Oxford Health
NHS Foundation Trust

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6 April 2021

Dear Ms Hayes

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS
INQUEST INTO THE DEATH OF MRS LISA THOMPSON

I write in response to your report dated 10 February 2021. Firstly, thank you for your report. The Trust has considered your concerns very carefully and I hope that my reply will provide you with assurance that the Trust is taking appropriate action.

Following the conclusion of the inquest into Mrs Thompson's death your office provided the Trust with an audio recording of your summary of the evidence, findings of fact and conclusion. A copy of the audio recording was shared with the Trust's Head of Quality Governance, Clinical Director for Oxfordshire Mental Health (Dr Rob Bale, who gave evidence at the inquest) and the author of the completed Root Cause Analysis Report. Separately, the Trust received a complaint from Mrs Thompson's husband on 1st October raising 10 concerns and the Complaint Investigating Officer, who is a Service Manager at the Trust, has listened to the recording.

As such, the Trust has been on notice of your concerns and had the opportunity to include your concerns as part of the investigation into Mr Thompson's complaint.

The concerns you raised with us were:

(1) There was no clear care plan in place following an emergency review of Mrs Thompson on 13th March 2020

(2) The care plans and risk assessments at the mental health Trust were not updated:

  (a) with material information on the facts and circumstances of Mrs Thompson's overdoses of her medication;

  (b) the two most recent overdoses were not recorded;

(c) with further information disclosed by the doctor who treated her most recent overdose that Mrs Thompson had lied about the severity of her overdose that it was probably double that which she initially disclosed also that this was her 4th overdose and another could not be ruled out;

(d) on 13th March 2020 following a review with the Trust Consultant Psychiatrist on 13th March 2020 when there was a telephone conversation between Mrs Thompson and her care co-ordinator.

In Mrs Thompson's case, there are several points at which updated information is added to Mrs Thompson's records, but the Trust agrees with you that the updates were not added under the Care Plan and Risk Assessment sections of the records. That is not in line with our policy.

In relation to the review on 13th March 2020, there is a plan written down in the main body of the notes on 13th March 2020. However, the care plan and risk assessment were not updated. As you heard, the care co-ordinator then spoke to Mrs Thompson. On reflection since the inquest [redacted] recognises that it was not clear to the family what the plan was, even when the care co-ordinator made her call. The family did not go home with a clear message.

We have considered our approach in terms of ensuring patients and their families go home following a consultation with a clear plan. This will be picked up in the quality improvement work that I describe below. We recognise that often patients and their family members may be in a state of distress in such consultations and our clinicians need to ensure that our patients understand clearly the plan made at the end of a consultation.

The Trust's complaint investigation has been completed and the Trust wrote to Mr Thompson on 12th March 2021 to report on the findings of the investigation. I can report to you that the Complaint Investigation Officer identified the following issues to be addressed by the Trust:

1. To ensure patients on the Care Programme Approach have a current and up to date risk assessment and care plan which is shared with the patient (and their family as appropriate).
2. Review how risk formulations and assessments are recorded and reviewed in the electronic care record, ensuring consideration of family's views and ensuring best practice is adopted in relation to involving families in our patient's safety plans.
3. Embed Multi-disciplinary Team care plan reviews for patients at risk of suicide.
4. Review the current Clinical Risk Assessment and Management mandatory training to include safety planning which takes into account family involvement using the triangle of care approach[1]. In common with many mental health trusts, OHFT uses the Triangle of

[1] https://www.oxfordhealth.nhs.uk/carers/triangle/

Care, which is a therapeutic alliance between carers, service users and professionals. This is a national accrediated scheme which seeks to ensure at all times the involvement of carers and families in care and treatment. For further information I attach a leaflet produced for professionals ("A") and a leaflet for service users (B"), which I hope is helpful.

The Complaint Investigation has recommended actions to be taken and those are in place. Some issues have been worked on previously and there is ongoing work for the Trust to continue to carry out in order to keep the quality of our services under constant review. One of the actions we are taking is being completed by our Chief Nurse, who is working with senior colleagues to review themes that have arisen from complaints, serious incident investigations and inquests. This is to ensure that we can particularly identify themes, such as ensuring family involvement in care and treatment and improving how risk formulation is documented, in order to improve outcomes for patients. Based upon the thematic findings from the investigations of complaints and serious incidents we think that a Quality Improvement approach should be taken to explore risk assessment, formulation and documentation processes within our mental health services in order to improve practice in these areas.

To that end, the Trust has a Quality Improvement team[2] who are dedicated to working with our local teams to continually improve the quality of our services. Our Chief Nurse has asked the Quality Improvement team to ensure areas of improvement relating to this tragic serious incident are considered alongside other themes identified from the thematic review, in particular:

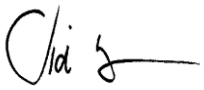
- Ensuring family members are included in care and treatment in a systematic way using the triangle of care.
- Ensuring risk formulation and suicide risk assessment are enhanced and embedded in the safety planning for patients, including their families and ensuring cumulative deliberate self-harm events are noted and acted upon.

Please be assured that this work is a high priority for the Trust. Trust audits in the coming year will include looking at the the quality of risk assessments and care plans. We have also included safety planning questions into our CPA and Essential Standards audits. I also hope it will help to inform you about work being carried out if I attach the Trust's Action Plan record ("C").

[2] The Oxford Healthcare Improvement (OHI) centre supports the trust in providing safe, better quality care to patients and improve the working lives of staff. OHI's aim is to improve patient safety and the quality of care for people in hospital, communities and homes through a programme of quality improvement, research, training and collaboration. OHI team members come from a range of backgrounds to ensure that practice-based problems are viewed through different lenses and improvement projects are approached in a systematic manner with clear evaluation. The team includes clinicians, non-clinicians, researchers and analysts.

Once again, thank you for your report and please do not hesitate to contact me if you would like any further information at this stage. I am happy to write to you again if you would like to receive an update on the work being carried out by our Quality Improvement team.

Yours sincerely



[redacted]

Chief Executive