NHS
Nottinghamshire Healthcare
NHS Foundation Trust

Chief Executives Office
The Resource
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[redacted]

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13 December 2021

Mr Gordon Clow
HM Assistant Coroner for Nottingham and Nottinghamshire
Nottinghamshire Coroner's Office
The Council House
Old Market Square
Nottingham
NG1 2DT

[redacted]

Dear Mr Clow

Please find below the organisational response to the recently received Preventing Future Deaths Report following the unfortunate death of Mr. Paul Barton, the inquest of which was concluded on 15 September 2021 We offer our sincere condolences to Mr. Barton's family.

Concerns raised within the Report:

(1) The approach of the Crisis Resolution Home Treatment Team of considering their role to be limited to avoiding the need for patients to receive inpatient treatment. The primary role of any medical professional ought to be the protection of life, but within the written and oral evidence from the CRHTT the focus was on prevention of hospital admission alone.

CRHT teams were originally set up to provide urgent and intensive support for individuals who had serious mental health problems and who would otherwise be likely to require inpatient hospital admission. This remains a core function of the service. The key aims of the service as outlined in the service specification are:

- Act as a 'gatekeeper' to mental health services for functional all age mental health admissions.
- Provide immediate multi-disciplinary, community-based treatment 24 hours a day, 7 days a week, including a face-to-face assessment within 4 hours.
- Ensure that individuals experiencing acute, severe mental health difficulties are treated in the least restrictive environment as close to home as clinically possible.
- Remain involved with the patient until the crisis has resolved, or the patient is well enough to be linked in/discharged to the appropriate care pathway.

- If hospitalisation is necessary, be actively involved in discharge planning and provide intensive care at home to enable early discharge.

A detailed assessment should be undertaken as below:

The aim is to help to reduce service users' vulnerability to crisis and maximise their resilience. In line with the Royal College of Psychiatrists (RC PSYCH) best practice guidance and core fidelity standards, the initial assessment gathered from multiple sources includes:

- An investigation into the nature of the crisis and the presented problems.
- The identification of immediate social stressors and social networks.
- Psychiatric history including past records and family history.
- A comprehensive evidence-based assessment which includes: Mental health and medication; Psychosocial needs; Strengths and areas for development.
- The identification of the clinical signs and symptoms, including ability to self-care, if mental health problems are found.
- A physical health review takes place as part of the initial assessment, or as soon as is practically possible. The review includes but is not limited to: Details of past medical history; Current physical health medication, including side effects and compliance with medication regime; Lifestyle factors e.g., sleeping patterns, diet, smoking, exercise, sexual activity, drug and alcohol use.
- An assessment of practical problems of daily living.
- A documented risk assessment and management plan which is co-produced and shared where necessary with relevant agencies (with consideration of confidentiality). The assessment considers: risk to self; risk to others; risk from others.
- The identification of the person for whom it is a crisis, other people affected by the crisis and associated risk to them.
- Identification of dependents and their needs, including childcare issues, and any young or adolescent carers.
- A social assessment including education and employment.
- A multidisciplinary assessment of the service user's needs.
- A multidisciplinary assessment of the service user's level of risk.
- Planning for supported transition to other services.
- All service users have a documented diagnosis and a clinical formulation.
- The service user and the team can obtain a second opinion if there is doubt, uncertainty or disagreement about the diagnosis, formulation or treatment.
- Written information about the service, its role and contact details are provided to all service users and carers present at initial assessment

Based on the detailed assessment, a decision will be made as to whether the individual will benefit from CRHTT input or if an alternative service is required, which may include inpatient admission, onward referral, and discharge.

The service specification describes the process as below:

- The team begins discharge planning at the point of assessment and this is communicated to relevant parties.

- Involvement is time limited, and people are promptly discharged when acute care is no longer needed. At least 90% of service users stay less than 6 weeks (length of stay = active treatment not phone support pre/post discharge) and service users and involved family are given at least 48 hours' notice before discharge from the CRHTT (excluding hospital admissions).

Prior to discharge the team should ensure that:

- There is good understanding (service users, family, carers, relevant others) of why the crisis occurred and how it could be avoided in future.
- Coping strategies have been explored with the service user and family/carers.
- A Relapse prevention plan is in place.
- Service user/family/carer have had an opportunity to express their views about the service and contribute to service improvement.

The team must facilitate discharge and transfer of care to an appropriate service, dependent on clinical situation and local provision. This could include Primary Care, Assertive Outreach Team, Early Intervention in Psychosis, Continuing Health Care, and other mental health services.

A clear discharge plan is given to the service user on discharge, and sent to all other relevant parties within 48 hours and must include details of:

- On-going care in the community/aftercare arrangements.
- Crisis and contingency arrangements including details of who to contact.
- Medication, including monitoring arrangements.
- When, where and who will follow up with the service user as appropriate.

Clinical outcome data is collected at assessment and discharge as a minimum.

Post discharge service users or families may contact the CRHTT directly for support or advice for at least 2 weeks following discharge.

As demonstrated, the expectations of a CRHTT assessment and plan are clear and require detailed information gathering and consideration of a wide variety of factors on which to base care planning and decision making. This should include whether a hospital admission is required but this cannot be the sole determining factor.

To ensure that all staff are aware of these parameters, the CRHTT operating procedure will be updated by 31 December 2021 to include more detailed explanation as above. The updated procedure will be shared with all staff via email and discussed with all staff via team meetings. This will highlight the broader considerations for CRHTT support as part of a safety plan, and individual discussions as part of ongoing supervision will also support a broader understanding.

(2) This inquest was one of a number of inquests I have conducted where staff members from Nottinghamshire Healthcare NHS Foundation Trust have placed great reliance upon their interpretation of a patient's intention and / or a patient's denial of ongoing

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suicidal intention. This is so even where, as was the case for Mr Barton, there is a clear and established pattern of fluctuating and contradictory intentions and desires towards suicide.

There are a range of measures in place and planned to address practice in this area including training and reflective practice opportunities. All clinicians must complete mandatory annual training in suicide awareness and prevention. This training outlines the many factors that should be considered when undertaking a risk assessment in a potentially suicidal patient. This includes not only the immediate presentation, but corroborating evidence from family members, recent events, and patterns of behaviour, thinking and underlying factors such as established mental health conditions, compliance with medications and substance misuse. From this comprehensive gathering of information, a formulation should be developed based on this range of evidence on which to base the care planning and safety planning. This plan should never be based solely on an individual denying suicidal intentions at the time of the assessment. Rather, it should weigh this in the context of recent events and known facts. This current training is only available online for Adult Mental Health staff.

A priority of the Trust's Towards Zero Suicide Strategy (2020-2023) was to review the Trust's suicide prevention training offer and implement a new training model to bring this into line with the Trust's Towards Zero Suicide approach (2020) and Health Education England's Suicide Prevention Competencies. A paper to agree the proposed training, method of delivery and resource requirement was presented to the Trust's Senior Leadership Team on 26 November 2021 for approval.

This paper proposes three levels of training:

- Level 1 – Suicide Awareness Training for non-clinical staff, online 3-yearly.
- Level 2 – Suicide Awareness Training for all clinical staff, online 3-yearly
- Level 3 – Suicide Response Training for clinical staff required to provide a clinical response to suicidality, 3-yearly, either face to face or via Microsoft Teams.

It is however recognised that training alone does not achieve embedding of learning into practice or operational and quality improvements. Therefore, the Trust is proposing that the required resources not only deliver training but also support embedding training into practice. This would include:

- Clinically based engagement and support: Bespoke / tailored training and facilitated team learning (including discussion and reflection) to further adapt the training to clinical areas and embed learning and the use of appropriate clinical tools.
- Additional bitesize training based on learning themes (including those from patient safety processes such as investigations and Coroner Inquests), clinical tools and safety planning.
- Prioritisation for teams who experience greater exposure to suicide and self-harm (as identified through Trust data) and be based on related learning to promote safe and responsive services which can also be evidenced.
- Reviewing and further development of related resources.

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- Involvement in evaluation and improvement relating to risk assessment and safety planning.

Following approval of the proposals, an implementation plan will now be developed, which will be shared with the CQC and Coroner on completion.

The CRHTT operating procedure will be updated by 31 December 2021 to include more detailed guidance about risk assessments and the clear expectation that the presenting information at the time of the assessment is evaluated, considering recent events.

Further training is needed for all staff working in CRHTT as this forms a core part of their role. The training offer includes some team training sessions facilitated by the Trust wide Clinical Lead for Suicide Prevention. Three of these sessions have already been delivered and these will continue as a regular space for teams to reflect on cases and access senior supervision.

In addition to this, there is a four-day training programme facilitated by one of Adult Mental Health's Clinical Nurse Specialists, which all CRHTT staff will be offered. Three sessions have already been completed and there will be three sessions running each year. This covers attachment and trauma, stabilisation skills, overview of Mentalization- Based Therapy (MBT), Structured Clinical Management (SCM), Dialectical Behavioural Therapy (DBT) and crisis role in these interventions, managing crisis telephone calls and working with young people in crisis.

The Learning and Development Department have also been providing sessions relating to culture and values (Appendix 4). This begins with a diagnostic tool (Appendix 5) completed confidentially by team members to elicit the strengths of the team and areas that need to be worked on. There will then be sessions facilitated by the Learning and Development team to assist in achieving the identified improvements.

Starting in January 2022 bespoke training workshops will be provided for each CRHTT by [redacted] from the Learning and Development Department and will be used as continuous learning and reflective practice spaces to augment and embed this learning.

There are monthly interface meetings between CRHTT and the LMHTs. During these meetings, case examples are presented in order to jointly share learning and discuss practice issues, as well as developing and maintaining good working relationships.

Carer peer workers are being recruited into each team. The Job Description is enclosed as Appendix 6. These roles will ensure there is a specific focus on the needs of carers, including discussion of expectations and inclusion in discussions about assessments and care plans. Leaflets and information sources will also be reviewed and regularly updated for carers. In addition, peers will link to wider carer networks in the Trust.

The teams are working on the core fidelity principles (Appendix 7) and part of this activity is an annual feedback process that includes patients, carers, staff and key stakeholders. These returns measure progress and enable adaption of actions needed.

A dashboard is in development so that the Key Performance Indicators (KPIs) can be reviewed routinely on a monthly basis. This is currently operational but is being updated with a final version expected by 31 December 2021.

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(3) The quality of the Trust's own investigation into the circumstances of Mr Barton's death. It failed to identify themes of concern. It included many false and inaccurate statements, failed to challenge false assumptions made at the time and introduced new false information which was not taken from any available records. It caused distress to the family and did not reassure me that the Trust had taken an appropriate response to the concerning facts of this case.

We unreservedly apologise for the distress and disruption caused because of our mistakes. The Operational Manager has reviewed this report and the relevant themes have been identified. The Quality Improvement Plan is being updated to ensure these are captured and acted upon. We will share this with you on completion.

A final version of the report is enclosed (Appendix 1), along with the attachments (Appendix 2 and 3). Following on from correspondence with your office in October 2021, we have not yet shared this amended report with the family, or a copy of this response. We understand from an email dated 20th October 2021 that the family preferred not to hear directly from the Trust at this time. We are very willing to share the documents directly with them should they wish to receive information in this way and remain open to meeting with any of Mr Barton's relatives in the future to discuss his care, investigation content or processes, or to try and answer any outstanding questions they may have, should this be something they would find helpful.

This has been shared with the investigator for their learning and reflection. In the short-term, this will also be raised as a more general lessons learned to remind all staff of the importance of factual accuracy.

These actions set out will be monitored within the Trust through a specific Quality Improvement Plan with General Manager [redacted] as the nominated lead.

In addition, it has been identified that key themes regarding the quality of our Serious Incident Reports have required a more robust and Trustwide review and action plan.

The Trust's Governance arrangements to oversee the management of serious incidents (SIs) is outlined below:

Serious Incident Review Group		
Chaired by the Associate Director of Quality	Accountable to Quality Operational Group	The group meets weekly to discuss all new SIs, ensure appropriate immediate action has been taken and agree level of investigation required. There is Executive Director attendance and recently attendance from our main commissioners. Following that meeting the Executive Director of Nursing, AHP & Quality will escalate significant SIs to the Executive Team weekly.
Divisional CIRCLE meetings – Mental Health and Forensics		
MHS – Chaired by the Associate Medical Director FS – Chaired by the Deputy Director for Forensic Services	Accountable to Divisional Quality and Risk Groups	The divisional Clinical Incident Review Creating a Learning Environment Group (CIRCLE) receive and review incidents which are identified as serious and in need of more focused scrutiny which is outside the remit of any other current group within the division, to ensure appropriate action is taken and find appropriate lessons to be learnt in order to reduce episodes of recurrence,

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		identify any need for service review or development and address any clinician activity which requires further action.
Quality Operational Group		
Chaired by Executive Director of Nursing, AHPs & Quality	Accountable to Quality & Mental Health Legislation Committee	This group meets monthly, and responsibilities include CQC compliance and quality standards, patient safety, clinical effectiveness, and patient experience. QOG – receives Quarterly Patient Safety Reports, which includes details of all SI's progress on investigations, outcomes, learning and were appropriate any specific themes and trends.
Quality & Mental Health Legislation Committee		
Chaired by a Non-Executive Director	Accountable to the Board of Directors	This Board Committee provides assurance on all aspects of quality and mental health legislation. As part of the agenda, they receive six monthly Patient Safety Reports, relating to serious incidents, learning and outcomes of investigations.

As a Trust over the past two years, we have looked to further strengthen the governance and assurance in relation to the management of Serious Incidents through the overall review of team structures, systems and process and policy revision. This includes:

Establishment of a Centralised Patient Safety Team:

As a result of an organisational wide review of governance, during 2019/2020 we created a Trustwide Patient Safety team. (Previously there were teams in each division which led to inconsistent approaches). There is now a Trustwide Head of Patient Safety (also the Trusts nominated Patient Safety Specialist). The Head of Patient Safety reports to the Associate Director of Quality and has open access to the Director of Nursing, AHPs and Quality.

The Patient Safety Team has responsibility for the overall co-ordination of incidents and investigations across the Trust. By undertaking this review, it has enabled us to eliminate variation in the management of incidents/serious incident investigations between directorates/divisions. It also enables a consistent approach in the appointment of investigators, preparation of terms of reference and ensuring investigators have points of contact to discuss investigations and concerns.

We have also taken the opportunity to develop a centralised Investigation Team, at present this is a small team of 2 SI Investigation Leads who will primarily be apportioned the most significant and time critical cases. However, we are looking to support this centralised team with the employment of a limited number of experienced bank SI investigators, again these individuals are independent of the divisions/services and will have significant experience of being involved in investigations.

<u>Establishment of Family Liaison Team:</u>

As a Trust we looked at the opportunity to significantly improve the communication and interaction we have with families and patients when an incident occurs, and more particularly a serious incident. With this in mind our investment group has approved the funding of a Family Liaison Service. The team will comprise of 3 full time posts. The family liaison team will work across all Trust services to support patients/families/carers through the difficult process of

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serious incidents, inquests and investigations into serious incidents. The purpose of this role is to provide explanation and support through what can be a difficult process for families.

The three posts are currently out to advertisement and we would envisage making an appointment in November, to commence in post early 2022. As a Trust we see this as an important and pivotal team to ensuring a consistent support mechanism for families through what is a stressful and difficult time for them and to also ensure their voice and questions is represented in the investigation itself.

Medico-Legal Team:

Although our Medico-Legal team is well established, the Trustwide governance review gave us the opportunity to centralise some of the provisions still available within some services. The Medico-Legal team and in particular the Inquest function now covers all Trust services.

The inquest team provides a strong link between the coroner's office and the trusts operational services. They provide support in the preparation of court papers/statements and also supporting staff through what can often be a difficult process. They also provide a link to the families involved, and of course with the development of the Family Liaison service, it will be imperative that these two teams work closely and seamlessly together.

Review of Trust Policy:

With the appointment of our Director of Nursing, AHP and Quality (Executive Lead for Patient Safety) in January 2020, there was also the opportunity to review and refresh existing practices in relation to the process for the management of serious incidents. Some of the immediate changes made were:

- All Comprehensive (Level 2) investigations would be approved by an Executive Director.
- Terms of reference for a comprehensive investigation would be approved by an Executive Director
- All Concise (Level 1) investigations would be approved by an Associate Director of Nursing.

We also took the opportunity to work with our internal auditors, to review our processes and polices related to incident reporting and serious incident management and as a result changes to the Managing Serious Incidents (SI) and Reporting and Learning from Deaths policy (15.02), were made which formally reflected the changes made by the Director of Nursing, AHPs and Quality shortly after her appointment.

Review of Staff training

Incident Investigation

We have worked with external partners to ensure that staff undertaking serious incident investigations are trained and knowledgeable in investigation techniques. We are now providing a new 2-day training event for investigators based on a "Systems Based Approach". This approach is advocated by the Patient Safety Incident Response Framework (PSIRF) which will be implemented within NHS Organisations from April 2022. The role of SBA is to identify the

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systems-based problems when an incident occurs, rather than focusing on the individuals involved. Our aim is to train 100 investigators year on year.

We have recognised that whilst the centralised investigation team gives us a consistent approach to investigations, the volume of investigations means we must utilise operational staff as part of the overall investigation process, hence the provision of incident investigation training. However, in training these people we also need to ensure we continue to eliminate variation, so to assist with this we have put in place support and mentoring which will be provided through the dedicated centralised investigation team.

Quality Assurance of Investigation Reports

We also recognised that we also needed to strengthen our overall review of our investigation reports and ensure those individuals who are approving/authorising the final report have the skills to critically appraise the report and ensure it is fit for purpose.

With this in mind, as part of our training offer, we have also worked with our providers to establish a Quality Assurance training course for people who approve or sign of Concise/Comprehensive reports. The course provides the attendees with skills to critically access the investigation report and ensure in concentrates on Systems Based outcomes and SMART actions. Our aim is to train at least 50 people each year. The purpose of this training is to provide senior individuals who have responsibility for approving reports to with the skills to analysis the report, ensure fairness, that systems-based learning has been applied and that the report and findings reflect the agreed terms of reference and any questions raised by the patient or family.

Implementation of Just and Restorative Culture

As a Trust we had significant progress in embedding a Just and Restorative Culture by ensuring we act with compassion, treating people fairly and justly and embracing a learning culture; where if something goes wrong, we seek first to understand. When things do go wrong in all cases we should:

- Seek first to understand before taking action
- Focus on restoration, not retribution and consider what was responsible rather than just who was responsible
- Consider the psychological impact on all individuals involved

In Notts Healthcare there are many ways we are already working together to create a Just and Restorative Culture (JRC), and we can demonstrate that it is the overall Culture linked to Compassionate Leadership that will ultimately enable colleagues to feel safe enough to speak up without fear of reprisal or blame, to feel heard and supported.

Overview

There is recognition that this overall review, restructure and development of both teams and training has been necessary to strengthen the governance in relation to serious incident investigations. Whist some of these changes have been established for a little while others have either come online in the last few months or will do in the very near future. We believe that through the governance review and significant investment for centralised investigators and family liaison service we will be able to ensure:

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- Strong governance in relation to serious incidents
    - Oversight through our meeting structure
    - Approval of Terms of reference
    - Final approval and sign-off of Concise and Comprehensive investigations
- Elimination of variation
- Development of expertise through training in the use of Systems Based Approach (SBA) to SI investigations
- Providing SI approving managers, the skills, and techniques to critically appraise investigations
- Support and guidance for all our staff attending and involved within the coronial process.
- Through the implementation of the Family Liaison service, we will be able to ensure families have:
    - An identified point of contact
    - Their voice and questions are represented within the investigation process
    - Clear lines to ensure the outcome of the investigation is fed back to them and they have the opportunity to comment
    - The appropriate level of support throughout the SI process and inquest.

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

Dr [redacted]
Chief Executive

Enc *Appendix 1 – Final Version of the Trust's Concise Investigation Report*
Appendix 2 – Document embedded within the Quality Improvement Plan
Appendix 3 – Email embedded within the Quality Improvement Plan
Appendix 4 – Creating Capability Changing Culture Document
Appendix 5 – Diagnostic Tool linked to Team Culture Training
Appendix 6 – Job Description for Carer Peer Support Worker
Appendix 7 – Core Fidelity Principles Scale

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