NHS
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NHS Foundation Trust

Private & Confidential

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Your ref: 02719-2019
Our ref: GA 337

2 April 2020

Dear Ms Dolan

Inquest into the death of Gemma Elizabeth Azhar

I am writing further to my letter of 26 February 2020, in response to the issues raised in your Regulation 28 report. I am grateful to you for raising these matters and for the opportunity this has provided to review our Time to Talk Service procedures in relation to discharge of patients. Once again, I wish to express my condolences to Gemma's family and friends for their sad loss and I know this is an extremely difficult and distressing time for them. I would also like to offer my apologies for the problems that occurred with Gemma's appointments and for the fact that we did not communicate more effectively with Gemma. This has resulted in further discussion and reflection in our Time to Talk service and we acknowledge that there is important learning from the events surrounding Gemma's tragic death.

Following the evidence given at the inquest by [redacted] Clinical Lead, about the role and remit of our Time to Talk Service, it may be helpful to provide some further information. The Time to Talk Service is not a crisis service, and operates a high volume, high throughput model which receives an average of twenty four thousand referrals each year. The service is not clinically established to provide urgent support to people with severe mental health conditions ie. those at a high level of risk of suicide, severe self-neglect, significant self-harm or harm to others, and significant risk which needs monitoring within a

multi-disciplinary setting, or who would be best supported by a multi-disciplinary approach. We also ensure that when people self-refer to Time to Talk, they are made aware, through correspondence and information on the website, that the service is not able to offer urgent support, and we provide information on how patients can access such support.

The service is required to see 75% of all referrals within 6 weeks and all patients are routinely informed about how to access more urgent care. If patients have been assessed in Time to Talk with this level of difficulty, or the referral information and any additional information indicates an urgent need, they are referred to secondary care services i.e. the Assessment and Treatment services, run by Sussex Partnership NHS Foundation Trust (SPFT).

Nevertheless, it was unacceptable to cancel two of Gemma's appointments at such short notice. We should have taken a more active approach in maximising the opportunity for a clinical conversation to explore with Gemma her reasons for declining the offer of a further appointment with potential to assess the level of risk. Although Gemma did not wish to agree to a clinical appointment, where risk could have been fully assessed, a phone call undertaken by a clinician could have potentially promoted engagement and offered opportunities to clarify her situation and needs.

You expressed concern specifically on the lack of any written, formal process or protocol addressing situations where two cancellations have occurred and a patient has disengaged from the service. In addition, you considered that there was lack of evidence that the new process described at the inquest had been communicated to all staff in the Time to Talk Service in a structured and formal way.

As [redacted] confirmed at the inquest, Time to Talk staff working in the North Area were notified by email of the new procedure ie. that efforts should be made to find an alternative therapist to prevent short notice cancellation of appointments and, if no-one was available, the duty therapist should have further discussion with the patient before any discharge took place. (This email was sent on 9 December 2019).

I can confirm that the following action has been taken in response to your comments:

(1) A Standard Operating Procedure (SOP) has been created to confirm the processes to be followed when the Service has cancelled appointments. A separate, existing SOP concerning patients who do not attend or who cancel appointments has also been updated. The updated SOP ensures that cancellations of appointments by patients are identified and includes an additional digital audit system as a weekly measure to monitor numbers.

The new SOP will ensure that administrative staff contact the duty therapist about any patient in circumstances similar to Gemma (where two assessment appointments have been cancelled). This will enable the duty therapist to try to promote engagement and maximise the opportunity for a clinically informed conversation with the patient, with further action taken as necessary. As a further safeguarding measure, a digital alert system, coordinated by the data analysts, will provide a process which will alert senior therapists to

any patient who has had two appointments cancelled by the service, and who has not yet been contacted by a clinician.

The new SOP also incorporates a new service resource for patients - reserved assessment slots. These will be offered on a daily basis and ensure that if the service has to cancel an assessment for any reason there will be a number of un-booked slots which can be used to maximise opportunities to offer alternative same day assessments where possible.

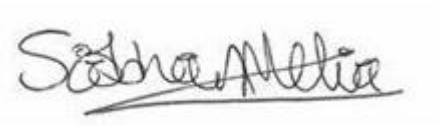
The SOP has been reviewed and agreed at the Team Governance Meeting and Area Governance Meeting. It has now been disseminated to all staff via the senior leadership team for each locality and has been integrated into team training and formal induction processes. It is also accessible to all staff via the service shared electronic folder system.

(2) Prior to the inquest, work was also carried out on a SOP regarding clinical notes guidance for Time to Talk staff, ratified at the Team Governance Meeting on 26 February 2020 and reviewed by the Area Governance Meeting on 20th March. This provides updated guidance to all staff on writing clinical and administrative notes on our electronic IAPTUS patient record system. It will ensure that information recorded is consistent and comprehensive, including confirmation of the reason for any service cancellation. It also includes guidance on recording any patient risk(s) identified. As above, senior team leads will ensure that all staff are trained and made aware of this process in each geographical area and it will be integrated into induction processes for all staff. All staff will access the SOP via the service shared drive. These actions will be completed by the end of May 2020.

I appreciate that you did not raise the issue of clinical documentation in your letter. However, I wanted to offer this information as further evidence of the work that is being carried out continually to improve our systems for patient care and communication.

I hope the actions described above will demonstrate to you and to Gemma's family that we have taken very seriously the concerns you raised. If you or Gemma's family need any further information, please do not hesitate to let me know. Equally, if there is any support we can offer to Gemma's family, we would be very happy to arrange this.

Yours sincerely



Siobhan Melia
Chief Executive