Stockport
NHS Foundation Trust

Mr H Mullen
Deputy Chief Executive/Director of Strategy
& Planning
Oak House
Stepping Hill Hospital
Poplar Grove
Stockport
SK2 7JE

Telephone: 0161 483 1010
Direct line: [redacted]
E-mail: [redacted]

7th March 2019

Mr C. Morris
H. M. Area Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Mr Morris

Re: Prevention of Future Deaths: Inquest into the death of Mr Malcolm Marshall Shaw

I am writing in response to concerns raised in your letter dated 10 January 2019 which we received following the inquest into the death of Mr Malcolm Marshall Shaw held on 2 January 2019.

In your letter information was requested in relation to two matters of concern which arose during the inquest.

The launch of the revised programme of investigation training for those who undertake patient safety investigations

I can confirm that programme of investigation training has been developed and launched. We have the following programme in place:

- Quarterly Root Cause Analysis training, delivered by the Trust's Quality Governance Team. This has been in place for a number of years
- In September 2018 the Trust introduced training sessions with an in-depth focus on statement gathering and writing.
- In February 2019, we have launched a revision to the training provisioin. Earlier last year the Trust had recognised that it was heavily reliant on a small team in undertaking and leading on patient safety investigations and therefore widened participation to include other staff.
- In February 2019 the Trust has implemented a check list to be completed at the time the panel meet to hear the final investigation report. The check list, advocated as best practice by NHS Improvement, supports the Executive Director in identifying if the key requirements for a good investigation have been met during the investigation. The checklist includes identification of the training status of the investigation team; that is whether they have received appropriate training.
- A training session is to be held with the Executive Directors on 12 March 2019, this will support consistency of overview and scrutiny of investigations.
- The Trust always ensures that an appropriately trained person leads or facilitates the investigation team when they undertake an investigation into a patient safety incident.

I understand that during the inquest [redacted] Chief Nurse & Director of Quality Governance, explained that in line with the Trust's Quality Governance Framework, a considerable amount of work

had already happened to address the issue of consistency in investigations, some of this work is described above.

- **Frontline staff do not appear to have been provided with any guidance as to how to capture the best evidence as to the circumstances of the fall as soon as reasonably possible after the incident**

I understand that [redacted] was able to describe some of the actions put in place since Mr Shaw's fall to support staff in these situations. These have been expanded on further, and include:

- Earlier last year the Trust developed a specific methodology aimed to support quality improvements, this is called the Patient Safety Collaborative approach and is widely recognised in the NHS as best practice.
- In June 2018 the Trust launched a Safer Mobility Collaborative aimed at reducing inpatient falls by March 2019. Part of the collaborative included the launch of an immediate assessment of the circumstances of the fall, taking statements from staff and talking with the patient to assess that all actions to ensure patient safety are in place.
- In January 2019, the Trust further enhanced its approaches to monitoring falls via our Quality Safety Leadership Summit, held three times a week. At this meeting, senior nurses are able to ensure that full investigations have started and include immediate statements. The Trust is pleased to report that it continues to be on target to reduce the number of falls within the organisation.

I trust that the information provided above is satisfactory to you, please do not hesitate to contact us if you require any clarification.

Yours sincerely

Hugh Mullen
DEPUTY CHIEF EXECUTIVE
DIRECTOR OF STRATEGY & PLANNING