Nottinghamshire Healthcare NHS Foundation Trust
Duncan Macmillan House
The Resource
Porchester Road
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[redacted]

26 April 2024

Private and Confidential

Dear Mr. Wall

Regulation 28 Response – Mr. Daniel Tucker – April 2022

Please find below the Organisational response to the received Regulation 28 Report to Prevent Deaths following the death of Mr. Daniel Tucker, the inquest of which was concluded on the 6 February 2024. We offer our continued sincere condolences to Mr. Tucker's family.

1. **A continuing practice/culture of minimising the importance of a ward specific risk assessment and care plan.**
I am concerned that, notwithstanding the existence of a clear, appropriate policy and significant commendable actions by the Trust since Daniel's death to address this issue, there remain clinical and nursing staff who do not fully recognise or accept the importance of completing and utilising the required risk assessment and care plan. This suggests there may be a persisting training or cultural issue.

Response:

The Trust expectation remains that care plans and risk assessments are individualised and fully updated following the 72-hour assessment period. Throughout a person's admission care plans and risk assessments are expected to be kept contemporaneous and accessible to all staff to support a patients care. At the inquest evidence was provided about how an improvement in care planning had been demonstrated and the oversight of this is a continual process to ensure this is maintained. A monthly audit is completed which is shared within

the clinical team to ensure any discrepancy for expectations is addressed and updated. The latest figure for this from March 2024 was 81% compliance with care planning expectations.

The oversight of care planning is a feature of the Trust rapid improvement programme. This is a Trust board supported priority focus to improve the quality within adult mental health (AMH) service inpatients wards. With regards care planning the emphasis of this work has been the engagement of our patients regarding their experience of care planning. Secondly the Trust is looking to move to an alternative care planning tool through the Dialog+ model. This is an evidence-based tool which has received positive feedback in their evaluations. AMH's Head of Nursing colleagues are involved in supporting the implementation plans. Additionally, an allocated worker model is in the implementation phased at Highbury Hospital. This sets a key expectation of allocated staff members to have a deep understanding of individual care plans on each clinical shift to ensure effective and meaningful care is offered in line with said care plan. This will be in addition to a named nursing team.

Regarding risk assessments this is also a feature of the rapid improvement work with clear emphasis in the understanding of risk within the clinical areas. A key element of this is the introduction of safety huddles which is within the pilot stage within AMH before role out to all wards. These safety huddles support the team to reflect on the dynamic risks within the ward ensuring risk is well understood and shared amongst the team to ensure effective robust plans are in place.

Trust guidance relating to risk assessment, formulation and safety planning has been reviewed in line with NICE guidelines and the latest updates from NHSE and suicide prevention evidence and literature. Nottinghamshire Healthcare's Trust Lead for Self-harm and Suicide Prevention is leading this work and has met with NHSE and other leaders in suicide prevention to scope good practice and share learning. Updated guidance is reflected in the Trust's new Clinical Risk and Safety Policy (due to be ratified early May 2024) and guidance documents relating to psychosocial assessment, formulation, and safety planning in relation to suicidality, including self-harm have been developed. Audits, and risk and safety forms within healthcare records (including risk and safety assessments, formulation and care and safety planning forms) are being reviewed and updated to reflect the latest guidance, and support improvement and safety. In April 2024, the Trust also commenced development of a Trust Clinical Risk and Safety Panel, to provide governance and guidance relating to clinical risk and safety, including policy, training, and support for complex cases.

Suicide prevention and self-harm training was reviewed and enhanced in early 2024, to provide assurance re quality and oversight, and include updated self-harm awareness and response training in addition to suicide prevention awareness and response training for compliance with NICE guidelines and to support consistent language, content, and approach. This training continues to be supported by Learning and Organisational

Development but is now coordinated and assurance provided by the Trust Lead for Self-harm and Suicide Prevention and the suicide prevention training team regarding quality and consistency of training. The Suicide Prevention team also work with clinical teams to support implementation of good practice and guidance in relation to self-harm and suicide prevention with a further 8 colleagues from within the Care Groups becoming licenced Train the Trainers in March 2024 with supervision and support (including co-delivery) from the training team to support further implementation.

Mandatory training for risk is at 85% for Redwood 1 at Highbury Hospital. This is monitored by senior leads to support staff to attended to this training. Additional training that may support staff's confidence with regards risk is being considered to augment existing risk assessment training.

The need for clear risk assessment and care planning lead to the review of MDT records and an improved template to capture discussions and plans in a more meaningful manner has been completed by AMH Clinical Directors. This has been launched and is due for full evaluation in July 2024.

2. **Inadequate system of allocating a named nurse to patients and recording the same**
I am concerned that, notwithstanding the existence of a clear, appropriate policy requiring the same, the current system of allocating a named nurse and ensuring patients receive regular and effective 1:1 sessions with them are inadequate. I am also concerned that no record is kept of the named nurse appointed to each patient, thus (as in this case) hindering any investigation where issue around the role and actions of that person arises.

Response:

It was recognised within the inquest that an urgent review was needed for the system of named nursing within AMH inpatient acute wards. This work is being led by the Head of Nursing at Highbury Hospital. The expectation would be for named nurses to be allocated on admission and wherever possible this should be the admitting nurse due to continuity of care. Where this is not possible for example where a staff member will be taking some annual leave, an alternative nurse anticipated to be working within the 72 hours will be allocated. This is current work in progress and in the engagement phase with the ward teams.

To ensure that all patients know of their named nurses and that there is a clear record of this an interim measure has been agreed for the named nurse to be cleared detailed within the care plan. For the patients experience this will mean that upon receipt of their care plan they will have this detail to hand and will be confident of who their named nurse is. This will also provide a record should the identification of the named nurse be required for

governance processes such as an investigation. Audits will now be ongoing to support oversight and compliance.

Longer term the allocated worker, as detailed in point 1, and the named nurse work will feature as part of the nurse's development through training, coaching and support to fully understand the roles and the importance this has for high quality and safe patient care.

3. Inadequate skills/knowledge/training on how to encourage patients to engage
I am concerned that clinical, nursing and/or support staff may not currently have sufficient skills or knowledge in dealing with patients who appear unable or unwilling to engage with staff and/or treatment.

Response:

Mr. Tucker had very clear reasons for seeking an alternative bed which may have supported his engagement with the team. Whilst Mr. Tucker was recorded on a transfer list seeking an alternative bed this process was no robust enough. The process has since been reviewed which saw the transfer procedure reviewed to ensure the full MDT was explicitly clear of the need for transfer and rationale for this. In addition, our bed management recording has been amended to hold a single bed list to include all admissions and transfers. This now offers a clear oversight and allows for prioritisation based on all known factors.

To further support clinical training oversight, the Trust has a newly formed Clinical education steering group which is a strategically led group with representation from senior staff within learning and development and clinical practice. The remit for this group is to carry out a comprehensive review of all training, both mandatory, essential and desirable, across the whole of the trust to align with the needs of each care group. The group will carry our mapping exercises on current provision and sign off new training to ensure it meets the quality and safety requirements for the staff attending. The review will align with the NHSE optimize, rationalize and reform plan. The group has clear governance procedures which will guide the review and implementation. It will allow clear data to be produced so that the care group needs can be met in a timely manner, by adapting the training delivered according to the needs of the service.

More specifically, additional training has commenced to support staff which has included additional suicide awareness through formal training over January 2024 – 78% of Redwood 1 staff attended during this month, additional training is being arranged for those unable to attend in January and new starters that have joined the team since. Alongside this bitesize training sessions were made available, and training is in development regarding positive behavioural support. The Trust have invested in additional self-harm and suicide prevention training – Storm which is due to start to roll out in June 2024.

I would once again express our deepest condolences to Mr. Tucker's family.

Yours sincerely

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Executive Director of Nursing AHPs and Quality

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