NHS
Surrey and Borders Partnership
NHS Foundation Trust

29 April 2022

Private and Confidential

[redacted]
Chief Executive

Chief Executive's Office
Surrey and Borders Partnership NHS Foundation Trust
Third Floor
Leatherhead House
Station Road
Leatherhead
KT22 7FG

Ms Jessica Russell-Mitre
[redacted]

Dear Ms Russell-Mitre,

Melanie Elms (deceased)
Regulation 28 Report to Prevent Future Deaths
Response from Surrey and Borders Partnership NHS Foundation Trust ("the Trust")

Thank you for the Regulation 28 Report to Prevent Future Deaths (PFD report) dated 7th March 2022, in relation to the inquest touching the death of Melanie Jane Elms. I am mindful that the PFD report has been received nearly 11 months after the inquest concluded. This makes any timely learning difficult, and also means that some of the PFD report relates to issues that have already been addressed. I would welcome PFD reports to be sent in a more timely fashion in the future, and if possible within 10 days of the conclusion of the inquest, as stipulated by the Chief Coroner in his guidance.[1]

Prior to the PFD report being issued, I understand that the Trust provided you with the following documents:

i. A statement from [redacted] Associate Director for Working Age Adult Inpatient Services, outlining the actions taken by the Trust in response to its Serious Incident (SI) report.
ii. Informal Leave of Absence Policy – in draft form as it had not been finalised at the time of the hearing.
iii. Absent Without Leave (Section 18) / Missing Person policy.
iv. 8 Key Steps to Safety document.
v. Guidelines for Management of People with Alcohol Use Disorders (AuDs) Admitted to Mental Health Wards.
vi. Risk Assessment Training Slides.
vii. Care Planning Training Slides.
viii. Blank page from the updated Ward Walk Book.

Notwithstanding this, a PFD report was issued to the Trust. The Trust respectfully notes that the matters of concern set out in the PFD report are very specific to the facts of Melanie's inquest and that, to an

[1] Chief Coroner, Revised Guidance No. 5 (2020), para. 38

extent, they appear to address one off incidents, rather than wider concerns. Our response therefore tries to address the wider issues to which the specific problem relates.

1. <u>The care package arranged for Melanie following discharge from lengthy inpatient admission was not followed and was altered to something which the treating doctor did not consider adequate</u>

   The Trust recognises that the care package that Melanie's inpatient Consultant Psychiatrist originally envisaged for her on discharge from hospital in 2017 included carers visiting her at home to assist with personal care, medication and outings. As the Consultant explained to the Court, a number of carer agencies were contacted, but for various reasons none of them were able to assist immediately. An alternative temporary plan was therefore agreed with Melanie, her husband and the Consultant, which was for Melanie to attend the Abraham Cowley Unit (ACU) three times per week for therapeutic input. However, as Melanie's husband was unable to transport her to the ACU, it was later agreed that Melanie should attend the Joseph Palmer Centre (JPC) instead. Melanie's Consultant was not present at the meeting when this decision was made (as she was on leave), but at the inquest hearing she agreed that attending the JPC was a good plan.

   At the inquest, the Consultant gave evidence that it did not look as though the carers support ever materialised, and that this was not helpful. However, the Consultant also admitted in evidence that she did not know why this was, as she was not part of the community team. Having reviewed the progress notes from the community team written in September 2017, there are several entries to suggest that Melanie did not in fact agree to work with carers at her home. It was not therefore possible for the original discharge plan to be put into place, given Melanie's refusal to work with carers.

   In any event, it may be helpful for you to know that as of June 2020, the Trust has implemented a flow programme to ensure consistent ways of working, that are supporting teams to plan a safe, effective and timely discharge. This is a significant piece of work and has involved the application of quality improvement principles to lead to both process and practice change. Some of the aspects of this work include:

   - The development of a "ward view" that clearly identifies everyone on a ward, the community team they are supported by, their length of stay and a set of coloured icons to denote potential barriers to discharge. Teams will work on daily actions to identify and resolve those barriers and then can confidently plan for a discharge meeting (to involve key parties) where a safe discharge plan can be discussed and confirmed – leading to a date for planned discharge where those discharge plans will be enacted.

   - As part of this work Surrey County Council has invested in a Hospital Discharge Team with Mental Health Social Workers who will work alongside Trust staff to plan a discharge and assess people's need for support under the Care Act (including those subject to s117 aftercare under the Mental Health Act). These workers have complete (read only) access to SystmOne so they can access all necessary information to look at needs upon discharge.

   - The Trust has invested in additional discharge co-ordinators who will generally be the point of contact for Housing Associations and Housing officers and a Mental Health Housing and Accommodation Protocol is being finalised that sets out how Districts and

Boroughs, the Trust and Surrey County Council can work together to ensure an appropriate discharge for someone who has housing needs.

- The Trust has also commissioned voluntary sector organisations to provide in-reach support and these people will provide additional support (for the first month post-discharge) to help people move on from hospital. This is an additional service independent to assessed longer-term support needs.

The Trust is also now using Smartboards, which are virtual whiteboards, to record plans for discharge. The Smartboards are located in the patient's electronic record on SystmOne, so that it is available for all clinicians to review. The Smartboard can be updated with new information in order to record and progress a person's discharge plan.

2. <u>The walk book not properly completed</u>

On behalf of the Trust, I apologise that the ward walk book was not properly completed when Melanie went on leave on 30th January 2018. This was an issue that was identified in the Trust's SI report, a copy of which was provided to you for the purposes of the inquest. On page 12 of the SI report, it is stated as follows:

> *When Melanie left the Ward on the day of the incident, the Walk Out record was partially completed. No details of the expected time of return or the purpose of leave were recorded. The staff initials were not also recorded. This indicates that no discussion took place with Melanie regarding her expected time of return.*

Since Melanie's death, the ward walk book has been updated. As above, a blank page from the updated walk book was provided to you on 29th April 2021. There are now sections in the walk book for the following to be recorded:

- Name of staff member signing the patient out on leave
- Confirmation that a risk assessment has been completed prior to leave
- Name of the nurse who has performed the risk assessment
- Time the patient is due back
- Any additional comments

Completion of the ward walk book forms part of staff induction training. The Ward Manager and the Shift Coordinator are responsible for checking that the walk book has been properly completed, during his or her daily and weekly ward checks. A weekly audit checklist is sent to the Matron, confirming that all checks have been completed.

In addition, the wards have updated the 8 Steps to Safety (a document previously provided to you), so that it now incorporates 10 Steps to Safety. This document must be read out and signed by all staff on duty at each handover. In the document, there is specific reference to patient leave, and staff are reminded that:

- They must have read and understood the patient's risk assessments and care plans, checked that the MISPER form A is in place and that the section 17 leave form (if required) is current, before agreeing to leave,
- A return time must be agreed with the person if they are informal, and they must have a method of contacting the person, and
- If the person fails to return from leave, the MISPER policy must be followed and the police informed.

3. There was no extra planning for changes in circumstances: Melanie faced never being allowed to return to family life with her husband and son due to Child In Need proceedings; changes in medication and less support from family due to the Social Services requirements.

   Planning for discharge from inpatient services commences at the point of admission. The Trust's Care Planning Approach (CPA) Policy recognises that discharge from the inpatient setting to the community is a time of particularly high risk of suicide. It is therefore a requirement that all people discharged from the Trust's inpatient services must be seen within 72 hours of discharge or sooner. If a person is homeless the pre-discharge CPA meeting must take place on the ward, not in the community. It is also mandatory for carers to be involved in the discharge planning process, their needs for support must be established and the sustainability of the caring role considered.

   The CPA policy also recognises that care planning is a dynamic process, and encourages clinicians to review and, if necessary, update the patient's plan of care at every contact.

   The information provided above in response to concern 1 is also relevant and I hope will assure you that discharge planning is now more robust and comprehensive.

4. There was no missing person plan in place with timeframes and steps of escalation for Melanie's leave

   The Trust has an Absent Without Leave (Section 18) / Missing Person policy (copy previously provided), which outlines the action to be taken in the event of a person absent without leave, or a missing person – see paragraph 7 of the policy. There is also a process flowchart at Appendix 2 of this policy.

   The Trust has also now created an informal leave of absence policy. This is a new, standalone policy, which specifically deals with leave for informal patients. At the time of Melanie's inquest, the policy was still in draft form, however I can confirm that the policy was finalised and issued on 23rd July 2021. I attach a copy of this for your information, entitled Management of Leave for Informal Patients policy. The policy states at paragraph 8.5 that leave arrangements, which need to be documented in the patient's electronic record, should include what to do if a crisis occurs. Timeframes for escalation are not currently included in the policy, however the policy will be reviewed and amended to include these.

   In addition, a Missing Persons from Healthcare Memorandum of Understanding (MOU) was drawn up and agreed between the Trust and various other partner agencies, including Surrey Police. The MOU was published in April 2021. I attach a copy to this letter. The aim of the MOU is to provide guidance to all partner agencies when a patient goes missing, and to ensure a coordinated and joined up response.

5. The risk assessment prior to leave was not adequate
6. The risk assessment prior to leave was not recorded

   These concerns will be addressed together. The Trust has written a new Policy specific to informal inpatients leaving the ward, the 'Management of Leave for Informal Patients' policy. In particular, the policy sets out:

   - a clear process for agreeing leave from the ward – paragraph 8.0 (page 10);

- the requirement for risk assessing patients before they go on leave – paragraph 9.0 (page 11); and
- specific actions that needs to be taken prior to an informal patient leaving the ward – paragraph 10.0 (page 13).

Staff awareness of the Policy is ensured by the completion of a competence framework for those staff who take responsibility for facilitating leave. Staff can only facilitate section 17 leave (for detained patients) or absence for informal patients when deemed competent to do so. Competence is reviewed on an annual basis. A copy of the competence framework checklist is attached.

As set out in response to concern 2 above, the updated ward walk book (walk book) also requires confirmation that a risk assessment has been completed prior to leave. The walk book can now only been completed by a registered healthcare professional and is audited at the end of every shift to ensure it has been correctly completed.

Before completing the walk book it is expected that the patient's risk assessment and the ward handover document (SBAR) is checked by staff to ensure they are appraised of any changes in their risk profile. The SBAR is now a 'live' document, completed on the medical records system as opposed to a Microsoft Word document, meaning it provides a more contemporaneous summary of relevant information. The staff are then expected to make an entry in the medical record progress notes, summarising their assessment of the risk prior to allowing the patient to leave the ward (see paragraph 9.5 of the policy).

In the weekly audit conducted by the Ward Manager, the Manager is required to check the quality of the risk assessments and care plans. A sample of five risk assessments that have been documented in the progress notes where a person has asked to leave the ward will also be audited on a monthly basis to ensure compliance. Healthcare professionals also have a duty to ensure accurate records are made in the medical records.

In addition, it may be of interest for you to know that NHS England is currently leading on work to review the approach to risk assessment in mental health services. This was recently presented in a workshop to the Mental Health Nurse Directors Forum, which was attended by the Trust's Director of Safety and Experience/Patient Safety Specialist. The Trust has commenced a full review its risk assessment policy and procedure, to bring it in line with the national work. It is envisaged that best practice guidance in relation to risk assessment will be published by the end of 2022.

I trust that the above information addresses the concerns that you have raised, and assures you that the Trust has taken further additional steps to prevent a similar death occurring in the future. However if you have any queries or questions, please do not hesitate to contact me.

Yours sincerely,

[redacted]
Chief Executive