Norfolk and Suffolk
NHS Foundation Trust

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Hellesdon Hospital
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Ms Jacqueline Lake
Norfolk Coroner's Service
County Hall
Martineau Lane
Norwich
NR1 2DH

11th October 2022

Dear Ms Lake

Regulation 28 notification made in response to the death of Eliot Harris.

I write to you in respect of Eliot Harris who died in April 2020 and who's inquest was heard in the Summer this year by you. Firstly, however please accept my sincere apologies for this delayed response to the concerns raised by you post the conclusion of the inquest in August 2022.

In recognising that this response will be shared with Eliot's family, I would like to take this opportunity to apologise wholeheartedly to Eliot's family for the tragic loss of Eliot whilst under our care as an inpatient.

The concerns you raised are outlined below with our trust response to each point:

1) Substantial evidence was heard at the inquest with regard to observations which were not carried out in respect of Eliot Harris in accordance with NSFT's Policy and with regard to staff not undergoing training and assessment of their competency to carry out observations correctly. Quality audits undertaken following Eliot Harris's death, show that observations are still not being carried out and recorded in accordance with NSFT's most recent policy – more than two years following Eliot's death. Not all staff have completed training with regard to carrying out of observations or have undergone and assessment of their competency to carry out observations.

Therapeutic Observations are an intervention that supports safety. They are also a restrictive intervention thereby requiring clarity of understanding, training, clear team processes and strong individual accountability in order to support safety and dignity. You heard at the inquest the work the Trust has taken following Eliot's death observing that the processes of training and competency on the ward, and the application of observations required further improvement.

Locally, within Great Yarmouth Acute Service the team have implemented a Safety Day, which is training specifically developed for the ward and includes sessions on clinical risk assessment, care planning, learning from incidents with a detailed focus on therapeutic observations policy. To date, 19 of the 27 staff have attended the day with two further days planned. In addition, the Matron is leading on refreshing staffs understanding of the therapeutic observation policy by re-completion of the competency assessment.

Learning from the inquest has been shared with the ward team which has included the vital importance of completing therapeutic observations in line with the policy. The learning will be further shared within a Registered Nurses Day scheduled for November.

The goal of improving the application of therapeutic observations is important with a continuing improvement and monitoring focus. Training and audits form parts of the system to manage the safety and quality. The Trust is commencing a planned review of the Therapeutic Observations Policy, examining options to strengthen all areas including training, documentation, ward controls, guidance for staff and assurance processes. In addition, the ward has reviewed and significantly enhanced their local induction process which is overseen by the Clinical Team Leader.

2) On the night of Eliot's death, a Nurse in Charge had not been allocated and members of staff were not allocated specific tasks – they were told to "muck in", as a result there was some confusion as to who was responsible for specific jobs. The evidence at the inquest was not clear as to whether specific tasks are allocated to specific members of staff on Night Duty and whether and how a Nurse in Charge is appointed for each night's rota.

Clarity of role within a shift is important to ensure all the required actions are completed in an effective way. The ward has improved their processes which now ensures the nurse in charge is identified and roles allocated to the shift team members. To achieve this, the daily allocation form has been reviewed which clearly identifies the nurse in charge. In addition, the Matron oversees the off duty rota and delegates nurse-in-charge duties each shift. This is monitored by the Clinical Team Leader and Modern Matron. Additional to this aspect the trust is formulating a seminar on shift co-ordination and accountability this will be rolled out to all Charge Nurses including those joining from an agency, the timescale for sign off of this is three months.

3) Multi Team Meetings were not fully and properly recorded in the clinical records. At the inquest, evidence was heard there "is still some way to go" with regard to improving record keeping and for ensuring important matters such as rationale for decisions is fully recorded.

Comprehensive recording of the Multi-Disciplinary Team (MDT) meeting is essential as this supports high quality effective care. Record keeping is an essential action to support the evidence of care provided. The ward has developed an aide memoire to guide staff as to the areas to be considered as part of the MDT review. This serves as a Terms of Reference for the meeting in order to improve the comprehensiveness of record keeping. In addition, the MDT hold a daily brief review of each patient which is recorded in the patient's records. An audit of the quality of MDT meetings was completed in August by the Nurse Consultant which demonstrated sustained improvement. An anonymised copy of the audit is attached. The changes are being monitored on a monthly basis with results fed back to the team by the Nurse Consultant.

The ward has a new dedicated substantive Consultant Psychiatrist commencing in mid-October 2022.

4) Eliot's Care Plan was not up to date at the time of his death. At the inquest evidence was heard that although audits show there has been an improvement in completion of Care Plans, there "is still some way to go" and staff still need to be prompted to complete these.

Care plans provide details of the agreed interventions between the patient, family and team to support an individual's recovery. Alongside other clinical documents, they assist the staff in their communication of the assessed needs of the individual, and the actions being taken. In November 2021, The Trust started the process of implementing a new style of care plan referred to as Dialog +. This care plan is recovery focused and is designed to work with the patient to understand the areas of their life which are important to them which they wish to improve. As part of the implementation within the ward, a training session was held within the Safety Day and the team awayday which were further supported by individual sessions with staff when required.

As an individual's care and treatment progresses, the ward employs a process to support the completion and revisions to of care plans as an individual's care and treatment progresses. This includes strengthening the wards systems through the allocation of primary nursing responsibilities and the use of audit to monitor required improvements. The provides feedback Clinical Team Leader leads the review of care plans and other clinical documentation as part of management supervision, all of which will enable further improvements. The care plans are used alongside the multi-disciplinary team meetings and handovers to support communication of care amongst the team

5) Staff were reluctant to enter Eliot's room following concern for his wellbeing. The evidence did not reveal what is now in place to ensure staff enter a patient's room immediately if there are concerns for a patient's welfare (having considered their (staff's) own safety).

Supporting people, during times of risk and harm, as soon as it is safe to do so is important part of providing good care. Through our physical interventions training we promote consideration of safety, accompanied with message to seek support. Alongside this consideration of safety, human factors can influence people's thinking when experiencing unfamiliar or intense situations. We are therefore seeking insights from other mental health Trusts as to any actions and programmes that they apply. In addition, the Safety Day includes a session on the Therapeutic Observation policy which includes a discussion on entering a room when there are immediate concerns for the patient's welfare and how seek help if there are potential concerns for their own safety. This message has been strengthened within the Therapeutic Observations ' Policy on a Page'

To enable easy access to the key clinical policies, the ward has implemented a Safety Folder, which is prominently displayed on a wall within the ward office and contains brief summary of each policy.

6) It is not clear from the evidence what is now in place to ensure that relevant and requested physical health checks are carried out. The process of ensuring health checks are carried out has not changed since Eliot's death and remains a retrospective process.

Physical health is a priority in caring for people during an admission to hospital. For many vulnerable people, admission to hospital is an opportunity for an assessment of their physical health enabling the Trust's clinical teams to link the individual with primary care (GP) or specialist assessment and support.

To meet this priority the Trust has a Physical Health Policy which provides guidance for staff on the practical actions to take in completing an initial physical health assessment. Understandably, an admission to hospital is an intensive, worrying time for people and they may not be able to initially engage in the assessment. The policy directs action of follow up attempts to complete this. The ward had made changes following Eliot's death applying this through their handover and diary systems which support keeping an action open until completed.

The ward has implemented a revised physical health audit which is completed monthly. The audit is completed for all patients admitted to the ward with the results shared with the medical, nursing, Clinical Team Leader and Matron. The dedicated physical health nurse on the ward has improved staff training who can now complete ECGs and phlebotomy.

I would like to thank you for taking the time to raise these issues. I hope that I have given you assurance of our commitment to improve the quality of care received by all our service users with particular attention given this case to those who find themselves in unusual and very specifically stressful situations.

Yours sincerely

Chief Executive Officer