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Private and Confidential
Mrs Rachael C Griffin
HM Senior Coroner for Dorset
The Coroner's Office for the County of Dorset
Town Hall
Bournemouth
BH2 6DY

27 June 2018

Your Ref: RCG/02814-2017/SD

Dear Mrs Griffin

Re: Inquest touching the death of Joanne Elizabeth Richardson (deceased)

I write to you further to the above mentioned Inquest which concluded on 25th April 2018 when you raised concerns and the Regulation 28 Report dated 8th May 2018.

You raised three concerns. The first concern was that, critical patient information between the Trust's Steps to Wellbeing Service (S2W) in West Dorset and the Trust's Community Mental Health Team (CMHT) had not been shared. Secondly that patient information is recorded in two different electronic patient information systems and that not all staff have access or regularly review information in each of these systems. Thirdly that Mrs Richardson had not been followed up in a timely manner by the CMHT, after making contact with the Crisis Team. You requested a review of the policies regarding communication between teams, in particular between the CMHT and S2W.

We have reviewed our processes and policies regarding communication and joined up working between CMHTs and S2W services alongside relevant legislation and guidance.

Currently administrators check both electronic patient information systems – IAPTus for S2W for all referrals received by the CMHTs and Rio for S2W and CMHT teams to see if the patient is known to either service. Read only access for both systems are available to administrators and team leads. If the patient has a history with local mental health services, this information is copied by an administrator onto the S2W clinical notes and

makes this available to the allocated assessing clinician, prior to them assessing the patient.

After the assessment, a copy of the assessment letter (summarising presenting problems, agreed treatment plan, risk summary) is copied to the other teams who are involved with the patient. Any significant changes to the treatment plan that take place during contacts with teams are communicated to the other teams involved.

It is also standard practice that at the point of discharge, for a patient who is under the care of both services for a discharge letter to be sent to the other team and GP. We have reinforced the expectation that, when a patient is being seen by both teams, a discussion is had between S2W and CMHT clinicians, prior to discharge to agree an appropriate discharge plan. Furthermore, we have reinforced the expectation that treatment decisions are communicated to patients face to face or over the telephone in order to allow collaboration and feedback. These decisions can then be formalized in a written letter to the patient, but this should only happen after a discussion has been held with the patient and other team.

In addition to the communication processes described above we introduced the following measures to aid closer working between teams. On IAPTus (S2W) a label has been identified that will be a visual aid on the personal information page of the record indicating that a patient is also known to the CMHT. The Rio (CMHT) system does not have this functionality. However, a report has been developed that identifies patients who are under the care of both services.

If there is a significant change to a client's risk, indicating that there is a significant risk of harm, the allocated clinician will share this information with the other service in a timely manner, by telephone in the first instance. If it has not been possible to speak via telephone then this information will be shared via email using the team referral inbox that is screened daily. This will be used to share urgent information pertaining to a client's risk and then be uploaded to Rio or IAPTus respectively.

The CMHT hold weekly multidisciplinary team meetings to review cases. A S2W practitioner is able to phone into a set slot at a CMHT / team meeting. This enables case discussions and review of risks for those people who are under the care of both services. Any discussions will be documented in the CMHT team meeting minutes and both clinical systems.

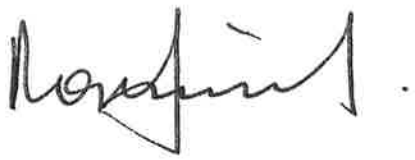
With regard to your concern about timely follow-up, our Crisis Teams inform CMHTs by email when they have had contact with one of their patients. The Root Cause Analysis review highlighted that there was a failure to record the CMHT assessment and care plan in response to receiving information about Mrs Richardson's contact with the CHTT.

Emails from the CHTT are sent to CMHT clinicians involved in the patient's care and to a generic CMHT account that is monitored by the administration team. They ensure that a clinical member of the team is aware of the message. The need to act on such information and to document decisions on the electronic record has been reinforced within the CMHT involved through discussion of this omission in care. This learning has been disseminated to all CMHTs across the Trust.

I hope that the actions outlined provide assurance that the Trust has investigated this matter thoroughly, communicated this learning and new processes to staff, and introduced additional measures to ensure that communication of clinical and risk information between CMHTs and S2W in Dorset is reliable, clear and timely.

If you have any queries at all, please do not hesitate to contact my office.

Yours sincerely



Ron Shields
Chief Executive