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National Medical Director
Skipton House
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SE1 6LH

Mr Alan Romilly Craze, Senior Coroner for the
area of East Sussex
Unit 56
Innovation Centre
Highfield Drive
St Leonards on Sea
East Sussex
TN38 9UH

18th December 2019

Dear Mr Craze,

Re: Regulation 28 Report to Prevent Future Deaths – Martin Leslie Haines, who died in Lewes Prison 18th March 2018

Thank you for your Regulation 28 Report (hereinafter the 'report') dated 16 August 2019 concerning the death of Martin Leslie Haines on 18 March 2018. Firstly, I would like to express my deep condolences to Mr Haines' family.

I note that the recent inquest concluded that Mr Haines' death whilst detained in HMP Lewes was as a result of cardiac arrest in the presence of Venlafaxine, Amitriptyline and alcohol.

Following the inquest, you now raise concerns in your report to NHS England regarding:

1. The fact that Mr Haines was able to brew or distil his own alcohol.
2. The failure to carry out diagnostic testing and monitoring of his diabetes and to confirm his considerable cardiovascular disease.
3. The standard of care appears to have fallen well below that which he could have received in the community.
4. There were no protocols or agreements between healthcare staff and the prison service as to how to respond to an unresponsive body.
5. Responsibility for healthcare fell between the prison service, Sussex Partnership Foundation Trust (contracted to provide both mental and physical health within the prison), MedCo Ltd who provided the GPs, and Forward Trust who were contracted to supply the alcohol and substance misuse treatment service in the prison. There was insufficient communication between these bodies and they had separate IT databases.

This response seeks to set out the actions which have been taken following the death of Mr Haines and the learning that has been taken forward by commissioners from this very sad incident. I am also mindful when responding of the earlier death of Mr Justin Peter

Gallagher who died whilst detained at HMP Lewes in June 2016, the action plan instilled following his death, the delays in embedding necessary changes, and the similar concerns you raise in the related Regulation 28 report.

I now respond to the concerns raised in turn:

1) The fact that Mr Haines was able to brew or distil his own alcohol.

I understand that The Ministry of Justice will respond directly to the Coroner on this.

2) The failure to carry out diagnostic testing and monitoring for his diabetes and to confirm his considerable cardiovascular disease

I can confirm that Sussex Partnership NHS Foundation Trust (SPFT) undertook a Root Cause Analysis Investigation following Mr Haines death and three recommendations were made:

a. healthcare staff should be trained in how to detect diabetes and hypertension;
b. long term conditions such as diabetes and hypertension are managed in line with National Institute for Care Excellence (NICE) guidelines; and
c. reviews of repeat medication comply with NICE guidelines.

In response to this SPFT created a training session for all staff which was completed by the end of 2018 and is now incorporated in the yearly training programme, covering NICE guidelines on the management of diabetes, hypertension and Chronic Obstructive Pulmonary Disease.

3) The standard of care appears to have fallen well below that which he could have received in the community

Despite previous clinical reviews, including the one conducted following the death of Mr Gallagher, SPFT have failed to embed the agreed improvements and there continues to be failings in care. An on-going action plan remains in place and will continue to be monitored closely for the remainder of the trust's contract which ends on 31 March 2020. To support this, and ensure a reduction in any risk to patients, commissioners have appointed a clinical reviewer (previously Director of Nursing in an acute trust) to attend HMP Lewes weekly and act as a facilitator to resolve any issues which affect delivery of services.

Commissioners have implemented a more rigorous approach to contract management, procurement and mobilisation of services, taking learning from HMP Lewes (and other prisons) into account. This is detailed more in response to Concern (5) below.

A Quality Improvement Plan was implemented following Mr Haines death, actions were agreed and achieved in 2018 but further reviews found they had not all been embedded into practice. As a result, SPFT was served with a Contract Notice in November 2018 relating to poor performance and a further Service Development Improvement Plan (dated 8 June 2019) was agreed with commissioners. Actions from this are in various stages of completion with some having been achieved, and others noted as in progress whilst embedding into practice.

4) There were no protocols or agreements between healthcare staff and the prison service as to how to respond to an unresponsive body

The Prison and Healthcare providers have reminded staff of the protocols in relation to responding to an unresponsive body, including the need for prison staff to elicit a verbal or non-verbal response from each prisoner when cells are unlocked. Further reminders have been issued on the need to immediately call an ambulance when a Code RED or Code BLUE is called, including a new poster in the control room.

5) In my opinion, the underlying problems were due to the fact that responsibility for healthcare in prison was split between the prison service, Sussex Partnership Foundation Trust (contracted to provide both mental and physical health within the prison), MedCo Ltd who provided the GPs, and Forward Trust who were contracted to supply the alcohol and substance misuse treatment service in the prison. There was insufficient communication between these bodies and they had separate IT databases.

In 2017, NHS England (NHS E) reviewed the model of commissioning in Kent, Surrey and Sussex as it was becoming increasingly apparent the model was not delivering the benefits anticipated and services were not integrating effectively. In line with other prison groups in England , NHS E made the decision to commission services using a Prime Provider model. This model ensures a single contract and provider, accountable for the delivery of integrated healthcare in a prison (or group of prisons). This model has been found to be more effective in management of services, development and delivery of integrated pathways between the different healthcare teams in the prison. Commissioners have worked more closely with Governors to ensure that they are able to provide officer support (enablement) to increase healthcare access to prisoners including supervision of medications, movement of prisoners to and from appointments and out of hours access where required.

The current healthcare contracts with existing providers end in March 2020 (SPFT and Medco) and October 2020 (Forward Trust) respectively.

NHS E have undertaken a procurement process for provision of these services after those dates. The services procured is an Integrated model of delivery which means that the contract has been awarded to one provider for the delivery of all services to HMP Lewes residents. This is a tried and tested form of service delivery and puts the responsibility for delivery of all elements of the contract with one provider only. This will negate any communication issues and the provider will use one database system only.

NHS E awarded the contract to Care UK in October 2019 and the services are currently being mobilised for a delivery start date of April 2020. Monthly Mobilisation Boards have been established and include all incumbent providers, the prison, social care and the new provider. These Boards are overseen by NHS E & I Commissioners.

Once the contract starts NHS E governance process will have oversight via Contract Review Meetings, Partnership Boards and Local Delivery Quality Boards.

Transition of Services

The SPFT Board has taken the decision to withdraw from prison healthcare delivery at the end of the current contract in March 2020 following prosecution of the Trust by the CQC. A detailed transition plan has been developed, to ensure the continued delivery of healthcare services during the mobilisation of new contract which will be closely monitored by commissioners via the Transition and Mobilisation Meetings. Performance will continue to be monitored at the Contract Meetings which form part of the usual governance process and have agreed a Contingency Plan with HMPPS should there be any significant issues or concerns for the welfare of men at Lewes.

Electronic Patient Records

All healthcare providers are given access to electronic healthcare software, SystmOne. Substance misuse services have their own database which records performance and on which payment is based. Clinical information is recorded on SystmOne. At present NHS E holds responsibility (and the budget) for the provision of IT into prison healthcare in Ken/Surrey and Sussex. This responsibility will transfer to providers as part of the move to

the Prime Provider model, giving them greater control over use of more innovative IT and software solutions. All users of SystmOne can create tasks for other team members and which are linked to patient records where applicable, this reduces the risk of messages going astray. NHS E Commissioners will review the use of tasks by providers by end of October 2019, as a result of concerns raised in this Regulation 28 notice.

Since Mr Haines' death, NHS E Health and Justice have made reviewed it's commissioning contract performance and quality assurance systems. Improvements include:

- Revised governance and reporting structure including establishment of a Quality Board and Serious Incident Panel (in place)
- A dedicated Quality Assurance Team comprising a band 8c Senior Quality Lead and an 8b Quality and Safety Manager for Kent, Surrey and Sussex have been appointed to bring additional oversight and support to the quality of healthcare delivery A Serious Incident Panel has been established which looks at all serious incidents reported by providers and follows a process by which learning is captured and shared.

Commissioners monitor performance in a variety of ways including Quarterly Contract Management meetings which are chaired by NHS England Commissioners. Agenda items include provider performance against a set of metrics, serious incident reviews, complaints and business cases for funding for initiatives. All providers attend these meetings any unresolved issues which require partnership working are escalated to the local Partnership Board, which is attended by healthcare providers, NHS England, Prison Governors, HMPPS , Public Health England, Local Authority and CCGsfor resolution. Any risks and issues not resolved at local level are escalated to Health Wellbeing and Social Care Regional Care Board.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

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National Medical Director
NHS England and NHS Improvement