NHS
Herefordshire and Worcestershire
Health and Care
NHS Trust

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

[redacted]

[redacted]

5th May 2023

Mr D D W Reid
HM Senior Coroner
Worcestershire Coroner's Court

[redacted]

Dear Mr Reid,

Re: Inquest touching the death of Charlotte Comer
Regulation 28 report to prevent future deaths - response

Thank you for forwarding on your Regulation 28 report. I have read your report with great care and note the concerns that you have raised as a result of the coronial inquiry into the death of Charlotte Comer. In your report, you highlighted the following points of concern and I will respond to these concerns together, as each concern represents a sequence of events.

Concerns

During the 2½ years in which Charlotte's mental health care was provided by the Trust, she had a total of 8 different care coordinators. Furthermore, in those 2½ years there was a 5 month period when Charlotte had no appointed care coordinator at all. The care coordinator role is particularly important for a patient with such a complex case history as Charlotte.

The Trust fully recognises that the care coordinator system as it existed at the time failed Charlotte, and we are focused on ensuring no other patient has the experience that Charlotte very regrettably did. At the time of Charlotte's death, the Trust had already embarked on Transformation of its community service provision in line with national developments. In October 2020, we received additional funds to test new models of integrated care as set out in the national Long Term Plan. The roll-out of the Transformation was phased across the county, and Worcester City began its process of Transformation in October 2021, after Charlotte had died. The period of uncertainty associated with the Transformation, as with any significant change, did see a turnover of staff. Coupled with the effects of the pandemic, and a growing and acknowledged national scarcity of qualified and registered healthcare staff, this unfortunately did see a period of acute staffing shortage particularly evident among those staff fulfilling care co-ordination and leadership roles.

It is worth explaining at this point that the traditional function of care co-ordination, historically core to the delivery of Community Mental Health Services, has evolved through Transformation. Central to the new

model is an approach to personalised care and support planning embodied in the role of key worker. The key worker can be any member of the multidisciplinary team (MDT) working with a patient, but will typically be the team member with the most input into that patient's care who is therefore best placed to provide meaningful continuity of care. This separates out a crucial continuity function from the registered professional statuses (Registered Mental Health Nurse, Occupational Therapist, Social Worker) historically associated with care coordination, with the aim of enabling a more flexible and efficient allocation of capacity across a team also including others e.g. link workers, psychologists, and ultimately intended to ensure that each patient is consistently looked after in a way best suited to their needs. It's important to note that this does not mean that core professional roles have been dispensed with, or that the professional input to the now Neighbourhood Mental Health Teams (NMHTs) has reduced. In fact, under Transformation, the established numbers of Mental Health Practitioner (MHP) fulfilled by the professions previously listed has increased on the former number of Care Coordinators. In many cases, and where clinically indicated, MHPs will also continue to act as key workers, and after the acknowledged dip in staffing numbers, recruitment and retention for these groups of staff is improving.

At the time of and in the period running up to Charlotte's death, though, Care Co-ordinators faced large caseloads and an emphasis on fulfilling all the needs of their patients themselves, (whereas Transformation enables a more dynamic team approach led by key worker input to ensure that patients' needs are met by the right professionals at the right time).

I am pleased to be able to say that caseloads for MHPs and key workers are now lower than they were at the time Charlotte was under our care. C.20-25 patients per Care Coordinator is now typical, and within national guidelines. The management and leadership of the NMHTs across the county has also been significantly reinforced, so that effective oversight of team activity has been enhanced. The leadership structure for Worcestershire NMHTs consists of fourteen posts (an increase on the previous structure) and all those posts have now been substantively recruited to.

You have asked whether we have fully understood the circumstances that pertained at the time and how the resultant discontinuity of care contributed to Charlotte's sad death. I believe Charlotte's experience of multiple care coordinators is effectively addressed in part through the change to a key worker approach and the overall expansion of the team inherent in the Transformation. Further, though, we now have in place systems and processes to ensure that patients whose acuity is escalating can be appropriately overseen. The Worcester City "huddle" takes place twice-weekly and focuses on those in high-need groups taking into account acuity, diagnosis and other concerns or vulnerabilities such as high-risk medications. In the event that a patient does not have an allocated MHP and it is judged that their risk has escalated materially such that they require that (or other) input, then this is picked up, and other work reprioritised if necessary to facilitate this. I hope the above serves to alleviate your concerns about our ability to effectively manage patient care especially for those patients with more complex presentations.

The erroneous decision to pause Charlotte's referral to the Priory Hospital for specialist treatment for Body Dysmorphic Disorder was taken by a senior clinician acting on her own, despite a Multi-Disciplinary Team meeting having decided that the referral was appropriate. When asked about how the senior clinician could have overridden the MDT decision, the Trust's Community Services manager for the Worcestershire Neighbourhood Teams told the inquest that he could not say whether the senior clinician was not aware of the correct decision-making procedure, or whether she was, but chose instead to ignore it. When asked whether the same issue could arise in future, he told the inquest that he himself would be in a position to prevent the senior clinician making the wrong decision, but could not guarantee that he would be made aware of the issue so as to be able to do so.

The Trust fully accepts that a lead clinician sought to cancel Charlotte's Priory referral in error. Evidence of this human error was reflected in the original Root Cause Analysis (RCA) and, consequently, actions have been put in place for a new process for funding arrangements.

Any decisions regarding funding arrangements for specialist services are now established at weekly MDT meetings. Any proposed change to an application must therefore also be brought to a subsequent MDT meeting, and any clinician wishing to challenge or change the MDT decision must be present to make their case. Each decision or change, and the rationale for it, must be clearly and contemporaneously recorded in the patient's clinical notes. This process ensures mandatory open discussion in a recorded forum (MDT) as a precondition for any change. If the MDT is unable to come to a consensus, the issue will be escalated to the Associate Director (or Deputy Associate Director in their absence) and the Associate Medical Director for a decision. The rationale for the initial decision and challenge must be presented to them, and the decision of the Associate Director and Associate Medical Director will be final. Finally, the whole is overseen by an already extant funding oversight board within the Trust which meets once a month. This process has been clearly communicated to all staff.

I hope this reassures you that the Trust has understood how a senior clinician was originally able to override the MDT decision in Charlotte's case, and how there is now a robust system in place to ensure that such a thing cannot occur in future.

I hope that the above adequately addresses your concerns.

I do not have any submissions to make in respect of publication of this response. I shall be grateful if you could kindly send a copy of my response to those to whom you copied your Regulation 28 report.

Yours sincerely

Chief Executive