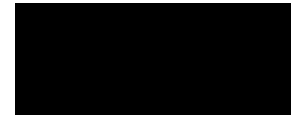
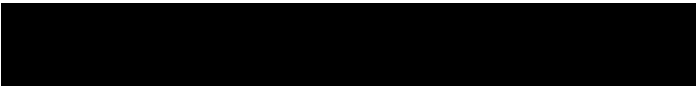


Miss J Kearsley
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Coroner's Court
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Medical Directorate
NHS England - North
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26 February 2016

Dear Miss Kearsley

Re: Jake Robinson (Deceased)

I have now had the opportunity to review and to consider the responses received from Bodmin Road Health Centre, Greater Manchester West Mental Health Foundation Trust (GMW), Salford Clinical Commissioning Group (CCG), and Trafford Clinical Commissioning Group (TCCG). These set out the detail of the relationships between the providers, the commissioners and the patient.

Greater Manchester West Mental Health Foundation Trust have verified that they do not have any record of the faxed letter sent by the Bodmin Road Health Centre Practice, relating to the clinical advice that would have allowed Jake to maintain his treatment for benzodiazepine addiction. To remedy this, Greater Manchester West Mental Health Foundation Trust have undertaken a serious incident review and have implemented systems to capture and act upon letters or faxes received. The Bodmin Road Health Centre has similarly noted risks and taken steps to manage urgent correspondence and to confirm actions. Greater Manchester West Mental Health Foundation Trust have identified that their initial review of the case did not identify the missing letter, despite Jake's mother raising this specifically. Greater Manchester West Mental Health Foundation Trust has noted this within their internal review.

Salford CCG, as the lead Commissioner with Greater Manchester West Mental Health Foundation Trust have identified that the two services, namely Phoenix Futures and Trafford AIM provide different services to different client groups and that the relationship between the two can be improved. I note that a Dual Diagnosis Steering Group has been set up by local commissioners to review this. Greater Manchester West Mental Health Foundation Trust acknowledges that the Community Mental Health Team could have attended an appointment jointly with Trafford AIM to improve engagement and assessment for Jake.

In order to reduce the risks of recurrence of a similar incident at these and other organisations across Greater Manchester so that referrals are managed and monitored by the responsible commissioning and provider organisations I intend to undertake the following actions by 29 April 2016.

I will send a reminder letter to all GPs outlining best practice when sending urgent correspondence. That is, the practice should make contact by telephone, or otherwise, to obtain timely verification that the urgent letter or fax has been received and to note this within records, and not to rely solely on the sender's fax confirming transmission. This letter will also include guidance on suicide prevention and the need to note the risk, irrespective of any previous understanding by the recipient, so long as that risk persists.

I will also ensure that a letter is sent to all mental health service commissioners outlining NHS England expectations that commissioned services must establish arrangements for the following:

- a. How urgent correspondence is handled and acted upon. This is also a contractual obligation which will be monitored by the commissioner.
- b. To provide assurance to the commissioner on the robustness of clinical risk assessment tools, particularly in relation to risk to self and historical events.
- c. Where different services / service providers interface, to ensure that the structured management for shared care is clear and unambiguous.
- d. Undertake a review of systems that are in place to track and establish lessons learned from any incidents and near misses.
- e. To review policies and procedures for vulnerable patients who have a propensity to miss appointments.

If you have any queries in respect of the above please do not hesitate to contact me.

Yours sincerely



Medical Director, Lancashire & Greater Manchester
Director of Commissioning, Lancashire