

Mr R. Guy Davies
Assistant Coroner
Cornwall and the Isles of Scilly
The New Lodge
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Chief Officer
Sedgemoor Centre
Priory Road
St Austell
PL25 5AS

Tuesday 12th June 2018

Dear Mr Davies,

Thank you for your regulation 28 report to prevent future deaths pertaining to Miriam Roach.

In your report you identify two matters of concern and the action to be taken by NHS Kernow Clinical Commissioning Group (NHSK) as commissioners of mental health services as follows;

A review of the aftercare or transition arrangements for those discharged from hospital to home with a moderate to high risk of self-harm and/or suicide following incidents of self-harm or suicide, including a review of the obligations for putting in place contact plans for such patients.

Please find below NHS Kernow Clinical Commissioning group's response to this action;

A number of service areas are currently subject to transformation and enhancement. These areas include Psychiatric Liaison services working from the Royal Cornwall Hospital Trust (RCHT), transforming from its current hours of service of 08:00 to 22:00 to a 24 hour, 7 day a week service responding to people with a range of complex needs and will be compliant with the required national standard by 31st March 2019, in advance of the NHSE target date of 2020/21.

In addition NHS Kernow and Cornwall Foundation Trust (CFT) have agreed to commence a formalised process to review a number of service specifications which will prioritise those currently subject to transformation. The review of aftercare and transition arrangements as you requested will be addressed within this as related to the delivery of more than one service. This action will be led by the Mental Health commissioning team.

This action will commence over the summer and will be expected to be completed by December 2018. CFT's progress will be reported monthly via the integrated assurance meeting hosted by NHS Kernow CCG with overall assurance reported to NHS Kernow CCG's Quality and Performance Committee.

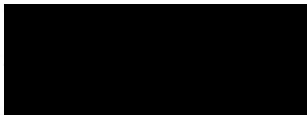
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NHS Kernow recognises the value of sharing the learning from serious incidents to the wider health community. The quality team will share the learning and associated actions related to this incident with our partners in Devon, Somerset and Dorset via our Community of Practice and with NHS England and NHS Improvement through our Quality Network.

If you require any further information or I can be of any further assistance please do not hesitate to contact me.

Yours sincerely,


Chief Officer