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By email to leicester.coroner@leicester.gov.uk
Lydia Brown
Assistant Coroner
Leicester City and South Leicestershire
The Town Hall
Town Hall Square
Leicester LE1 9BG

Dear Mrs Brown

Re: Margery Astill

Further to your report dated 11 July 2017, in accordance with paragraph 7, Schedule 5 of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, I offer the following response.

We have investigated the matters of concern that have arisen during the course of the inquest of Margery Astill. Leicestershire Partnership NHS Trust takes these matters very seriously and I hope that you and Ms Astill's family will be satisfied that we have taken the appropriate measures to prevent such an occurrence happening again.

The matters of concern you have raised are as follows:

1. *Diary systems for ensuring referrals to different specialisms were not effective, such as for physiotherapy and the failure of these systems was not identified until the inquest was held. Furthermore, the system for entering and updating/amending incident reporting was unclear and reported incidents were not reviewed by a senior employee in a timely fashion on this occasion.*

   Mental Health Services Older Persons (MHSOP) Ward Staff Teams have developed, and are in the process of implementing, a Standard Operating Procedure for the safe and effective management of the ward diary. Implementation is being led and embedded in daily practice by the Senior Inpatient Matrons and undertaken by each individual Ward Matron. The process also clearly defines how the ward tasks will be allocated and documented. This process will be subject to an ongoing monthly audit to provide assurance that this is being embedded in practice.

   MHSOP currently formally review all incidents weekly however there is a system in place for daily incident analysis which is supported by the Trust's Patient Safety Team that assures that the correct processes are being followed.

MHSOP Ward Teams have also successfully piloted ward Safety Huddles and these are in place across Organic Wards as part of team working. Safety Huddles have been instrumental in supporting the ward teams in their shift by shift communication creating space to be able to dynamically assess the ward climate and talk about patient risk and incidents and how these are to be managed.

As a further assurance measure the MHSOP wards are also being robustly supported with routinely designated safeguarding practice supervision sessions which look at, and analyse how, incidents have been managed and what has been learned from this when in-patient harm.

The previous installation of CCTV was to support the detection and prevention of crime. However within MHSOP it has been instrumental in bringing a new level of understanding incidents that occur on the wards. CCTV now forms a key part of the post incident analysis process. As an additional assurance measure to ensure that the CCTV is being used in this way, plans are in place to routinely undertake an audit of cross checking reported incident's and what parts of the CCTV recordings were reviewed to support the investigation process.

2. *Communication with family members was inadequate and inaccurate, the "named nurse" system was ineffective and therefore opportunities were lost to share information and to keep the family informed and involved. The failure of the Trust to engage with family members of patients with mental health issues have been raised in the past as a concern, and contrary to NICE Guidelines.*

The Trust acknowledges that the communication shared with the family following both the incidents was not an accurate description of the events which was later revealed in the CCTV footage. When the staff involved in the incidents provided Mrs Astill's family with information regarding her falls, their form of communication did not convey the accuracy of the situation. In order to enhance the nursing staff with their communication skills, the nurses involved have subsequently attended a bespoke training course delivered by LOROS (Leicester Hospice Charity). This training course supports enhanced communication skills needed to support patients and relatives.

The service has approved the updated named nurse role and responsibility patient and carer information leaflet. Posters will be displayed on each ward defining the role of the named nurse to ensure that both patients and carers are clear about what to expect. A named nurse checklist has also been established to support Registered Nurses to carry out this role. This provides a clear accountability and audit trail whilst setting standards around timely communication with relatives and carers.

The Trust further acknowledges the Coroner's concern that it has not engaged with family members of patients with mental health issues which is contrary to Nice Guideline 136[1]. With particular reference to mental health services for older

[1] Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services (NICE Guideline, 136)

people and inpatient admissions the service will be undertaking a spot check audit against the quality standard's as set out for hospital care.

3. *Mrs Astill had two unwitnessed falls during her time in the unit, both were recorded on CCTV and both were due to interaction with other patients. The first fall was quickly attended by numerous nursing staff members, but there was a considerable delay in actually physically attending to the patient, examining her or taking basic observations. In a professional nursing environment this delay in first aid provision was of concern and the Trust should consider enhanced training to ensure immediate effective interventions.*

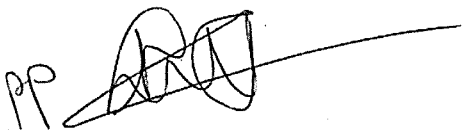
   The Trust resuscitation lead has the responsibility for the Resuscitation Councils (UK) Basic Life Support and Immediate Life Support training. As part of their review they will analyse the CCTV footage to understand if there are any organisational changes required to the training, or if this is purely an individual training requirement.

   In addition to the above, I can confirm that the Trust Resuscitation Committee is overseeing the implementation of clinical drills. These drills re-enact patient emergency situations in the clinical setting in which staff on duty will participate in and will then be offered immediate practice reflection and feedback with regard to how they have responded to and managed this in practice.

   The MHSOP Clinical Education Lead is also scheduling in further experiential learning and practice development training opportunities to reflect on the immediate person centred approach to support emergency medical situations.

If I can be of any further assistance to you please do not hesitate to contact me.

Yours sincerely,



Dr Peter Miller
Chief Executive