Oxford Health
NHS Foundation Trust

Mr C Butler
HM's Senior Coroner for Buckinghamshire
29 Windsor End
Beaconsfield
Buckinghamshire
HP9 2JJ

Chief Executive's Office
Trust Headquarters
Littlemore Mental Health Centre
Sandford Road
Littlemore
Oxford
OX4 4XN

19 May 2021

Dear Senior Coroner Butler,

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS
INQUEST INTO THE DEATH OF ROY MORRIS

I write on behalf of Oxford Health NHS Foundation Trust to respond to your Regulation 28 Report following the inquest into the sad death of Mr Roy Keith Morris, which you concluded on 26th March 2021. You raised matters of concern which are as follows –

1. The application of the CPA policy for patients such as Roy so that they will have a detailed care plan with which they can engage and which informs the family the care coordinator and the community team on discharge from the inpatient setting.

2. Reinforcing the importance of the role of care coordinator and insuring the timely allocation to inpatients shortly after admission so that they can work over a meaningful period with the patient, the family and the mental health teams in anticipation of the discharge into the community.

I will state immediately that as an organisation we understand and accept the concerns that you have raised. As stated in your report, our CPA policy stipulates the requirement of a detailed care plan and recommends that the individual (our patient) and their family are involved in designing the plan of care and support required to ensure a timely and smooth discharge from hospital. We have therefore sought to strengthen the understanding and application of our policy within our teams by creating a task and finish group with relevant clinicians. The group's main functions will be as follows:

- To focus on the role of the Care Coordinator: the expectations of the role and the interventions and engagement required in discharge planning in line with our CPA policy.

- To review the standard operating policies for our community mental health teams to reflect the standards of practice expected in the role of care coordinator, which is pivotal to the delivery of care.
- To review the induction process and package for both permanent and locum staff, with an aide memoire for both existing staff and new and locum staff to familiarise themselves with the role and expected standard of practice for the role and their team's structure and processes.
- To review the structure and process of care coordinator allocation within mental health community teams and the expectations of the role in order to ensure adherence of the Trust CPA policy.
- To review the daily bed management and escalations meetings to capture care co-ordinator allocation and clear communication between the mental health community teams and inpatient teams. This will involve discussion at each ward's rapid reviews (which are held three times per week on each of the acute wards) and escalations at our twice daily teleconferences (chaired by senior nurses and service managers) for our inpatient and our community teams. This work will be supported through the newly appointed patient flow manager and will strengthen the daily action log from the bed escalation meetings to quickly identify and resolve with service managers any barriers to completing the allocation of care coordinators. The revised bed meetings and escalations calls will ensure that we are allocating care coordinators at the earliest opportunity to support engagement in discharge planning.

Once the Standard Operating Procedure for Community Mental Health Teams has been finalised, with easy-to-follow guidelines as aide memoires, the Head of Service and Head of Nursing will jointly deliver a series of workshops and road shows with all community teams to disseminate the updated and focused material to support the required consistency in approach to care coordination. The workshops will commence in early June 2021.

In addition to the above work, we currently have several initiatives underway to support our work to improve the quality of engagement with families. The Trust's Buckinghamshire Mental Health directorate is leading Trust quality improvement work within the next 12 months on working with families, the goal of which is to improve our engagement and embrace the Triangle of Care.

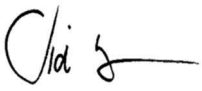
To explain, the 'Triangle of Care' is a working collaboration, or "therapeutic alliance" between the service user, professional and carer/s that promotes safety, supports recovery, and sustains well-being. The Triangle of Care adopts six principles, all of which we are embedding in practice as follows:

- Carers and the essential role they play should be identified at first contact with services or as soon as possible thereafter: we are using better lives assessments and carers' assessments to identify who are carers and how best to work with them, as well as using our admission check lists audits to ensure standards are adhered to.

- Staff should be aware of carers and trained to engage with carers more effectively. The Trust has reviewed and re-launched the Trust's carers' strategy. Carers awareness training forms part of the carers' strategy being rolled out within our teams.
- Policies and protocols should be in place to ensure confidentiality and improve information sharing with carers – this is in place within our teams in the Trust.
- Defined roles (Carer link workers) responsible for carers should be in place – this is in place within our teams.
- Carers should be "introduced" to the service and provided with a range of information. We are capturing this on the wards with our carers link nurses and primary nurses offering one to one time with carers within 72 hours of a patient admission to the ward.
- A range of carer support services should be available to which to offer or signpost carers.

We will be happy to share with you our agreed standard operating procedure and the associated guidelines for care coordinators alongside the completed Quality Improvement project and outcome from the work with families group, which we hope will assure you that we are committed to strengthen both the importance of the role of care coordinator and ensuring the timely allocation of care coordinators to patients after admission in order that they can work over a meaningful period with the patient, the family and the mental health teams in anticipation of each patient's discharge back into the community.

Yours sincerely



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Chief Executive