Nottinghamshire Healthcare
NHS Foundation Trust

Chief Executive's Office
The Resource
Duncan Macmillan House
Porchester Road
Nottingham
NG3 6AA

2 June 2023

Private and Confidential

Dr Didcock
HM Assistant Coroner for Nottingham and Nottinghamshire
Nottinghamshire Coroner's Office
The Council House
Old Market Square
Nottingham
NG1 2DT

Dear Dr Didcock,

Please find below the organisational response to the recently received Preventing Future Deaths Report, following the unfortunate death of Mr Thomas Jayamaha.

The Matters of Concern raised within the report:

1. **<u>Delayed progress of the Autism Strategy work across the Trust.</u> I ask that the Nottingham and Nottinghamshire Integrated Care Board provide a joint response with the Trust to address this concern, as I accept progress with the Autism work will depend upon resources and the agreed Commissioning of specific services.**

The Trust and the ICB have worked in partnership to produce an action plan (Appendix 1) outlining the implementation of key components of the autism strategy and implementation plan including flagging and identification, reasonable adjustments, peer support, care planning and workforce. The

ICB and Trust will work together, with wider system partners to support improvement ambitions set out in the response.

2. Insufficient progress with Complex Case Management.

Mr. Thomas Jayamaha was referred to the Trusts' Local Mental Health Teams (LMHTs), on multiple occasions, however the complexity of his case was not appropriately identified, and the cumulative effect of multiple referrals did not prompt sufficient enquiry by the team.

To safeguard against this in the future a clinician-led triage assessment is being rolled out in a staged manner across the teams (as part of our Transformation Programme). In addition, a Monday – Friday, Daily Triage Meeting attended by leads from multiple teams within the Directorate, is also being introduced across all Adult Mental Health (AMH), Local Mental Health Teams (LMHTs).

The roll out of the LMHT transformation programme has been staged over a three-year period, with Triage Assessments rolled out across that time, but with Triage Meetings rolled out in Year 3. Year 1 (21/22) focused on the Mid Notts teams, where the triage assessment process is now complete. Year 2 (22/23) has focused on the South County Teams, where the triage assessment process is now also complete. Year 3 (23/24) is the City Teams, where the process of introducing the triage assessment is currently ongoing, in line with the planned activity.

Triage Assessment

This is a different way of managing referrals from the traditional booking system. When referrals are received by the team the patient is telephoned within 1 working day to make a triage assessment of their needs, to signpost or refer to alternative services if appropriate or to ascertain appropriate priority level if a full assessment is required.

It also affords an opportunity to explain what the service has to offer and expected waiting times. Once the telephone triage has taken place, if next steps are clear and agreed with the patient, this is actioned on the day. Alternatively, if less clear and there is a level of complexity, this will be fed back within the LMHT MDT either on the same day, or the next day, and a decision made about next steps.

To support this process, a triage form (see Appendix 2) has been developed and was launched in RiO in June 2022. This form enables the conversation with the patient to be recorded directly into RiO using the SBARD approach (Situation, Background, Assessment, Risk/Recommendations, Decision). The form will then be generated into a letter template so that the outcome of the discussion will be shared with the patient and referrer as a care plan, rather than needing to type a separate letter. The form also prompts the triage worker to explore with the patient who their support networks are both personal and professional, who they would like us to contact and if the patient has any additional support/communication needs to strengthen engagement with services.

Following a review of the form earlier this year, several changes were made. The form now captures why a contact with a patient has not been able to take place, some examples of this may include:

patient has not answered the phone or incorrect contact details were provided by the referrer (further reasons listed in the triage tool). This is to help us understand what the main challenges are to engaging with patients at this stage and then support further developments to reduce some of these barriers. Where an internal referral has been made from another service within Nottinghamshire Healthcare NHS Foundation Trust, a telephone triage may not always be required, however all external referrals should receive a triage call. Where it has not been possible to contact the patient after two attempts, the team should revert back to making a decision based on the written information provided by the referrer and, if further information is required, should involve a discussion with the referrer to support decision making regarding next steps for referral. This is to ensure that decisions relating to referrals are made in a timely manner so that patients can receive the support they need in an appropriate timeframe.

Once the triage tool has been completed by the triage worker, the tool can be downloaded into a care plan letter that can then be sent out to the patient and referrer, so they have a copy of the discussion and agreed plan. Another amendment to the form was the addition of the Mental Health Crisis Line number on the letter, should the patient need additional support at any time.

The Trust acknowledges it is important to be reassured that this new process is being adhered to consistently within the relevant LMHTs. As the form sits within the RIO system, compliance can be easily established through the use of audits. Not only does the audit establish whether a form has been completed for each referral, but in cases where it has not, a reason code needs to have been recorded, which provides additional detail and data to review.

Triage assessment progress in City LMHTs

The planning phase of implementing the triage assessment process was due to begin from April 2023 onwards. However, the city teams have reflected on and responded to the positive feedback from the other teams and have begun to pilot triage earlier than was initially planned. Progress has been varied across the four city teams as follows:

LMHT City South

City South are conducting the full triage assessment process as described above. This has been the case since January 2023.

LMHT City Central

City Central are conducting the full triage assessment process as described above. This has been the case since March 2023.

LMHT City North

City North began the new triage process but had to put his on hold due to a number of staff vacancies. The team are now working with the Transformation Team to implement this, anticipating full roll out by the end of quarter 2, 2023. This is currently in the planning phase.

LMHT City East

City East did implement the triage process in January 2023 and were finding benefit from this but have also currently had to put this on hold due to the impact on the team of vacancies and absence. The team is also working with the Transformation Team to implement by the end of quarter 2. This is currently in the planning phase.

Daily Triage Meeting

The next phase of the triage process is to establish a wider Daily Triage Meeting. The daily triage meeting remit will be for new referrals into service. The aim of the meeting is to provide support to the triage workers around decision making on next steps where there is a level of complexity, and next steps are not as clear. This will ensure the patient receives care from the right professional on the right pathway for them, and their referral into services is managed in a seamless and efficient way. The MDT approach will also support a 'no wrong door' approach to the patient experience, reducing barriers and thresholds when accessing the best pathway for their needs.

Key Objectives

- The aim of the meeting is to support decision making around patient pathways following the triage call.
- The triage worker will use the MDT forum to support decision making where the case appears more complex and/or they require more guidance regarding next steps.
- The MDT will help identify and agree the most appropriate pathway and ensure patients are not being passed around services or coming up against complicated thresholds to accessing services.
- The meeting will provide support to the triage workers each day.
- This will enable a daily MDT forum without making it resource heavy for each team.
- Each team will take it in turns to provide the MDT representation. So, for example a psychology representative will attend each day, but for each team the psychologist would only be attending once a week. This would work the same way for the other professions supporting the MDT make up.
- Each specialism in the meeting will provide a representative for all patients discussed rather than just their own team.
- It will enable wider teams/services to attend such as, Step 4 Psychology, Personality Disorder Pathway workers, Early Intervention in Psychosis colleagues, Substance Misuse Colleagues (SMS).
- Each day a rotating member of the MDT will take it in turns to chair the meeting. Their role will not be to make the final decision but to ensure time keeping, facilitating the MDT to contribute to the discussion and ensure actions are agreed and allocated for each patient discussed. The triage workers will not need to take the chairing role.
- All decisions/actions made within the meeting will be documented in RiO and action sheet completed.
- This removes the need for written internal referrals/meetings
- Supports recommendations following Coroner's Inquest

The process has been piloted within our Mid Notts teams in 2022, and logistic and practical amendments have been made. The meeting is currently due to be fully instigated in the Mid Notts team by the end of quarter 2, 2023, with roll out across all LMHT's by the end of quarter 4

The Terms of Reference are attached as Appendix 3 for a more in-depth description of the process.

3. **<u>The Serious Incident Investigation process.</u>**
   The last issue I identify as a risk for the future is the quality, and quality assurance, of Trust Investigations. If a review is limited in scope and does not consider previous Serious Incident Investigation reports, and does not produce robust learning, as in this case, there is a continuing risk that similar issues will occur again.

As an organisation we understand the importance of the investigation of Serious Incidents and ensuring that the investigation undertaken is both detailed and robust and provides every opportunity to establish learning to prevent recurrence. In this case our investigation fell below the standard we would have expected and for that we would unreservedly apologise for the distress and disruption caused as part of your coronial process.

The learning from the outcome of this preventing future deaths report will be shared as part of on-going training provided to staff undertaking serious incident investigations and those involved within the approval process of investigations.

<u>Incident Investigation Training:</u>
We continue to work with external partners to ensure that staff undertaking serious incident investigations are trained and knowledgeable in investigation techniques. We will continue in our commitment to providing a 2-day training event for investigators based on a “Systems Based Approach” (SBA). This approach is advocated by the Patient Safety Incident Response Framework (PSIRF) which will be implemented within NHS Organisations during the autumn of 2023. The role of SBA is to identify the systems-based problems when an incident occurs, rather than focusing on the individuals involved. Our aim is to train 100 investigators year on year.

We have recognised that whilst the centralised investigation team gives us a consistent approach to investigations, the volume of investigations means we must utilise operational staff as part of the overall investigation process, hence the provision of incident investigation training. However, in training these people we also need to ensure we continue to eliminate variation, so to assist with this we have put in place support and mentoring which will be provided through the dedicated centralised investigation team. We have established monthly drop-in meetings (via MS Teams) to enable staff with on-going investigations have access to both advice and supervision support to assist with their investigative responsibilities.

<u>Investigation Terms of Reference</u>:
For each serious incident investigation, clear and specific terms of reference are drafted and shared with the divisions for comment at draft level before final sign off. They assist with the scope of the investigation and carefully balance ensuring that investigators are clear of the investigation requirements and expectations, and that they are directed to any specific areas to be considered, without being too prescriptive which could risk restricting the panel / investigator in their review.

When completed, terms of reference are signed off as follows:

- Concise level terms of reference are signed off within the Division concerned by either Head of Nursing or Associate Director of Nursing
- Comprehensive level terms of reference are signed off at Executive Director level

Quality Assurance of Investigation Reports:
We also recognised that we needed to strengthen our overall review of our investigation reports and ensure those individuals who are approving/authorising the final report have the skills to critically appraise the report and ensure it is fit for purpose.

Whilst historically we have facilitated a one-off session to assist managers with the quality assurance process, we have now looked to extend our training offer. Therefore, working with our training providers, we have commissioned a series of Serious Incident Quality Assurance training events during 2023/2024.
The course will provide the attendees with skills to critically assess the investigation report and ensure it concentrates on Systems Based outcomes and SMART actions. Our aim is to train at least 50 people each year. The purpose of this training is to provide senior individuals who have responsibility for approving reports with the skills to analyse the report, ensure fairness, that systems-based learning has been applied and that the report and findings reflect the agreed terms of reference and any questions raised by the patient or family. The Trust recognises the need to consider neurodiversity when undertaking investigations. Guidance has now been developed to support investigators to consider individual need, reasonable adjustments, access to learning development and consultation forums

Family Liaison Team:
As a Trust we also recognise the valuable part that families play within the investigation process. With the establishment of our Family Liaison Team during mid 2022 it has enabled us to take the opportunity to significantly improve the communication and interaction we have with families and patients when an incident occurs, and more particularly a serious incident.

The Family Liaison Team will therefore play an important part in ensuring we improve the quality and inclusivity of the serious incident investigation process for families. Family Liaison will also be involved in the serious incident investigation and quality assurance training.

Divisional/Directorate response:
The Adult Mental Health Directorate of Nottinghamshire Healthcare Trust have in the past 12 months reviewed their clinical governance processes and employed a new Clinical Governance Team. This includes a Serious Incident and Complaints Lead. This band 7 clinician's focus is on supporting investigators with serious incident investigations and ensuring that the quality of the report is to the highest standard. A new process has now also been developed that ensures all serious incident reports within the directorate are reviewed by the appropriate Operational Manager that is responsible for the team or individual that was involved in the care of the patient that is deceased. The Operational Manager reviews the report and often meets with the investigator to ensure all elements are the report are factual and the investigation covers all appropriate issues. Recommendations are also discussed and based on this, quality improvement plans are developed and implemented.

I hope the information above provides the assurance that we have and continue to consider your recommendations seriously, and that we are actively seeking to improve the services we provide by implementing the actions outlined.

Yours sincerely

[redacted]

[redacted]
Chief Executive

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