05 JUN 2019

NHS
Norfolk and Suffolk
NHS Foundation Trust

Trust Management
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Hellesdon Hospital
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Hellesdon
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NR6 5BE

Our Ref: JW/ML

30 May 2019

Private and Confidential
Mr Daniel Sharpstone
Assistant Coroner for Suffolk
The Coroners Court and offices
Beacon House
Whitehouse Road
Ipswich
IP1 5PB

Dear Mr Sharpstone

Re: Mr Anthony Buckingham

I write in response to your prevention of future deaths report dated 15 April 2019 following the conclusion of the inquest into the death of Mr Anthony Buckingham. I know you will share a copy of this response with Anthony's family and I would like to express my condolences for their loss. Anthony's death is a tragedy and it is essential the Trust takes all opportunity to learn.

The report listed five areas that could have been done to try and prevent his death. I will respond to these in order.

1. Daily visits from the mental health team

   The Trust's internal investigation identified that Anthony had no contact with mental health services prior to February 2018. Following referral to the Trust he was provided with support by the Home Treatment Team. This team provides short term support for people experiencing acute mental health needs, through visits and telephone calls. From the period 16 February 2018 to 13 March 2018 the team completed seven face to face contacts and seven telephone contacts. The decision as to the frequency of contact is considered by the multi-disciplinary team in conjunction with the service user, based on their presenting needs. The multi-disciplinary team approach assists to ensure all perspectives are considered and the judgement is a shared decision. Through this process contact can be increased and decreased on a flexible basis. Additionally, where an individual's needs require an admission to hospital the home treatment team are able to initiate the actions required to complete this.

2. Involvement of the next of kin

   The Trust's internal investigation confirmed that the next of kin details were not obtained from Anthony, thereby impacting on their ability to engage his family. This was not picked up during the period of contact with the Home Treatment Team. A recommendation of work was made by the internal investigation resulting in the care team evaluating their processes. The clinical team leader monitors this taking action where required. The Trust obtains assurance of this improvement through means such as audit and its quality and safety reviews.

3. Formal mental health act assessment

   The report doesn't identify at which stage of care a request for a mental health act assessment may have been appropriate. Following the initial assessment, Anthony was accepting treatment and engaged with the appointments and telephone calls offered. This was in keeping with the principle of least restrictive treatment.

4. Involvement of the practice nurse

   The Trust's internal investigation identified learning regarding the need to liaise and work with other agencies involved in the care of the service user. The team's current working process is to allocate an individual staff member to each service user; they have some additional responsibilities to ensure the care package is comprehensive and includes all other agencies. In addition, the multi-disciplinary team meetings help identify key others involved in care and allocate action of who will engage them.

5. Use of Corner House care facility

   It is critical that Trust services engage with other agencies to ensure there are comprehensive packages of care in place for our service users and carers. Such support needs are individual based on assessment. The range of statutory and non-statutory support that is available is significant and ever evolving. Thinking of this wider partner network and the requirement for close working, our suicide prevention lead has hosted two events bringing together non-statutory and statutory agencies, service users and Trust services in order to open channels of communication and raise awareness what each other provides. These events of introduction have been well received leading to the building and strengthening of networks. We have more planned for all areas of the Trust over the coming months.

In support of all the above actions the Trust is strengthening its clinical and service leadership to ensure they have the necessary breadth of skills and resource to lead safe and effective services. Of particular note, the Trust will be introducing Patient Participation Leads for each locality, who will work alongside new Clinical Directors to lead the components of quality and patient experience. The Trust is finalising the recruitment to these roles which will be fully effective from September 2019. A key function of this new approach will be the accountability to share learning, implement and monitor recommendations from serious incidents. Their role is to support the local clinical services function effectively, working alongside their network of partner agencies.

The Trust will gain assurance these interventions are working through a number of indicators. This will include audit, user feedback and the outcomes of quality and safety reviews. To support an effective assurance system, the Trust is implementing a new governance structure enabling a combined and tiered approach that will provide the culture and conditions for improvement.

Thank you for providing this report to the Trust.

Yours sincerely

Jonathan Warren
Chief Executive