than that of the national average and the reasons for this are multi-facetted which I will not expand on here. Additionally, where a patient is deemed to have capacity, and has been removed from section under the Mental Health Act, they are able to make the decision to return home which, in some instances, may be against our advice.

Mrs Doodes' had repeatedly expressed her desire to leave the ward and had been positively engaging with the clinical team in an effort to achieve this in the days prior to her eventual discharge on the 18 March 2020. A referral had been made to the Trust's Home Treatment Team in preparation for this event and for further safety planning in the community setting. The decision to discharge Mrs Doodes was accepted as an appropriate decision at Inquest, as reflected in section 4 of the Prevention of Future Deaths report.

Moving to a 'at home' care setting after risk has appeared to escalate on the in-patient ward, can seem counterintuitive and may be hard to accept. However, it is a practice supported by the best evidence

and is particularly the case where staff and teams are very familiar with the person and have experience of engaging and working with them, such as was the situation with Mrs Doodes.

As a NHS Trust, we endeavour to provide the best possible care and work as closely to National Institute for Health and Clinical Excellence (NICE) Guidance as possible. The NICE guidance for patients with a personality disorder, which was the diagnosis given to Mrs Doodes, states that inpatient hospital admission is rarely helpful and can indeed worsen the risk of self-harm, and goes further, to state that inpatient admissions should ideally be limited to no more than 72 hours. Helping patients and their families and carers to understand this and recognise the profoundly destabilising effect of anything other than a brief crisis admission can be very difficult, particularly as Mrs Doodes had had a number of longer admissions in the past.

With the above factors in mind, we have identified learning for us in that we need to support our clinicians to improve the discharge process and we therefore intend to review the Trust's mental health acute ward discharge policy to support this.

The current discharge policy is lengthy, with many pages of checklists - our concern is that a preoccupation with these numerous less important factors may distract from those most vital to a safer and more satisfactory discharge. Therefore, to improve the quality of our discharges we will prioritise the most important steps within the policy with a refreshed knowledge of the roles and responsibilities of the multi-disciplinary team. Our priorities around discharge are:

- Communication with families and carers
- Communication with the patient's GP
- Medication
- Care following discharge
- Crisis information

Additionally, we are committed to working on the length of stay in our hospitals in an attempt to ensure that it is closer to the national average whilst continuing to work in line with best evidence such as the NICE Guidelines. This will often (and perhaps more frequently) mean that families and carers may find the rationale for discharge contrary to their wishes and/or counterintuitive. For this reason, time to enable families to work through, question and hopefully accept this will need to be prioritised as although Mr Doodes was involved in his wife's discharge planning, we recognise that he did not feel as supportive of the plan as we would have liked.

Clinical Documentation and staffing levels

The Trust's clinical staff view a patient's medical documentation holistically to support clinical decision making, taking into account the views of all services involved rather than a relying on a single entry. In Mrs Doodes' case appropriate clinical documentation had been completed by members of the wider clinical team, including risk assessments and care planning. However, we acknowledge that at times, documentation and paperwork is not always as robust as we would like.

Sadly, services are finite and we have to balance the extent to which we prioritise the most comprehensive documentation, against the time available for clinical care with patients and their families. As part of our plan to improve mental health services we will be reviewing our accepted documentation standards, with the aim of supporting and directing our clinicians to spend the maximum amount of time providing compassionate, person-centred care, while minimising what may ultimately be, unhelpfully defensive documentation. This approach will also allow clinicians as much time as possible time to have difficult discussions with families and carers, for example around discharges from hospital. As such, consideration will be given as part of the review of the discharge policy (described above) to include a template for documenting inpatient discharge decisions. This template will support effective communication and will be designed to make note keeping concise with space to succinctly include the rationale used, which we hope will be helpful in supporting staff to

evidence their decision making; and also aid the members of the wider multi-disciplinary team in explaining clinical decisions to families and carers in the future.

You also requested clarity around the availability of consultant psychiatry staffing. This is an ongoing nationally recognised problem and The Royal College of Psychiatry national census in 2019, estimated 9% of consultant posts as being vacant, this is thought to have since exceeded 10%, and in general, services manage this gap by the employment of locums. We recognise this challenge more acutely in Cornwall where there has been a significant shift in the vacant posts in past 2 years as recruitment to the county has become more difficult. At present the number of vacant consultant posts filled by locum staff in Cornwall varies between 15-20%. We work very hard to recruit substantively to posts whenever a vacancy appears, and we will also promptly appoint a locum psychiatrist to ensure that gaps in service provision do not lead to unnecessary pressures on services. Despite our best efforts, at times these gaps can emerge and we have other contingencies that we can use in urgent situations.

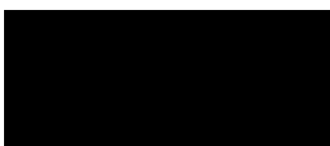
At the time of her discharge, Mrs Doodes was under the care of our general psychiatry service where consultants work as 'pairing partners' - which means that they cross-cover one another for periods of absence or leave. Both Mrs Doodes' lead consultant and his pairing partner are substantive consultants employed by the Trust. Mrs Doodes' lead consultant was stranded in India as the Covid 19 pandemic began to surge, resulting in the 'pairing partner' consultant overseeing her care. These arrangements for cross cover are well tested and colleagues are familiar with them, needing to adapt their working week when providing a period of cover.

As a Trust, we continue to struggle with profound shortages of a wide range of trained and untrained staff across many of our services. For this reason, we are especially focussed on the time we spend with patients and their families and would like to thank you for the opportunity to explain how we intend to maximise this, whilst adhering to best practice and working in very pressing circumstances. It is important to note that we are making extraordinary effort to increase our workforce in all professions. Measures we are taking to expand our mental health workforce include:

- Introduction of new roles to complement our existing workforce, e.g. mental health workers in GP surgeries, Peer Support Workers (people with lived experience of mental ill health) and Clinical Associate Psychologists among others,
- Undertaking our first international nurse recruitment programme, the first cohort are expected to be in our employment by March 2022,
- Significantly increasing our number of apprentice roles, including mental health nurse apprentices.
- Improving retention of staff by making us a great employer, creating better career pathways and more obvious opportunities for progression as an expert clinician.

Thank you again for bringing your concerns to my attention - they are clearly relevant and important issues around a crucial aspect of care at the point of discharge from hospital. I trust that this response provides assurance that action is being taken to address the matters that you have raised.

Yours sincerely



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