Portsmouth Hospitals University
NHS Trust

Trust Headquarters
F Level, Queen Alexandra Hospital
Southwick Hill Road
Cosham
PORTSMOUTH, PO6 3LY
[redacted]
[redacted]

08 January 2024

Dear Mr Simpson,

Response to Regulation 28 report to prevent future deaths following the inquest into the death of Jack Farrington dated 14th September 2023, received by the trust on November 9th, 2023

I write to provide the Trust's response to the regulation 28 report issued following the inquest into the death of Jack Farrington. For ease of reference the matters of concern identified by you in relation to Portsmouth Hospitals University NHS Trust (PHU) during the inquest, as described in the report, are set out below in italics with PHU's response underneath each concern.

1. Handover on Arrival

I heard that there is no specific structure in place at Queen Alexandra Hospital Emergency Department for ensuring the full and accurate handover of information about a patient who arrives whilst subject to detention under the Mental Health Act. I heard evidence that the receiving staff are not required to ask about a patient's history of absconding or self- harm. This gives rise to the possibility of a patient's risk not being properly assessed. It was accepted in evidence at inquest that the hospital has a duty of care for all persons on its premises and not just those who have been formally admitted as patients. In written submissions after the inquest hearing the hospital have stated that risks of absconding and self- harm are managed by the escorting mental health team. This does not, in my view, absolve them of responsibility for managing these risks whilst the patient is present at their site.

Trust Response:

The Trust agrees that the accurate handover of care and risk refers to the transfer of information and responsibility for a patient from one health care professional or team to another. In the context of patients detained under the Mental Health Act, we recognise that whilst responsibility for the patient remains the same, there is a need to effectively communicate and share information about the patient's care and potential risks. This ensures continuity of care and enables the receiving team to be aware of specific risks or considerations to the patient's detention under section.

Whilst PHU is not a provider of specialist mental health services, specialist support is provided by our partner mental health organisations on an in-reach basis.

The patient at the time of his attendance was accompanied on a 1:1 basis by a Solent NHS Trust member of staff in accordance with his Section 17 leave requirement, with verbal handover on arrival by the attending South Central Ambulance Service to the Emergency Department (ED). This handover, as per Professional Record Standard Body (PRSB) Ambulance handover to [redacted] [redacted]

emergency care standard 2019, is standard and expected practice which will include the reason for attendance and any potential risks associated with the admission.

The Trust uses a Mental Health Primary Risk Assessment Survey Tool to assess patients on arrival to ED, this has been updated following this incident (see response to Q3). In addition, the use of a standardised handover triage and risk assessment tool are in review to ensure that patients' risk of self- harm or absconding are considered at the point of handover.

A meeting has been arranged with Solent NHS Trust on 9 January 2024 to review transfer of care priorities which will include clinician to clinician discussion prior to a patient's transfer to the Emergency Department.

In addition to a proposed clinician-to-clinician discussion, our colleagues at Solent NHS Trust are working on developing an electronic handover system. This system will provide the ED team with more information about the patient's needs and risks before they arrive. We will agree the timeline for implementing this system at the scheduled meeting on January 9, 2024.

2. Flagging of Risk

I heard evidence that it is possible for patients' risks to be 'flagged' within the Oceano records system to ensure that all staff are made aware of these. This was not done in this case and that this was not done as a matter of course. The Acting Medical Director was not aware of an established policy or procedure about using this existing functionality.

Trust Response:

We can advise that since the death of Jack Farrington the flagging of patients with a mental health requirement in the ED now occurs at the department's safety huddle which takes place every 2 hours throughout a 24-hour period. During this huddle, the department's senior team highlight patients with a mental health requirement discussing:

1) Identification (patients presented with a mental health concern who are at risk)
2) Assessment (discuss the department's current concern for these patients including any immediate risks or crisis situations)
3) Resources (identifying available resources to support including the mental health liaison team)
4) Safety measures (considering any additional safety measures that may be required i.e., 1:1 supervision, removal self-harm objects and appropriate environment for assessment).

The Trust Oceano System does have the facility to flag patients with specific needs, however there are challenges in the visibility of this for clinical staff. The Trust is undertaking an improvement programme for the way our electronic systems are used to ensure that they link with each other to flag patient needs and risks. This programme is being led by our Chief Nursing Information Officer in conjunction with divisional clinical and IT leads. This work, which is in development, will include a Trust Alert Policy and Standard Operating Process (SOP) for the use of alerts and is aimed to be in place by April 2024.

We are currently addressing the specific mental health flag requirement within the ED. We are developing a local Standard Operating Procedure (SOP) that will provide guidance to clinical staff on the appropriate use of the flag. Our goal is to have this SOP in place by February 2024.

The Trust is currently in the final stages of recruiting a senior lead for mental health. Once this individual is appointed, they will be responsible for overseeing the progress of this work stream. We are pleased to inform you that the successful candidate will assume the role no later than April 2024.

3. Risk Assessment Tool

A "Mental Health Primary Disturbance Survey" tool was used to assess Jack on his arrival at ED. This indicated that his risk level was 'level 5+ black' and this in turn set out a requirement of the mandatory presence of security guards. However, when Jack absconded there was evidence that no security guards were present. There was evidence that clinicians made risk-based decisions that such guards were not necessary.

However, I heard evidence that the hospital board were not aware of this tool mandating a security presence and that the tool outcomes were not reflected in trust policies about the risk of absconding. The Acting Medical Director has stated that this tool requires assessment as to whether it is fit for purpose.

Trust Response:

We can confirm that the Trust has undertaken a full review of the Mental Health Primary Disturbance Survey in accordance with Acute Psychiatric Emergency guidance (APEx) and the Royal College of Emergency Clinicians Mental Health in Emergency Departments guidance (2023) updating the tool to reflect best practice guidance for enhanced observation requirement. The tool includes a clear guidance for escalation of concerns to senior nursing staff for support, this includes night-time and out of hours available support.

The Trust has also introduced a twice daily Plan of Care Mental Health Huddle which is led by senior nursing staff and attended by all divisions and the in reach Southern Health NHS Foundation Trust Mental Health Liaison Team. The risks and plans for all Mental Health patients in the hospital, including the ED, are reviewed to ensure the best possible allocation of specialist nursing support is in place. The Mental Health Liaison Team is also available to provide guidance to staff out of hours.

The allocation of security personnel to support the care of mental health patients is situation and case specific and may vary dynamically for any given individual patient. This is assessed by the local clinical team with support from the Mental Health Liaison team and regular review in the Mental Health huddle. As was discussed at the inquest, the presence of security staff can at times be provocative for Mental Health patients and cause an escalation in their distress and resultant behaviours. A collaborative approach is necessary whereby security staff work closely with mental health professionals and clinical staff to ensure a coordinated and appropriate response to patient needs, supported by risk assessments to ensure their safety and the safety of staff.

4. Paper and electronic records

There were records kept during Jack's presence at Queen Alexandra Hospital which were either not stored or had been lost prior to the inquest. This significantly hampered the investigation and restricted information available to the jury.

I accept that the location of patients with mental health issues whilst awaiting transfer to a mental health unit has changed since Jack's death. I also understand that mental health nursing records are now kept within an Enhanced Care Plan, but this is still in paper format and therefore the risk of inadequate information sharing and failing to store records remain.

Trust Response:

As noted by the coroner, the Trust continues to work to improve its processes regarding the care and documentation of the care of patients with mental health needs. Patients awaiting mental health placement are predominantly cared for in the Acute Medical Unit (AMU) with the recent introduction of the mental health nursing records being located within the Enhanced Care Plan.

Within the ED, bank and temporary members of staff are provided with a temporary ICT login, and a login for Oceano allowing for electronic documentation of patient assessment and delivery of care. Our partner organisations, Solent NHS Trust, and Southern Health Foundation Trust mental health teams, also now have access to Oceano allowing them to input their assessments and plan of care directly into the Trust's ICT system negating the need for paper records.

The Trust fully agrees that the current hybrid between paper and electronic records creates greater complexity and inefficiency, impacting the ability of the multidisciplinary teams to locate all necessary information for each patient. The ambition of PHU and similar NHS Trusts who have not already done so is to move to a true paper free Electronic Patient Record (EPR). We are working with the Integrated Care Bord (ICB) and other Acute Trusts in Hampshire and Isle of Wight to achieve that goal over time.

5. <u>Partnership Working in the care of patients with significant mental health needs</u>

The Trust acknowledges that addressing the needs of patients with significant mental health requirements is an ongoing and growing challenge throughout our healthcare system. Although the Trust does not offer specialised mental health services, we have observed a rising number of patients seeking care who are not suitable for the acute hospital environment.

We are committed to continuing to work closely with our partner organisations to provide the best possible outcomes for patients with mental health needs who access our acute care services. The Trust hosts a Mental Health Coordinating group which meets bi–monthly in partnership with our system colleagues to review ways to improve the pathway and experience for patients. This group reports into the PHU Mental Health Operation Board which is chaired by the Deputy Medical Director and has membership from across our health and care system partners.

I hope the content of this letter provides the assurance required to demonstrate that the Trust is aware of, and responding to, those issues of concern raised in the regulation 28 report. If you have any further questions, then please do not hesitate to contact me.

Yours Sincerely

Portsmouth Hospitals University NHS Trust

[redacted]

[redacted]
Chief Executive

[redacted] [redacted]
Portsmouth Hospitals University NHS Trust, Trust HQ, Queen Alexandra Hospital, Southwick Hill Road, Cosham, PO6 3LY
Registered charity number: 1047986

Working together To drive excellence in care for our patients and communities