NHS
Nottinghamshire Healthcare
NHS Foundation Trust

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Our Ref RH/cls

20 February 2018

Strictly Private & Confidential
Andrew McNamara
Assistant Coroner
H.M. Coroners
Office and Main Court
The Council House
Old Market Square
Nottingham
NG1 2DT

Dear Mr McNamara

Please find below the organisational response to the recently received Preventing Future Deaths Report following the unfortunate death of Michael Richard Drewry, the inquest of which was concluded on the 18 December 2017. We offer our sincere condolences to Michael's family.

1. **The failure of the Crisis Team to ensure consistency and continuity of care for the deceased, in particular the changing personnel who visited the deceased.**

   Continuity of care is a challenge within our Crisis Resolution and Home Treatment Teams due to the service operating 24 hours a day, 7 days a week. Staff work 12 hour shifts and need to be able to respond swiftly to urgent referrals, within 4 hours and 24 hours whilst also maintaining robust care and treatment for those patients already on their caseload.

   It is acknowledged that continuity in a person's care is important, however, the Crisis Teams fundamentally operate to respond to, manage and contain risk and therefore this is not always possible.

   For patients receiving the highest intensity of care (Red - RAG rating), which entails a person being seen one or more times per day, the consistency of staff is not possible and the challenge between intensity of clinical contacts and continuity in staff is acknowledged. For patients receiving care at a lesser intensity (Amber RAG and Green RAG rating) the Crisis Teams always attempt to provide continuity where possible within a team held caseload.

   The Trust is shortly to introduce the Modified Modified Continuity Index (MMCI) into its routine reporting systems, at both individual and team levels. This is a measure calculated using the total number of patient visits and the number of different clinical staff visiting the patients and gives a resulting score between 0 and 1, the more staff providing care to the patient the lower the score will be.

   The MMCI is due to be implemented in early April 2018 for a trial period in one team before full implementation to all Crisis teams. Once in place it will allow us to monitor which teams are managing consistency in care to enable learning to be spread across teams.

The MMCI will be integrated into an Individual Patient Reporting System and will be presented alongside other service delivery metrics and outcomes. These measures will facilitate individual health care professional (HCP) and team supervision.

In addition, the Crisis Teams are currently also working with the commissioners in reviewing the service, taking in to account the current constraints of providing continuity of care across all Crisis Teams within Adult Mental Health, with the most recent meeting held in January 2018.

At this meeting they were informed of the challenges surrounding continuity of care and have agreed to review the commissioning of the crisis services across Nottinghamshire. Whilst there is no timescale attached to this at present however, a task and finish meeting is being convened in March 2018.

Finally, the Trust is working with Meridian Productivity Specialists over a period of 18 months, focussing on Mental Health Services to ensure the right resources in the right place at the right time with the right quantity and quality of care.

2. **The failure of the Crisis Team to make accurate and prompt records of all consultations with the deceased.**

Crisis Team staff are fully aware that contemporaneous notes must be recorded about the patient and must be written at the time of the event or as soon afterwards on the Trust Patient Information System (RiO).

Staff have been instructed and trained to ensure that they comply with this process. To support them to do this they have been issued with the correct software and devices to enable them to achieve this whilst in the vicinity of the patient's whereabouts.

On occasion, staff do have to return to base due to the intermittent availability of the telecom service signal/network therefore delaying the entry on the RiO system. Staff have been reminded of the importance of this in team meetings (held 31/01/2018) and will be monitored ongoing in managerial supervision on a monthly basis.

3. **The failure of the Crisis Team promptly to report/escalate any matters of concern to senior members of staff so that appropriate and timely steps could be taken in relation to the management of the deceased's care including, if necessary, hospitalisation;**

Crisis Team staff are fully aware the need to escalate any concerns regarding a difference in presentation of any patient.

When staff are concerned following a contact with a patient, these concerns must be escalated to senior members of staff. This can be done through the daily handover of patients who are on RED in the RAG rating alongside any other patients causing concern and a doctor is present at these meetings. There is also a line management structure through which issues can be escalated to senior managers and staff have been reminded of this process which is included in the operational procedure.

There are also two Multi-Disciplinary Team meetings (MDT) each week to ensure safe and effective management of the patients on amber and green. Any discussions held are recorded in RiO detailing the decisions and actions taken. Staff have been reminded of the

importance of timely input in team meetings (held 31/01/2018) and reminded again in managerial supervision on a monthly basis.

These actions will be monitored within the Trust through a specific Quality Improvement Plan with the General Manager as the nominated lead. These actions are regularly updated and require both Directorate and Divisional sign off.

I hope the information above provides the assurance that we have considered your recommendations seriously and are actively seeking to improve the services we provide by implementing the actions outlined.

Yours sincerely

Ruth Hawkins
Chief Executive
Nottinghamshire Healthcare NHS Foundation Trust