A member of:
Association of UK University Hospitals

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Ms Schofield
Senior Coroner West Sussex
Sent by email: [redacted]

11 May 2020

Dear Ms Schofield

Response to Regulation 28 Report dated 16 March 2020

I write formally to respond to your report to prevent future deaths, under Regulation 28 Coroners (investigation) Regulations 2013.

Your report raises the following concerns:

1. Mr Ashley's care and treatment plan was not updated when his mental health deteriorated;
2. Staff were not recording interactions with Mr Ashley in the Carenotes system, and often emails were not copied into these notes. Therefore there was a lack of compilation of key information relating to Mr Ashley;
3. There was no system in place for Lead Practitioners to be notified of an important entry in a patient's Carenotes where action was required;
4. Mr Ashely had not been seen by a Psychiatrist for over a year and there was no evidence that the deterioration of his mental health (and his non-compliance with his medication) had been reviewed by the professionals' weekly meetings;
5. There was a discrepancy in the Trust's own policies as to when a risk assessment should be reviewed;
6. Save for the duty scheme, there appears to be no procedure in place for another practitioner to cover a Lead Practitioner's case load or any formal handover when they are on leave. Therefore there was no single person who has update knowledge of a patient who may be in need or whose mental health was deteriorating;
7. The MHLT did not make use of the patient's Care & Support Plans or Central Risk Assessment;
8. There was no clear procedure for GPs to be updated by Care Coordinators with details of a patient's current treatment plan if it had changed. This was particularly important where there was no regular assessments by a Psychiatrist who would in normal course of events, be providing such updates.

I address your concerns as follows:

1. **Updating of care and treatment plans when a patient deteriorates**

In the case of Mr Ashley, it is acknowledged that his care plan contained out of date information and did not accurately reflect his changing circumstances. There were also missed opportunities to update his risk assessment using the risk event functionality within our Carenotes system. These concerns were identified in the Trust's Serious Incident Review and [redacted] Team Leader, gave evidence at the inquest of how the service had responded to those concerns through caseload reviews, clinical records audits and supervision.

The Trust monitors performance in each of these areas and there are individual performance dashboards for each team within the Carenotes system that allow clinicians to monitor their own performance when they log onto the system. Team Leaders and other managers also have access to team/service based reports through our "Report Manager" performance system and these provide an audit function and allow managers to have an overview of team performance.

I am informed that at the inquest, [redacted] was also able to confirm that clinicians receive regular clinical and managerial supervision and this allows managers and clinical supervisors to monitor the quality of someone's work and record keeping as well as address any concerns about individual practice. This process remains in place with compliance monitored at a team and Trust level.

The Trust is continuing to monitor compliance with care plans, risk assessments and supervision and since autumn last year, we have revised our care plan and risk assessment formats/processes, updated our policies and training programme to improve standards of care.

In my letter to you dated 20 December 2019, I detailed some of these steps and I would like to confirm that the Trust has successfully implemented these changes with a view to preventing future deaths. Specifically, we have introduced a new universal risk assessment and this captures risk events in chronological order and improves record keeping. Although the format of the risk assessment has changed, the principles of robust risk assessment, remains the same, and our Trust continues to use the '5 P's' risk formulation model to provide a narrative and summary of the past risks.

We have invested in the recruitment of a Lead Clinician, and they are responsible for delivering face-to- face risk assessment training, and to date has provided training to over 950 clinical staff. The training utilises national and local learning from serious incidents pertinent to the clinician's work environment and has been consistently well evaluated.

I regret that the risk assessment was not updated in the records as it should have been in Mr Ashley's case, however his risks were continually assessed and I understand that this was accepted by the Coroner's expert, [redacted]

2. **Staff were not recording interactions with Mr Ashley in Carenotes and often e-mails were not copied into these notes. Therefore there was a lack of compilation of key information relating to Mr Ashley**

It is standard practice for all interactions with patients to be recorded on the Carenotes system and these records are available and accessible to clinicians in all parts of our service to review. In the case of Mr Ashley, it was evident that our acute and community services used his health records to share information, make clinical decisions and review his care. However, I understand that you had specific concerns that email correspondence from Mr Ashley's sister, was not uploaded to his record. I would advise that it is not customary practice to upload all email correspondence. However, the Trust would expect a record and detail of [redacted] contact to be recorded on the system.

At the inquest, staff explained that they use an out of office assistant (automatic reply) to advise patients, carers or other health professionals of their absence and how to seek help if required. I understand that the Lead Practitioner used this system whilst he was on annual leave and [redacted] was directed to contact a duty worker. However, [redacted] was under the impression that the Trust had a system for monitoring emails of the Lead Practitioner who was on leave when she sent her emails which isn't the case but we will ensure out of office automatic replies are clear in how someone will seek help when the practitioner is on leave.

The Trust recognises the importance and value of carer involvement, and this is acknowledged in the Serious Incident Report, specifically the role [redacted] played in caring for her brother. We continue to emphasise the need to actively seek consent from patients to allow carers and family to participate in their treatment and care. As a result of this recommendation and learning from other similar incidents, the Trust now provides a Carer's Pack specifically designed to involve families and carers. The pack provides information about a carer's entitlement to a carer's assessment and the relevant local services they can access for support. I am **enclosing** a copy of the pack with this letter for your information. We also have bespoke Carers Training provided by paid Carer Leads, and local teams have updated their "Triangle of Care self-assessment tools" and developed action plans to improve carer engagement.

3. **There was no system in place for Lead Practitioners to be notified of an important entry in a patient's Carenotes where action was required**

I acknowledge that our Carenotes system does not have an automatic function to alert Lead Practitioners and/or the clinical care team when another clinician has accessed a patient's records or recorded clinical activity. However, I would like to reassure you we have processes and procedures in place to allow clinicians to share information when

required. In the case of Mr Ashley, it is evident that there was sharing of information between the teams which were involved in his care e.g. the Worthing Recovery & Wellbeing Team, and Mental Health Liaison Team, shared information when Mr Ashley used out of hours services and the Lead Practitioner or Duty Worker responded to concerns and reviewed his treatment and care.

I acknowledge that in this case, it was a specific concern that a Lead Practitioner when returning from leave should be aware of important developments regarding his/her patient. It is the responsibility of a Lead Practitioner and other members of staff returning from leave, to review their caseload and establish if there were any concerns during their absence and I understand that Mr Ashley's Lead Practitioner did make himself aware of events when he returned from leave (he addressed this in his addendum report at the Inquest). Nevertheless, I wish to reassure you, that I agree that it is important that there should be a handover following a leave of absence, particularly in the case of the most vulnerable patients and staff are actively encouraged to ensure that this takes place and this will become part and parcel of staff risk assessment training.

4. **Mr Ashely had not been seen by a Psychiatrist for over a year and there was no evidence that the deterioration of his mental health (and his non compliance with his medication) had been reviewed at the professionals' weekly meetings**

Mr Ashley had a medical review on 1 August 2017 with a Psychiatrist and should have had a 12 month follow up review thereafter.

Mr Ashley did have a medical review/telephone consultation with a Consultant Locum Consultant Psychiatrist on 30 October 2018 when there was a concern about his health.
I regret that Mr Ashely was not seen by a Psychiatrist as regularly as he should have been i.e annually, however I can report that the Trust has successfully appointed two substantive Consultant Psychiatrists for Worthing this year, and they joined the team in March. They are supported by an Associate Specialist. This will enable us to facilitate medical reviews in a timely manner and negate the need for a waiting list. The medical caseload is currently being reviewed with a view to ensuring that every patient has an annual medical review as required.
In respect of your concern that Mr Ashley's condition was not discussed in the multidisciplinary (MDT) meetings, I would like to reassure you that MDT meetings occur weekly and Lead Practitioners and other colleagues are invited to present cases where they require advice and support, or cases which require a multidisciplinary approach. The decision as to whether a case should be discussed at a MDT meeting, is a matter of clinical judgment, and in Mr Ashley's case, his Lead Practitioner and others involved in his care, did not consider this support was necessary and his care was reviewed by the experienced staff who were directly involved in his care.
My understanding is that it is not common practice for every patient to be discussed at a MDT meeting.

5. **There was a discrepancy in the Trust's own policies as to when a risk assessment should be reviewed**

The Trust accepts that the current Clinical Risk Assessment and Safety Planning/ Risk Management Policy and Procedure policy is unclear as it has two potential review dates when the risk assessment should be updated. The current policy is under review and this has been addressed as part of that. The new policy is in the final stages of ratification and will be available for staff very shortly.

6. **Save for the duty scheme there appears to be no procedure in place for another practitioner to cover a Lead Practitioner's case load or any formal handover when they are on leave. Therefore there was no single person who had up to date knowledge of a patient who may be in need or whose mental health was deteriorating**

This concern was addressed in my letter of 20 December 2019 wherein I sought to convey that Mr Ashley was treated as part of a team, and that a plan was in place (as part of his overall care plan), to ensure that there was adequate support when his Lead Practitioner was not available. Prior to going on leave, I understand that Mr Ashley's Lead Practitioner visited to discuss cover arrangements and his crisis/contingency plan. It is apparent that Mr Ashley understood the arrangements as he attended his planned appointments at the Wellbeing Café and Clozaril Clinic, and he accessed the duty system and the Mental Health Liaison Team for further support.

I appreciate that there may be some merit in delegating care to an individual colleague when the Lead Practitioner is on leave, however such a system is not without risk as a patient may find himself without a contact in the event that the delegated colleague is himself absent for any particular reason. The duty system will always ensure that there are experienced mental health practitioners available to respond to an urgent enquiry or crisis, who will have access to up to date knowledge of the team systems, and how to access urgent Multi-disciplinary Team care and intervention. Rather than delegating responsibility to just one individual, the system which is in place, ensures that the team as a whole will take responsibility to ensure that care is provided, when the Lead Practitioner is absent. I would also add that the Carer's pack and the Trust's Carer's handbook, contains guidance on what to do in the event there is concern for the person being cared for.

7. **The MHLT did not make use of the patient's Care & Support Plans or Central Risk Assessment**

I understand that [redacted] was critical of the assessment undertaken by the MHLT and considered that they should have considered the care plans. I would like to explain that the MHLT has its own assessment format and this includes a risk assessment and action plan section and is designed in this way for ease of sharing information with primary care. At the Inquest, I am informed that the MHLT Team Leader gave evidence as

to how he and his colleagues reviewed Mr Ashley's health records and contacted Worthing Recovery and Wellbeing to agree a treatment plan for him, in the knowledge that his Lead Practitioner was on annual leave and Mr Ashley required support from a duty worker.

8. **There was no clear procedure for GPs to be updated by Care Coordinators with details of a patient's current treatment plan if it had changed. This was particularly important where there was no regular assessments by a Psychiatrist who would in normal course of events, be providing such updates**

Mr Ashley should have had a medical review on an annual basis and I wish to assure you that it is our practice to send a clinical letter to the GP as well as a copy to the patient. It is also Trust practice to send a copy of the care plan and information about changes to medication or physical health assessments undertaken by our service. I am informed that the GP practice received copies of Trust letters from the last medical review and copies of the assessments undertaken by the Mental Health Liaison Team and these contained details of the perceived risk and action plan agreed with the patient.

I do hope that you will be reassured that in light of the recruitment of two Psychiatrists, going forward, reviews will take place without any undue waiting time and GPs will continue to be kept informed of all reviews which take place.

I trust this response addresses your concerns and provides you with reassurance that the Trust takes its responsible to reduce the risk of future deaths seriously. However if any further clarification is required, please do not hesitate to contact me.

If following receipt of this response you would like to meet with the clinical team to see and discuss how the various changes have been implemented I would be only too happy to facilitate this.

Yours sincerely

Samantha Allen
Chief Executive

ENC: Carer's Pack ***(N.B: to follow hardcopy by post)***