Sheffield Teaching Hospitals
NHS Foundation Trust

Chief Executive's Office
Clocktower
Northern General Hospital
Herries Road
SHEFFIELD
S5 7AU

[redacted]

30 June 2021

Ms Coombs
Office of H.M Coroner
The Medico-Legal Centre
Watery Street
Sheffield
S3 7ES

Dear Ms Coombs

Prevention of Future Deaths Report – Laura Booth

I write to formally respond to your Prevention of Future Deaths (PFD) Report dated 5 May 2021, following the very sad death of Laura Booth. I wanted to say at the outset how saddened I am by Laura's death and how sincerely sorry I am for the additional distress and upset the outstanding concerns you outline in your report have no doubt caused her parents. I truly hope that we can learn from this case and take actions to ensure as far as is possible that nothing similar happens again.

Firstly, I would like to thank you for acknowledging the progress we have made with regard to our nutrition services in response to this sad case.

I fully appreciate your concerns with regard to the knowledge and application of the requirements of the Mental Capacity Act (MCA) by the Trust's clinicians, including; the understanding of best interest discussions; the need to engage the patient, family and carers in these discussions; and the need to fully document each and every time they occur. We acknowledge the lack of understanding by some of our staff with regard to the importance of Laura's Health Passport, which, if it had been utilised correctly, would have ensured all staff understood her communication style, thereby supporting consistent involvement in decision-making.

Over the past few years the Trust has undertaken a wide range of actions to embed the requirements of the Mental Capacity Act (MCA) and ensure that there is proactive support for learning disability patients, and other patient groups who may lack full capacity. Prior to the Inquest into Laura's death, we had started to give this area of work greater emphasis and the conclusions that you reached give further weight to the importance of this work, which includes:

- The development and delivery of training, which, as detailed later in this letter has now been strengthened to ensure all front-line clinical staff have the required knowledge.
- A range of resources for staff which are easily accessible via the Trust's intranet site. These include clear and comprehensive guidance on the principles of the MCA, resources for raising staff awareness and contact details so that staff can access specialist support.

agreed to ensure the appropriate dissemination of information relating to MCA across relevant staff groups, in order to raise awareness.

In order to assess the impact of this training, the following measures have been put in place and are on-going:

- The current post-training evaluation will be replaced with a process of pre- and post-training assessment of learning to demonstrate increased knowledge.
- A programme of MCA/Best Interests audits commenced in June 2021, to examine the application of legislation in practice and to measure improvements post training. Clinical areas where poor compliance is identified will receive targeted training.
- Complaints will be analysed to identify any concerns relating to the application of MCA, which will be fed into the MCA steering group for action and into MCA staff training, where appropriate.

This training and the supporting resources will be further developed following the introduction of the Liberty Protection Safeguards in April 2022. The Trust has funded and is recruiting to a specialist team to support the implementation of this new process, which will further embed MCA processes and awareness across the organisation.

What action the Trust will take to ensure that senior clinicians are familiar with the provisions of the Mental Capacity Action and any subsequent legislation developed with the same aims and objectives and make this business as usual for those individuals and the junior doctors they supervise.

In addition to the mandatory training described above, additional training including workshops and master classes such as Assessing Mental Capacity are already available and bespoke training can be arranged, tailored to specific teams e.g. training on MCA/DoLS has recently been arranged with the senior clinical staff from Infectious Diseases, at their request.

We are committed to rolling out this more advanced training to all senior decision makers. This will initially be targeted at Clinical Directors who will then be tasked with deciding how best to deliver this within their directorates, which cover a wide variety of services. This approach will enable us to ensure training is tailored to the intended audience and that uptake is high. The progress of this advanced training will be monitored by the Mental Health Steering Group to ensure that all appropriate staff groups receive this training.

I also understand that you have kindly offered to deliver training and that you are meeting with Dr [redacted] Deputy Medical Director to discuss the format of this training.

In addition, in order to ensure that we recruit staff with the appropriate skills and knowledge, questions relating to the understanding of the MCA and DoLS are being made available for use in interviews for senior clinicians.

How individuals who lack capacity will be supported to influence decisions about their own care as much as possible.

The need to ensure individuals who lack capacity are supported to influence decisions about their own care is explicit within the training described above, and is reflected in Trust documentation available for staff, including Best Interests Checklist and Best Interests Decision Record. These documents act as an aide memoire to guide staff through the best interests process and their use in practice is emphasised through the training process.

Resources to support patients with communication needs, such as the communication booklet, are available via the intranet and these, along with the Health Passport support staff to identify and respond to the communication needs of patients with a learning disability. In addition,

communication booklets have been given to each ward; further work is being undertaken to check that hard copies of the booklet are available in all areas and promote its use. The work to promote the use of the Health Passport is described in more detail later.

Reassuringly, in a recent survey of learning disability service users, run by the NHS Benchmarking Network, 84.2% of respondents felt staff explained things in a way they could understand (compared with 81.0% nationally) and 90.5% felt listened to (compared with 83.0% nationally).

How families are brought into these discussions where patients cannot make decisions for themselves and what measures are in/being brought into place to ensure that there is a clear audit trail of the thoughts and feelings of families and relatives.

The involvement of families is also reflected in the Best Interests Checklist and Best Interests Decision record, described above and there is clear guidance for staff about who must, where practicable, be included in consultation when deciding on best interests.

The importance of including family/advocates in decision making will continue to be made explicit in MCA training and the impact of this will be assessed, as described previously, through pre- and post-training evaluation of knowledge and audit of application in practice.

In the recent survey of learning disability service users, 94.4% of respondents felt staff listened to their family's views (compared with 81.4% nationally).

What measures will be taken to ensure continuous compliance to both the practical application of the statutory regime as well as individual understanding of it.

As described previously, a programme of MCA/Best Interests audits commenced in June, to examine the application and recording of the MCA and Best Interests decision making process following the principles outlined in the MCA Code of Practice. The audit will include reviewing evidence of patient, family and/or advocate involvement and the use of the Health Passport. The results, which will be available in October 2021, will be used to identify clinical areas within the Trust requiring additional training and support.

Any breaches in lawful practice should be reported as an incident on Datix, by any member of staff. All such incidents are reviewed by the Specialist Advisor - MCA and DoL Safeguards and in future thematic analysis of these incidents will be reported to the MCA Steering group to identify opportunities for learning or areas which require additional support.

In addition, the planned processes for pre- and post-training assessment of learning will assess staff knowledge of the principles and processes.

What measures the Trust have in place to ensure that staff are aware of hospital passports and the contents of those and how they can seek advice and support if they do not understand or cannot locate a passport which should be available to them.

The current Health Passport was updated and agreed by a task and finish group of the Sheffield Adult Safeguarding Partnership, and agreed with Mencap, in 2019. The front page of the Health Passport prompts professionals to gain consent to treat or to act in the person's best interests. In addition, the 'All About Me' booklet (developed by the Alzheimer's Society) is available to support the identification of communication needs for dementia patients and this has been disseminated via the Dementia Steering Group.

Awareness of the Passport has been raised during the annual city-wide Safeguarding Awareness Weeks and Transition events. However, a recent audit by Sheffield Health and Social Care Trust showed that less than 50% of people on the case register had a Passport and they are now

working to increase this. In addition, a spot check in the hospital suggested that of those who did have a Passport, more than half had not brought it to hospital with them.

The Health Passport will be re-launched, along with the 'All About Me' and Hospital Communication Booklets as part of the MCA communication strategy. The communications will aim to raise awareness of the Passport and encourage staff to ask relevant patients if they have a Passport; if they do, staff should ensure that this is visible and accessible and if they do not, staff should advise the patient/carer to ask their provider to fill it in with them. As part of the re-launch staff will be advised to photocopy the Health Passport and give the original back to the patient (so it does not get mislaid), then ask the patient for permission to put the Passport in a visible place so that it is accessible to all staff who come into contact with the patient.

To support these communications, the Learning Disability Intranet Site will be updated to ensure clear visibility and accessibility of the Health Passport. In addition, the Transition Team will promote the use of the Health Passport when supporting young people to transition to adult services.

As part of the proposed programme of audits there will be a specific focus on learning disabilities, through a review of care of a sample of patients known to have a Learning Disability. This audit will include specific criteria to identify if the records reference a Health Passport or if the patient was asked if they had a Health Passport.

In addition to these specific actions, you also highlighted concerns about the fact that the verification of death form records Laura's death as being expected, when this was not reflected in the views expressed by the staff caring for her. As requested, Dr [redacted], Clinical Lead for Infectious Diseases, has reviewed the verification of death process in this case and I attach a copy of his report for your information. Dr [redacted] notes that, whilst at the start of Laura's admission her death was not expected, this picture changed during her stay. On the last day of her life, Laura had a respiratory arrest from which she was successfully resuscitated, after which the decision was collectively made between the clinicians and Laura's parents to move to best supportive care and not pursue further active treatment, escalation or resuscitation attempts. In this context, the death was expected and therefore Dr [redacted] has concluded that the documentation was accurate.

Having outlined the actions we are taking in response to your report, I hope that I have been able to convey how seriously we have viewed this matter. We are absolutely committed to learning from Laura's death and implementing these actions.

Finally, I hope that my response has addressed the concerns and actions you identified in your Report. Please contact me if you have any queries or points of clarification.

Yours sincerely

[redacted]

Chief Executive

Encs.