NHS
Sussex

Ms Penelope Schofield
Senior Coroner
County Records Office
HM Coroners Office
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West Sussex
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NHS Sussex
Wicker House
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22 08 2023

Dear Ms Schofield

I write in response to your Regulation 28 report and the covering letter dated 29.06.23, addressed to our Chair, [redacted], in respect of the concerns you have highlighted after hearing evidence at the Inquest touching on the death of Rachel Garrett.

I would like to begin by extending my sincere condolences to Rachel Garretts family. This must have been an extremely difficult time for them, and I hope that my response provides them and you with assurances that NHS Sussex is taking action to address the issues set out in your report.

Your matters of concern below have been reviewed and NHS Sussex' response is also outlined below:

Concerns

> *Patients who attend a Hospital A&E Department with mental health difficulties are in most Hospitals seen by a Mental Health Liaison Team (made up of Consultant Psychiatrists and Mental Health Nurses). These staff are not employed by the acute Hospital Trust but are employed by a local Mental Health Trust (in this case I was Sussex Partnership NHS Foundation Trust).*
>
> *As a result of their employment status, the Mental Health Liaison Team (who have the best knowledge of the patient having been caring for them) cannot invoke the Doctors or Nurses holding powers under Section 5(2) Mental Health Act (Section 5(4) for nurses). If a patient decides to abscond from the Acute Trust Hospital the Mental Health staff cannot detain/hold the patient. They would have to ask a Doctor within the Acute Hospital to do so. This Doctor may not have any knowledge of the patient and would be unlikely to act immediately in a busy A&E. By this time the patient would be long gone.*
>
> *Due to this technical issue around the employment status of the Mental Health Team, those suffering with a deteriorating mental health in an acute setting are at risk in these circumstances.*

The response

As Commissioners of NHS services, NHS Sussex does not usually have a role in relation to the employment model of staff for particular services. However, if NHS Sussex, are made aware of an issue that is creating a risk for patients then we recognise that as the Commissioners, we do have a duty to raise the issue with the Provider/s concerned and to ensure that the issue is addressed.

Since Sussex Partnership NHS Foundation Trust were interested persons and were represented at the inquest touching on the death of Rachel Garrett, they were already aware of the concerns that had been raised by HM Coroner and were also aware of the issue of the PFD report. We have therefore asked them for their input, and they have provided the following information:

> Mental Health Liaison Team (MHLT) staff are employed by partner specialist Mental Health Trusts for reason of professional supervision & management as is the arrangement in the majority of instances around England's 184 hospitals with an emergency department.
>
> In the case of an admitted patient, Mental Health Liaison Teams are not the 'admitting team'. The admitting team will be typically medical or surgical with the MHLT staff there to advise. Rachel Garrett had been admitted to the short stay ward.
>
> The volume of work in Emergency Departments and delays to finding beds for people with Mental Health needs, admitted or not admitted, are a related but separate issue and there is a system improvement plan to address these.
>
> They are not the commissioned work of a MHLT service which is about the first 24hours of care.

We have also contacted University Hospitals Sussex NHS Foundation Trust and they have advised us that they are in the process of recruiting for a Head of Mental Health Nursing. We are also aware that they have recently advertised for a Head of Nursing - Mental Health. The advertisement states that University Hospitals Sussex is seeking a highly experienced and motivated Senior to lead the strategic and operational development of mental health pathways within our Trust.

We have investigated HM Coroner's concerns with the Mental Health Commissioning Leads and have also raised them with the Chief Medical Officer for NHS Sussex.

With regards the steps that NHS Sussex have already taken, we can report that in June 2023 the patient safety collaborative (PSC) were commissioned by NHS Sussex ICB to conduct a 4 week independent review of the Mental Health crisis pathways for adults, children and young people in West Sussex and Brighton and Hove. The PSC were asked to identify the significant challenges in these pathways and to make recommendations for partners across the system to improve service delivery. The partners included Sussex Partnership NHS Foundation Trust (SPFT), University Hospitals Sussex NHS Foundation Trust (UHS), the Local Authorities and NHS Sussex ICB. The independent review identified the challenges to the system across the various partners and some of those challenges related to the Mental Health Liaison Team (MHLT). One of the long term goals identified for SPFT, UHS, the Local Authority and NHS Sussex ICB is to draw from best practice from within and outside Sussex to agree a vision for the future shared model of crisis care across the system.

The report was published in June 2023 and work is ongoing to improve the provision of Mental Health support services across the systems in Sussex in order to improve the outcomes for patients suffering from Mental Health crisis.

The issue of how the MHLT provides advice and support in A&E is therefore a matter that we will take up again with NHSE and with our partners, Sussex Partnership NHS Foundation Trust and University Hospitals Sussex NHS Foundation Trust.

Two of the actions that we will take forwards as a matter of some urgency are to make contact with other ICBs to explore how they are addressing the employment of Mental Health Liaison Teams within the Acute Care Hospitals and also to look at workforce and practices with our Providers to try to resolve these issues on a local level. Whilst we are still trying to resolve the concerns that have been raised, this is a recognised National issue and as such we therefore do not yet have a local solution.

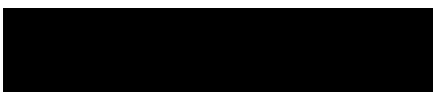
We note that NHSE are also due to respond to HM Coroner on the issue in any case and we will liaise with NHSE so that they are made aware of the steps that we are taking and can offer any further advice.

I hope that we have provided you with some assurance that NHS Sussex ICB is taking steps to address the concerns outlined in your report and that we are continuing to take action to prioritise patient safety.

Thank you for raising this matter with NHS Sussex. If I can be of any further assistance or if HM Coroner would like a further update on how the above steps are being progressed, I would be happy to provide a further update.

I look forward to hearing from you.

Yours sincerely,



Chief Nursing Officer

On behalf of NHS Sussex