

Mrs Joanne Andrews
Area Coroner for North East Kent
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Legal Services
Trust Headquarters
Farm Villa
Hermitage Lane
Maidstone
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ME16 9PH

Website: www.kmpt.nhs.uk

24th June 2022

Dear Madam

Re: Inquest touching on the death of Robert Arthur Brown

We were extremely sad to hear of the death of Mr Brown and have extended our deepest condolences to his family.

Further to the inquest into Mr Brown's death, I write in response to your letter of 20th May in order to share with you the changes and improvements that we have made in order to further strengthen the support we offer to the family, friends and carers of people who use our services.

This letter provides information additional to that set out in our letter to you of 15th December 2021. We wanted to highlight the specific areas of improvement that we have made and importantly, to acknowledge the recent amendment to the Health and Care Bill (2021) on the 30th March 2022. This amendment places a new duty on NHS hospital trusts to ensure that unpaid carers are involved as soon as possible when plans for a patient's discharge are being made.

With this in mind, this letter sets out the changes made over the last eighteen months as well as our planned changes aimed at supporting carers that come into contact with the trust.

Changes that have occurred over the past eighteen months in KMPT

- In June 2022, we were joined by a new, Deputy Chief Medical Officer. This newly created role includes a strong focus on clinical quality and safety and in particular, the improvement of collaborative working with carers. They have already started their work across all care groups and with all professions. We anticipate significant strengthening of our support to carers as a result of this new and high-profile leadership role.

For further details about how your personal data is managed by the organisation please visit <https://www.kmpt.nhs.uk/about-us/confidentiality-and-gdpr/>

We are proud to be smoke free

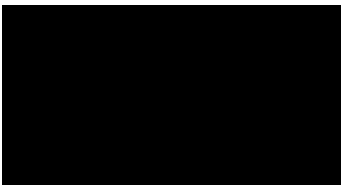
- We have adapted for use across the trust, our in-house carer awareness training package. This is a well-established programme that includes sessions delivered by carers of those who use our services has previously run only in our forensic service. It will now be mandatory training for all staff.
- All wards have been reminded that if their patient is about to be discharged and lives with friends, family or carers, in instances where the patient has told us that they do not wish us to share information, we have a duty to notify the friends, family or carers that the patient has been discharged to that address. All staff are aware whilst they may not be able to discuss care/ discharge plans with friends, family or carers where consent has not been given, they should listen and feedback views into multi-disciplinary team meetings .
- Ward staff now have regular conversations with friends, family and carers regarding carer wellbeing and any concerns they may have. Expectations are discussed on an ongoing basis throughout the admission. This process supports and informs the treatment and discharge planning. This facilitates safety planning at discharge. We are in discussions with East Kent Carers to facilitate a carer awareness /think family workshop for staff.
- We have established a group of carer champions across the trust who support the dissemination of information from the Triangle of Care as well as supporting teams with queries regarding carer support. They also act as a point of contact for friends, families and carers. In addition to this, there are now dedicated carer lead posts within the Acute Care, Older Adults and Forensic Care Groups.
- In February 2022, we launched our Carer Reported Experience Surveys. Links are sent out to wards and teams to share with carers. There is also information on the trust website. Feedback is collated monthly and shared with care groups and the trust Triangle of Care meeting. This feedback will inform ongoing improvements as well enabling us to learn from and celebrate good practice.
- The trust wide Triangle of Care meeting continues to meet quarterly and continues to review, update, shape and develop carers information, policies and procedures in relation to the six standards of the Triangle of Care. The meetings are a joint conversation with a range of local carers and any documentation and products produced are co-produced with carers
- On June 9th 2022, KMPT held the first joint carers conference with Kent Community NHS Foundation Trust (KCHFT) to celebrate Carers week 2022. The conference provided an opportunity for family, friends, carers and healthcare staff to come together, share experiences and develop further, a shared understanding of how we can work in partnership to support those who care for their loved ones accessing mental health and community health services in Kent and Medway. Following the conference, feedback will be collated and utilised in further projects supporting carers.

Further Work Ongoing

- We have arranged a learning event in the Trust for October 2022 which will focus solely on carers and suicide prevention. The working title for the event is 'The Key Role that Carers have in Suicide Prevention'. This learning event will include the presentation of cases where learning has been identified, involvement from carers and will follow a workshop style to enhance discussion and learning
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- On 20th June 2022, the Chief Medical Officer and Chief Nurse wrote to the Senior Management Teams with responsibility for our wards. The letter urges them to discourage the use of the term 'carer breakdown' or if it is used, to use it with a description of the concern, so that staff are clear about what it means for a particular patient. It also asks that they advise their teams to ensure that discharge planning is carried out with input from carers/family/other support networks. We have attached a copy of the letter for your information. The teams will be sharing this information and feeding back in relation to any issues, concerns or quality improvement ideas that they may have.

If you require any more information or would like any more details about any of the information within the correspondence from 15th December 2021, then please do not hesitate to contact me.

Yours sincerely



Chief Executive

Priority House
Hermitage Lane
Maidstone
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ME16 9PH

20 June 2022

SMT Colleagues
via email

Dear all,

Some of you may know that we have been issued with a Coroner's Regulation 28 – Prevention of Future Deaths report (PFD) on the death of a gentleman recently discharged from hospital with no liaison and discussion with his wife about his discharge. The concerns raised by the coroner are two-fold:

1. "Carer breakdown" (as quoted by us) to be likely to have increased the risks of suicide on discharge was not addressed during the hospital admission nor any enquires made about this on discharge.

The ambiguity of the term "carer breakdown" needs addressing. It appears to be used as short-hand for a variety of scenarios – such as a breakdown in communication/relationship between the patient and carer; a carer no longer able to cope with the needs of their loved one or a breakdown between our services and the carer. As you can see, this phrase does not help to understand what the issue is or what is needed.

Please can we urge that you discourage the use of this term or use it with a description of the concern, so that staff are clear about what it means for a particular patient.

2. No process in place to contact a carer on discharge (where there is no CPA), hence a patient could be discharged without notice to a carer and care/support that is anticipated to be in place on discharge may not be available.

We are sure you will agree that when a person refuses permission or dissuades a clinician from communicating with those expected to take on a caring role this should be regarded as a red flag for risk. In this circumstance, setting out clear communication with carers and community services is essential.

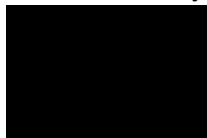
Please can we ask that you advise your teams to ensure that discharge planning is carried out with input from carers/family/other support networks.


We will follow up with the Clinical Directors and Heads of Nursing around system changes that will be required, including policy review on these matters. Also, if you have any thoughts or suggestions about improving discharge processes currently in practice, we would appreciate if you can share them with us.

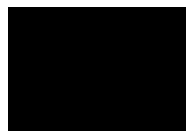
Wider learning around PFD's will form part of a Trust wide safety and learning event in the autumn but the two concerns outlined above require your immediate attention and action.

We are grateful for your support with this.

Yours sincerely




**Chief Medical Officer
and Consultant Psychiatrist
Revalidation Officer, Caldicott Guardian
and Chief Clinical Information Officer**




Chief Nurse

