Tees, Esk and Wear Valleys
NHS Foundation Trust

20 October 2023

Office of the Chief Executive
West Park Hospital
Edward Pease Way
Darlington
Co Durham
DL2 2TS

Private & Confidential
Mr James E Thompson
HM Assistant Coroner for
County Durham and Darlington
H M Coroners Office
PO Box 282
Bishop Auckland
Co Durham
DL14 4FY

Dear Mr Thompson

Inquest into the death of Nicholas Stout
Regulation 28 Report to Prevent Future Deaths Response

I am writing to you in response to your direction in the prevention of future deaths notice served to Tees, Esk and Wear Valleys NHS FT on 15 June 2023 regarding the death of Mr Nicholas Stout.

I am responding in the same format and with similar information to that in the response letter sent August 2023, I hope this consistency will be helpful.

We have taken Nicholas's death very seriously and our investigation has sought to establish where lessons can be learned and/or services improved.

The details of the actions implemented and embedded by us following this incident were detailed within the statement of [redacted], Modern Matron. We do not intend to repeat the detail in this response other than to reference the specific paragraphs that are relevant to the concerns raised in the Regulation 28 report.

For the purposes of responding to your specific concerns raised in the Regulation 28 Report, I shall address each of them in turn:

1. **The nationally set time from initial contact with the crisis team to some form of assessment is 4 hours. I heard evidence that achievement of this target in every case is not realised. It is of concern that timely assessment and treatment of persons undergoing mental health crisis should be assessed as speedily as possible and within the set time period.**

1.1. **Trust Response**

Ensuring timely assessment and treatment for people experiencing a mental health crisis is crucial and we endeavour to meet all expected timescales for the assessment of people in crisis.

The national standard for very urgent assessments to be completed is within 4 hours. Urgent assessments should be carried out within 24 hours.

For all new patients and those individuals not open to other secondary mental health services, the UK national triage tool is undertaken to initially triage and assess the patient and to agree the priority of assessment. This is in line with national standards set out by NHS England. The clinician carrying out the triage assessment will develop a safety plan, in discussion with the patient and their family/carer, to ensure the patient is safely supported until the crisis assessment takes place. If an immediate response is required due to an imminent safety or wellbeing concern this would be requested through 999 emergency services in line with national guidance. As per the evidence of [redacted], the crisis service is not commissioned or resourced to provide an emergency response and clinicians do not have the appropriate skills, and in many cases, a suitable legal framework to provide such a response.

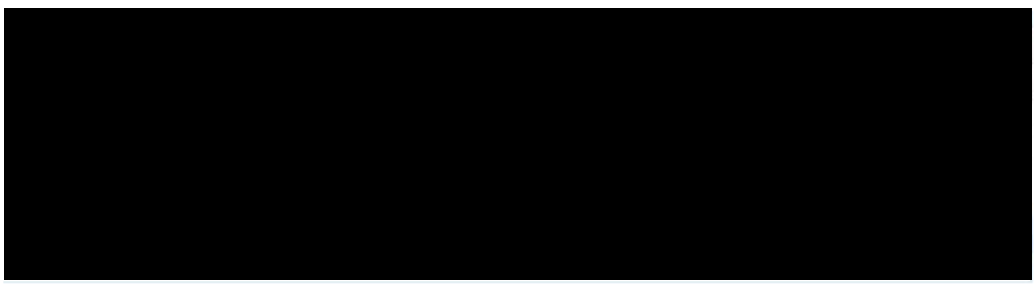
In evidence, [redacted], speaking to [redacted] statement, confirmed that during known periods of high demand, additional staffing is provided to ensure that targets are achieved. However, we acknowledge that crisis service acuity can be unpredictable, and may change from day to day.

To support maintaining safe staffing levels, the crisis service management team review staff resource daily in line with the Trust's safe staffing levels escalation procedure and attend the daily safe staffing meeting, this meeting is Care Group-wide. This allows for alternative options of support to be identified at times of increased acuity and to ensure that assessments are not delayed and are carried out in a timely manner.

Additionally, the Crisis Team have introduced an escalation procedure to ensure that if there is a concern that an assessment would not be undertaken within the given timescales, that this is discussed with senior management. Arrangements will then be made to ensure that assessments are not delayed which can include deploying staff resource from other teams, and management stepping into clinical roles.

There are examples where response times are breached due to patient preference for appointment times or venues and this is supported by the risk assessment and safety planning approach detailed above. Breaches are also recorded when teams are unable to locate service users post-triage and/or they do not attend their appointment. There are weekly reporting processes in place to monitor responses to very urgent referrals which allows for clinical oversight of decision making, target compliance and support allocation of any additional resource or intervention if required. Any breaches and compliance with the standards are monitored through our governance structures, reported monthly within Specialty Governance meetings and escalated through to the Care Group.

Table 1 - Durham and Tees Valley 4 hour response target (very urgent)



2. **The triage tool was explained in evidence to be essential in ensuring the patient received the correct treatment/service and is to be undertaken every time a patient contacts the Crisis Team. I was informed there was an aspiration to**

achieve completion of the Triage Tool every time, but it is not being completed on every occasion. It is of concern that such a key document which identifies risk,

care and other matters is not completed on every occasion as it is mandated to be done.

2.1. Trust Response

In evidence, HMC heard evidence from [redacted] that development work had been undertaken in the Durham and Darlington area in relation to the triage tool assessment process and staff development.

Development work was undertaken in June 2022 to embed the use of the national triage tool. The service has ensured that all current registered practitioners have received an induction regarding the crisis team processes, and all new members of the team are fully inducted. The induction includes education regarding the triage tool, guidance as to the use of the triage tool and the rationale that underpins its use. This enables staff working within the Crisis Team to be clear on team processes and to ensure that triages are undertaken by trained senior registered practitioners.

[redacted] confirmed that a monthly audit was undertaken to monitor the use of the triage tool, as well as case management supervision with clinicians, reviewing that this had been completed. Supervision is carried out on a quarterly basis in line with the Trust Supervision Policy. As part of the development work, discussions were held with all staff within supervision regarding the use of the tool and triage documentation.

Audits of compliance with the triage tool sit within the Trust's quality assurance schedule. Specifically, the monthly “QA5 audits”, which encompass triage and assessment standards. The Trust has a well-established Quality Assurance and Improvement Programme which was first initiated in April 2021. This is focused partly on patient care documentation, recognising that high quality documentation is an enabler of high-quality patient care, as well as observation of practice and talking to teams in clinical areas. The programme comprises of a range of quality assurance tools that are used to gain a holistic assessment of the quality of patient care. These tools are subject to review to ensure they are informed by current areas of risks where further assurance is required. The Quality Assurance and Improvement Programme has proven to be an effective method of monitoring compliance against key standards of care related to patient safety, clinical effectiveness and patient experience. It has facilitated significant sustained practice improvements and provides the organisation with both quantitative and qualitative assurance evidence.

The QA5 tool includes questions about the triage process including use of the tool, the quality of completions as well as the outcomes. Audits continue to show sustained improvement in the use of the triage tool and documentation. The most recent three months of audit data showed a 100% compliance with the completion of the triage tool where the tool was identified as being required.

3. In relation to making safeguarding referrals for children, the evidence I heard was in this particular case a referral should have been made and was not. I was told training had been undertaken to make all staff aware of what action to take. However, I was told in the majority of occasions it was believed a referral would be made. It is of concern in terms of protecting children that I was not satisfied that a referral was made in all situations that warranted such a referral.

3.1. Trust Response

As an organisation, safeguarding is recognised as an integral part of our care delivery. All staff are required to undertake mandatory training for safeguarding children and adults, this training is updated at regular intervals to ensure staff remain updated with relevant policies and procedures, ensuring that staff understand the importance of safeguarding referrals and that referrals are made promptly whenever there is a concern for a child or vulnerable persons welfare.

In evidence, [redacted] confirmed that since this incident, staff have received additional training in relation to the Parental mental ill health on children tool (PAMIC). [redacted] confirmed that the tool considers how a parent's mental health may impact on a child and supports the clinician completing the tool to consider whether a referral to the local authority for safeguarding teams should be completed and actions that should be considered to safeguard the child/children.

As a Trust we are committed to learning from this incident and have implemented the necessary improvements to prevent such incidents from happening in the future. Safeguarding concerns are now a standard agenda item discussed daily within community and crisis huddles, attended by all members of the multi-disciplinary team. Any identified actions are promptly acted upon, with individual clinicians taking responsibility for allocated tasks. The learning in relation to this incident has been discussed within team meetings, and the review from the incident has been shared with the team to ensure widespread awareness.

To strengthen safeguarding practices across the organisation, the Trust safeguarding team allocate members of the team to link in with different clinical areas across the Trust. This provides increased support and guidance within the teams, enabling timely and effective handling of safeguarding concerns. The organisation has also issued a Patient Safety Briefing following this incident, this briefing has been shared throughout the wider organisation to ensure that the learning from the incident has been communicated and lessons learnt across the Trust.

To provide assurance and to maintain consistent monitoring across the organisation, the Trust has enhanced its quality assurance schedule and has introduced the QA5 audit detailed earlier in this response. A recent addition to the audit tool includes reviewing compliance against PAMIC tool completion, whether a safeguarding concern has been identified in the past month, and whether appropriate actions have been undertaken when a safeguarding concern has been identified. This audit helps us to ensure agreed policies and procedures are being followed and to take corrective action where necessary to ensure safeguarding procedures are being followed.

Additionally, to provide immediate support and advice during core working hours, the Trust have allocated safeguarding duty workers. This professional lead is available to discuss any safeguarding concerns and to offer guidance on how to address concerns safely, ensuring a child's welfare remains a central priority. Outside of regular working hours, the Trust safeguarding policy directs staff to contact the local authority safeguarding team to ensure that concerns are promptly discussed and addressed as required.

We were recently inspected by our regulators, the Care Quality Commission (CQC), who pay close attention to the application of mandated safeguarding standards in practice. The CQC have not raised any concerns about our safeguarding practices.

4. **I was told in evidence that a Safety Plan which is compiled with input from the patient, their families and practitioners did not exist in Mr Stout's case. I was told**

it is crucial document for identifying risks and ways to mitigate them. I was also told work was commenced by your organisation in December 2020 to ensure full

and complete compliance with this requirement, but I was not reassured there was such compliance with the completion of Safety Plans in all cases at this time.

4.1. Trust Response

In evidence, [redacted] confirmed that work had been undertaken by the Trust to ensure that safety plans were completed. [redacted] indicated that a monthly audit was in place to check compliance with completion of safety plans and summaries.

[redacted] confirmed that additional training in relation to the importance of completing safety summaries and plans had been completed with crisis staff and all staff had now completed this.

As part of the Crisis Team's daily huddle, every patient's care is discussed. As part of the huddle safety summaries and safety plans are checked and discussed as a multi-disciplinary team. Any changes or updates that are required are identified and staff are tasked to complete these.

Within the Early Intervention in Psychosis (EIP) Team, staff have regular caseload supervision which looks at patient care and safety management documents such as the safety summary and safety plan. Results from QA5 audits are fed back to staff in monthly team meetings. Audit outcomes are reviewed through service and specialty governance meetings and escalated through to Care Group Boards. A function of these groups is also to develop and monitor improvement plans and actions for areas where audit compliance falls below the expected standard.

In both teams, bespoke safety summary and safety plan training, that is supplementary to mandatory harm minimisation training, is delivered and allows for exploration of specific risks and scenarios related to their service provision. This training is a regular offer within the teams and is completed as part of the induction of new staff into the team.

All staff complete the Trust mandatory Harm Minimisation training. This training supports clinicians to develop skills and competence in the completion of person-centred safety plans that look at a range of risk factors when safety planning. Additionally, the crisis service is arranging for crisis clinicians to attend the non-mandatory "Connecting with People" suicide awareness training.

Monthly QA5 audits are conducted in accordance with the Trust Quality Assurance schedule. The tool asks questions about the quality of the safety summary and if it reflects the patient's current level of risk. The tool also reviews if it is documented appropriately as to how these risks will be mitigated and managed within the safety plan. Audits continue to show sustained improvement in the completion of safety summaries and safety plans including the quality of these documents. They allow an opportunity for timely corrective actions where required and live supervision for clinicians.

As a Trust we recognise that staff need support in managing their caseload and an integral part of this is effective caseload management supervision. In addition, caseload oversight follows the patient pathway so that our response remains central to a patient's need, whilst also ensuring the right staff have the right skills to offer at the right time to promote recovery. For these reasons the Trust implemented a new Caseload Management Supervision Policy in January 2023 following a successful pilot in the last

quarter of 2022. This policy ensures that monthly caseload supervision is completed, the use of an electronic caseload dashboard to facilitate and highlight areas of supervision and time to consider the quality of essential care documents.

We believe we have taken all reasonable steps to make clear our standards and to train and support our staff to reach the expected standards. We proactively monitor and quality assure compliance through a robust governance process.

We trust that this response provides the necessary assurances that action has been taken to address matters of concern.

Yours Sincerely

[redacted]

[redacted]
Chief Executive