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Children & Family Health Devon

NHS
Devon Partnership
NHS Trust

CONFIDENTIAL

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Tel: 01392 208683

Date:
25 March 2025

Mr Richard T Middleton
Assistant Coroner Dorset
Civic Centre
Bourne Avenue
Bournemouth
BH2 6DY

Sent via e-mail [redacted]

Dear Mr Middleton,

Re. Mr Alexander Kieran Ari Channing – Regulation 28 report.

I write in my capacity as Interim Chief Nursing Officer & Allied Professions Lead for Devon Partnership NHS Trust (DPT) in response to your regulation 28 report dated 31 January 2025.

If I can first pass on my condolences to Mr Channing's family and friends.

In your report you highlighted areas of concern to The Vice Chancellor of Arts University Bournemouth, The Chief Executive of Dorset Healthcare NHS Foundation Trust, along with us Devon Partnership NHS Trust (DPT). In respect to the concerns pertinent to DPT I respond as below:

There appears to be a failure amongst staff at the Exeter CMHT to appreciate that there can be a direct transfer of a patient's care to another CMHT Trust without the need for a patient to have to first register with a GP surgery –

Patient transfers to out of area services remain a challenge for all NHS providers. We have an agreed standard operating procedure that articulates the process to collaboratively transition a person between community mental health services from Devon Partnership Trust to another Trust. At times the referring team may still experience local challenges in relation to an out of area transfer, as the policy relates to DPT's processes only. Details on referring a person to another Trust where they do not yet have a GP can be found on page 6 point 6.6, this is the specific detail,

1. Person without a known Address and/or Registered GP on Transfer

1.1. On occasion a person may not have a known address or registered GP in Devon or part of Devon that is covered by the team the person is transitioning too. This occurs where a person has been placed out of area or temporarily moves (home address) or is in unstable accommodation or is released from prison. The lack of address/changed address or registered GP, should not be the sole reasons for declining a transition or transferring to another team/service whilst in the first 3 - 6 months of the initial transition. If a service, even a monitoring service is offered by a Trust service it is incumbent on the service being transitioned to, to make reasonable adjustments (i.e. allocate to a practitioner/service

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regardless of the eventual locality a person may be accommodated or where the GP will be registered)

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Where this is the case, transfer will be planned and managed in a sensitive way taking into account an individual's needs. The existing service keyworker/care coordinator or person identified in the Service Standard Operating Procedure [SOP], will be responsible for management of the transfer and ensuring all communication is clear to the user, referrer and receiving service to ensure that the person receives a seamless service.

Until a person's eligibility for services is determined, there should be no gap in service provision. The current services will continue until either the services the person is transitioning to are in place, or the assessment shows that there are no eligible needs. It should be noted that some services have long waiting lists. A person that is needing to transition to one of these services will have their referral reviewed with the local knowledge and prioritisation for their waiting list status in the service being transitioned to, this service will support the transition when agreed.

The services covered by the Policy recognise that smooth transition planning may require collaborative involvement of a potential receiving service for a short period of time before the person becomes eligible for that service, initially in a consultation and liaison capacity. This will allow for adequate planning and hand over, without lengthy periods of uncertainty about what the onward service might look like. In general, this would not be expected to exceed between three to six months ahead, with the longer length for particularly complex cases. e.g. if a person is not eligible for a service until they are aged 18 or 65 or move to within the catchment area of a service, does not mean work on transition should not be undertaken prior to the cut-off point. It is not a case therefore of waiting for 3 months before a key worker is allocated, then a further 3 month wait until the new key worker starts to work with the referred person.

The Trust aims to provide high quality, safe and effective services to all patients and recognises the importance of enabling effective continuity of care, particularly at times of transition when patients may be particularly vulnerable. It is important that any required transition process is managed sensitively and collaboratively to support continued engagement of the person and their support networks and safe and effective service delivery.

There was a lack of involvement of a responsible clinician in the process of discharge planning from the district hospital in Exeter to the care of Bournemouth CMHT at Dorset Healthcare NHS Foundation Trust –

In terms of discharge planning from Liaison Psychiatry, in relation to the planned discharge from the district hospital in Exeter, I can confirm that the following paragraph has been added to the Liaison Psychiatry Services Exeter, Torquay and Barnstaple Specialist Services Directorate Standard Operating Procedure. It gives detail on page 12 of the attached document.

[redacted]

For people who have been placed under Section 2 or Section 3 within the DGH and the plan is made for discharge to the community (not psychiatric hospital). The agreement is that the Consultant who rescinds the section will consider if 48 hour follow up by Home Treatment Team is required and make that referral prior to discharge. In those cases where this is not required then the rationale will be clearly documented in the patient electronic records.

Individuals will be discharged from the service when the objectives and goals of the care and treatment have been met. This may be following an assessment in the Emergency Department or after a period of assessment. We will endeavour to signpost the person using our service to appropriate support in the community as required and liaise with our partner agencies.

We do recognise and accept that an individual's motivation to engage in treatment may vary according to their mental state. If an individual has made a choice not to engage in treatment, then we will aim to signpost them to other appropriate services, unless there is evidence to suggest that their capacity may be impaired, which would then require a capacity assessment to be undertaken.

Upon discharge from Liaison Psychiatry a written assessment letter is provided for the patient, to the General Practitioner and, if applicable, the care team that is taking on the care and treatment of the individual. A copy is offered to the individual who is also given a service user satisfaction survey. The individual is also always asked whether they would like their carer or relative to receive a copy.

Exeter Torbay and North Devon Liaisor

Our aim is to ensure good working practices and relationships between the Liaison Psychiatry team and across the Network functions within the Trust and with agencies/services outside the Trust. DPT endeavours to ensure that any transfer of care of patients from the Liaison Psychiatry Team to the appropriate Network function within or outside DPT is managed as rapidly and effectively as possible.

There is no policy in place at Devon Partnership NHS Trust which encourages a repeated proactive approach in seeking consent from a patient to share information at relevant times.

Devon Partnership NHS Trust has a policy in relation to confidentiality. In the attached policy it states that the person has a right to restrict disclosure to share information. DPT staff members would routinely review a person consent to share information. These reviews of confidentiality should take place when newly allocated to a new worker, identified new risks occur, or periods of transitions between teams.

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The person has the right to request restricted disclosure of all or some of their confidential personal information. If such a request is made there should be careful consideration of this and all reasonable attempts to respect their wishes and address their concerns should be made. Explanation of why the sharing is necessary in the particular circumstances should be given and the risks in relation to any restriction.

Explicit consent must be received from the person and recorded on their electronic patient records for any sharing of information which is not directly related to their care. For example, someone may wish to have information shared with some family members but not others. It is important to ensure the consent is clearly recorded and understood. The person may change their mind about disclosure at any time before any disclosure is made and afterwards to prevent any further disclosures.

If you feel that you need further detail, please do not hesitate to contact me again.

Yours Sincerely

[redacted]

Interim Chief Nursing Officer & Allied Professions Lead

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