B 55/19 Conc.

NHS
Barnsley Hospital
NHS Foundation Trust

Our Ref: [redacted]

4 January 2021

Mr Stephen Eccleston
Assistant Coroner of South Yorkshire (West)
Medico Legal Centre
Watery Street
Sheffield
South Yorkshire
S3 7ES

Dear Mr Eccleston,

I am writing following receipt of your Regulation 28 Report dated 12 November 2020. We again offer our condolences to Carolyne's family and our apologies for the treatment and care that she received whilst she was an in-patient in December 2018 and January 2019.

Our trust strives to provide the best care to our patients and we recognise from our own SI report, and from your Regulation 28 Report that things could have been done better, and that we can improve the safety and care that we give to our patients in the future.

Below I have addressed each of the points that you have raised in the same order as per Part 5 of the Regulation 28 Report for your ease of reference and I have enclosed the relevant enclosures to assist with assurance that the Trust has now put in place a number of measures to address the Regulation 28 report and to improve patient safety.

1. *Evidence was given that Carolyne's mental health issues could have inhibited her insight and ability to follow advice around falls prevention. The SI report author accepted in evidence that the question of whether hospital staff had sufficient access to advice to support them in caring for patients with mental health needs had not been addressed in that review.*

   With reference to including this aspect in a Serious Investigation (SI) an SI investigation is undertaken in accordance with the The Serious Incident Framework. It describes the process and procedures to help ensure that serious incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again.

   At Barnsley Hospital all incidents and near misses are recorded on the Trust's incident reporting database which is called Datix. The individual ward areas will grade the risk based upon the level of harm and escalate accordingly through the various patient safety and governance forums.

In the context of a fall, all falls with a moderate or severe grading have a Root Cause Analysis report prepared (definitions adopted from the National Reporting and Learning System. Moderate harm is defined as "Any unexpected or unintended incident that resulted in a moderate increase in treatment, possible surgical intervention, cancelling of treatment, or transfer to another area, and which caused significant but not permanent harm, to one or more persons receiving NHS-funded care. Severe harm is defined as: Any unexpected or unintended incident that appears to have resulted in permanent harm to one or more persons.)

The Root Cause Analysis is undertaken to determine if the fall is avoidable or unavoidable. This meeting is chaired by the Head of Nursing Quality who will review the Root Cause Analysis document with the ward manager or senior nurse of the ward where the fall took place, and conclude at the end of that meeting if the fall is avoidable or unavoidable and escalation to a Serious Incident will be made where this is deemed avoidable.

Since the inquest of Carolyne, the Trust has now included the following two questions in the Root Cause Analysis document:

- Does the patient have a diagnosed mental health condition?
- Does the patient have a diagnosed mental health condition which affects their ability to understand and retain information on how to keep themselves safe from falling?

(page 8 of the Root Cause Analysis document **EXH1**)

The rationale is to ensure that nursing staff are aware of mental health conditions which may have an impact on a falls risk and that they can also be given due consideration for inclusion within the SI report (if the fall is deemed to be avoidable).

2. *Nursing evidence was to the effect that advice and guidance was limited. In particular that mental health staff could take a very long time to attend a ward when asked but, more generally, that mental health input was insufficient to support hospital staff in caring for such patients and was known to be provided to a better standard in other hospitals*

Mental Health Liaison Psychiatry Service are a service commissioned by Barnsley CCG . They are based in the Emergency Department and access into in-patient wards, and into which all of the hospital areas can contact and refer for advice. The service is delivered by South West Yorkshire Partnership Trust (SWYPT). Consultations with SWYPT have demonstrated that they have invested a significant amount of resources recently into the Mental Health Liaison Psychiatry service to achieve 'CORE 24' Status and to make the service 'All-age'. This is the same level of mental health service support provided into each of the other South Yorkshire and Bassetlaw Integrated Care System Trusts (although Barnsley's service is the only 'all-age' service).

At inquest, [redacted] and [redacted] gave evidence that they were familiar with the processes of making a referral to the mental health service, as are all registered staff in procuring mental health input where required. For clarity, we have sought

guidance from SWYPT of the service that they provide to ensure that both parties are acting appropriately in terms of their contractual obligations. They are listed as follows:

a) *The services provide an interface between general medicine and psychiatry in the general hospital setting (ED and wards) for patients experiencing a mental health crisis. The service is provided 24hours a day 7 days a week and was recently extended to include children (5+years) and young people.*

b) *It is expected that all referrals are responded to within 1 hour of receipt. With emergency assessments completed with 4 hours and all others within 24 hours*

c) *All assessments as a minimum, have a New Comprehensive Assessment [NCA-bio-psycho-social assessment] and a risk assessment [FIRM Formulation Informed Risk Management] completed. These are entered by SWYPT staff on the patient's electronic record and a corresponding entry is made in the general hospital's paper record*

d) *The team operates a two-shift staffing model to cover the 24-hour period. A long day shift has 3 Band 6 nurse practitioners on duty - 2 staff cover nights. All staff are skilled/experienced in acute psychiatric care and all are trained in the assessment of children and young persons.*

e) *During office hours of 9am-5pm liaison staff have access to a Clinical Lead and an operational manager. Medical cover is provided during the day [9-5] by a mid-grade doctor in adult psychiatry, with access to a duty adult consultant psychiatrist and CAMHS consultant psychiatrist. Out of hours cover is provided by access to a senior nurse clinical lead and on call Consultant Psychiatrists for adults and CAMHS.*

3. *I was concerned that staff in Barnsley hospital did not take sufficient account of Carolyne's mental health needs in formulating falls risk assessments and mitigations. I was concerned that there may be inadequate specialist provision to support staff in caring for patients with mental health needs such that these patients, some of whom may be challenging to care for, would therefore be placed at greater risk of falls than would be the case if risk assessments were formulated with their specific needs in mind.*

Following receipt of the outcome at inquest, the executive nursing team have reviewed and updated the falls risk assessment process to include specific assessment of the patient's mental health condition, and whether this impacts on their ability to retain information in an effort to reduce their risk of falling. In addition, the management plan has been updated to include a direct reference to an intervention to contact Mental Health Liaison (**EXH 2 and 3**) in both groups of patients (aged under 65 years of age and aged over 65 years of age).

The assessments for both groups includes consideration of escalating the patient for enhanced care. The Trust has a policy (Enhanced Care Policy) to include the interventions as described in the falls risk assessments above (**EXH 2 and 3**). The policy is due for renewal in early 2021 and these elements will be reflected in that update. The Trust will provide you

with a copy of the updated policy once it has been formally approved through the Trust's governance processes.

As the falls assessment process has been updated we are informing the nursing staff of this change at Senior Nurse Forum meeting, Falls Prevention Group, Falls Steering Group and this will also be included in the monthly nursing quality report. The patient Safety Team will also prepare a "Learning From" bulletin which will be sent to all employees of the Trust to explain the changes to our falls risk assessment processes in respect of mental health.

In 2019 the Trust launched its first Mental Health Strategy. The delivery of the strategy is undertaken by the Mental Health Strategy Implementation Group (MHSIG). The Trust is committed to improving the experience of staff and patients with a mental health condition at Barnsley Hospital. The learning from this case has been shared with the MHSIG.

I hope that the above has provided sufficient assurance to HM Coroner and Carolyne's family that we have reflected upon the care that Carolyne received, reviewed the services available and has put in place robust measures to reduce the likelihood an incident of this kind from re-occurring.

Yours sincerely

[redacted]

[redacted]
Chief Executive