NHS
Norfolk and Suffolk
NHS Foundation Trust

[redacted]

Trust Management
1st Floor Admin
Hellesdon Hospital
Drayton High Road
Hellesdon
Norwich
NR6 5BE

23 April 2018

Private and Confidential
Mr Nigel Parsley
HM Area Coroner for Suffolk
The Suffolk Coroner's Service
Beacon House
White House Road
Ipswich
Suffolk
IP1 5PB

Dear Mr Parsley

Re: Regulation 28 report following the inquest of Ms Rachel Edwards

I write in response to your report dated 27 February 2018. Under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 you requested the Trust consider issues of service delivery following the conclusion of the inquest into the sad death of Ms Edwards.

I will address the matters you raised in the order received:

Medication on discharge from hospital

You raised the matter that Ms Edwards had a known risk of stockpiling medication. Despite this risk she was discharged from hospital with 14 days of medication, referred to at the inquest as standard practice. You explained further examination identified that the prescription for Tramadol was given for seven days indicating there had been some assessment of risk. The records were not clear what numbers had been given for each medication. You were concerned that individual consideration of the service user's needs and risks may not be consistent.

Discharge from hospital is a known period of opportunity and risk for services users. It can represent a sign of the individual's recovery whilst also presenting new challenges. Each service user's journey through this period is different and requires a responsive individualised approach from the care team.

The Trust will make an assessment of the medications prescribed upon discharge and this consideration will continue across the Trust. In the majority of situations an individual's recovery into the community is supported by a period of care with the Crisis Resolution and Home Treatment team.

Separate but linked, the Trust has completed some exploratory work on examining deaths of our service users where prescribed medication is listed within the cause of death. This has shown that opioid medication has the highest prevalence, matching the national picture. The Trust supports the work of Public Health England and the Faculty of Pain Medicine in raising awareness of opioids, their benefits and uses, but also the risks associated with them. The Trust has raised the learning of the prevalence of opioids as a cause of death with its staff through its safety together newsletter and is completing a further thematic review of the deaths, in order to identify what additional learning may be made. This is being presented to the Trust's Mortality Review Group in May 2018.

Notification to GPs of the prescribed medication upon discharge

You raised the matter that there was no automated notification to the service user's GP of the type and amounts of prescribed medication issued at the point of discharge. This information is crucial to help reduce the potential of over prescribing. You heard that the current process involves human action through use of emails.

There is a national programme looking to build these electronic bridges between different elements of the health system. Locally, the Trust is planning the technical changes required. At this time, there is no confirmed date for completion of this work. I would be pleased to update you on progress over time.

Advocacy

Your third point raised the matter that Ms Edwards' situation was heavily influenced by the physical pain she experienced. She received disappointing news regarding her pain management treatment, increasing her sense of hopelessness. You heard evidence that she did not have an advocate to support her. You stated that advocacy services provide support to people in need and that we should consider establishing a formal system for an advocate to be appointed, where this may be beneficial.

The Trust supports the significant and valuable role that advocacy services provide. The Trust is established in working with advocacy services as part of statutory frameworks, such as the Mental Health Act, Mental Capacity Act and complaints regulations. Equally, the Trust works with advocacy services where this has been requested by the service user to support the best possible forms of communication and collaboration. Such services are not commissioned by the Trust and the process to access such are either through service user consent or under the guidance of the above named frameworks. The Trust will register this matter with its commissioners.

Thank you for raising these matters. If I can be of any further assistance please do not hesitate to contact me.

Yours sincerely

[redacted]

[redacted]
Chief Executive