Oxford Health NHS
NHS Foundation Trust

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Also sent by email to:
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5th April 2017

Dear Mr Butler

Regulation 28 Report to Prevent Further Deaths following the inquest concerning the death of Mr Jack Portland

I am writing in response to the concerns raised in your Regulation 28 report dated 21 February 2017, which followed the inquest relating to Mr Portland's death. Thank you for bringing these concerns to my attention.

I will address your concerns in turn using your numbering.

Concern 1

The provision of copies of leave forms is not in fact mandatory under either the Mental Health Act Code of Practice or Trust policy (the Trust's current granting of leave form, which suggests that this is the case, is misleading). Nevertheless, it is acknowledged that in many cases patients and their families find it useful to have a copy of the form in addition to being involved in discussions around the granting of any leave and conditions. The section 17 leave form has been amended and is currently going through the Trust's governance processes for approval. It is anticipated that use of the new form will be implemented no later than 28th April 2017. The newly designed form allows the consultant to indicate, following discussions with patients and families, if copies should be provided and, if so, to whom.

In addition, a new standard operating procedure (SOP) for managing leave (appendix 1) includes the need for staff to have a discussion with the family, where appropriate consent is given by the patient, regarding the patient's leave from the ward and to do this every time there is a change to the leave agreed.

This SOP has been welcomed by Sapphire ward staff as it clarifies responsibilities and standards in relation to leave. After the testing period on Sapphire ward and a review, which is planned for end of April 2017, this SOP will be expanded and implemented across all adult wards.

Concern 2

The new SOP referred to above is being tested on Sapphire ward. It clarifies and simplifies the management of leave on the ward. It gives clear instruction as to how leave is granted, the nursing level assessment, and simplifies the recording of leave on one collective ward document (appendix 2).

The Trust acknowledges that the risk of human error when recording information in numerous places is unacceptable, and has therefore ended this practice. The team now works from one central document, and no longer records leave on a whiteboard.

Concern 3(i)

The new SOP includes the physical handover, once an hour, of the general observation chart between allocated staff. At handover both members of staff must now assure themselves that the sheet is fully filled in and in order.

Staff have been strongly reminded that it is not appropriate to fill in observations paperwork prospectively or retrospectively. This is now monitored by the Matron. We are in the process of reviewing the Trust's Observation Policy, and will ensure that this is also made very explicit within the new version. This policy review will be complete by the end of April 2017.

Concern 3(ii)

The responsibility for ensuring that patients are back from leave now clearly rests with the person allocated to carry out general observations. That staff member is also responsible for informing the shift co-ordinator, who will co-ordinate the implementation of the AWOL policy, if a patient does not return on time (appendix 3). The shift co-ordinator is always a qualified nurse.

On occasions when a patient is AWOL the attached guidance clearly lays out the actions required and, in accordance with the AWOL Policy, staff should complete the Missing Patient Action Checklist to give a clear record of action taken.

This has been clearly communicated to the team and added to every staff member's supervision sheet to ensure that individuals have the opportunity to discuss the procedure and check their understanding. Copies of the attached guidance and Missing Patient Action Checklist are available on all acute inpatient wards for ease of reference and use.

For all acute wards there is ongoing work using quality improvement methodology aimed at increasing the number of patients who return from leave on time. This work includes weekly

monitoring and review by the Matron of data collected on the wards showing the number of patients returning on time and late, which assists in identifying trends or issues. The team's compliance with SOPs and any breaches are explored and relevant supervision and training implemented for individual staff when necessary.

An existing SOP which covers shift co-ordination has had a new action added, which is that the shift co-ordinator signs off all relevant sheets, including observation charts, to ensure that all staff have fully completed the required paperwork, including the leave record form, and it is in order before handing over to the next shift.

Concern 4

The admission checklist for the wards includes the requirement to update the risk assessment upon admission. This is further prompted by the electronic 'patient status at a glance' (PSAG) board in the nursing office. All qualified staff receive the Clinical Risk Assessment and Management training which includes consideration of the various sources of information a clinician may use to evaluate risk.

In Mr Portland's case, there was evidence of a handover from the Dene, however it is acknowledged that more effort should have been made in obtaining historic information from HMP Woodhill. This has been discussed with staff in the ward's business meeting, and the Matron will continue to work with the team to ensure they meet the required standards of the Trust Clinical Risk Policy. This will be the responsibility of the Senior Matron who will ensure that historic risk information is obtained for those patients who have received care and treatment in a prison setting.

Concern 5

An initial review is completed for every serious incident, as was the case following Mr Portland's death. Each initial review report should be completed within 5 days of the incident/ death, reviewed by the senior clinical team and also by a weekly Trust wide executive meeting. The purpose of the initial review report is to set out the initial facts known, to identify any immediate action or learning required and to help develop the scope for the RCA investigation. The initial review report into Mr Portland's death identified three immediate actions all around the timeliness of initiating the AWOL procedure. The initial review report was shared with the CQC.

The first RCA investigation report was shared with the family, Coroner, commissioners and the CQC. We have acknowledged the mistakes in the timeliness and thoroughness of the first RCA investigation. In response to the concerns raised by the family, about the omissions in this first investigation report, identified at the first pre-inquest meeting, a third investigator did review the report. The initial plan was to add an addendum to the first RCA investigation report. However, this work highlighted weaknesses in the first investigation approach and identified further omissions, as well as learning around documentation. Therefore, following discussion with the CQC, commissioners and Buckinghamshire

Safeguarding Adult Review Group, the Director of Nursing made the decision to re-open the serious incident and to commission a new investigation with new authors. The timescale for completing the second RCA was 31 November 2016. This timescale was based on the national timescale of aiming to complete an investigation within 60 days. The family, commissioners and CQC were informed of this decision to commission a second RCA investigation and the timescale.

The second RCA investigation was completed by two new investigators and a second internal review panel was convened (with different members from the first panel) by 31 November 2016. The report was then shared with the family, coroner, commissioner and CQC. We did not send a copy of the second final RCA investigation report to the family until 15 December 2016. We apologise, this was unacceptable and we do not have any satisfactory reason for this delay; it was as a result of an internal confusion about who was going to send the final report.

The initial review report (completed within days of Mr Portland's death) identified the immediate concerns and actions to be taken. The second RCA report therefore did not focus on the immediate actions taken, as this was not the purpose of this investigation.

Concern 6

The Trust's approach to the RCA process is that it is an open and supportive process with a focus on learning. Investigators do not routinely take formal statements or transcripts of meetings as part of the investigation; personal notes are kept to inform the investigation. Drafts of RCA reports are routinely shared with all staff interviewed and they are invited to feedback on content and accuracy at that stage. In this case, it was not felt that there was additional documentation available from the RCA investigations to further inform the Coroner's investigation. The Trust does, and will continue to, cooperate in sharing information requested by Coroner, where such information or documentation is available.

Concern 7

The second (final) RCA investigation report identified 4 recommendations based on the contributory factors to Mr Portland's death, each with an action and timescale. It is acknowledged that there were additional concerns identified at inquest which included the understanding and implementation of the AWOL procedure, and the need to review how leave is managed, specifically around how information is recorded and the use of the whiteboard. The additional concerns will be added to the second RCA investigation report with appropriate corresponding actions, and the actions will be monitored centrally.

In relation to concerns 5-7 (those specifically relating to the investigation of incidents), I can confirm that the following action has been taken:

- Communication and involvement of the family in the investigations did not meet the standard the Trust expects of staff. Therefore from March 2016 the patient safety manager became the family's single point of contact to improve communication.

- A series of training sessions were held on promoting the status of families in investigations, ensuring they are central to the process ('Making Families Count'), which were co-delivered with the charity Hundred Families in May and June 2016
- The Trust has improved its capacity for completing comprehensive and timely investigations, including appointment of a dedicated, full time post of RCA investigator/author in the adult mental health directorate. This person was appointed in February 2016.
- Weekly monitoring processes were introduced from July 2016 to better identify the right investigators, timely allocation of investigators and review of the progress of investigations. We now report on the timeliness of RCA investigations on a weekly basis to the Executive Team and quarterly to the Board of Directors.
- A survey completed of RCA investigators in August 2016 to ensure changes in training meets their needs.
- The Trust commissioned an external review of the quality of SI investigations completed in November 2016 to help the Trust to identify where and how to improve.

The following further actions are currently being or will be undertaken:

- A review of RCA training for investigators, including an additional module on involving and working with families during an investigation (Lead: [redacted]. Timescale: new training to be delivered from 30th June 2017).
- The introduction of a new standard that all investigators will complete refresher RCA training at least every 3 years (Lead: [redacted]. Timescale: from 1st Nov 2017).
- New staff and family information leaflets to describe the RCA investigation process, standards and what families can expect with central senior contact points for further support as needed are currently being developed (Lead: [redacted]. Timescale: introduced from 1st July 2017).
- The second RCA investigation relating to Mr Portland's case is to be amended to include the additional concerns arising at inquest and actions will be added to the action plan (Lead: [redacted]. Timescale: 30th April 2017).

Once again, I thank you for bringing your concerns to my attention. I hope the information in this letter addresses your concerns and provides you with some reassurance that your concerns have been or are being addressed. If you require any clarification of further information, do not hesitate to get in touch.

Yours sincerely

[redacted]

Stuart Bell
Chief Executive Officer
Oxford Health NHS Foundation Trust