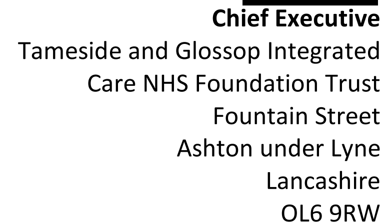

Chief Executive
Tameside and Glossop Integrated
Care NHS Foundation Trust
Fountain Street
Ashton under Lyne
Lancashire
OL6 9RW

11 July 2023

Strictly Private and Confidential

HM Coroner
Coroner's Court
1 Mount Tabor Street
Stockport
Cheshire, SK1 3AG

Dear Mr Briggs,

I am writing further to the inquest regarding the death of Mr Roger Southwick (who died on 9th November 2022) which concluded on 10th March 2023 and the subsequent Regulation 28 Notice issued to the Trust. I hope to set out below my response in terms of what we are already doing and what we plan to do in relation to your concerns.

You expressed concerns regarding the falls risk assessments, specifically the inaccurate falls risks assessment and the failure to record and act on family concerns regarding mobility by re-assessing falls risks.

All patients being cared for on a ward in the hospital are discussed at the daily ward safety huddles by the consultant(s), nurse(s) and allied health professionals involved in their care and treatment. Those patients who are at greater risk of falls are identified clearly during this discussion and a "falling leaf" symbol is also applied to the electronic white board to provide a visual cue to staff. Nursing staff are aware that those patients identified as a falls risk must have a falls risk assessment in place.

In 2022 the Trust held a "Falls Risk Summit" chaired by the Executive Director of Nursing, which brought together members of the multidisciplinary team from across the organisation. The summit enabled a focussed review of falls data, themes, learning and each Clinical Division supported the development of a Trust wide action plan to improve the processes, education and resources for falls prevention. Progress on this action plan is monitored via the Safer Care Group. The learning and actions taken in response to this Regulation 28 Notice will also be monitored via the Safer Care Group. The Safer care Group feeds into the Patient safety Board and ultimately into the Trust Service, Quality, Assurance and Governance Group.

The requirement of when and how complete a falls risk assessment is clearly described in the Trust's Slips, and Falls Policy, which is accessible to all staff in the Trust (attached for your information). There has been a focused piece of work undertaken on the Acute Medical Unit in relation to falls risk assessment and the accuracy of this. During the inquest of Mr Southwick, the falls proforma was not completed in line with Trust policy following a fall. This proforma has been recirculated within the Acute Medical Unit team with emphasis on the importance of the accuracy of this document. As such a monthly audit has been implemented and is completed by the ward link nurse for falls.
This focused piece of work has been discussed at a number of forums including:

- The Patient and Staff Quality and Safety Forum (PASQAF) and Confidential Enquiry into Peri-Operative Deaths (CEPOD) which occur bi-monthly. PASQAF CEPOD are multidisciplinary meetings and allow for continuous oversight and learning to be shared across the Trust.

- Safer Care Group –The Safer Care Group was created to lead the development, implementation and monitoring of work within the Safer Care portfolio which includes falls. The Group is chaired by one of the trusts Deputy Chief Nurses and the patient safety clinical lead. This group reports into Service Quality and Governance (SQAG) via the Patient Safety Programme Board. The group monitors performance, training and audit in relation to harm prevention across the Integrated Care Foundation Trust. It measures compliance against key targets taking responsibility for identification of gaps and develops improvement plans to address and action these. Oversight of divisional work is monitored via this group, with key update reports including a summary of training compliance, audit results, action plan updates, learning from incidents and any quality improvement work being delivered.

The purpose of these forums is to initiate discussion, shared learning and improvement in regards to learning and reflective practices in the future.

The Trust also has a Quality Assurance Round, this is an audit which is undertaken by each ward manager on a monthly basis. Amongst the metrics reviewed and monitored is that of falls risk assessments in line with Trust Policy. Each audit requires the ward manager to review a minimum of three sets of notes to identify that the risk assessments have been completed; on admission and every seven days thereafter. The audit also includes three sets of notes to be reviewed to ensure that patients have individualised falls care plans if required.

To share the learning further the Trust has introduced a separate Standard Operating Procedure (SOP) to ensure a consistent approach to care following an inpatient fall. I have attached the checklist and SOP for your information. The process will have daily oversight at the Trust Safety Huddle and will be overseen by the Divisional Heads of Nursing.

The Trust have reviewed the Falls prevention policy and have identified further improvement to the policy which will now include the assessment of the patient to include changes from their 'baseline' mobility, this will facilitate a holistic patient and relative/carer approach to assessing mobility and any acute changes.

To provide additional oversight and learning of falls incidents the Trust now also operate a scrutiny process which comprises of the following:

- Incident Review Group (IRG) which is held twice a week and reviews incidents recorded across the Trust and provides a consistent approach to the investigation and grading of similar incidents. IRG supports the provision of 72-hour reviews for potential serious incidents ensuring that the appropriate level of investigation is being undertaken and the appropriate recording of harm is being undertaken. IRG reports into the Serious Incident Review Group, which has Executive attendance. The focus of IRG is immediate sharing of learning and also to identify any immediate risks or celebration of good practice.
- Serious Incident Review Group (SIRG). The Serious Incident Review Group is held on a weekly basis and supports robust governance systems relating to the declaration, investigation, completion and learning from serious incident investigations declared in line with the Serious Incident Framework (2015). SIRG has replaced the current Executive Scrutiny Panel and reports into the Service, Quality Assurance and Governance Group (SQAG). SIRG has Executive oversight and receives and reviews all incidents where a patient(s) is suspected to have come to significant harm, or where a never event is suspected; determine the agreed level/ type of investigation to be completed and where relevant, to agree external reporting to commissioning and regulatory bodies. SIRG is a multi-disciplinary meeting chaired by the Executive Chief Nurse and Executive Medical Director and ensures that there has been a holistic MDT approach to managing the incident, in relation to falls this can include physical and acute medical presentation of the patient, Medication and pharmaceutical review, nutritional status and mental health capacity of the patient triangulating this with the details of the incident.

- Safer Care Assurance Panel has been created to review falls and pressures ulcer incidents, which caused moderate harm. Chaired by a Deputy Director of Nursing or Head of Nursing, this forum reviews Root Causes Analyses (RCAs) to identify areas of good practice and any missed opportunities or lapses in care to ensure learning can be gained and future harms prevented.

The above scrutiny process ensures the Trust to have oversight of incidents, particularly those relating to falls, on a regular basis where learning can be shared. This also feeds into the Trust Wide Learning Forum which has been created to share learning from the panel and deliver education to prevent future harm(s) occurring. All Heads of Nursing, Matrons and Ward Managers are invited to attend. Areas focussed on to date in relation to falls prevention include:

- The importance of recording lying and standing blood pressure (BP) in preventing falls
- Medicines and the risk of falls
- PJ Paralysis and why it is important for patients to keep mobile to prevent falls

The Trust are continually improving the falls prevention work. The Trust held a 'Focus on Falls Week' in September 2022 and this is now an annual event. The Trust strive to improve the experience and outcomes for patients by avoidance, where possible, of patients falling and/or reducing the number of falls occurring whilst in our care.

I hope this response has provided assurance that the Trust has taken your comments and concerns seriously and action taken to minimise the risk of such event occurring again. Should you require any further information, please do not hesitate to contact me through the Legal Services Team on

Yours sincerely,

Chief Executive