Improving lives together

Cygnet

Alison McCormick
Assistant Coroner for Berkshire
Coroner's Office
Reading Town Hall
Blagrave Street
Reading
RG1 1QH

15 May 2024

Dear Madam

Inquest touching the death of Sarah Adams

I write to provide the response from Cygnet Health Care ("Cygnet") in relation to the Regulation 28 report sent to Cygnet Hospital Harrow, alongside Berkshire Healthcare NHS Foundation Trust and Reading Borough Council, following the above inquest. In the Regulation 28 Report you identified a concern relating to ensuring that staff are trained in the discharge process, and specifically the issues which may arise in respect of out of area placements.

For all patients at Cygnet planning for discharge begins from admission. A key part of this is the discharge care plan which is started when a patient is admitted and updated throughout their admission following every ward round. The objective is for this care plan to provide a comprehensive picture of the arrangements for discharge from the time of admission; including risks, discharge location, transfer arrangements and support needs.

Care planning and risk assessment training is provided to staff to support them in completing care plans, including discharge care plans. This is via a 4.5 hour face to face session. The session is provided by the Regional Nursing Director to all the Clinical Managers to then be cascaded at each site. At Cygnet Harrow this session has been provided to all members of the multi-disciplinary team (MDT) and is due to be refreshed on an annual basis, or more frequently if a need is identified.

This training is aligned with Cygnet's broader training offering, particularly our e-learning risk training. This training is provided to all members of the MDT and refreshed on a two-yearly basis. The session provides guidance to staff in assessing risk, utilising the relevant tools and ensuring that risk assessments are of high quality and triangulated with the care plans, continuous notes and information from families and carers. We are acutely aware that risks can increase at discharge and that risk assessments need to be undertaken carefully to ensure that we implement steps to minimise this. The risk training has been reviewed and from 1 July 2024 will include updated and more specific guidance in relation to risk assessing around discharge.

Discharge arrangements are specific to each individual who is being discharged and Cygnet needs to be flexible as it discharges to multiple different community organisations. To ensure that our processes are consistent and nothing is missed Cygnet has detailed policies covering the discharge process. The new discharge policy was reviewed and published March 2024.

This policy was benchmarked with a large mental health Trust to ensure we had the best evidence and our policies were in line with those of the sector. The documentation to support discharge includes the discharge notification form which was also updated in March 2024 to specifically highlight the need to document the plan for post-discharge community support, including when this support will commence. This form is shared with the patient and all relevant stakeholders on discharge to ensure that all relevant agencies are aware of the agreed plan. Cygnet also utilises a discharge checklist which must be completed by the Responsible Clinician for every discharge. Completion of discharge forms and summaries is monitored both locally, via the Medical Director, and centrally at Board level to ensure that all sites are providing the necessary documentation in a timely manner to support onward care. This data is highly visible so that if documents are not being sent in accordance with set timeframes this can be immediately identified and addressed.

Further, a supplemental set of training slides for staff induction are in development to provide support to staff in understanding the content of the discharge policy, including the discharge checklist, the key risks to consider, accurate documentation and communication with community teams. These slides will be deployed by 1st June 2024 for all Cygnet Hospital sites to assist new staff with prompt familiarisation with our processes. .

In addition, our Group Medical Director is arranging a Safer Discharge Conference planned to go ahead in Summer 2024. The learning conference will look at specific risks associated with discharge and the practical arrangements surrounding discharge. Our stakeholders, including community mental health teams and Local Authority Adult Social Care Teams, will be invited to this conference to share actions taken to improve discharge processes, checklists, policies and improved communication with a focus on patient centredness and to ensure that our commissioners and collaborators are aware of our processes and what role they will undertake in the discharge process. The conference will include panel discussions that involve carers and Expert by Experience leads. It is also planned to invite the Parliamentary and Health Ombudsman to discuss their recent findings and report "Discharge from mental health care: making it safe and patient-centred".

On 1 June 2024 we will commence a quality improvement project in relation to the learning from this inquest, this will look at exploring a working arrangement with the Samaritans. This would provide for any high risk patients ready for discharge to be, with their consent, referred to the Samaritans. The Samaritans would then contact the discharged patients within 24 hours and if they have any concerns they can take appropriate action. This model has been successfully utilised in other mental health organisations and can bridge the gap between discharge and being reviewed by their community teams providing an additional risk mitigation and safeguard on discharge.

Since this inquest Byron Ward now also has a Cygnet Social Worker. This role provides coordination of the discharge arrangements including liaison with family and community services which further assists with ensure that discharges processes run smoothly. Cygnet Health Care takes the care and safety of its patients extremely seriously and is continuously working to improve its practice to provide the highest possible standard of care. Representatives from Cygnet Harrow were present in court throughout the inquest to ensure that the learning from this matter was captured and disseminated. I hope that this response provides some measure of reassurance to HM Assistant Coroner and Ms Adams' family.

Yours sincerely

[redacted]

[redacted]

CEO