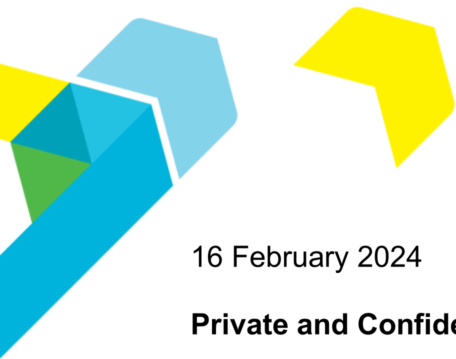


NHS Surrey and Borders Partnership NHS Foundation Trust

16 February 2024

Private and Confidential

[redacted]
Chief Executive

Chief Executive's Office
Surrey and Borders Partnership NHS Foundation Trust
18 Mole Business Park
Randall's Road
Leatherhead
KT22 7AD

Mr Darren Stewart OBE
Assistant Coroner for Surrey
[redacted]
[redacted]

Dear Mr Stewart

Larry Spriggs (deceased)
Regulation 28 Report to Prevent Future Deaths
Response from Surrey and Borders Partnership NHS Foundation Trust ("the Trust")

Thank you for the Regulation 28 Report to Prevent Future Deaths (PFD report) dated 22 December 2023, in relation to the inquest touching the death of Larry Spriggs. I have considered the report carefully, together with the Trust's Chief Medical Officer, the Chief Nursing Officer and other senior colleagues from the relevant divisions.

We have reflected on the concerns set out within your PFD Report and have outlined below the steps that have been taken and are being taken to address these.

Evidence of the cultural change in the delivery of care and treatment of patients

In 2023, the Trust launched a new five year strategy to meet the needs of the people we serve across Surrey and North East Hampshire. This strategy focuses on delivering high quality care and placing people who use services at the centre of everything we do. We have identified a number of strategic ambitions which includes strengthening involvement with people, carers and families and being a learning organisation.

In relation to inpatient wards, the Trust has embarked upon an Inpatient Improvement Plan which has the overarching aim of developing our inpatient care through safety and quality improvements to ensure better outcomes for those using our services. This is reported through the Inpatient Improvement Board and encompasses clinical, workforce, infrastructure, digital and environmental change. There has also been a review of our operational model for inpatient services. As of 1 September 2023, all of the Trust's inpatient services have been managed under one Hospitals Division with shared quality and operational management structures allowing cultural change to be delivered through compassionate, inclusive leadership.

In addition, the Trust has now adopted the Patient Safety Incident Response Framework (PSIRF) which is part of the approach to patient safety that is described within the National Patient Safety Strategy. PSIRF will enhance our safety and learning culture by creating much stronger links between patient safety incidents and learning, working in collaboration with those affected by the incident. In turn, this fosters a culture of transparency and openness amongst staff in reporting incidents and engagement in implementing improvement to embed learning.

The improved safety culture within the organisation is demonstrated in the results of our staff survey. Our overall staff engagement scores across the Mental Health & Learning Disability and Mental Health, Learning Disability & Community sector showed that we were within the top three Trusts within this sector. In particular, 92.3% of staff reported that our organisation encouraged them to report errors, near misses or incidents, and 82.4% of our staff feel secure raising concerns about unsafe clinical practice. This tells us that staff involved in an error, near miss or incident feel they are treated fairly and that there is confidence that our Trust will take action to ensure that these do not happen again.

As part of our ambitious plan to continue to improve culture within the organisation, the Trust has also registered for the NHS England Culture of Care Programme. This aims for wards to provide safe, therapeutic and equality focused care in accordance with co-produced Culture of Care Standards for Mental Health Inpatient Care. This programme includes Quality Improvement coaching for up to four inpatient wards which will receive close support to implement change theory by testing several changes over the two year programme. In addition, it provides leadership coaching as well as to support to move towards a holistic approach to safety.

There have been a number of initiatives specifically relating to culture change on Victoria Ward. Since early 2023, the Matrons and Ward Managers from the older adult wards have been participating in an Action Learning Set which is an opportunity to reflect on issues on the wards and provide group counselling to identify solutions. This is being facilitated by an Organisational Development consultant on a two monthly basis, who also attended an away day for qualified staff working on Victoria Ward in December 2023. This focused on team working and a number of changes for implementation were discussed and agreed.

From 2024, there have been separate monthly meetings for Health Care Assistants and for qualified staff in addition to the overall staff meeting. The purpose of these meetings is to address development needs specific to that staff cohort and are predominantly teaching sessions. It is intended that these sessions will greatly enhance staff knowledge and skills while increasing staff feelings of belonging and a desire to continually improve the care and treatment for people on our inpatient wards.

In addition, we receive insights into our culture via the Your Views Matter survey results, which asks people to share their experiences with our services. From August 2023 to February 2024, we received 81 responses in relation to our inpatient services for older adults. Of these, 73 people rated their overall experience as “very good” or “good” and 76 responded that the care and services they needed were organised “very well” or “well”.

We recognise that there is still work to be done around cultural change to support the care and treatment of people using services and their families and carers. As part of this, we have recently commissioned an external review of quality control processes and are currently working on our implementation plan.

The adequacy of arrangements in place at Farnham Road Hospital to assess and manage inpatients risk, including the prescription of anti-anxiety medication.

Further to NICE guidelines indicating a change from the global stratification of risk into “low, medium or high”, the Trust developed and successfully piloted a new Risk Assessment Template which went live in January 2024. This, together with the mandatory suicide prevention training for clinicians which was introduced in November 2022, has improved our ability to assess inpatient risk.

The Risk Assessment Template allows clinicians to formulate risk presentation taking into account a range of factors and identify the most appropriate way to manage risk. This includes whether medication should be prescribed. Clinical decision making is made on a case by case basis and must also consider NICE guidelines which outline a preference for therapeutic intervention over the prescription of medication. Such decisions are often finely balanced, particularly where there are additional risks, for example, in prescribing benzodiazepines in older adults.

Passage of information between staff concerning patients care and treatment.

Measures have been introduced to improve the passage of information between staff across our inpatient wards. It is acknowledged that embedding change takes time and we are committed to continually improving our processes to ensure effective and timely communication of information.

At the twice daily handover between staff, key documents including the 10 Keys Steps to Safety and the SBAR (Situation, Background, Assessment, Recommendation) are reviewed. The SBAR is updated electronically twice per day by the nurse in charge prior to handover.

Additionally, there is a daily handover between the nurse in charge and the junior doctors on the ward. Where any member of staff receives information which suggests that risk should be reviewed urgently, including concerns raised by family or carers, that information should be handed over to the nurse in charge. Information that is handed over verbally should then be added to the SBAR and the nurse in charge will consider the need for review of the risk assessment or therapeutic measures such as an increase in the level of observation. This can be implemented immediately and does not require waiting until handover. A Daily Safety Report is also completed by inpatient wards and discussed at the daily safety call meetings attended by senior leadership from all wards.

On each night shift, a Hospital Duty Manager (who is a senior nurse) is identified to complete a Daily Handover Report for the morning staff. This includes details of staffing levels, incidents on the ward and actions taken to maintain safety. The Daily Handover Report is shared with all senior staff on the day shift, including the senior matrons and associate director. Furthermore, on call junior doctors also produce a written handover report detailing any safety issues, health monitoring or additional tasks to be completed by the day team. This range of measures ensure that safety critical information is passed between staff in a timely manner.

The adequacy of arrangements to manage and implement intermittent observation at Farnham Road Hospital.

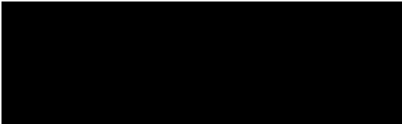
Observation competency checklists are completed at staff induction for all substantive and temporary staff working on Victoria Ward. An observation prompt sheet is provided to staff completing observations. The responsibility for overseeing observations lies with the nurse in charge. From June 2023, Victoria Ward introduced the Supportive Observations Audit Tool. This provides a quality assurance process for not only the policy compliance around supportive observations, but also in the wider context of MDT overview, clinical rationale, care planning and the views of the person. Audits of ten people in the care of the Victoria Ward are carried out on a monthly basis.

In addition, and in co-production with the Victoria Ward clinical team and the Quality Improvement team, a digital solution has been developed for the recording of supportive observations and therapeutic engagement. It is intended that this will be tested and evaluated for its impact on safety prior to a decision about wider roll out across the organisation as part of the current Inpatient Improvement Plan.

There is a national observation improvement programme underway and the Trust is leading one of the work streams around workforce and training. The programme is led by the National Mental Health and Learning Disability Nurses Directors Forum who are reviewing therapeutic observations and engagement practice. The Trust is part of the Project Board and will be implementing recommendations from the review alongside other mental health trusts.

On behalf of the Trust, I would like to offer our sincere condolences to Mr Spriggs' family for their loss. We hope that our actions outlined above assures you and Mr Spriggs' family that we have reflected on your concerns and provided reassurance as to our processes.

Yours sincerely,



Chief Executive