Inspected and rated Outstanding

CareQuality Commission

NHS
Dorset HealthCare University
NHS Foundation Trust

Corporate Office
Sentinel House
Nuffield Industrial Estate
4-6 Nuffield Road
Poole, Dorset
BH17 0RB
[redacted]

Andrew Bridgman
Assistant Coroner
South Manchester area

Dear Mr Bridgman,

Re Regulation 28 Report following the inquest touching on the death of Lauren Bridges

We acknowledge receipt of the Regulation 28 Report issued to Dorset HealthCare University NHS Foundation Trust following the inquest touching on the death of Lauren Bridges. The report, dated 19th September 2023, was received by Dorset HealthCare on 24th November 2023, following contact with your office.

Our thoughts are with Lauren's family following their loss and we are truly sorry for the circumstances in which Lauren died.

After Lauren died, we undertook a review of the care and support offered and we have made changes to the way in which we support our patients who are receiving care out of area.

In respect of the specific regulation 28 matters of concern notified to the Trust, I will respond to these in turn:

a) The omission to update the Hospital Overview timeously and correctly.

In respect of the Hospital Overview document, we have made a number of changes and improvements to ensure that this is updated in a timely and correct way. The changes we have made are detailed below:

1. The Trust has undertaken a comprehensive review to ensure that all patients who are receiving acute care funded by the Trust in Out of Area beds are accurately identified as such on our clinical system.

2. We have enhanced the daily Hospital Overview situation report which is accurate at the point it is sent, with the purpose of providing a summary at the start of the working day across the organisation to key colleagues including senior clinicians and managers. The information contained in the daily Hospital Overview template is updated manually by the night practitioners from data contained in the clinical system. It is then checked by both the Out of

Area Co-Ordinator and the Clinical Site Managers, who are clinicians who are overseeing bed flow decisions, to ensure that the information contained in this document is correct for that point in time. The Hospital Overview is then emailed to key colleagues to provide a summary of the bed state every 24 hours.

3. In addition, the Trust has also added a specific section to the daily Hospital Overview template showing patients who are in out of area beds who require repatriation to a local bed. This ensures that Clinical Site Managers are taking these patients into account when making daily decisions on bed allocations.

4. We have also made improvements to our automated reporting. We have updated the electronic admission form template that is embedded in the patient record system so that when a patient requires admission, we capture more robust information, which is then also reportable in a bed state automated report. This automated report provides additional information in respect of patients in excess of the Hospital Overview document, for example a list of names and length of stay for every patient admitted to hospital, to an out of area bed, and those awaiting admission. This more detailed information is used by clinicians directly involved in bed flow and inpatient care to support their daily work.

b) It can be inferred from the absence of any documentation regarding discussions about Lauren's repatriation to an available bed that no such discussion took place.

In respect of this matter of concern, I have focused our response on actions we have taken to improve the oversight, routine review, and documentation in respect of admission and / or repatriation decisions including for patients whose inpatient care is provided out of area:

1. The Trust has implemented a new Standard Operating Procedure (SOP) for Enabling Purposeful Admissions. This clearly sets out the required process, roles and responsibilities of key staff and the required recording in respect of inpatient flow decisions. This SOP has been communicated to staff and included on our staff intranet.

2. We have reviewed our daily clinical meeting that takes place in respect of bed flow and set out requirements in the meeting's terms of reference, including standard items for discussion and recording standards. These terms of reference are included within the Enabling Purposeful Admissions SOP.

3. As referred to during the inquest, we have appointed a dedicated Out of Area Coordinator post, which is a clinical post. We have also written and implemented a SOP for the 'Use of Out of Area Acute and Psychiatric Intensive Care (PICU) Mental Health Inpatient beds: Therapeutic inpatient care and proactive discharge planning'. The SOP includes standards to be met in respect of regular contact and recording of that contact with patients who are out of area, and their families / carers, as well as with clinicians working in out of area providers overseeing that care.

4. Clinical Site Managers now use a live Microsoft Teams channel for communicating updates between them on requirements around bed flow, which is linked to patient electronic records. This replaces previous paper handover records and ensures that there is documentation of bed flow discussions and decisions, for example, if there are moves of patients between wards in order to create bed capacity in a specific ward to facilitate an admission, that this is

appropriately communicated between Clinical Site Managers. This supports better handover between Clinical Site Managers coming onto a shift, so they can understand the status of pending admissions and decisions taken in the previous shift. In addition, discussions regarding individual patients are also recorded in the patient's own electronic patient record (known as RiO) to ensure a complete up to date record for each individual patient.

5. A regular audit takes place every month involving reviewing the records of all patients receiving their care out of area against the standards set out within the SOP. This audit is undertaken by our Nursing and Quality Directorate and will remain ongoing. Audit standards include evidence of OOA coordinator input, date of last input, that the patient has an allocated Care Coordinator, date of last input from them, date of last contact with patient and family, date of Care Programme Approach meeting, date of last clinician attendance at a multi-disciplinary team review, and whether there is a discharge / repatriation plan.

I can confirm that all of the actions detailed have been completed and ongoing assurance where required is monitored via the monthly audit. We hope we have provided assurances that Dorset HealthCare has addressed the areas identified in the Regulation 28 Report and that we have taken the matter extremely seriously. The DHC Board are sighted on the significance of the Regulation 28 Report. We will continue to report our progress to both our Board and NHS Dorset Integrated Care Board so there is clear visibility of the service improvements being made.

We are now confident that the circumstances for Lauren would not be repeated, which we hope will bring some comfort to Lauren's family. We are also keen to reiterate our sorrow for the circumstances in which Lauren sadly died.

Yours sincerely

Chief Executive