NHS
Herefordshire and Worcestershire
Health and Care
NHS Trust

Chief Executives Office
2 Kings Court
Charles Hastings Way
Worcester
WR5 1JR

[redacted]

[redacted]

15 December 2022

HG Mark Bricknell
HM Senior Coroner : Herefordshire

[redacted]

Dear Mr Bricknell,

I am writing to respond to the Regulation 28 Report to Prevent Future Deaths which was addressed to [redacted] Clinical Lead for Herefordshire and Worcestershire Healthy Minds. As Healthy Minds is a service delivered by this Trust I am responding on behalf of the Trust.

Thank you for raising your concerns. Our Healthy Minds service is delivered adopting a national model of Increasing Access to Psychological Therapies (IAPT) programme. I enclose for your information a link to the national IAPT manual for your information. The model states it '*provides assessment, normalisation, simple advice and if appropriate, signposting elsewhere. This is usually a single session activity. The second is providing a multi-session course of NICE-recommended psychological therapy for anxiety related problems and/or depression to people for whom that is indicated. Nine out of ten people are seen within 6 weeks of referral.'*

In terms of service development and delivery, the model identifies an ambition to deliver services so that '*at least 1.9 million adults can access care each year by 2023/24.*' In Herefordshire and Worcestershire our annual target is to have 21,448 people access this service annually. As you will observe, the volume of people for whom this service is aimed, identifies that it is for those who are experiencing lower levels of common mental health disorders. It is also important to note that in terms of identifying those individuals who are suitable to receive IAPT services the manual includes ' *IAPT services provide support for adults with depression and anxiety disorders that can be managed effectively in a uni-professional context. NICE recommended therapies are delivered by a single competent clinician, with or without concurrent pharmacological treatment, which is typically managed by the GP…*'

The national model does note that '*drug and alcohol misuse are not automatic exclusion criteria for accessing IAPT if, following assessment, it is determined that the person would benefit from IAPT interventions in line with NICE guidance. However, IAPT does not provide complex interventions to treat drug and alcohol misuse'*. The service adopts that national practice guide (attached for IAPT services and dealing with people with alcohol and drug misuse.

[redacted]

The IAPT model is highly prescriptive and identifies how providers should approach their workforce provision. The IAPT manual provides that 'approximately 40% of the workforce in a core IAPT service should be Psychological Wellbeing Practitioners (PWPs) and 60% high intensity therapists.' There is a national approach to training for IAPT services and the curricula and training materials are mandated through Health Education England. The manual expands that '*all PWPs should have completed an IAPT training course or be in the process of doing so, with linked professional registration with the relevant professional body'*. The manual also reflects the importance of in-service training '*A key feature for the IAPT programme is the in-service training opportunity, Trainees have the advantage of being able to practice, daily, the required skills for the therapies they are being trained to deliver, with the people who are experiencing the relevant clinical problems*.' In addition, the model provides a highly prescriptive approach to clinical supervision, supplemented by the IAPT supervision guidance. In our service all trainee psychological wellbeing practitioners are supervised weekly by a Senior Wellbeing Practitioner, who themselves has weekly supervision with the Service Lead, who has weekly supervision with the Clinical Lead. Every trainee practitioner has to discuss every assessment they complete, with the Senior Wellbeing Practitioner signing off their decisions, with an escalation process in place for any issues not resolved through the supervision process. Our approach is in line with other IAPT services across the country.

In terms of whether Healthy Minds was the appropriate service for the patient, my clinical team consider it was appropriate. As indicated above, the IAPT model recognises that for some patients they will also have alcohol and addiction issues and this does not preclude them for receiving IAPT services. The patient was motivated, engaged with Turning Point and had reduced her alcohol intake, all positive indicators that IAPT services may be beneficial to her. From assessment there was going to be a 9 week wait for treatment, which would allow an opportunity to demonstrate that her alcohol usage hadn't increased and become a problem again. There was no evidence of severe mental illness or risks identified at the time of assessment. Whilst waiting for treatment, the patient had also been assessed by our neighbourhood mental health team (NMHT), with the assessment being completed by the experienced clinical lead for that service, who felt that no further care co-ordination of specialist mental health input was required, noting the patient continued to be engaging with Turning Point.

I appreciate your concerns that the service did not communicate with others involved with the patient, however, our clinical view was that was not necessary. The Healthy Minds team were aware of the assessment from the NMHT that there were no significant mental health needs identified and that she was continuing to engage with Turning Point. Discussion about information sharing and confidentiality is discussed in all initial assessments, although due to the nature of the service, where the majority of referrals to Healthy Minds are self referrals, the service is reliant on the patient disclosing any other external services with whom they are in contact. If necessary information proportionate to the risk faced can be shared with other agencies, although there was no clinical reason to do so in the present instance.

Finally, I recognise your concern that the patient was discharged when she did not attend her treatment appointment, however, I also note that our actions were in line with the service policy and national model for IAPT services. In order for IAPT therapy to be successful the patient must be motivated and ready to engage, unfortunately, at times whilst patients initially indicate that they wish to access IAPT support, this is not always sustained. The patient received details of the treatment appointment by letter and a SMS prior to the appointment time. Following her missing the appointment she received a call to her mobile phone asking her to contact the service if she wished to continue. She was also sent a detailed letter discharging her from the service, which provided information on how she could refer back into the service if she wished to do so. The discharge letter was shared with the GP, which was appropriate. If there were concerns about a patient not attending a treatment appointment, and there

were concerns about the risk to themselves, then this would be followed up, for example by contacting the GP, although in the present case, this was not indicated.

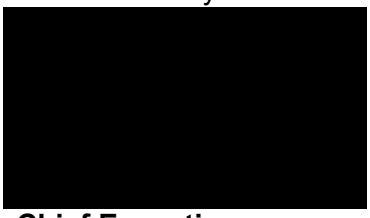
I do appreciate your raising your concerns with the Trust, although having reviewed the circumstances of this case, the initial assessment was felt to be appropriate and was reviewed the day after the assessment by a more senior colleague in clinical supervision, which led to the plan being confirmed by letter the following day. An appointment for treatment on 12th November was sent by letter on the 4th November and also by SMS. The patient did not attend. A telephone call was made to the patient on the same day asking if she wished to continue. As no response was received she was discharged from treatment, following which a detailed discharge letter was sent to the patient and copied to her GP. I understand that she sadly died on 2 February 2022 with the cause of death being 1a) Ketoacidosis, 1b) excessive alcohol consumption 2) Fatty liver, ischaemic heart disease. Following the patient's death, her care was reviewed by an independent experienced clinician through a structured judgment review (which is based upon a national model for reviewing care) which rated the care as being excellent (on a scale ranging from very poor care to excellent).

It is important to review this matter against the IAPT model, which as outlined above is a highly prescriptive approach for those who are suitable to access the lower level interventions for common mental health disorders for such a large volume of people each year. Whilst I accept the concerns that you have raised, taking into account the IAPT approach and circumstances of the case, I am satisfied that the actions taken in terms of this patient were appropriate.

I have no representations to make in respect of publication of either your letter or my response.

I hope that the above adequately responds to your concern, however, if you consider it is helpful to discuss further do not hesitate to contact me.

Yours sincerely



Chief Executive