NHS
University Hospitals Birmingham
NHS Foundation Trust

Trust Headquarters
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Our Ref:SB.KS.LTRKAPOOR.01.10.19

1 October 2019

For the attention of Adam Hodson
Assistant Coroner for Birmingham and Solihull
50 Newton Street
Birmingham

Sent by way of email: birmingham.coroner@nhs.net

Dear Mr Hodson,

Inquest touching the death of Prabhaker Nath Kapoor
Response to Regulation 28 Report to prevent future deaths

I write in response to the Regulation 28 Report made by you following the Inquest into the death of Mr Kapoor, which concluded on 5 August 2019.

University Hospitals Birmingham NHS Foundation Trust (the Trust) has carefully considered the concerns raised within your report to prevent future deaths regarding a review of safer swallowing and update of our Moodle training package.

1. **Review of Moodle training**
   Moodle is an internal training e learning platform used to provide training packages to our staff on a range of subjects.

   A review of the training package had been commenced prior to the death of Mr Kapoor although it had not been completed at the time of the Inquest. A review has now been undertaken, and the content of the training package has been updated by our Speech and Language Therapy team (SLT) to reflect our standard operating procedures relating to 'dysphagia' and patients who are 'nil by mouth'. The training package is currently being developed and will be available for staff by 21 October 2019. The training package will be available to both new and existing staff.

   The Moodle package is only one way in which we provide training to our staff around safer swallowing and managing patients with dysphagia. It is an adjunct to a training programme provided by the SLT team, who provide the following training on an annual basis, or more frequently if specifically requested:

   1) Ward based training for registered and unregistered nursing staff.

2) Specialist training for patients with disease specific swallowing problems (e.g. head and neck cancer, Parkinson's disease etc.).
3) Stroke swallow screening training for specialist nurses who screen patients who have had a stroke.
4) Junior doctor/Registrar/Consultant training-explaining signs symptoms and ways to manage swallowing problems.
5) In service swallow assessment and management training for allied health professionals.
6) Ward based training to implement the International Dysphagia Diet Standardisation.

2. Review of our training provision

Following this incident a task and finish group was set up, chaired by our Deputy Chief Nurse, to review safer swallowing practices across the Trust and to review the ongoing work to align our education provision, policy and procedure documents.

Review of standard operating procedures

A review of our existing standard operating procedures relating to managing patients who are nil by mouth and managing patients who have dysphagia has been undertaken by our SLT team.

Following review the documents have been updated and we are satisfied that they provide all our staff with clear guidance, rationale, and clinical expectations when managing and caring for patients who have dysphagia and/or are placed nil by mouth. There has been consultation with a consultant oncologist, consultant geriatrician, consultant ear nose and throat surgeon, palliative care consultant and lead for nursing education. The standard operating procedures have been reviewed by our task and finish group referred to above and will be reviewed and ratified by our Operational Quality Assurance Group on 1 October 2019. Following ratification the documents will be disseminated to all staff via our communications team and will also appear on our intranet.

All that having been said we recognise that the evidence base for restriction of water in those on a thickened fluid regime is extremely weak. There is no NICE recommendation in either direction; NICE simply references a Cochrane systematic review of the limited literature. This systematic review identifies no evidence of excess risk associated with access to water in this group of patients. We will continue to review this literature and determine whether our current procedures remain reasonable. In the meantime we are though clear that trust wide adherence to current recommendations must be maintained.

Rolling education programme – 'preventing harm study days'

We have developed 'preventing harm' study days which are provided on a monthly basis to both new and existing staff. The days were created to ensure that all our staff have access to specialist led training. The session includes, amongst other training, education and training on the standard operating procedures referred to above.

Practice update

A practice update on 'managing patients with swallowing difficulties in hospital' has been developed and disseminated to all of our staff by our Quality and Clinical Assurance team in order to raise awareness and minimise the potential risk to patients with dysphagia.

I would like to assure you that the concerns raised within the Regulation 28 Report have been taken seriously which I hope is demonstrated by the steps we have taken in reviewing our processes, guidelines, training and education.

Yours sincerely,

[redacted]

Medical Director