Nottinghamshire Healthcare
NHS Foundation Trust

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

14 August 2023

Private and Confidential

Ms S Cartwright
HM Assistant Coroner for Derby and Derbyshire
Saint Katherines House
Saint Mary's Wharf
Mansfield Road
Derby
DE1 3TQ

Dear Ms Cartwright,

Please find below the organisational response to the recently received Preventing Future Deaths Report, following the sad death of Mr Cole.

The Matters of Concern raised within the report that relate to Nottinghamshire Healthcare NHS Foundation Trust (thereafter referred to as the Trust):

Concern that the Trust is doing too little to identify and address the risk of suicide for Veterans

Nottinghamshire Healthcare Trust is committed to working collaboratively with patients and staff to prevent suicide and reduce harm. This includes how we work with patients to meet their needs and also equip our workforce to have the right knowledge and skill to respond effectively to suicidality and promote safety. As such, we have a Trustwide Lead for Suicide Prevention, Rachel Lees. This role is a Trustwide role which is responsible for developing and implementing Nottinghamshire Healthcare's suicide prevention strategy, and working with other partners across the wider system. This role works strategically and clinically to reduce harm and promote safety in relation to suicidality, particularly focusing on training delivery, clinical practice and sharing of learning and key messages. This role provides expert professional advice, guidance and support, working closely with colleagues at all levels of the organisation to develop and improve practice.

Through triangulation of our mortality surveillance data within Nottinghamshire Healthcare Trust, we recognise that the Veteran group do present with factors that impact on their ability to access and

receive support. Subsequently, they can present with an increased risk of harm. We are committed as an organisation to supporting this patient group and plan to do the following –

1. The three yearly review of the Suicide Strategy is underway and will include a focus on staff awareness of factors which may be affecting different sub-groups of patients and clinical considerations and implications for practice. Specifically, this will reflect the enhanced risk for the veteran patient group from what we have learnt in the Trust and nationally. Our Trust essential training for Suicide Awareness and response will also reflect this.
2. The Trust holds an annual Suicide Prevention conference where this learning will be reflected. Our colleagues in OpCourage and Trust Armed Forces Community Network will also be in attendance and hosting an information stall.
3. The topic for July's Trustwide Suicide Prevention Champions Network meeting was Veterans and Suicide Prevention with the Operation Lead for OpCourage Midlands attending as the guest speaker to present and share information about the Armed Forces Covenant and OpCourage with colleagues. This meeting was recorded and is being shared Trustwide through various Communications, including being made available on the Trust's intranet.
4. Rachel Lees will undertake a thematic review over the next 9 months of patients that are veterans and open to services to understand care and treatment and identify any learning. This will be reported through the Quality Operational Group for learning.

Nottinghamshire Healthcare is also a Gold Member of the Armed Forces Covenant and has recently been re-accredited by Veterans Covenant Healthcare Alliance and are "Veteran Aware." (Appendix 1)

Concern that there is a lack of understanding as to the appropriate services to make referrals to for Veterans by the Trust mental health practitioners.

The Trust has taken action to gain knowledge of appropriate Veteran services which are available, and we are able to make referrals to. As a result of this, we have looked to update our mental health practitioners with regards to this information. All this information has been collated from Nottinghamshire Healthcare culture and staff engagement facilitators, who are part of the Veterans' Network. Leaflets and posters have been provided and are being distributed throughout the Mental Health Care Group and shared with the wider Trust for review and distribution. As part of the information provided is a card that has a QR code on it, practitioners can scan this code and it takes them to the Veteran information pages on the Nottinghamshire Healthcare Trust intranet site 'Connect.'

Concern that there is a lack of understanding as to the services available for Veterans.

All inpatient sites now display posters that state that 'We are Proud to be Veteran Aware' and include the contact details for the Veterans and families service Champions. Posters are being distributed to all community team bases and will be displayed by the end of August; follow up checks are planned. The Trustwide Lessons Learned Bulletin (Appendix 2) contained information relating to Veterans, and this is shared Trustwide and available on the staff intranet site. Specifically in the Adult Mental Health Care Group the monthly communication the 'Governance Gazette' in July (Appendix 3), features an article on Veteran services, this communication is distributed to all teams and is discussed in the team meetings which are attended by all levels of staff. The article also has links to

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Op Courage and *Army and You*. The Nottinghamshire Healthcare culture and staff engagement facilitators are presenting to the members of the Adult Mental Health Quality and Risk Group, which is attended by senior operational managers, service managers team leaders and trainers on 07 September 2023.

This information has been shared with the Trust for wider learning and Care Group relevant business managers and governance leads are review plans to disseminate this information with the emphasis being focused for the specific areas to include training.

The Patient Medical records (RiO) now request that a section to be completed which seeks to ask if they are a veteran. We are in the process of scoping if this can be a mandated question and to also add a hyperlink which will guide the practitioner to the services available. We also plan to add a prompt about ensuring that the patient is supported with the referral if required. This functionality will be audited in 6 months' time to review accessibility and whether this can be used more widely.

For our Forensic Care Group we have specific pathways and support available for Liaison and Diversion we provide a veterans pathway in custody which includes a mandatory referral to the service – Liaison and Diversion also work closely with and direct individuals to Op Nova in the community.

For Offender Health Services, Clinical Specialists provide all the specialist therapeutic input for individuals and groups. They supervise healthcare teams and provide Veteran Awareness training for healthcare teams and all prison staff. This work is supported by Care after Combat who provide support and individual mentorship for veterans making all necessary practical preparations for release. These preparations start as early as a year pre-release to take into account the often lack of or limited civilian living prior to incarceration. This and the through the gate mentorship are significant in the reduction/minimisation/prevention of Adjustment Disorder which many of the men experienced on leaving the Armed Forces and which is often a contributing factor to offending behaviour. The Care after Combat team also co-facilitate the regular groups. They also take on full responsibility and cost for the production, printing and delivery of the Wellbeing/Action packs.

Concern that there is too much emphasis on Veterans being solely responsible for self-referral, with no assistance to assist in accessing appropriate services.

The Trust has reflected upon the self-referral pathway for Veteran related services that require a self-referral and recognise that this can present with difficulties in accessing further appropriate services. For example, the impact having to tell a personal and sensitive story repeatedly can be distressing and result in a barrier to such services being accessed.

We recognise that OpCourage remains a self-referral service for Veterans however, as a Trust, we have made the decision to always support this process. This process will be monitored through the audit of veteran patients.

We recognise that a cultural change is required in practice to ensure that where a self-referral is required, that we undertake this in collaboration with the patient to ensure access is not restricted and will be kept under review and oversight.

In addition, guidance has been written for staff to demonstrate professional curiosity in relation to a service users' motivation or ability to complete self-referrals. This identifies those who need support to self-refer and clinicians will complete this with the individual or for them if appropriate. This guidance will be included in the updated version of the Local Mental Health Team (LMHT) Standard Operating Procedure (SOP), which will be provided for reference once completed by the end of August 2023. This SOP will incorporate the need to refer Veterans to OpCourage rather than rely on self-referral due to the known difficulty our Veterans have in seeking support. All LMHT staff will be provided with a copy via email and this section will be highlighted in the business meetings. The Trust will need to have assurance that this practice is embedded, therefore an audit will take place over a period of three-month period to identify that staff are exploring if a service user requires support to access self-referral services and for the specific needs of Veterans these referrals are being made on their behalf.

A Veteran folder (Appendix 4) has been developed to help and support referrals for Veterans, this has been shared throughout the Adult Mental Health services And is currently being reviewed by our Mental Health Services for Older Peoples leads and Specialist Services leads to check suitability for patient group and will be shared across Mental Health Services by 18 August 2023.

There was a presentation of Mr Cole's findings from the inquest at the Mid Notts and Bassetlaw Local Quality and Risk Meeting on Monday 24 July 2023. The learning from this continues to be shared via the business meetings with the teams across the Mental Health and Forensic Care group and Quality & Risk Meetings for wider learning. The emphasis being that support with self-referral will be considered for those who require this.

Concern of a lack of understanding (or effort) as to how to request and obtain military DCMH medical records.

Support has been sought from the Head of Information Governance (IG) to identify the process in which to have any military records released. The Trust was informed by the MoD that the records needed to be formally requested and written consent sought from the individual prior to the application being made.
IG colleagues then worked to produce a procedure that would clarify this process for staff with the appropriate contact numbers included for each armed forces and the necessary consent forms enclosed as an appendix.

This procedure (Appendix 5) was approved on 1 August 2023, by the Information Security Forum (ISF) which is the Trust's IG and IT Security meeting. The procedure has now been published on the Trust's Intranet Policies Page and it is being explored how this can be added to the veteran demographic section to support staff in reminding them of this new process.

As a result of the development of this, it will be circulated via the Executive Weekly Briefing, the Line Managers' Bulletin and a link will be added to the Veteran information page on Connect, as well as being included in the next Trustwide Lessons Learned Bulletin. Each Care Group and Care Unit within the Trust has developed their own sharing mechanisms which include discussion in the Care Unit Quality Oversight Group/Quality and Risk Meetings, Service Business Meetings and Team/Ward Meetings with Governance leads ensuring this is included in the relevant agendas.

Concern as to the quality of the Trust's Investigation Report and the process of review is not sufficiently robust.

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 unreservedly apologise for the distress and disruption caused as part of your coronial process. We recognize that there are cases where the standard of report writing and investigating has not been to the level required and have undertaken a number of measures to improve this.

The Mental Health Care Group introduced a panel sign off process which collectively reviews the investigation to provide a higher level of quality assurance and triangulation of information. We envisage our reviewed and strengthened governance will mitigate this risk moving forward.

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.

Incident Investigation Training:

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 two-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 provide five two-day Serious Incident Investigation training sessions each year, which enables the opportunity for 125 attendees across those sessions.

Investigation Terms of Reference:

For each serious incident investigation, clear and specific terms of reference are drafted and shared with the Operational Care Groups 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 Operational Care Groups 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 reviewing/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 external training providers, we have commissioned a series of Serious Incident Quality Assurance training events during 2023/2024. Between September 2023 and December 2023, we will facilitate six one-day training events.

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 that within the six sessions we can train approximately 150 individuals. The purpose of this training is to provide senior leaders 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.

Review of active Investigations & Inquests:

Whilst we appreciate the need for the work outlined above in terms of the development of our staff in terms of expertise to both undertake investigations, and critically analysis the resulting investing reports. We are also mindful that we have a significant number of completed investigations and upcoming inquests, where we believe we need to undertake a pro-active and objective review of active inquests in the Trust to identify cases where lessons should be learnt and responded to. This will include but not be limited to:

- Consideration of learning for the Trust, what lessons have been learnt or need to be learned from this matter.
- Ensuring family engagement and compliance with Duty of Candour
- A summary of key themes from both current and historical cases which may support improvement work.

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

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Chief Executive
Nottinghamshire Healthcare NHS Foundation Trust

Reference:
Kapur N, While D, Blatchley N, Bray I, Harrison K (2009) Suicide after Leaving the UK Armed Forces —A Cohort Study. PLoS Med 6(3): e1000026. https://doi.org/10.1371/journal.pmed.1000026

Encs:
Appendix 1: CEO email dated 24th July 2023
Appendix 2: Trust Lessons Learned Bulletin
Appendix 3: Excerpt from AMH Governance Gazette for July 2023
Appendix 4: Veteran Pack
Appendix 5: Procedure for obtaining military DCMH medical records

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