NHS
Oxford Health
NHS Foundation Trust

Mr D.M. Salter
HM Senior Coroner
Oxfordshire Coroner's office
The Oxford Register Office
2nd Floor
1 Tidmarsh Lane
Oxford
OX1 1NS

Chief Executive's Office
Trust Headquarters
Warneford Hospital
Warneford Lane
Headington
Oxford
OX3 7JX

Tel: 01865 902769
[redacted]
www.oxfordhealth.nhs.uk

20th October 2017

Dear Mr Salter,

Regulation 28 Report to Prevent Further Deaths following the inquest concerning the death of Mr Liam Thomas

I am writing in response to your letter dated 4th September 2017, and the enclosed Regulation 28 Report to Prevent Further Deaths following the inquest concerning the death of Mr Liam Thomas.

The particular concerns raised by you were as follows:

1. Mr Thomas' access to plastic bags which are a restricted item on the ward.

2. The consistency and standard to which daily environmental checks are carried out.

3. The communication with Mr Thomas' family while he was an inpatient on Phoenix ward.

I will address these in turn.

Concern 1

Plastic bags are a restricted item on all wards. There are posters displaying this in the ward reception areas, and on several points inside the wards. Staff are requested to draw all visitors and patients attention to this and to remove any restricted items before anyone enters the ward environment. Plastic bags are a very common item, and are regularly brought to the ward. Mr Thomas' sad death drew our attention to the fact that there had been an inconsistent approach to managing this across our wards. Some staff were removing the bags at reception, but at other times visitors (especially regular visitors) were asked to take the items to the patient's room and then return the bag to the nursing office, but there was no way of checking if this had been done. Following this incident clear guidance was issued to

all staff that plastic bags must be removed at reception, if this is impractical, staff must accompany the visitor or patient to the patient's room, allow them to remove the items and remove the bag, disposing of it or placing it in patient's locker which can only be accessed under staff supervision.

We have added a column to the visitors' signing in book for staff to confirm that all visitors and returning patients have been advised about restricted items and asked to hand over any such items they may be bringing on to the ward. Staff will be required to complete this, which will be monitored by matrons weekly by checking the visitor's book, at the same time as the monitoring of environmental checks.

In addition, we looked at alternative safe ways for patients and visitors to bring items on to the wards, and ordered paper bags to be available on all wards as an alternative to carrying items in plastic bags. Staff will offer this as an alternative to visitors at the reception area, and for patients who bring back items when they enter the ward

The advice on restricted items on wards has also been added to the Admission Information packs, and included on the admission check list for staff to complete. Admission checklists are audited by the ward matrons on a monthly basis.

Our carer and family information pack given to families on admission also contains information about restricted items. The distribution of the family information pack is included in the admission check list, which is monitored monthly by the ward matron

Concern 2

Following this sad incident we also became aware that the recording of the daily environmental checks was inconsistent. All staff interviewed were clear that this had to be done a minimum of once daily, and there was evidence that this was consistently allocated at the start of each shift. However the recording of it was inconsistent and we therefore did not have sufficient evidence that it had actually been carried out.

A new standard operating procedure (SOP) for carrying out environmental checks was devised and an example of the form is included at appendix 1.

Matrons are now required to review the checks carried out on a weekly basis to ensure consistency in reporting, and ensure that any gaps in recording are addressed directly with staff. Matrons are reporting on their monitoring monthly to the senior matron.

In addition we are currently trialing several different versions of the form to ensure that it supports staff fully in carrying out this important task. We expect to make a final decision on a form to be used by all by end of October 2017.

Concern 3

The Trust is signed up to the 'Triangle of Care' 6 principles of involving carers, family and friends. We were very disappointed to learn that Mr Thomas' family did not feel adequately communicated with during his inpatient admission. This was complicated by the fact that Mr Thomas was unsure about the extent to which he wanted staff to communicate and at times asked staff not to inform his family of how he had presented on the ward. However, we recognise the crucial role families play in a patient's recovery and the importance of ensuring that families feel involved and supported through what is often a very difficult time.

The team on Phoenix ward have been facilitated to reflect on this incident, particularly the experience of Mr Thomas's family, and since this incident a lot of work has taken place to improve the support and involvement of carers across adult services.

We have devised a Carer's Handbook (attached at appendix 2) and all wards have 'welcome leaflets' explaining the practical workings of the ward such as visiting times and restricted items. The Carer's Handbook has been devised for use by our community teams as well as inpatient wards, in recognition of that fact that family (or carer) involvement in care is equally important in both settings. There is an expectation that all workers distribute these appropriately as well as them being widely available in outpatient clinics and ward reception areas. The handbooks are also made available at various Family and Carer events, forums and reference groups which are regularly held locally by teams. Staff are regularly reminded to distribute the handbook to patients' friends and family through their monthly business meetings.

We have also employed a full time Patient and Carer Experience lead, who is overseeing the Carer and Family surveys which we co-designed with carers, and which provide direct feedback to wards and community teams about the experience of carers and families, and gives teams the opportunity to liaise directly with carers about the improvements they are making.

Earlier this year we introduced a new tool called IWantGreatCare which asks patients and carers a series of questions about their experience of the care they have received and give them opportunity to leave free text feedback. This is immediately received by team managers so they can respond dynamically to concerns raised. The tool is available online and on paper, and we rely on staff on wards and in community teams to ask patients and carers to give feedback, as well as posters and materials in wards and outpatients clinics advertising the feedback tool. In addition our patient and carer engagement lead regularly visits all services to work with managers to ensure plans are in place to address the feedback teams receive and hold open surgeries in wards and outpatient clinics encouraging patients and carers to give feedback. Staff also have an app on their ipads which they can encourage patients and carers to use to give feedback after their contact with them. We monitor the responses by team monthly which is reported in our leadership meetings, and a report on patient experience is forwarded to the board of the Trust on a quarterly basis. This allows us to identify teams where feedback is low, and address this on a local basis. IWantGreatCare also allows people to leave specific comments about individual staff

members and request contact from the team manager.

Additional concerns

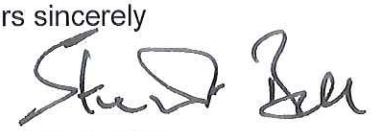
I note that, in your covering letter to the Regulation 28 report, you also raised queries regarding the processes surrounding the removal and return of risk items from patients, for example at times of heightened risk. Specifically you enquired whether it is recorded when items are removed from or returned to patients. Patients may access their secure lockers on a frequent basis throughout the day, and are always observed by staff when doing so, recording all items going in and out of lockers would be extremely labour intensive, however when banned items are found and removed from patients this is recorded in their clinical notes. In addition all patients have individual care plans which detail the care delivered including the management of risk, and therefore any items which are not considered safe for that individual based on their specific risk assessment will be recorded in that plan.

I also note your separate letter, dated 4th September 2017, following your inquest into the sad death of Mr Andrew Crawford, in which you again identified concerns regarding communication with family. I hope that the matters you raised are addressed in this letter, specifically in the section relating to 'Concern 3' above. I acknowledge your intention to share a copy of this letter with Mr Crawford's family.

In addition to the above, the Trust carried out a Serious Incident (SI) Investigation which you have already received. An independent outside investigator was appointed to carry this out and the report highlighted a number of recommendations which have all now been completed.

The above actions as well as those highlighted in the SI report were taken in order to reduce the risk of this very sad incident happening again. We will continue to monitor our adherence to our policies and standards. I hope the information in this letter provides you with reassurance that appropriate action has been taken to improve the safety of our environments and address the issues you helpfully highlighted in your Regulation 28 Report. If you require any clarification of further information, do not hesitate to get in touch.

Yours sincerely



Stuart Bell, CBE
Chief Executive Officer