K.J.

Birmingham and Solihull NHS
Mental Health NHS Foundation Trust

Chair & Chief Executive's Office
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Our Ref: JS/DF/CEO Corres

18 September 2015

Mrs Louise Hunt
HM Senior Coroner, Coroners Court
Birmingham and Solihull Areas
50 Newton Street
Birmingham
B4 6NE

Dear Mrs Hunt

REGULATION 28: REPORT TO PREVENT FUTURE DEATHS

I am writing further to your letter dated 23 July 2015 pursuant to Regulation 28 of the Coroners (Investigations) Regulations 2013.

Thank you for informing me of your concerns relating to the care provided to Mrs Doreen England by Birmingham and Solihull Mental Health NHS Foundation Trust. I can assure you that these have been taken very seriously.

In your letter of 23 July 2015, you raised the following matters of concern:-

1. Despite a waterlow score on admission confirming that Mrs England was at high risk of pressure sore formation, no care plan was prepared. Staff at the inquest confirmed that they had a lack of knowledge about pressure sore formation and how to prevent pressure sores occurring. Staff working on mental health wards dealing with elderly patients must have a clear understanding of basic medical care, in particular how pressure sores occur and what steps are required to address those at high risk.

2. Since these events staff confirmed at the inquest that they had still not had training on pressure sore formation and prevention.

3. Rosemary Suite had no leadership at the time. Staff were completing paperwork but not then actioning risks that were identified. The consultant and ward doctor were on leave at the same time and medical cover was only available from doctors off site who had to be requested to attend. The ward and Trust need to ensure that there is clear leadership on the ward with adequate medical cover.

was to write to you again in March 2016 to confirm that all future actions have indeed been delivered. I will diarise this matter and ensure that you receive a letter to this effect.

Yours sincerely

John Short.

John Short
Chief Executive

K.J

RECEIVED
22 SEP 2015

Department of Health

From Ben Gummer MP
Parliamentary Under Secretary of State for Care Quality

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 4850

Mrs Louise Hunt
HM Senior Coroner – Birmingham and Solihull
50 Newton Street
Birmingham
B4 6NE

21 SEP 2015

17th September 2016

Dear Mrs Hunt

Thank you for your letter to Secretary of State about the death of Ms Doreen England. I am responding as the Minister with responsibility for care quality at the Department of Health.

I was saddened to read of the circumstances surrounding Ms England's death. The standard of care described in your report is disappointing and unacceptable. Please pass my condolences to Ms England's family and loved ones.

You detailed the treatment received by Ms England following her admission to the Juniper Centre, culminating in her death 30 September 2014.

The report noted a number of concerns including the following;

- Staff working on mental health wards not being trained in pressure sore formation and prevention; and
- Registered Mental Health Nurses (RMNS) training curriculum not covering the subject of pressure sores in any detail.

I note that you have also asked NHS England to respond to your findings and I understand that Sir Bruce Keogh – National Medical Director at NHSE has responded to your report. Mrs England's case has been tabled for discussion at

the Quality Surveillance Group in order to address the deficiencies in care and to look at what needs to happen to prevent any recurrence.

With regard to your concerns about staff training, I have consulted Health Education England (HEE), which is the body established to help improve the quality of care delivered to patients by ensuring that our future workforce is available in the right numbers with the right skills, values and competencies to meet their needs.

While HEE have a responsibility for promoting high quality education and training, they are not responsible for setting curricula or the standards of training; in this instance this would be the responsibility of the Nursing and Midwifery Council (NMC). Nevertheless, HEE have confirmed that they will work with the NMC to influence training and curricula as appropriate.

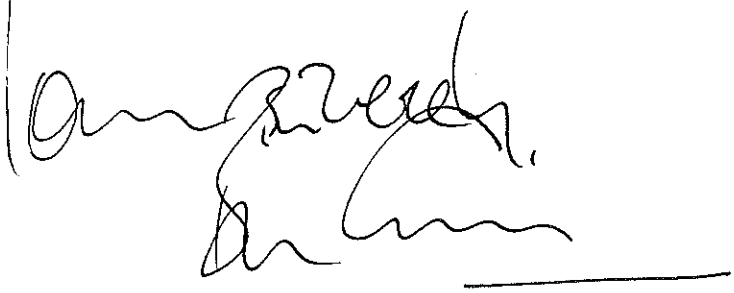
HEE do take account of the impact of actions on the whole health and social care workforce, especially where the performance of the whole system is so inherently interlinked.

Health Education England Strategic Framework 2014 -29 – Framework 15 builds upon a Strategic Intent Document published in February 2013 and the feedback to that and the refresh published in July 2013 and can be found at https://hee.nhs.uk/2014/06/03/framework-15-health-education-england-strategic-framework-2014-29/

Framework 15 identified the five characteristics required of the future workforce to meet the needs of future patients. One of which is the need for a workforce with adaptable skills, responsive to evidence and innovation to enable 'whole person' care, with specialisation driven by patient rather than professional needs.

HEE plans to undertake a long term piece of work to review the curricula of all NHS commissioned training programmes to include areas of health, including learning disability, mental illness, physical illness and physical ill health and social support needs. Working with regulatory bodies, HEE will agree the standards and content for education and training; this is anticipated to be completed by April 2017.

I hope that this information is useful. Thank you for bringing the circumstances of Ms England's death to our attention.



BEN GUMMER

K Jones

NHS England

Bruce Keogh
Medical Directorate
6th Floor, Skipton House
80 London Road
SE1 6LH
bruce.keogh@nhs.net

4th September 2015

H.M. Senior Coroner
Mrs Louise Hunt
Birmingham & Solihull Areas
Coroner's Court
50 Newton Street
Birimingham
B4 6NE

Your ref: 003059/2014 – DOREEN ENGLAND (LH/AS)

Dear Mrs Hunt,

Re: Doreen England, Deceased

NHS England has received your regulation report dated 23 July 2015 relating to the unfortunate death of Doreen England. It was upsetting to read of the significant failures of care that contributed to her death and we are saddened to hear of this deficiency in care delivery and extend sincere apologies to the family of Mrs England.

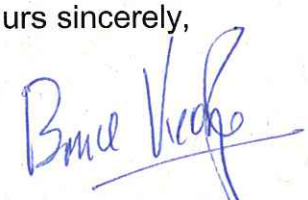
There are aspects of care in that have been highlighted in the report which demonstrate an urgent need for rectification. In particular there is a lack of an appropriate response to assessing Mrs England at high risk of developing pressure sores. Her risk had clearly been identified and documented on at least two occasions but had not resulted in appropriate delivery of care. In situations like this whilst staff may not have the necessary skills to respond themselves to the risk identified, there should have had ready access to specialists, specialist equipment and easily accessible advice.

It is also a significant concern that at the time of the inquest the organisation involved does not appear to have responded in correcting these issues. We are in communication with Birmingham Cross City CCG which has undertaken a significant amount of work in relation to this case already and who commission the service and will also ensure CQC are aware of the case.

NHS England has oversight of such issues as the convenor of local quality surveillance groups (QSGs) which bring together the commissioners and regulators in local areas. In this case, the matter has been tabled for discussion in our Quality Surveillance Group, where we will oversee the need for a specific action plan and seek assurance that the deficiencies in care have been addressed in order to prevent a recurrence. We will ensure you are made aware of the outcome and actions resulting from these efforts.

I hope that this response containing details of the action proposed provides assurance.

Yours sincerely,



Bruce Keogh KBE, MD, DSc, FRCS, FRCP
National Medical Director
NHS England

[redacted]