

Nottinghamshire Healthcare NHS Foundation Trust
Duncan Macmillan House
The Resource
Porchester Road
Mapperley
NG3 6AA

Monday 4 March 2024

Private and Confidential

HMC Bower

Dear HMC Bower

RE: Preventing Future deaths Response, Tammy Watkins

Further to the Inquest into the death of Miss Tammy Mary Louise Watkins, I write in response to the Prevention of Future Deaths order Nottinghamshire Healthcare NHS Trust were issued with on the 5 January 2024.

Ms. Watkins died on the 6 of June 2021 at Bassetlaw having been a patient at Rampton High Secure Hospital.

We accept the findings from the Inquest and would like to assure you that we take the findings and actions very seriously and provide the updates below in response to your concerns:

1. Poor Quality Acute Physical Healthcare in the Mental Health Setting

The Trust recognises that Physical Healthcare is a key quality priority to improve the care to patients and reduce the risk of harm. The Trust have recognised the need to fully review how and what physical healthcare is offered across all inpatient services and successfully recruited an Associated Director of Physical Healthcare last year. This is a strategic post and covers all three care groups. Their initial priority has been to scope all physical health models of care across inpatient services with the aim of understanding the unique needs of patients across our services. The next phase will look to address the associated training needs and structure of who provides what care across the inpatient services to mitigate future harm associated with the deteriorating patient.



Active work has commenced in Adult Mental Health inpatient services and Rampton Hospital and will continue to roll out across all services over the next 12 months. The work is informed by best practice, the needs of the patient group and learning from the thematic reviews of incidents of past harm, alongside learning from staff in practice. The work is overseen in the Trust Physical health strategic group and is overseen by the Quality Operational group and Committee.

The output of the review will be the development and delivery of a Trust Physical Healthcare Strategy which will set out and define clear roles, responsibility, and accountability within the framework. The strategy will include both internal and external stakeholders such as local Acute and General hospitals that our patients access whilst an inpatient at Rampton Hospital to ensure best possible outcomes. Working collaboratively will ensure improved communication and enable practitioners to work together with a shared approach, incorporating a system wide response. The oversight, leadership and governance of physical health care will also be reviewed and amended accordingly. We would be happy to share this work and the key findings and actions with HM Coroner to show the progression and development of this work.

2. Failure to Adhere to the National and Local National Early Warning Score (version2) Policy.

NEWS 2 was introduced in the Trust in 2020. We recognise that the implementation has been more complex and additional improvement support has been implemented to address these gaps.

NEWS 2 training has been delivered to all frontline clinical staff who would be required to undertake this assessment and supports the policy requirements.

In addition to this, at a glance posters are within each of the inpatient wards alongside lanyard attachments to support easy to access guidance when undertaking a NEWS2 assessment. A full audit process around NEWS2 is now in place and is monitored and responded to within normal governance frameworks with current compliance at 98%. Rampton hospital have ensured that senior nursing staff have increased visibility and presence in patient facing areas, to provide 'in action' learning, role modelling and opportunity to provide direct feedback to colleagues. Clinical supervision is also recognised as a key aid to supporting and developing practice by sharing feedback and providing one to one clinical input to improve practice and aid a culture of learning. Having senior Quality Matrons deliver and provide clinical supervision further strengthens this approach and encourages a culture of continuous learning and improvement. Quality Matrons will use clinical supervision to introduce scenario-based examples of patients who require escalation to assess staff members competency around NEWS2.



A further training needs analysis is currently being undertaken to understand if this can be enhanced to support and improve front line knowledge and clinical skills. HM Coroner will be updated as this moves forward.

3. A lack of robust policy relating to Ingestion of Foreign Bodies

The procedure for the management of patients who have ingested foreign bodies has been reviewed and updated following the death of Tammy. There is a focus to implement a bespoke care plan for patients who present a clinical risk of ingestion with a clear framework of how to act should this clinical incident occur. The revised policy with these additions are for ratification at the Trust Clinical Policies approvals group 6 March 2024. This will then be widely disseminated to all areas whereby the risk of ingestion of foreign bodies is present.

To review current practice and to continue to address areas of concern, Rampton Hospital are undertaking case reviews of subsequent similar presentations to identify if the learning from Tammy's death has been embedded and sustained. We will ensure that any learning or areas for continued training are identified within these case reviews are responded to and included within Hospital Life Support training/ any future enhanced training that is provided.

A comprehensive learning event was held on the 5 February 2024 this included a wide range of clinicians, managers clinical leaders and frontline staff, this event shared and discussed the outcome of the PFD with a specific focus on the risks associated with ingestion behaviours, barriers, improved partnership working and a solution focused approach to reducing and mitigating this risk wherever possible.

4. Emergency Medical Calls

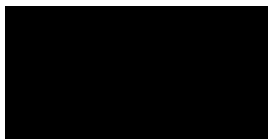
The process for emergency medical calls within Rampton Hospital has been reviewed and the process has been reinforced back to all staff that where immediate concerns are present regarding the physical health of a patient, it is expected that they will call for an ambulance. This is reviewed in line with the increased senior leadership and local learning.

The development of the Physical Health Strategy will further complement this work as the key aim is to ensure staff are clear on the remit of their roles and what actions they are accountable to take when a patient is deteriorating.

I hope that the information contained within this response provides assurance to you and Ms. Watkins's family that we, as a Trust have heard and understood the significant concerns raised throughout and as a consequence of this inquest, and that we are committed to continuing to make these important improvements to services and processes for future patient care.



Yours sincerely



Executive Director for Nursing, AHPs & Quality

