NHS
Greater Manchester
Integrated Care

[redacted]

Date: 23 December 2022

Ms A Mutch
HM Senior Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Ms Mutch,

Re: Regulation 28 Report to Prevent Future Deaths – John Fallon 13/03/22

Thank you for your Regulation 28 Report dated 04/11/22 concerning the sad death of John Fallon on 13/03/22. On behalf of NHS Greater Manchester Integrated Care (NHS GM), I would like to begin by offering our sincere condolences to Mr. Fallon's family for their loss.

Thank you for highlighting your concerns during Mr. Fallon's Inquest which concluded on 7 September 2022. On behalf of NHS GM, I apologise that you have had to bring these matters of concern to our attention but it is also very important to ensure we make the necessary improvements to the quality and safety of future services.

Following the inquest, you raised concerns in your Regulation 28 Report to NHS GM that there is a risk future deaths will occur unless action is taken. The medical cause of death was 1a) Choking on food; 2) Dementia.

I hope the response below demonstrates to you and Mr. Fallon's family that NHS GM has taken the concerns you have raised seriously and will learn from this as a whole system.

This letter addresses the issues that fall within the remit of NHSGM and how we can share the learning from this case.

The inquest heard evidence that although he needed his dentures to chew in a satisfactory way, SALT assessments are not routinely carried out where an individual goes from eating with dentures to eating without dentures. As a consequence the diet is not routinely altered in a care home setting to reflect the reduced chewing capacity;

A swallowing assessment is a specialist assessment from a speech and language therapist (SALT). It is given to patients who are thought to have swallowing difficulties because of several medical reasons such as dementia, cancer or a stroke.

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As outlined in the Tameside and Glossop Integrated Care NHS Foundation Trust (TGICFT) Community Dysphagia Policy, swallowing assessments are usually only given to patients who are thought to have swallowing difficulties with fluids, not with food, although the two are likely to coincide. This policy has been shared with colleagues in the community. The Trust would not accept a referral for a swallowing assessment from a care home if the patient's swallowing difficulty was thought to only be with food. This is because difficulties in swallowing food can be managed by changing the texture of the food that is given to the patient and does not require a specialist assessment, although the Trust would offer advice and support if needed. Under Regulation 9 of the CQC guidance – Person Centred Care, the responsibility for diet modification lies with the care home.

This policy is in-line with the Royal College of Speech and Language Therapists (RCSLT) position paper dysphagia-in-care-homes.pdf (rcslt.org) – see Section 6; Feeding Safely Routines. The paper also covers the use of dentures, stating that – 'dentures, if worn, should fit well' and to 'be aware that some individuals prefer to eat without their dentures and softening the diet may help.' TGICFT's approach to SALT assessment is also in-line with other Trusts'.

A SALT referral was not made for Mr Fallon. A Safeguarding Review was carried out on the 31st March 2022 following this tragic incident. Learning has been identified from the current risk assessments in relation to patients with dentures, and work began in April 2022 to ensure that the risk of eating without dentures was included in the assessment. Additional learning has also been identified around the importance of highlighting the risks in eating specific foods without dentures for someone who is deemed to have capacity; as well as ensuring capacity assessments are undertaken for specific instances such as this. The nursing home has undertaken several actions following this incident including:

- All choking risk assessments, nutritional care plans and oral health care plans have been revisited and reviewed.
- All diet notifications have been reviewed.
- The nursing home chef now completes risk assessments on all modified food before serving to residents.
- Created an information chart with each resident's food consistency and level of support that the resident needs during the meal. This chart is always available to staff.
- Residents that have dentures will be risk assessed before each meal to ensure they have their teeth in before starting any meal.
- A mealtime audit has been conducted by the management from the head office to ensure safe practice.

The learning from this safeguarding review has been shared more widely through Tameside's communication networks and an item is to be taken to their local Care Home Managers Forum in early 2023. Tameside's quality monitoring and assurance documentation has also now been strengthened to highlight this particular risk (November 22) and support embedding the learning into practice.

Evidence was also heard that the limited availability of dental services to care home residents means that situations where dentures require updating/replacing are not being dealt promptly which means there is a greater risk of choking on food that has not been adequately chewed;

All NHS Dental Practices are asked to prioritise care for high-risk patients (including those undergoing treatment for cancer), children, and vulnerable adults, while also maintaining capacity for unscheduled and urgent care.

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For people in residential and nursing homes there is access to general dental practices for those who can attend. The Community Dental Service (CDS) provide visits to care and nursing homes on request from either a patient or a carer via the non-dental professional referral form which was launched across all local authorities nationally in September 2021. Appendix 1 details a copy of the guidance issued. Online training was delivered to a representative from each local authority area in Greater Manchester on how to access and complete the form. Each representative was responsible for cascading the information to the relevant staff.

To date there have been 40 non-dental professional referrals received and processed through this system from Tameside. The provider of the CDS in the area has confirmed that they allocate one day per week for nursing and care home visits, with a waiting time of three to four weeks unless the referral is deemed urgent.

In addition, an online training programme is available for all care givers called 'Mouth Care Matters'. Mouth care is an essential part of maintaining good health and quality of life for vulnerable people and people with learning disabilities. People with good oral health can eat and drink properly, helping them take part in life, stay independent for longer and recover from episodes of frailty more quickly.
This training is suitable for the wider care team, including the responsibilities of care managers and the role of care staff carrying out admissions, assessments and provision of daily mouth care.
The link below provides further details:
https://www.gmthub.co.uk/dentistry/mouth-care-matters-in-the-community

NWAS used a suction machine to clear the airway on their arrival. The inquest heard evidence that these are not routinely in place at care homes and so if a resident is choking food cannot be suctioned out by staff.

The Safeguarding Review found that staff acted appropriately using their training in basic life support to help Mr Fallon when it was identified he was choking. Emergency services and the Digital Health service were also contacted immediately. Basic life support training including obstructed airway training is included in the care certificate which is part of the mandatory training for all staff. Checks of these training levels are completed at least annually at every contract performance and quality visit, by the Contracts and Commissioning Team. The Team are currently looking into any additional training in relation to obstructed airways that can be undertaken by care home staff.

Actions taken or being taken to share learning across Greater Manchester:

1. Learning to be presented/shared with the Greater Manchester System Quality Group. This meeting is attended by commissioners, including commissioners of specialist services, localities, regulators, Healthwatch and NICE. Through sharing in this forum, we expect members to review and ensure learning is incorporated into their commissioned services.

2. Shared learning from this and similar cases at Greater Manchester and borough level will be cascaded to professionals through relevant governance and learning forums to ensure that learning is incorporated into their services.

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In conclusion, key learning points and recommendations will be monitored to ensure they are embedded within practice. NHS GM is committed to improving outcomes for the population of Greater Manchester.

I hope this response demonstrates to you and Mr. Fallon's family that NHS GM has taken the concerns you have raised seriously and is committed to working together as a system including our service users, carers and families to improve the care provided.

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

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Chief Nursing Officer
NHS Greater Manchester Integrated Care

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