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Ref: NB/HR/401262

21 June 2018

Private and Confidential
HM Assistant Coroner Caroline Topping
HM Coroner's Court
Station Approach
Woking
Surrey, GU22 7AP

Dear Ms Topping

Regulation 28 Report – Henry Heselton

I write further to the above issued on 21 May 2018, following the conclusion of the inquest into the death of Henry Heselton.

I note your areas of concern, which I will address in turn, are as follows:

1. **The electronic mental health records were unclear. Vital information about Mr Heselton's mental health history, including that he had attempted suicide in the past, was difficult to find. His most recent care plan did not record this. The information is not easy to extract for professionals needing to find information about a patient in a crisis.**

It has been recognised, by the Trust, that our electronic patient record, RiO, supports the recording and sharing of vital clinical information, including risk, more effectively than the previous paper record system, including improved legibility, organisation, sharing and identification of key information. However the system has faults and limitations, and information can be difficult to find. It is therefore subject to ongoing review so that it can be redesigned in a way which supports clinical practice. The clinical workforce receives training and support to be able to use the system effectively.

The concern that vital information has not being readily available has been accepted and action taken to remedy this. There has been, since January 2017 (evaluated in April 2018), a revised Risk Summary Section in which all staff including medical staff are required to input risk information, according to national guidance (2008). This guidance specifies that there should be clear documentation of risk factors: demographic, background, clinical history, psychological and psychosocial factors and current context. The clinical assessment of these factors leads to a management plan which will include a 'My Safety & Crisis Plan' (a collaborative approach to safety planning). This is monitored, and staff are prompted to complete or update the plans at regular intervals, and this should always happen when there is a significant change in risk.

There has also been a review of the care planning process, and a Community Care Plan page developed (since January 2018), where all care plans are inserted so that they can be readily identified as well as the Risk summary.

2. **There was a lack of communication between the mental health teams and the general practitioner. The fact that contact had been made by Mrs Heselton with both the acute and community mental health team was not shared with his General Practitioner. This left her without relevant recent history to inform her clinical judgement when she was contacted by [redacted] on the 7th September 2016.**

Safe and effective clinical care is dependent on appropriate information sharing with patient, carer, GP and other agencies and this includes assessment of risk and care planning. At the following times information should be shared with primary care:

- After referral to Mental Health Services to let the GP know of the triage process which will include a plan for assessment to occur and the timing of it or other advice or signposting (which did not occur on the occasion referred to)
- After each initial assessment with details of the assessment, including risk.
- Psychiatric out-patient appointments
- Discharge from inpatient services
- Care Programme Approach meetings: these are care planning meetings involving the patient, their family and the important services that are involved in the patients care, eg. Housing, social care, community teams, police.
- Communication should also occur when there is a request to a GP for support with medication or physical health review.

Electronic communication has being developed to allow access to CHIE (formerly the Hampshire Health Record) and GP summary patient records and is being developed to allow access for GPs to the mental health record. But this does not mean that communication described above will be superseded.

To address the shortcomings in the care provided to Mr Heselton, these principles have been included in the review of the Acute Mental Health Team and Community Mental Health Team Standard Operating Procedures, and the team managers instructed to ensure that staff are aware of the requirement to communicate with GPs after triaging referrals and to regularly monitor that it is occurring.

I do hope that this letter provides you with the information and assurance that you require regarding the measures that have been put in place. Please do not hesitate to contact me if you require any further information.

Yours sincerely,

Dr Nick Broughton FRCPsych
Chief Executive Officer