NHS
Greater Manchester
Mental Health
NHS Foundation Trust

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24th April 2018

PRIVATE & CONFIDENTIAL
Ms Rachel Galloway
HM Assistant Coroner
1 Mount Tabor St
Stockport
SK1 3AG

Dear Ms Galloway

Re: Regulation 28 report to Prevent Future Deaths issued to GMMH following the Inquest of Ms Barbara Johnson, which concluded 16th March 2018

Following the outcome of the Trust's Root Cause Analysis investigation into the death of Ms Johnson and the subsequent inquest and concerns raised I would like to inform you and Ms Johnson's family of the actions taken by the Trust. For ease of reading, I have highlighted the concerns raised by you during Ms Johnson inquest with the Trust response beneath each point.

There was an apparent lack of training or instruction to nursing staff regarding handovers between shifts and no training or refresher training on the importance of handover and what should be included in the handover information. There is a reliance upon staff to familiarise themselves with the handover policy. In this instance, pertinent information such as a marked decrease in fluid consumption and the patient presenting with slurred speech was not handed over. I was advised that there is no local or national policy requiring refresher training or on the importance of handover and what should be included in handover which gave rise for your concern

GMMH does have a handover procedure and this is available on the Trust Intranet where all staff have access to the most up to date version of this procedure. Following learning from Ms Johnson's death the Trust accepts that there is a need to further promote the use of our handover procedure and to ensure staff are updated as to its contents. In order to address this the Trust will ensure that the process and expectations of staff when conducting or being part of a handover are included in the local induction template of all new nursing and nursing assistant staff.

I would also like to assure you that the process and expectations of handovers has been featured in the ward business meetings and will be shared through the local nurses' forums. Through these meetings, all existing staff will have been made aware of their responsibilities in relation to ensuring thorough handovers take place.

In order to evidence that staff have a good understanding of handover process and their responsibilities a local audit will also be undertaken by the Matron/Operational Manager and be completed by June 2018. A local learning event which discussed the learning generated by the Trust investigation into Ms Johnsons death has already been held but to further embed and share learning, a further Trust wide event will be held and will include the learning in relation to the importance of good handovers .

The Trust's Corporate Nursing Team are also completing a Trust wide audit to better understand practice and variance around handover management across the Trust. The audit will be complete by the end of June 2018 with the analysis and report to be finalised by August 2018 and presented to our Quality Governance Committee which is the sub-committee to the board. This report will inform Trust wide actions on the management of handovers going forward. We would be happy to share the results from this audit with you on completion as we are keen to be able to offer yourself and Ms Johnsons family assurance of how seriously the Trust have taken on board the concerns that have been raised following Ms Johnsons death.

Secondly, you note concerns that the nursing assistant did not appear to inform the qualified nurse on duty (or a doctor) of the marked decrease in fluid consumption over a period of a few days prior to Ms Johnsons death. The qualified nurse on duty on the day of Barbara's death was unaware of the marked decrease and did not accept that it was her role to familiarise herself in the patient fluid charts. This plus other factors resulted in a lack of medical review of the patient or any clinical response in the days prior to death.

The use of a fluid intake chart is important for some of our service users where there are concerns about their fluid consumption. The Trust accepts that it is vitally important that nursing assistants and nursing staff understand the purpose of the fluid intake chart and when to escalate concerns. In order to address this all nursing assistants in the Trafford division will trained on the use of fluid balance charts and when to escalate concerns. This will be over seen by the Matron/Operational Manager and be completed by 30.6.18.

As described above, the planned Trust wide handover audit will review all aspects of the handover process and expectations of staff who are handing over or taking part in a handover will be added into the local induction program for all new staff. Included in this will be the need to inform a nurse or doctor about changes to the patient's presentation including any physical observations such as fluid intake.

Similarly, existing staff will be made aware of their responsibilities through the team business meetings and nurses' forums. The Matron/Operational Manager will oversee this and this will be completed by 31/05/2018.

The local audit discussed above will be carried out to demonstrate staff understanding of handovers and their responsibilities. In addition to this a weekly audit of fluid intake charts will be completed for 3 months by the Ward Managers to ensure that staff continue to complete these charts and that any cases that require escalation to a doctor have been progressed.

Furthermore a recent change to Trust policy will ensure that any new support staff Bands 2 to 4 will have a nationally regulated competency based qualification which will ensure that staff are clear and competent in the core aspects of their role.

Finally, you note that it is of concern that the fluid charts would often not include all the liquids consumed by the patient and that there appeared to be reliance upon unrecorded liquids, which might have been consumed when considering the fluid charts. Your concern was that such reliance makes the purpose of keeping a fluid chart obsolete.

Concerns pertaining to fluid intake charts and their usage were taken to the Trust's Physical Health Committee (PHC) on 11.4.18. This group discussed alterations to the existing charts and training requirements for staff as well as how any agreed training will be delivered. Through this group Staff have been made aware of the need to ensure that all fluids that are offered and or consumed are recorded on the fluid intake chart as well as self-reported consumption of drinks.

Furthermore Trust leads have been identified to consider how dietetics can be part of the Trust induction program, as well as reviewing training being delivered in other parts of the Trust to produce a Trust-wide package which in addition to the action already taken or planned will include the issue you have raised above.

I hope that this response has provided some assurance to you and Ms Johnsons family and has demonstrated that as a Trust we have taken the concerns you have raised very seriously and will be utilising relevant local and Trust-wide forums to share this learning and steps being taken to address the concerns raised.

Yours sincerely

Dr Chris Daly
Medical Director

Department of Health

Steve Barclay MP
Minister of State for Health

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Tel: 020 7210 4850

Your reference: 7255/CLB
Our reference: PFD 1125656

Ms Rachel Galloway
HM Assistant Coroner, Manchester South
Coroner's Court
1 Mount Tabor Street
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15 May 2018

Thank you for your letter of 21 March to the Secretary of State for Health and Social Care about the death of Mrs Barbara Johnson. I am responding as Minister with portfolio responsibility for professional regulation.

Firstly, I would like to say how saddened I was to read of the circumstances surrounding Mrs Johnson's death. Please pass my condolences to her family and loved ones. I appreciate this must be a difficult time for them.

The matter of concern that you ask the Department of Health and Social Care to address is that on the importance of effective patient handover between nursing shifts. I understand from your report that in Mrs Johnson's case, pertinent information, such as a marked decrease in fluid consumption, was not handed over.

Nursing handover is a group of skills, qualities and abilities conducted in a huge variety of forms.

In modern healthcare, although formal large group handovers between shifts do often still take place, more common are the individual handovers between teams or individual staff, sometimes staff who work for different organisations. Communicating effectively to another caregiver the correct information, clarifying understanding, and agreeing a shared plan of what will happen now and who will do it as a result of the information handed over is a complex activity encompassing a number of skills.

Communication, transfer of clinical information, and care planning for a patient are all pre-registration competencies studied on all nursing programmes in a variety of ways. The manner in which this is evidenced is both academic

and more importantly in clinical practice, supervised and assessed by an appropriate healthcare professional.

A person seeking admission to the NMC's register must, among other things, satisfy the NMC that they hold an approved qualification attesting to the standard of proficiency that the NMC consider necessary for safe and effective practice as a nurse at the point of entry to the register.

In March 2018, the NMC published its new standards of proficiency. These standards include requirements that, at the point of registration, the registered nurse will be able to:

- Provide clear verbal, digital and written information and instructions when delegating or handing over responsibility of care;
- Demonstrate the ability to keep complete, clear, accurate and timely records;
- Demonstrate the ability to monitor and evaluate the quality of care delivered by others in the team and lay carers;
- Understand the principles and processes involved in planning and facilitating the safe discharge and transition of people between caseloads, settings and services; and
- Demonstrate the ability to work in partnership with people, families and carers to continuously monitor, evaluate and reassess the effectiveness of all agreed nursing care plans and care, sharing decision making and readjusting agreed goals, documenting progress and decisions made.

Once nurses are registered with the NMC they are required throughout their careers to uphold and act in accordance with the professional standards contained within the NMC's Code: Professional standards of practice and behaviour for nurses and midwives (2015).

The preamble to the Code emphasises that when joining the register and when renewing their registration, nurses and midwives commit to upholding these standards and that this commitment to professional standards is fundamental to being part of a profession. The following aspects of the Code are relevant to the matter of concern raised in your report:

- Paragraph 6.2 of the Code states that nurses must maintain the knowledge and skills they need for safe and effective practice.

- Section 8 of the Code concerns nurses working cooperatively and provides that nurses must maintain effective communication with colleagues, keep colleagues informed when sharing the care of individuals with other healthcare professionals, work with colleagues to preserve the safety of those receiving care and share information to identify and reduce risk.

- Section 10 of the Code relates to the responsibility of nurses to keep clear and accurate records relevant to their practice and provides that nurses must complete all records at the time or as soon as possible after an event; identify any risks or problems that have arisen and the steps taken to dealt with them, so that colleagues who use the records have all the information they need; complete all records accurately and without falsification, taking immediate and appropriate action if they become aware that someone has not kept to those requirements.

- Paragraph 13.5 provides that nurses must complete the necessary training before carrying out a new role.

In appropriate circumstances, the NMC enforce the standards set out in the Code through fitness to practise proceedings. Fitness to practise proceedings can result in the provision of advice by the NMC, the issue of a warning or the acceptance of undertakings by a nurse or midwife to take agreed steps in order to remedy concerns about their practice. Other sanctions available to fitness to practise panels include the imposition of a caution, a condition of practice order or the suspension or removal of the nurse from the register.

Further, in order to maintain their registration with the NMC, every nurse must 'revalidate' every three years to ensure that they practise safely and effectively.

The revalidation process requires the nurse to demonstrate that they have practised for at least 450 hours, obtained at least 35 hours of continuous professional development (including 20 hours of participatory learning), reflected on their practice and obtained five pieces of practice related feedback. The NMC does not prescribe any particular type of continuous professional development. It is for individual nurses to decide what activity is most useful to their development as a professional.

The standard of nurse training is the responsibility of the NMC, which has the general function of promoting high standards of education and co-ordinating all stages of education to ensure that nursing students and newly qualified nurses are equipped with the knowledge, skills and attitudes essential for professional practice.

The training curricula for nursing trainees is set by individual Higher Educational Institutions (HEIs) and has to meet the Standards of Education and Training set by the NMC. Whilst curricula do not necessarily highlight specific conditions or processes for nurses to be aware of, they instead emphasise the skills and approaches that a nurse must develop in order to ensure accurate and appropriate care is provided for their patients.

Care assistants are expected to undertake the care certificate which includes the importance of accurate and timely communication of any change in the patient's condition.

I should point out that we would expect individual organisations to have policies and procedures in place on the conduct of handovers that include the capture of physical healthcare information.

We would expect training on Trust handover policy to feature as part of the induction process provided by individual trusts. I understand NHS England's letter to you of 30 April makes the point that, while there may not be specific refresher training on effective patient handover, this topic would be picked up in other areas of training, for example, risk assessment and management which form part of core training for mental health staff.

In clinical practice, there are several tools afforded to nurses to be able to handover a patient more effectively. Many trusts are now adopting the SBAR (Situation, Background, Assessment and Recommendation) process for handovers which provides a clear structure and ensures that not only is key information communicated, but clarity on the response .

Following Mrs Johnson's death, I am informed that the Greater Manchester Mental Health NHS Foundation Trust has identified that there is a need to further promote its handover procedure and to make sure staff are updated on its contents.

To address this, the Trust will include the handover process and expectations in the local induction template for all new nursing and nursing assistant staff. The process and expectations for handovers have been shared in ward meetings and

Department
of Health

through nurse forums. An audit will be completed by June 2018 of compliance.

In addition, I am advised that all training assistants in the Trafford division will be trained on the use of fluid balance charts and when to escalate concerns by the end of June. A fluid chart audit will be conducted and the need to inform a nurse or doctor about changes to the patient's presentation will be included in induction and awareness raised among staff.

Finally, it is essential that staff in mental health settings also meet patients physical health needs. Under its inspection regime, the Care Quality Commission (CQC) is responsible for assessing the safety of care and treatment provided. To support mental health providers to comply with the standards, CQC published a guide in May 2017 setting out the evidence needed to demonstrate that the physical health needs of people with mental illnesses are being met.

I hope this information is helpful. Thank you for bringing the circumstances of Mrs Johnson's death to our attention.

Yours sincerely

STEPHEN BARCLAY MP

NHS England

70 YEARS OF THE NHS 1948 - 2018

Professor Stephen Powis
National Medical Director
Skipton House
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Rachel Galloway
HM Assistant Coroner
Coroner's Court
1 Mount Tabor Street
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30th April 2018

Dear Ms Rachel Galloway

Re: Regulation 28 Report to Prevent Future Deaths following an inquest concerning the death of Barbara Johnson (30 April 2017)

Thank you for your letter of 21 March enclosing the Regulation 28 Report ("Report") following the death of Barbara Johnson. Firstly, I would like to express my deep condolences to Ms Johnson's family. I was sorry to read about Ms Johnson's death.

The 'Matter of Concern' that you addressed to NHS England as well as to the Department of Health and Social Care, and to Greater Manchester Mental Health Trust, is as follows:

There was an apparent lack of training or instruction to nursing staff regarding handovers between shifts. Other than that which is provided during the nursing degree, there is no training or refresher training on the importance of handover and what should be included in the handover information. There is a reliance upon staff themselves to familiarise themselves with the handover policy at Tameside [sic] General Hospital (available on the intranet) and to read the same. In the present case, pertinent information (such as marked decrease in fluid consumption and the patient presenting with slurred speech) was not handed over. I was advised that there is no local or national policy requiring refresher training (or any training following completion of the nursing degree) on the importance of handover and what should be included in handover. This gave rise to a concern.

We have liaised with NHS Improvement as NHS Improvement is the national body responsible for overseeing foundation trusts and NHS trusts, as well as independent providers that provide NHS-funded care.

We believe that best practice would be for individual organisations, including mental health trusts, to have a policy/procedure on conducting handovers which would include the key elements of handover. One of the key elements would be information on physical healthcare. Many trusts are now adopting the SBAR (Situation, Background, Assessment, Recommendation) process for handovers, which provides a clear structure and ensures that not only is key information communicated between staff, but also provides clarity on the how this information should be responded to.

There are national-level resources to support this. For example, *Improving the physical health of adults with severe mental illness: essential actions, A report of the Academy of Medical Royal Colleges and the Royal Colleges of General Practitioners, Nursing, Pathologists, Psychiatrists, Physicians, the Royal Pharmaceutical Society and Public Health England* (October 2016) says the following:

Mental healthcare providers should ensure that…communication systems are used for handover and medical emergencies, such as the SBAR system (Situation, Background, Assessment, Recommendation) (p 12)

Communication and handover and systems should be used routinely to enable staff to communicate effectively about the physical health (and mental health status) of people with SMI [severe mental illness]. (p 31)

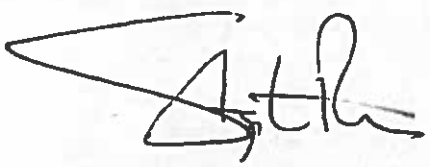
The report is available here: https://www.rcn.org.uk/-/media/royal-college-of-nursing/documents/news/2016/physical-and-mental-health-report-25-oct-2016.pdf

The Care Quality Commission (CQC) have published a brief guide on physical healthcare in mental health settings, which sets out the evidence that CQC inspectors of mental health services will look for in order to ensure that providers are meeting the physical health needs of people with mental illnesses in their inpatient services, linked to CQC's inspection domains. The guide is available here: https://www.cqc.org.uk/sites/default/files/20170612_briefguide-physical_healthcare_mental_health_settings.pdf

We would expect that training on a trust's handover policy would be part of the induction process in all trusts and, although not covered in specific regular training, would be picked up in other areas of training such as risk assessment and management, which form part of core training for all mental health staff. I suggest that you may wish to write to Health Education England, who are responsible for overseeing the development, education and training of the healthcare workforce in England.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,



Professor Stephen Powis
National Medical Director
NHS England