NHS
Birmingham
Community Healthcare
NHS Foundation Trust

[redacted]

25 July 2023

Private & Confidential
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Dear Ms Ollivere

REGULATION 28 REPORT TO PREVENT FUTURE DEATHS
INQUEST: CAROL ANN CLEMENTS (DECEASED)

Thank you for your Regulation 28 Report to Prevent Future Deaths dated 30 May 2023. May I take this opportunity at the outset to express my condolences to the family of the late Carol Ann Clements. I was sorry to hear about the fall that was experienced by Mrs Clements in one of our in-patient facilities.

Following receipt of the Regulation 28 Report, the Trust held a Round Table Meeting chaired by the Trust's Chief of Nursing and Therapies to review the matters of concern you have raised. At the meeting, key stakeholders from both divisional and corporate services reflected deeply on the matters of concern, how these could be addressed, how improved care could be delivered across our inpatient services and how any potential barriers to this might be addressed.

An in-depth action plan has been created around improvement to our falls assessment training, our enhanced supervision training, and how we audit falls risk assessments, led by the Divisional Director of Nursing and Therapies for the Adult & Specialist Rehabilitation (A&SR) Division. This will set out both the Trust wide and divisional actions required to address your concerns, along with agreed action owners and timescales for delivery. This action plan will be submitted to the Chief of Nursing and Therapies for approval by 25 July 2023.

Once approved, the delivery of the action plan will be monitored monthly via the Adults & Specialist Rehabilitation Inpatient Quality & Safety Committee and the Adults &Specialist Rehabilitation Divisional Quality & Safety Board, with any required escalations going to the Trust's Quality & Safety Executive and the Trust-wide Falls Prevention Strategy Group chaired by the Trust's Director of Therapies and Chief Allied Health Professional.

In terms of the Matters of Concern:

1. "*Enhanced Supervision Levels training is not included on mandatory training programmes.*

   Whilst some training sessions have been delivered by the trust to current staff members following this incident, I am concerned that new staff members joining will not be suitably trained in this area."

   Mandatory training is Trust-wide and covers general training required by all staff, whereas Essential to Role training is focused on the specific training required by each member of staff in the roles which they perform.

   The Adult & Specialist Rehabilitation Division, which covers Perry Trees Centre, already had some Enhanced Supervision training but it has now been deemed as Essential to Role and added to the Division's Training Needs Analysis (TNA).

   The Division will hold an Essential to Role training week which will follow the new starter's Induction week. The aim is for all new starters to complete the Essential to Role training week within 2 months of commencing in post. Falls training, including Enhanced Supervision training will be incorporated into this programme. The division are also undertaking a review of how we robustly oversee competency with all existing staff.

2. "*Falls risk assessment training is on the essential role training programme, however, I am concerned that this area is not covered suitably on induction of staff to the [Perry Trees] centre. This leaves a gap, particularly with agency staff, and I am not satisfied that with the current processes, agency staff will be fully versed on the completion of these risk assessments*."

   The division have developed a wider Divisional Falls Action Plan and will place the Essential to Role falls risk assessment training onto the divisional mandatory training tracker to enable compliance monitoring.

   Each ward has a local induction checklist for temporary staff (bank and agency) who have not worked on the ward previously. The Lead Matron has reviewed the induction checklist to ensure that essential elements of Falls Risk Assessments and Falls Prevention are included. Auditing of this checklist will be the responsibility of each Matron and discussed as part of the Inpatients Quality Review meeting.

The Trust will be working with National Health Service Professionals (NHSP) to provide a greater number of bank workers, which will reduce our dependency on agency workers. NHSP have agreed to have discussions regarding what Essential to Role training is required for these new bank staff. This gives BCHC the opportunity to add Falls Training, including Falls Risk Assessment training and Enhanced Supervision training onto their training plan.

3. "*I was told that since this incident, falls risk assessments are being audited for compliance. I was also told that they are not being audited for correctness. I am therefore concerned that errors, and consequently, staff training needs, would not be picked up in these audits*."

   The completion of a falls risk assessment has been audited for compliance for some time as part of the Trust's Essential Care Indicators (ECIs) audit. ECI's take place monthly in the inpatient areas and are undertaken by the matron for each site. The discussion and learning from the round table has prompted additional measures to be introduced which will ensure that the assessment accurately reflects the risk of the patient falling and interventions required. The Matron will be undertaking spot check reviews of falls risk assessments as part of the current care rounding. In addition, the division will develop a quarterly falls prevention effectiveness audit. This will audit correctness of falls risk assessments and impact of care plans. The findings of the audits, and progress with subsequent actions, will be shared and monitored within the Inpatient Quality & Safety Committee.

CONCLUSION

The Trust has recently launched an Essential Care Framework which provides the guidance and the tools to enable clinical teams to self assess how well they meet what matters most to our patients and their relatives. This is being led by our Chief of Nursing and Therapies. The work being carried out to improve our falls risk assessments training and our enhanced supervision training will be incorporated into this framework.

In addition, the Trust is embarking on a major change in our response to patient safety incidents, known as the Patient Safety Incident Response Framework (PSIRF). PSIRF is a significant shift in the NHS as to how we respond to all incidents, including serious incidents. This will require a cultural and operational change for all staff in the Trust, and the work arising out of this Prevention of Future Death Report also be reflected in how we shape our Patient Safety Incident Investigation (PSII) reports that will be replacing Root Cause Analyses.

I trust this response provides the assurance you seek that the Trust shares your concern that future deaths in similar situations should be prevented, and indeed that the work now being carried out will reduce considerably any possibility of a similar outcome in future.

Yours sincerely

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Chief Executive Officer