Department of Health

Philip Dunne MP
Minister of State for Health

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 4850

Ms Alison Hewitt
Assistant Coroner
HM Coroner for Surrey
H.M. Coroner's Court
Station Approach
Woking
Surrey
GU22 7AP

Dear Ms Hewitt

Thank you for your letter of 17 February 2016, following the inquest into the death of Adam Withers. I was sorry to hear of his death and wish to extend my condolences to his family and I apologise for delay in providing this response.

There are two concerns for the Department's attention. The first concerns the destruction of original paper patient records after they have been transferred to electronic format following a patient's death. You are concerned that such practice, when it is apparent that the death must be reported to either police or coroner, could undermine any police or coroner investigation. The Trust considered it was adhering to the NHS Code of Practice on Records Management when the paper record was destroyed after converting it to electronic format. You are unsure whether this was a correct interpretation of the Code and consider that no clear guidance on this issue exists.

Our view is that original paper records should not be destroyed after a patient's death where the death may be subject to investigation. I fully support the view that the NHS must be totally candid in its dealings with coroner or police investigations.

This raises a question about whether the Trust acted appropriately in destroying the paper record following Mr Withers' death. It is not clear from the information available whether the Trust was aware that a coroner's investigation was going to take place. Destroying the paper record might have been justifiable if that took place before the Trust was aware of the possibility of an investigation. Destruction would have been much less justifiable where an investigation was already underway.

The NHS Records Management Code of Practice is currently under review and a revised Code is due to be published when the review is complete. Clear guidance on the point you raise will be added to the revised Code before publication.

Your second concern relates to insufficient staffing levels both on Elgar Ward at Epsom General and in acute psychiatric wards in general. The Trust informed you at the inquest that there are no nationally set "safe staffing levels" for acute psychiatric wards. You are concerned that this could leave patients in such wards at risk due to inadequate supervision, observation and intervention.

As set out in the NHS Constitution, patients have the right to be treated to a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality. Reports on the failings at Mid Staffs highlighted the importance of the appropriate staffing levels to the delivery of safe and effective care. The Care Quality Commission's (CQC) Fundamental Standards require care and treatment to be provided in a safe way, and that includes safe levels of staffing.

Responsibility for staffing rests (as it has always done) with Trust boards. Trusts' staffing arrangements should enable the right numbers and skill mix of staff at the right time to deliver quality care and patient safety while doing so efficiently, taking into account local factors such as acuity, case mix and how to respond to fluctuations in workload.

This was underlined by:

- recent correspondence - a letter on safe staffing and efficiency was sent to NHS Trusts in October 2015 from NHS Improvement, CQC, NHSE, the Chief Nursing Officer and the National Institute for Health and Care Excellence; underlined by a letter in January 2016 from the Chief Executive-designate of NHS Improvement, Jim Mackey, and the Care Quality Commission's Chief Inspector of Hospitals, Professor Sir Mike Richards. Copies of these letters are enclosed.
- Lord Carter's review highlighted the importance of getting staffing right as a means of increasing the productivity and efficiency of the health service while providing good quality, safe care; and
- publication in July 2016 of refreshed National Quality Board (NQB) guidance on Safe and Sustainable Staffing.

https://www.england.nhs.uk/wp-content/uploads/2013/04/nqb-guidance.pdf

This refreshed guidance acts as a resource to support the decisions that trust Boards need to make, bringing together judgements about eg casemix and patterns of demand

Department
of Health

to ensure their arrangements underpin safety while still being affordable and sustainable.

It emphasises that Trusts' focus should be on patient outcomes rather than relying on input measures such as crude numbers or ratios of staff.

We do not agree that a minimum staffing level for services would be a "guarantee for safety": the evidence base is lacking and minimum staffing numbers and ratios would not take account of local circumstances, skill mix or case mix. Following publication of the revised guidance by NQB, further outputs will be developed by the national programme for individual settings including mental health and learning disability settings.

I hope that this reply is helpful and I am grateful to you for bringing the circumstances of Mr Withers' death to my attention.

Yours sincerely

P. Dunne

PHILIP DUNNE