Leicestershire Partnership NHS
NHS Trust

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14 December 2016

[redacted]
Lydia Brown
Assistant Coroner
Leicester City and South Leicestershire
The Town Hall
Town Hall Square
Leicester LE1 9BG

Dear Mrs Brown

Re: Victoria Halliday

Further to your report dated 20 October 2016, in accordance with paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, I offer the following response.

We have investigated the matters of concern that have arisen during the course of the inquest of Victoria Halliday. Leicestershire Partnership NHS Trust (LPT) takes these matters very seriously and I hope that you and Victoria's family will be satisfied that we have taken the appropriate measures to prevent such an occurrence happening again.

The matters of concern you have raised are as follows:

1. There are currently no local psychiatric intensive care unit beds for female patients and this means all female patients can only be placed out of area, potentially many miles away from home and local support.

Service Response

LPT is not currently commissioned to directly provide Female Psychiatric Intensive care beds (PICU). Our commissioners are in the process of procuring a local, medium to long term solution, for female Psychiatric Intensive Care Unit (PICU) placements in Leicester, Leicestershire and Rutland. The procurement process is unlikely to be resolved until 2017/18.

For patients who are placed out of area, through our Adult Mental Health (AMH) Bed Management Team, we keep in touch on a weekly basis with the placement providers to ensure that length of stay out of area is for an agreed period of time, and that repatriation back to local services is facilitated at the earliest opportunity. In Victoria's case, referrals to PICU were made from the Bradgate inpatient area due to her challenging presentation and its impact on staff. We have since tailored and structured psychological support and reflective sessions for ward staff who manage patients with personality

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disorder and are in the process of recruiting more psychologists to strengthen the psychological minded approach to care. This will ensure that NICE clinical guidance 78 is followed for inpatient stays.

We have also appointed a Band 7 nurse to lead on the implementation of the "Positive and Proactive Care: Reducing the Need for Restrictive Interventions" guidance across all inpatient areas of the Trust. This is anticipated to reduce the need for higher environmental restrictions (in Victoria's case, referral to PICU) and better management in acute ward settings.

2. There was no, or no effective, community psychiatric nurse involvement, and this was a missed opportunity to monitor and assist Victoria when she was in the community

Service Response

A standard community service exists within LPT for people with personality disorder in the form of community mental health team (CMHT), Crisis Resolution Team (CRT) and Specialist Personality Disorder Service (FDL). Victoria was accessing all these services during the course of her contact with LPT. An identified Community Psychiatric Nurse (CPN) from the CMHT, CRT was present during professional and CPA meetings whilst Victoria was an inpatient. Due to the nature of Victoria's presentation of presenting in different areas of the country in a crisis covering CPNs and CRT professionals tried to ensure continuity as much as possible.

In this case, the lack of effective CPN input during the time Victoria was a community patient was an isolated incident, with the assessing CPN failing to follow the standard operating team process, whereby the assessing worker accepts the person onto their case load if they have capacity. If they don't have capacity the assessing worker should present the outcome of the assessment at the next Multi-Disciplinary team (MDT) meeting in order to allocate to a Community Worker/CPN within the Team.

This issue was a finding of the Trust's investigation report, and as a result action has been taken, and is ongoing, in relation to the individual CPN under the Trust's formal performance and conduct procedures.

The CMHT Team Manager has ensured that all staff within the Team are aware of the current process for allocation of a Community worker following assessment. This information forms part of the induction process for all new starters to the team.

3. The "community support" referred to by the in-patient clinicians does not exist in reality for patients with this challenging presentation, leaving discharged patients and their families without adequate support.

Service Response

As stated in response 2, LPT provides a standard community service in the form of CMHT, CRT and specialist personality disorder service (FDL) for people with personality disorder to access. The community support available

at the time of Victoria's discharge would have been predominantly from the CMHT, with the allocation of a CPN and clinical review via the Consultant Psychiatrist. For people with a challenging presentation this support from the CMHT would usually continue whilst a patient is waiting for assessment/follow-up from Francis Dixon Lodge (FDL) our therapy services for people with personality disorders. The CMHT will continue to support patients while undergoing treatment at FDL. A referral to the Crisis Team is an option at any time for any patient and would be made by the CPN as required.

For patients not open to a CMHT who are identified as requiring CMHT input while an inpatient, a referral can be made to the locality CMHT for allocation to a community worker. This could be a CPN or an Occupational Therapist (OT) dependant on assessed need. All CMHTs have access to the Crisis Team and can refer patients in the event of a crisis situation for home treatment. This can be provided for up to six weeks, dependent on the needs of the individual patient. During this time CMHT involvement will continue.

However the community support as mentioned by the inpatient consultants refers to an "enhanced service" for people with severe and complex personality disorder (SCPD) who are difficult to maintain in the community with existing standards services and they inadvertently access acute services (inpatient and crisis services). LPT is currently not commissioned to provide this "enhanced service". Some Trusts have adopted innovative practice which is commissioned to address this gap and LPT is doing the same with our Commissioners in proposing testing a bespoke service for people with SCPD as part of a wider Personality Disorder service development.

4. The care programme approach (CPA) was not adhered to and NICE guidelines were not followed, specifically in ensuring there was a review after 2 admissions within 6 months, and to ensure the roles and responsibilities of all health and social care professionals involved were identified.

Service Response

All inpatients are subject to a Care Programme approach (CPA) and during their stay in hospital professional meetings are held which would have addressed NICE CG 78's 1.4.1.4 requirement of "Arrange a formal CPA review for people with borderline personality disorder who have been admitted twice or more in the previous 6 months".

However we acknowledge that it was a missed opportunity that the social worker was not invited to these inpatient professional meetings and that the CPA process was not followed through once she was discharged to the community.

In order to ensure roles and responsibilities of health and social care professionals involved in the CPA process are clear, understood and adhered to, a Standard Operating Procedure (SOP) is under development. Included in this SOP it will confirm and clarify the process to identify a Care Co-ordinator for patients in in-patient services, and will confirm and clarify the transfer and allocation process for the identification of the Care Co-ordinator in the community team, and associated reviews required.

A formal bi-annual CPA audit across AMH in-patient and community services has recently been completed and action plans developed.. There are specific questions within the audit in relation to the CPA Care Plan, showing a clear description of needs and there being a description of the action to be taken and by whom. The audit completed in 2014 showed good compliance in these areas.

5. There is no local network for the community support of patients diagnosed with personality disorder, although evidence suggested such networks were effective when adopted elsewhere.

Service Response

Further to our response to concern 3, LPT is not commissioned to provide an "enhanced service" to provide support and treatment for people with a severe and complex personality disorder (SCPD) in the community. A group of our senior clinical and operational leaders, with support from Commissioners, are working together to develop an integrated clinical pathway and model for care for people with Personality Disorders. As part of this proposal a dedicated team to provide this enhanced service is proposed, the purpose of which is to provide an intensive community based treatment support for both patients in treatment, and in crisis. The aim is to link the pathway together with supporting services in primary care, social care, and Police. We continue to work with our commissioners to negotiate our 2017/2018 contracts for provision of services, of which this remains an ambition to provide.

All of the actions outlined in this response will be monitored through the service's clinical governance arrangements.

We hope this reassures you that we have taken appropriate action in response to the issues you have raised under Regulation 28 and that we are committed to provide safe and effective care in order to reduce the risk to our future patients.

Yours sincerely

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Chief Executive

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