Nottinghamshire Healthcare
NHS Foundation Trust

Nottinghamshire Healthcare NHS Foundation Trust
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[redacted]

13 December 2023

Private and Confidential
Dr. Didcock
Assistant Coroner for Nottingham
and Nottinghamshire
Nottinghamshire Coroner 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 sad death of Mr Murray.

The Matters of Concern raised within the report that relate to Nottinghamshire Healthcare NHS Foundation Trust (thereafter referred to as the Trust) are detailed below, along with our response to each:

1. **There was limited risk assessment and risk management plan documentation for Mr Murray on Ward B2 now Beech Ward.**

Mr Murray was admitted to the ward informally and during his admission check with one of the ward doctors it was agreed that he could have his psychiatric observations reduced to general (every 60 minutes) and be allowed to leave the ward for short periods of time. This is out of procedure as patients should remain on 10-minute observations for a period of 48 hours post admission, to ensure a thorough assessment of the patients' needs and risk can be undertaken. This accelerated risk decision, and agreement for Mr Murray to access leave was not reviewed robustly by the wider team.

This has been discussed with the Multi-Disciplinary Team (MDT) across the unit and agreed that all leave from the ward areas, will only to be decided upon during weekly ward rounds, or the daily board review where the full MDT is present. To support this the ward round template has been updated to include the documentation of risk assessment analysis and clinical rationale linked to leave decisions. This will be monitored through the oversight quality checks completed by the Practice Development Leads and locally by the Ward Manager. It will also be added to the Adult Mental Health Operational Policy.

To ensure a consistent risk assessment skill level across the workforce, all the qualified nurses and MDT members at Sherwood Oaks have attended suicide awareness and response training, which includes a focus on risks associated with patient accessing leave. This is discussed further in section 4.

In addition to the changes made at Sherwood Oaks, there is currently a service wide review of the risk assessment and care planning processes linked to agreeing therapeutic leave, which will include the definitions of where leave in the grounds and leave in the community begin. This is being progressed via the AMH inpatient Rapid Improvement Group which is chaired by the Executive Director of Nursing and AHPs.

At a Trust level, we recognise that having one Policy that identifies the principles of risk assessments and collaborative and coproduced care planning for children, young people and adults is beneficial, and how it reduces confusion for the clinical teams. As a result, a Policy has been drafted and outlines the expectations for the clinical teams, while allowing flexibility to ensure that the correct risk assessment tools are used for each service. The Policy will also outline how the appropriate Risk Assessment tools are agreed, how the implementation will be managed and how the Trust will monitor the compliance with the Policy.

The Policy is currently out for consultation and a Topic Expert Group had been convened to ensure that the Policy is robust and is suitable for the services that the Trust delivers. The Topic Expert Group included Psychiatrists, Psychologists, Nurses and AHP's from a broad range of services.

It is foreseen that the Policy will recommend that clinical teams will receive training in the clinical risk assessment tools employed by each service, The training will be sourced from external providers or developed with the learning and development team to make sure that the learning materials reflect the Policy requirements and the individual needs of the people that we support. We will ensure you are sighted on the completion of this policy and training roll out.

SAFEToolTriage_UK 2.5 (1).pdf

MDT Template BLANK.docx

2. There was an inadequate door board system for monitoring the return of patients after unescorted leave on ward B2. The same arrangements remain currently, despite the ward move to Beech ward on new premises.

Historically the system of monitoring who leaves and returns to the wards, (locally known as the Door Board) was poorly adhered to in some areas. Significant work has been completed with the team on Beech (and across the site) to strengthen their adherence to the process which has seen a significant improvement in practice.

Each ward has a dedicated member of staff responsible for assessing individual mental state, checking leave parameters, and reiterating these to the patient prior to leave, confirming legality and permission issues with the nurse in charge, and managing those possessions a patient may take on or return with from leave, IE Cigarette Lighters and items bought at the local shops etc.

The staff member maintains a running log of when patients leave the ward, and are due back, their clothing, and a brief description to aid searching if a patient chooses not to return.
Given the frequent use of leave from patients across the site, the Care Group has sought ways to enhance this monitoring. As such, an electronic device is being procured which will allow multiple alarms to be set for each person's leave, ensuring an audible alarm will sound when a patient is due back on the ward. This will be trialled and rolled out based on the feedback of this pilot. We will share with you the output of this in due course.

This will reduce the time lag between someone failing to return and contact and search actions being taken.

To ensure there is consistent compliance with the door board system, a checking process has been incorporated in the Senior Nurse's daily observation spot checks. This includes a band 6 nurse or above observing staff completing their observations rounds, and quality checking their understanding and performance within the role. The spot checks also test individual understanding of the door board process, their knowledge of who is on and off the ward, and discussions to ensure they understand clearly how to escalate concerns if a patient hasn't returned.

To date, these checks have found the door board to be fully completed, staff who were completing the role were able to describe the expectations of them, and how they would escalate if a patient was late back from leave. Checks will continue through into quarter 4 of 2023/34.

The observation handover sheet is also located with the door board, so when the handover of observations is completed each hour, the door board is also reviewed ensuring that the incoming staff are clear on who is on and off the ward at that time.

3. **There was extremely limited family and carer involvement in Mr Murray's care, with no involvement in the care plan, nor involvement in ward rounds on ward B2 now Beech ward.**

The involvement of patient's family, friends and carers is vital when planning and delivering the patients care and treatment. We recognise that at times, we have got this wrong.
To understand how to improve in this area, all Adult Mental Health inpatient areas have completed the Triangle of Care Self-Assessment.

The findings from these are currently being reviewed and actions being agreed to ensure that families, friends, and carers voices are included in the planning and delivery of patient care. The Triangle of care process has also been strengthened as part of our ongoing quality improvement plans. Our Quality Standards Team also undertake reviews of Care Plans and look for clear evidence that these plans are produced with the patient, family and carers. The feedback from these reviews are monitored via the Senior Management Quality Review Meeting which takes place on a monthly basis, and progress on any identified actions is mapped and escalated as needed.

To aid and support this partnership, all-acute wards have recruited a Carer Peer Support worker whose working week is dedicated to liaising with patients and their families/carers and ensuring the link with MDT members, and clinical discussions is strong. This person will also support the patients and their family/carers in Ward round discussions and ensure that follow up actions are completed and communicated effectively.

To enhance the work of the Carer Peer Support Worker, it is planned that all patients will on admission complete a carer contact plan. This will include who the patient would like to be involved in their care and care discussions, and what level of information should be shared. The Carer Contact Plan is in the final stage of agreement and should be used through the in-patient wards by the end of December 2023. The use of the Carer Contact Plan will be reviewed in Quarter 4 of 2023/34.

There is also an expectation that the Responsible Clinician will oversee the involvement of the appropriate family member as required and this will be documented and monitored through the ward round oversight.

The launch of the Collaborative Care Planning Policy (mentioned above) will have family and carer involvement at the heart of what we do. This Policy will identify the implementation and monitoring standards to ensure that we are able to evidence coproduced care.

Finally, the family intervention team have devised a bespoke one-day training package which all of the Beech ward team including the MDT are booked on to attend. A copy of the training program is included below, and is scheduled to start in January 2023, with roll out through to June 2024.

Inpatient Family Caregivers.pptx

4. There was limited awareness of the ligature risk reduction pathway by staff on B2 now Beech ward.

As an organisation we have been delivering updated suicide awareness and suicide response training using content developed by 4 Mental Health, since Dec 2022. This training includes updated NICE guidelines in relation to assessment, risk mitigation and safety planning for suicidality and provides a Suicide Assessment Framework E-Tool (SAFE Tool) which has been embedded in RIO and SystmOne for documentation and audit.

As detailed in part 1 above, all qualified staff and MDT members at Sherwood Oaks have completed the above training.

The Trust has also identified Storm Skills Training as being applicable for our inpatient services, and we are in the process of procuring this training package, with an anticipated roll out through Quarter 4 of 2023/24. The Storm Skills Training is an evidenced skills-based training programme with a focus on suicide prevention and self-harm reduction. These training courses complement each other to support staff to make informed decisions regarding an individual risk of suicide or self-harm including, but not exclusively regarding the risk of ligatures. This will then inform the overall risk formulation and allow our clinicians to make individualised decisions regarding access to items that could be used to ligate.

The principles of holistic care will be employed to ensure that teams are aware of, assess and mitigate risk with clear documentation and decision making. This will apply to both informal and detained patients and will be underpinned through robust multi-Disciplinary team working.

At a ward level, staff inductions include recognising items that could be used as a ligature, fixed ligature anchor points are assessed, and a risk assessment document is maintained and communicated within the team, and individual risk is mitigated through a range of processes including the prescription of psychiatric observations (checks on the patient) at varying intervals.

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.

I hope that this update is useful to you and your colleagues.

If you require any further information, do not hesitate to contact the Trust.

Yours sincerely

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Executive Director of Nursing AHPs and Quality