NHS
West London
NHS Trust

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06 March 2024

Dear Madam

RE: Regulation 28 Report to Prevent Future Deaths- Mr Thomas Sweeting

I write on behalf of West London NHS Trust in relation to the Prevention of Future Deaths Report sent via email on 9th January 2024. The Trust has now had an opportunity to review the Matters of Concern raised.

I would like to begin by offering my sincere condolences to the family of Mr Sweeting for their very sad loss. As a Trust we have taken your concerns very seriously and have sought to address these issues as quickly as possible to ensure lessons are learned to benefit other patients in the future.

I, therefore, below respond to each of the matters as they were raised in your correspondence:

Matters of Concern

Concern 1

Mr. Sweeting was assessed in relation to his mental ill health presentation by the Consultant liaison psychiatrist, but the Trust template was not completed, which was not in compliance with the Trust policy and criticised in the Trust serious incident report. There is a concerning mismatch of what more junior colleagues are expected to do and be trained in, compared with Senior practitioners demonstrated work practises.

Although the Trust's review identified that a risk assessment had taken place, this was not recorded in line with the Trust policy. We acknowledge that this was likely due to service pressures in the team on the day and feedback has been provided to the Team involved, and to the sister services in our other two boroughs, to improve performance in this area.

There was a holistic assessment of Mr Sweeting's needs and a management plan which considered biological, psychological and social interventions based on the assessment of his needs at the time.

The Trust shares your concern about the perceived mismatch between senior practitioners' work practices and expectations of junior colleagues, and since this incident has confirmed that all members of staff received the same training and are expected to adhere to the same policies. Whilst it is normal practice in most healthcare settings for certain aspects of documentation and assessment to be delegated across the multidisciplinary team, including to trainee doctors, the supervising consultant retains responsibility for ensuring adequate supervision. Learning from this event has been incorporated into the teaching plan for future trainees rotating through LPS settings, and will be reflected upon by the senior practitioners involved in their monthly management meetings and annual appraisal.

Concern 2

No letter of discharge was sent at the time Mr. Sweeting was seen by the liaison psychiatry team, and a letter was only generated in response to investigations taking place after the death. The team acknowledged that there were "problems" with sending out letters at the time, and no evidence was brought before the court that this issue has now been resolved. Letters should be dispatched within 24 hours of attendance. Communication between the various community teams and setting out the treatment plan to the patient are important factors that were not effective during Mr. Sweeting 's care and remain a concerning omission where there may be a simple and effective remedy.

Following an attendance in an Emergency Department, where a referral to the Psychiatric Liaison service is made, two items of correspondence are generated to ensure communication with the patient's primary care team. The first is generated by and is the responsibility of the acute trust (the Emergency Department), through their electronic records system (Cerner). This includes a summary prepared by Emergency Department staff of their assessment and advice. All Liaison Psychiatry practitioners have access to this system and ensure a contemporaneous note is recorded on Cerner which Emergency Department staff may incorporate into their discharge note. The second letter is manually generated by the Liaison Psychiatry team itself, and is a specific letter to the General Practitioner (GP) providing a more detailed summary of the specific mental health interventions and plan.

The Trust acknowledges that at the time of this incident in the Hounslow Liaison Psychiatry Team there were issues with ensuring that the second (mental health specific) letter was sent to the patient's GP within 24 hours of attendance to Emergency Departments, due to capacity issues within the team which resulted in an administrative backlog.

At the time, the interim solution for this issue was to contact the patient's general practice by telephone to hand over any time-sensitive clinical information, including prescribed medications.

It was evident during the hearing that there were different accounts of the telephone exchange between the junior doctor and the GP. It is documented that the junior doctor spoke with the GP to ensure that the information related to Mr Sweeting's management plan was shared.

In light of the learning from this incident, the team undertook a formal quality improvement project between September 2021 and July 2022 that led to a sustained improvement in the quality and efficiency of GP correspondence.

An automated letter template has been developed, which auto-populates with information pulled from the electronic record, to simplify clinicians' work when completing these letters. A more robust GP communication process was implemented to send letters to GP practices via secure emails, to eliminate postal delays, with other copies sent by post.

This project significantly improved the problem of timely GP correspondence, however the risk of recurrence is not entirely eliminated. Therefore, in light of this Coroner inquest the service is initiating a 3-borough response to fully address on-going systemic obstacles to timely communication with primary care. GP correspondence is now monitored by the senior management team on a daily basis, is a standing item in the team governance meeting and monitored in the service-wide governance meeting. This will constitute the basis of a new service-wide tri-borough protocol for GP letters, which the LPS service and Clinical Lead are jointly developing as part of our response to this inquest. Since the implementation of the protocol, HLPS has achieved 97.1% of letters sent within one working day between 20/02/2024 and 05/03/2024. This is an improvement from 72.4% compared to the same period last year.

Concern 3

It was acknowledged that obtaining collateral information from the family is vital, but in this case was delegated to a very junior member of the team who was in the early stages of her training. It should be considered if this task is appropriate to delegate, and if so what information should be sought from families/carers and how that should be effectively used to support patient care.

The Trust has reviewed this practice, and whilst the collating of collateral information will remain an important training task for junior members of staff, that there was a shortfall in supervision in this instance and improvements were required in the expectation of how the task should be undertaken. To aid with this, a secondary induction programme into the service has been introduced for new staff, which sets out how this task will be demonstrated, and observed before carried out independently with supervision. The service has commissioned a piece of co-development work with our Experts by Experience as Carers representatives to improve the practices further.

Concern 4

The Trust showed good intentions of reviewing the training programme, but were unable to evidence that planned 6 monthly audits had actually taken place, and so there was no evidence before the court that the new training that had arisen from the serious incident findings was effective. Introducing new training, templates and supervision performance appraisals all seem to be positive interventions, but in the absence of any process to audit their effectiveness, it is concerning that the Trust have no way in which to judge their impact.

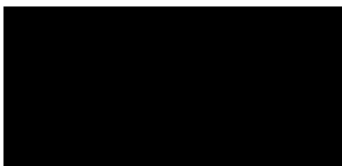
The Trust recognises that the purpose of an audit is to learn and understand whether there is a gap in practice. However, the Trust also adopted developmental programme and supervision structures to ensure the learning from incidents is embedded.

The Trust undertook three audit cycles since April 2023 on assessments following individuals presenting to Acute Hospitals with self-harm. This demonstrated that the service is consistently meeting the standards put forward by NICE (National Institute for Heath and Care Excellence). Since this incident, the service has also completed an external accreditation process led by the Royal College of Psychiatrists College Centre for Quality Improvement, known as the Psychiatric Liaison Accreditation Network (PLAN). This required validated assessment against multiple domains of practice, feedback from staff, referrers, patients and carers, and external peer review on the services provided.

The service governance structures in place to share learning through a Service Line Quality and Performance meeting into the borough team based Clinical Improvement Groups which are documented. A quarterly Mortality and Morbidity meeting has been introduced for liaison psychiatry teams to reflect on and learn from incidents. In addition, learning from our incidents is now fed into an annual team development programme, in the form of a thematic review of serious incidents, teaching and a complex case discussion forum. All clinicians receive regular clinical supervision which monitors the quality of work individual clinicians conduct.

I hope that the above information provides you assurance that we have acknowledged and taken action to address the concerns that you have raised, to reduce the risk of future preventable harm to our patients. As a Trust we are committed continuously to improving our services to address areas of underperformance related to patient safety, experience and the delivery of high-quality care.

Please do not hesitate to contact me should you have any questions or queries.



Interim Chief Executive Officer