Cumbria Partnership NHS
NHS Foundation Trust

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Your Ref:

Our Ref:

Date: 17 April 2015

Private and Confidential

Mr D.L.I. Roberts
H.M Senior Coroner
Fairfield
Station Road
Cockermouth
Cumbria CA13 9PT

Dear Mr Roberts,

Re: Inquest into the death of Alexander George Ball dated 29 January 2015

I am writing in response to your letter dated 19 February 2015, issued under Regulation 28 and pertaining to the death of Mr Alexander George Ball.

The Trust has noted the points you raised during the inquest which were subsequently highlighted within the Regulation 28. The Trust has also noted from your letter and your summary comments made at the time, that copies have been sent to the other agencies involved in Mr Ball's care but that the lead agency identified under section 6 is Cumbria Partnership NHS Foundation Trust in view of the fact that the Trust had taken the lead role in the Serious Untoward Incident investigation. We note that your comments were equally directed at the other parties, namely the North Cumbria University Hospitals NHS Trust, Mr Ball's General Practitioner and Greater Manchester West Mental Health NHS Foundation Trust as the providers of the UNITY drug and alcohol recovery services.

As acknowledged during the inquest, the Trust has undertaken significant work through the internal investigation process and the provision of the consequent action plan. Since the inquest, the Trust has reviewed the points you raised in respect of the two issues identified in the Regulation 28.

In regards to the first issue, that of communication between the partner agencies, our understanding was your specific concerns related to:-

- At the time of Mr Ball's admission into hospital on 9 February 2014 North Cumbria University Hospitals NHS Trust staff were focused on his physical care and did not think in mental health terms. Consequently there was no communication with the Mental Health Team;

- Following the above admission to the emergency department there was no formal communication between UNITY staff and the Mental Health Team with regards to Mr Ball's ongoing mental health care needs;

- Mr Ball's GP did not increase the fluoxetine, despite the recommendation made by our consultant psychiatrist and there was no communication between his GP and the consultant psychiatrist in relation to any differences in clinical opinion.

As detailed in the Serious Untoward Incident action plan, the Trust will facilitate an Oxford Learning Event with the identified partner agencies. The purpose of this event is to identify and address the issues of communication ensuring clarity over the pathway for clients presenting with both mental health problems and substance misuse problems across the various care groups. We plan to hold this event during June 2015 subject to agreement with partner agencies.

Prior to the Oxford Learning Event, I have requested that a range of immediate actions are introduced by the Trust's Mental Health Care Group in order to improve communication arrangements with partners. These improvements include:-

- Monthly meetings between key staff from the Trust's Mental Health Care Group and local UNITY team members. These meetings will take place at a locality level with the aim of providing a direct conduit for face to face communications.

- The monthly meetings will be supplemented by a county wide quarterly liaison forum which will provide feedback to the Trust's Mental Health Care Group Clinical Governance group. The emphasis of these meetings will be to enhance multi-agency communications with improved outcomes for patients presenting with complex needs across services within Cumbria.

The above actions will be implemented by the end of April 2015.

With regards to the second concern you raise in respect of the lack of a permanent care coordinator, the Trust has set an internal measure relating to the maximum waiting times patients should expect for the allocation of a care co-ordinator.

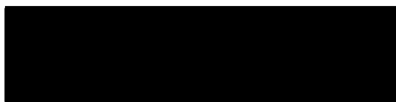
At the time of Mr Ball's death there were 74 patients on the waiting list to be allocated a care co-ordinator within our Adult community mental health service in Copeland. The internal measures to address this area are being supported by clinical leads within the service including responsibility for the active management of the waiting list and undertaking robust caseload reviews and supervision.

This has had the impact of ensuring that timely discharges and transfers take place, enabling capacity to be released to allocate new cases. The measures being undertaken with Copeland will be rolled out across the Trust during 2015.

I hope that the above information highlights the actions taken by the Trust to address concerns relating to the quality of services it provides to the local community. I also want to assure you that we at the Trust take very seriously our responsibilities for providing safe and effective care in all areas of our services and in our relationships with our partner agencies.

Should you require clarification or further information with regards to any of the points raised above please do not hesitate to contact me directly.

Yours sincerely,

pp  Director of Quality and Nursing

Clare Molloy
Chief Executive

Copies to: Ann Farrar, Chief Executive, North Cumbria University Hospitals NHS Trust
Bev Humphrey, Chief Executive, Greater Manchester West NHS FT