GIG CYMRU NHS WALES
Bwrdd Iechyd Prifysgol Bae Abertawe
Swansea Bay University Health Board

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Dyddiad / Date: 30/04/2025
Ein Cyf / Our Ref: [redacted]

To Kirsten Heaven, Assistant Coroner,
for the Coroner area of SWANSEA & NEATH PORT TALBOT

Dear Ms Heaven,

RESPONSE BY SWANSEA BAY UNIVERSITY HEALTH BOARD TO REGULATION 28 REPORT TO PREVENT FUTURE DEATHS ISSUED IN THE INQUEST OF JEAN PIKE

This letter is written in response to the Report issued under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and regulations 28 and 29 of the Coroners (Investigations) Regulations 2013 dated notification dated 7th March 2025 wherein you identified the following concerns and stated that it was your opinion there is a risk that future deaths will occur unless action is taken.

Swansea Bay University Health Board sets out below the concerns and the action taken which is within the power of the Health Board.

CORONER'S CONCERNS

Concern 1

That Jean Pike was discharge from Ward F of Neath Port Talbot Hospital on two occasions prior to her death by a consultant psychiatrist and that prior to the decision on both occasions there was no multi-disciplinary meeting between the consultant on Ward F and the professionals directly involved in caring for Jean in the community about Jean's mental health and the risks she posed to herself in the community. This was in circumstances where the consultant knew before the decisions to discharge that these professionals, which included Jean's care co-ordinator, were clearly stating that they were extremely concerned about Jean's mental health and that they did not consider that they could keep Jean safe in the community.

The coroner's expressed a particular concerned by the evidence I heard from Jean's care co-ordinator that care co-ordinators are rarely, if ever, consulted by consultant psychiatrists in Ward F of Neath Port Talbot Hospital before a decision is made to discharge a patient/ person under secondary mental health care.

Concerned that if there is a lack of clarity or a reluctance in Ward F at the consultant level to engage with care co-ordinators and professionals in the community (and before decisions are made to discharge) there is a risk that the concerns of the professionals managing a patient/person under secondary care will not be adequately considered in the

decisions made by Ward F clinicians. This also creates a continuing risk to life as it may lead to risk being ignored or not properly considered by Ward F.

Swansea Bay University Health Board Response:

Discharge processes within the adult mental health wards have been reviewed over the last three years and Terms of Reference were developed for the Multi-Disciplinary Team (MDT) Ward meetings in April 2022. The MDT meeting is held on a weekly basis, with the focus being to work collaboratively with colleagues in the Community Mental Health Services and other agencies/providers to provide holistic and patient centred care. The Terms of Reference for the MDT meetings and review process sets out the purpose and expectation of all parties within this process; including collaboration with care coordinators, families, and other agencies. Prior to each MDT meeting, a communication is sent to all Integrated team managers for CMHTs (this includes the Local Authority and Health manager), informing them of the MDT meeting agenda. Care Coordinators are able to attend to participate in the review and discussion of their patient(s) through making an appointment with the ward medical secretary. However, the CMHT representative at the meeting also acts as a conduit to cascade information and MDT decisions back to the team and individual care coordinators. Care coordinators also take opportunity to contact the ward for updates on patients outside of these formal meeting.

Within the adult Mental Health services, a weekly discharge planning meeting is held, where all inpatients progress and discharge plans are discussed and prioritised. Attendees at this meeting are representatives from each of the inpatient and community teams. The purpose of this meeting is for information sharing, working collaboratively to inform effective patient flow and discharge planning through the service.

There are going to be times where patients are appropriate for discharge in circumstances outside of the above timeframes; such as a short admission, in this situation and for planned discharged, the utilisation of a discharge checklist ensures that there is effective communication and collaboration with all parties. The purpose of the Pre-discharge checklist is to provide an overview of the necessary actions required in preparation for a patient discharge. The checklist includes the required stakeholders who need to attend, such as family/carer or advocacy, care coordinator, care providers and any other agencies involved. Other aspects of the checklist include social circumstances, occupational therapy needs, safeguarding, follow up from the Crisis resolution and home treatment team, and take-home medication requirements. The checklist provides a prompt to the ward team to ensure the care coordinator is involved in the patient's discharge. In addition to this, there is also a patient discharge pack which is provided, which includes information for the patient, family or care provider on discharge and ongoing support and signposting. The Pre-discharge Checklist was revised and improved in July 2022. Assurance around the effective implementation and use of the Pre-discharge Checklist is reviewed as part of a weekly audit of clinical records. The findings are shared with the Ward Manager and Clinical Lead and any improvements implemented.

Discharge planning has been a focus of a current clinical audit that is being undertaken by the Quality Improvement and Practice Development teams. This audit is looking at Discharges from the Adult inpatient Wards against the guidance identified in NG53 Transition between inpatient Mental Health Settings and Community or Care home settings. This audit commenced in March 2025 and the findings are planned to be presented in July 2025.

MHLD Services in SBUHB are actively involved in the National Patient Safety Programme. This is a programme of work led by the NHS Wales Executive Team, and includes the safe discharge work stream. This forum is developing a set of national standards around discharge, and includes the requirement that all patients discharged from Adult Mental Health wards (this is for Ward F, Clyne and Fendrod) receive a 72 hour follow up review. This has been in place since May 2024 and has been monitored for compliance since September 2024. During this six-month period,

there has been 230 discharges across adult inpatient wards, of these 90% have received the offer of 72-hour follow-up. Of those who were not offered, the reasons include patient discharged out of area, patient deceased and patients that had received an extended period of home leave as part of transitioning/discharge planning.

There is a focus across Wales for the implementation of Patient Centred Safety planning. SBUHB working with the NHS Wales Executives, were a pilot site for this approach within one of our CMHTs. Following the success of this pilot, there is an MDT task and finish group chaired by the Lead Nurse for Adult Community Mental Health Directorate, who will work towards scaling this in a phased approach across all adult mental health services over the next year. Patient centred safety planning is a patient led approach to managing emotional distress and crisis, through identifying means of support, distraction, contacts and strategies to maintain safety. This will be led by the patient and centred around them, and therefore consent and engagement will be required.

For those patients who engage with a Patient Centred Safety plan, they will still require a risk assessment, formulation, and plan to be in place. All patients who have been admitted to an inpatient setting, will have a risk assessment completed within 24 hours, and for care coordinated patients, this will form a review of their current risk assessment (as they will already have one from the community). As part of the admission process, the patients Care and Treatment Plan would be reviewed within 72 hours, where the care coordinator attends this meeting where possible in line with the operational hours of the community mental health teams. Both of the above criteria are reported to the NHS Wales Executives on a monthly basis. The monitoring of this has been in place since September 2024.

MDT working requires a shared responsibility and collaborative working. However, where different professionals are involved, this can bring different views and opinions on patient care and treatment. In these circumstances, clinicians including care coordinators, can raise concerns. There are a number of forums where this is possible. Within the CMHTs, there are weekly Community MDT meetings where clinicians raise and discuss patients from their case load; there is an item on the agenda 'cases that are escalating/of concern'. This is an opportunity for the care coordinator and the MDT to discuss the case; the care coordinator will receive peer supervision; alternative interventions can be discussed and a decision if gatekeeping or Mental Health Act Assessment is required. The team consultant has emergency slots within their clinics, and these can be utilised should a patient require an urgent review in the community.

Another area for support and escalation would be caseload supervision; this is a one-to-one meeting every 6 weeks with the team manager or deputy, in line with professional standards. It allows the care coordinator to focus on their individual caseloads, it is an opportunity for reflection, support, and development. Outside of these, more formal processes would include escalating any concerns they have via their Team Manager, escalated to the Lead Nurse, Head of Nursing and finally Nurse Director within the Service Group if required.

In addition to escalation routes, there is also a monthly community team manager meeting that is held and chaired by the divisional manager for Mental health services. This meeting allows for team managers to raise any concerns they have; to reflect on any trends or patterns that are emerging across all the teams and therefore make changes and review any processes that could improve. This is another opportunity for concerns to be escalated upwards.

Since June 2023, the NHS 111 option 2 service has been introduced. This service is accessible for the general public, professionals, and agencies, on a 24/7 basis relating to individuals in mental health crisis or for any urgent support. Calls to this service are answered by Mental Health Professionals, who will assess the call to triage and ensure the appropriate support, response and intervention is provided.

Concern 2

The decision not to discuss discharge with the care co-ordinator was not identified by the internal investigation undertaken by SBUHB, rather the investigation found 'there is evidence of regular and effective communication between support staff, community staff and hospital staff.'

This raises a concern that critical lessons have not been identified and learnt by SBUHB from Jean's death about the importance of including care co-ordinators and professions in the community before a decision is taken to discharge a patient from Ward F. This creates a continuing risk to life as it may lead to risk being ignored or not properly considered by Ward F.

Swansea Bay University Health Board Response:

The Health Board recognises that through this case, the coroner has identified additional learning for the Mental Health services that was not identified in the original Serious Incident Review and is grateful to the coroner for this. Following the inquest, a debrief session was convened to consider the coroners concerns and the required actions that were to be taken, noting that some actions had been implemented prior to the inquest hearing addressing the identified risk to life as outlined in concern 1. In addition to these, the Medical Director and Nurse Director for MH&LD have issued formal correspondence to all clinical areas and teams, reaffirming adherence to Section 3.4: Discharge and Discharge Planning of the Acute Adult Mental Health Inpatient Wards Operational Policy and the Pre-Discharge Planning Checklist and the patient/relative receives the "Moving on" information leaflet.

This formal correspondence will also be cascaded through the relevant forums throughout May 2025, such as Ward/Team manager meetings and consultant forums.

In relation to the Serious Incident Review Process, the MH&LD team is continually working towards improving this and in August 2024 a review was commissioned by the MH&LD Nurse Director, requesting that Professor Jason Davies: (RDIIAL Hub Director and Consultant Forensic and Clinical Psychologist)

Undertake a review of the purpose and processes related to the SIG (Serious Incident Group) functions and to make recommendations to Serious Incident Group and MHLD: Quality and Safety Committee detailing effective practice and potential changes to process.

This report was finalised and reported back to MH&LD Quality and Safety Committee in October 2024 with key recommendations which the Service Group are embedding.

One of these recommendations was around the processes of Serious Incident Strategy Meetings. A Strategy Meeting is held following some fact finding and established contacts with the service, and is chaired by the MHLD Nurse Director or one of the four Heads of Nursing. The chair acts as the commissioner for the review, ensuring any immediate actions are identified and carried out; identifies the scope of the review and terms of reference. There has been a focus on ensuring that this process includes the identification of questions and key lines of enquiry which are set out for the investigators. An emphasis has also been placed on the involvement of families, clinical advisors and identification of relevant policies and guidance related to the case. This meeting would identify cases where externality is required for the review, for example inpatient deaths are reviewed by HB SI investigators and cases where the chair has identified the need to request a reviewer from a neighbouring HB.

A further change has been implemented in the development of a two-stage process for sign off and approval of the learning and findings identified in Serious Incident Review Reports. The initial stage is for a focused group of senior clinicians to scrutinise and critique the outcome report to ensure that it meets the scope, terms of reference and areas of review as commissioned within

the strategy meeting. It also acts as a panel to ensure that the review has been thorough and whether there are any further areas that require exploration prior to it being signed off.

The second stage is a forum to share the findings and learning, identifying improvements and actions required, identifying leads for the improvement plan with a timeframe for return. This stage will support a wider cascade of learning and implementation of improvements. This second stage is currently being implemented with the first SIRL (Serious Incident Review Learning) meeting planned for May 2025. This will be evaluated as part of the ongoing SIG Review facilitated by RDIIAL and Prof Davies, and a will be set following the 6th SIRL Meeting in November 2025.

A series of learning events have been arranged in the Service Group through RDIIAL. RDIIAL (Research, Development, Innovation, Improvement, Audit & Learning) is known as the learning hub and reports into the MH&LD Quality & Safety Committee.

There was a learning event held on 20th September 2024, presenting shared learning from an inquest case and thematic links. Further learning events are planned for 6th May 2025 on implementation, monitoring and sustaining action/improvement plans, 19th May 2025 on Risk planning and safety, relating to policy and process and 9th July 2025 on collaboration, co-production, and family involvement with a particular focus on safety planning.

In line with the above review, further training has been provided to the Serious Incident Investigators within MH&LD Service Group. The Health Board Serious Incident Investigators received training from Consequence UK, an organisation which provides training on techniques and processes to increase the effectiveness of Serious Incident reviews. Following this, training on process mapping in particular, was cascaded to the MH&LD Serious Incident investigator team (October 2024) in line with this. This way of reviewing, aids the investigator to break down policy and procedures into step-by-step guidance, which in turn can be used by the investigator to map and measure the care provided. This allows the incident investigators to make more accurate analysis of the clinical input against the specified clinical processes and guidance. As with the change in process for strategy meetings, the Service Group are in a transition period regards the investigation methodology and will be monitoring and reviewing the process. To support this the team are implementing regular team meetings to reflect on the review process, identify themes in the learning and reflect on feedback on the reports.

Yours sincerely,

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Chief Executive Officer