NHS
Herefordshire and Worcestershire
Health and Care
NHS Trust

Chief Executives Office
2 Kings Court
Charles Hastings Way
Worcester
WR5 1JR

[redacted]

[redacted]

7 November 2023

Mr D D W Reid
HM Senior Coroner
Worcestershire Coroner's Court

[redacted]

Dear Mr Reid,

Re: The Late Anthony John Friend
Regulation 28 report to prevent future deaths - response

Thank you for forwarding on your Regulation 28 report. I have read your report with great care and note the concerns that you have raised during your inquiry concerning the death of Mr Anthony Friend.

In your report, you highlighted the following points of concern, and I will respond to these individually:

1. **As long ago as 28.11.22 (nearly 5 months before the accident which led to Mr. Friend's death), an Occupational Therapist employed by HWHCT, had concluded that the sling being used at the time of the accident on 17.4.23 (the "old toileting sling") was no longer suitable for Mr. Friend, ensured that two more suitable slings were provided instead, but did not remove the old toileting sling from Mr. Friend's home.**

2. **During a home visit to Mr. Friend's address on 2.2.23, noted that the old toileting sling was still being used, made clear to Mr. Friend's family and carers that it was *"not safe to use"*, but again did not remove it from the property;**

3. **During a home visit to Mr. Friend's address on 6.3.23, another Occupational Therapist employed by HWHCT, noted that the old toileting sling was still being used by family and carers, and that although the two more suitable slings provided by her colleague would be difficult to fit, they were nonetheless safer to use. She told the inquest that in hindsight she *"should not have allowed [carers] to carry on using the unsafe sling"* and that she did not know why she had not taken time to show carers how to use the safer slings which had been provided;**

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4. **During a home visit to Mr. Friend's address on 17.4.23 (just prior to the accident) in order to assess Mr. Friend for a new sling, noted that the old toileting sling was still being used. However, she told the inquest that despite her misgivings about it, she did not remove it from the address, and still expected carers to carry on using it for the next two weeks until a new sling arrived. She described this decision as *"an oversight"* on her part;**

5. **also told the inquest that;**
   (a) she should have ensured that Mr. Friend's carers were present for the home visit and sling assessment on 17.4.23 (which they were not); and
   (b) she should have contacted his new carers (Divine Health Services Ltd.) after that visit, to discuss their use of the sling.

As a Trust we recognise that at the time of this incident we did not have a robust policy and procedure in place to support our staff in the community with regard to the removal of unsafe equipment. Since the inquest we have formulated a working group to design a new policy around equipment provision and this will cover the necessary steps and procedures for our staff, around timely removal of unsafe equipment from a patient's home. We will have this new policy signed and operational by the 1st April 2024. A key element will be sharing this new policy which will be completed at individual team meetings and via our global all staff communication emails. Whilst we are developing the new policy we have issued more immediate instructions to staff via a focus on card approach.

As a Trust we recognise that more timely action was required about removal of older slings so we have in partnership with a range of professionals designed a focus-on-card around a step by step guide for staff when they identify unsafe equipment in a patient's home. This is a direct impact from this serious incident. This will act as a useful reminder document that staff will have access to when visiting patients in their homes and will be a vital part of new starter's induction packs.

In addition, this card has been shared at operational meetings and globally on 28 September 2023 via our communication team with all Trust staff; a copy of the card is attached for your information. As part of this all clinicians are now carrying laminated cards- "unsafe equipment- do not use", these can then be attached, photographed using NHS mobile telephones and uploaded to our electronic patient record system (EPR) as evidence, supported by supporting documentation. We recognise that this action may have alerted the care agency in the case of Mr Anthony Friend to not use the equipment. All occupational therapy staff have been educated via a powerpoint presentation on when to use the cards. Staff have reported they are supportive of the implementation of this card.

We have also designed a standardised template letter (a copy is attached for your information) for service leads to send to patients if our clinicians experience resistance when removing equipment from a patient's home and these will be stored on our electronic patient record.

We are also reviewing our manual handling and sling training that is provided to our staff to ensure this is adequate to support patient needs in the community. We are creating an algorithm to support staff decision making around when and what type of sling is suitable in a variety of situations. We hope to have this operational in the next 3 months. Early discussions have taken place regarding additional online training that illustrates various clinical scenarios, identifying risks and potential equipment that could be recommended.

We also identified that as a service we need to ensure we have more robust documentation. All staff attend annual clinical records training but since this inquest we have also implemented a quality improvement record keeping audit with our HASE/OT services to ensure compliance with national, regional, professional and local record keeping requirements.

6. At no time do either appear to have communicated their concerns about the continued use of the old toileting sling in writing to either of the agencies which were providing care for Mr. Friend at the relevant times.

The Trust fully recognises that there was a breakdown in communication between the external agencies involved in the care of Mr Anthony Friend.
We have since the inquest designed and introduced a new leaflet (copy attached) that is given to all our patients on initial assessment with the Housing, Adaptation and Specialist Equipment service (HASE). This leaflet has our contact details on. Any family can then easily and accessibly share these details with care agencies if required. This leaflet can also be used by other stakeholders including our GP colleagues when they refer patients to our service.

We have also introduced a new role into our countywide service, this role has a significant bias towards improving communication with our external agencies to prevent occurrences like this happening again. They will be involved in joint visits to clients and will have weekly clinical supervision, where tasks will be delegated to them to support improved communication between HASE and other agencies.

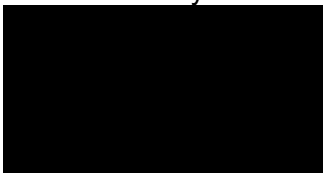
As a Trust we have a robust incident reporting system and are passionate about sharing learning from incidents and complaints with our colleagues in a supportive and compassionate manner with an aim of preventing any further incidents of this nature occurring. The Trust Board are well sighted via the quality report on incidents and complaints.

I hope this reassures you that the Trust has taken action to improve standard operating procedures around unsafe equipment in the community and to improve communication with external agencies through the development of new roles and leaflets. The Trust is committed to learning from this incident to avoid any similar occasions of staff not removing equipment when it is no longer appropriate to be used.

I hope that the above adequately addresses your concerns.

I shall be grateful if you could kindly send a copy of my response to those to whom you copied your Regulation 28 report.

Yours sincerely



Chief Executive

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