Great Western Hospitals NHS
NHS Foundation Trust

Private and confidential

Marlborough Road
Swindon
SN3 6BB

David Ridley, Esq
His Majesty's Area Coroner for Wiltshire

[redacted]

[redacted]

10 January 2024

Dear Mr Ridley

Re: Coroner's Regulation 28 Report

Thank you for your letter dated 17th November 2023 in regard to the Regulation 28 Prevention of Future Death Report, raising concerns about the circumstances which led to the death of the late Mr Ray Eggleton.

I was very sorry that the fall Mr Eggleton suffered in hospital contributed to his death and would like to again pass on our sincere condolences to his family and reassure you that we have taken the learning from this incident very seriously.

This letter is to respond to the concerns raised in the Regulation 28 and the actions the Trust is undertaking to address them in regard to safe staffing and enhanced care/ supervision.

Safe Staffing for Nursing Staff

The Trust has significantly invested in safe staffing levels over the last 2 years, this has ensured that all acute ward areas are now working to a 1:8 nurse to patient ratio for health care support workers and registered nursing staff. This is in line with national guidance. Year 1 (2021/2) there was investment in health care support workers and Year 2 (2022/3) there has been investment in the registered nurse staffing. This investment has come to a total of £7.1 million.

Alongside this there has been robust work on recruitment and retention, the Trust has moved from over 70wte Health Care Support Worker vacancies in January 2022 to zero vacancies in December 2023. There will continue to be fluctuation and change in specific areas and so continues to remain an area of focus and attention.

The Trust has robust safe staffing processes which are in line with national guidance and evidence based. This includes a 6 monthly safe staffing report to Trust Board which includes details of the Chief Nurses yearly establishment reviews with the ward managers. Nurse to patient ratios, benchmarking data, patient acuity, quality metrics and enhanced care data are reviewed as part of the Chief Nurse yearly establishment reviews.

The Trust's daily safe staffing process includes a three times a day safe staffing meeting, chaired by a divisional director of nursing, where any staffing concerns are highlighted and staff moved accordingly to support patient care.

There is also improved senior nurse support out of hours, with a duty Matron working till 20:00 pm and at weekends from 08:00 – 16:00 pm. This role supports the dynamic response required to adjust staffing levels or redeploy staff to accommodate the needs of patients that are at risk of falling or requiring enhanced supervision. Overnight there is a senior nurse 'site manager' who will support staffing and patient safety.

The Trust uses the national Safe Care Acuity and Dependency Tool in the three times a day safer staffing meetings. This is a tool that measures the acuity and dependency of patients on a ward and then applies a multiplier to calculate how many staff are required to care for that patient care mix. This, along with professional judgement, can help inform decisions on the best deployment of nursing staff across the Trust.

If wards identify patient with additional needs, the patients are assessed using the enhanced care assessment and then staff are either moved from another area based on the Safe Care Acuity / dependency data or by requesting through the nurse bank or agency.

There will be a further review of the Acute Medical Assessment Unit staffing using the national Safer Nursing Care Tool and the results will be used to inform future staffing models.

I hope this reassures you that the actions the Trust is taking in regard to safer staffing and how areas are supported to respond to differing patient needs.

Enhanced supervision

Enhanced care or enhanced supervision is when a patient has additional care needs that require support to keep them safe. Patients requiring enhanced care will often have some degree of cognitive impairment such as dementia or delirium or are at high risk of falls.

The Trust has had an enhanced care policy in place for several years. The Deputy Divisional Directors of Nursing are working with the Falls Team and undertaking a review of the current policy, paperwork and teaching. This work has an emphasis on the correct assessment and clear definitions of levels of supervision e.g. line of sight and within arm's reach. This is supported by a 'Stay in the bay' approach when health care support workers are providing enhanced care. This mandates that before the designated staff leaves, this duty has to be handed over to another member of staff.

This new approach is currently being trialled on 3 wards that frequently care for higher-than-average numbers of patients requiring enhanced care. During the enhanced care trial, the Falls Lead is reviewing daily to ensure that the enhanced care assessments reflect the patient care needs appropriately and then address any gaps in care and education. Once this trial has been completed a plan for roll out and engagement with all wards will be implemented and informed by the learning outputs from the trial.

The Trust is also updating the 'care rounding' document and process and aiming to roll out the improvements once the trial is completed successfully. Care rounding is the proactive approach to meeting care needs such as toileting and prompting over hydration particularly in those patients who have a degree of cognitive impairment whose awareness of their own needs might be impaired.

Falls improvement work

The falls team review all inpatient falls to identify areas for learning and improvement as well as delivering an ongoing education programme.

Some of this learning has identified that the point of transfer from one clinical area to another is a time of increased risk of falling. To address this the Trust is working hard to reduce the number of patients that move out of hours as well as highlighting this risk to increase staffs' awareness and ensure that falls prevention strategies are put in place immediately on transfer.

The other area of focus is to improve the handover process on the patient's risk of falling and a new handover tool is being developed which will highlight the falls risk in more detail.

There is also Trust wide improvement work on identifying and managing postural hypotension as a significant contributor to falls risk. A Clinical Fellow (non- trainee doctor with a proportion of employment set aside for research/Quality Improvement) will be working alongside the Falls Team to develop strategies to improve identification and response to this promoter of falls.
This has also been shared in a safety brief that was shared Trust wide for learning.

Falls Risk assessment

The Falls team will be providing additional training in the Acute Medical Unit on Multifactorial falls assessment, this training will include the essential components and sources of information required to support a personalised assessment, identifying key risks and level of supervision.

To support this work the Trust has recently recruited a number of Clinical Practice Educators to support the wards and assessment units, part of their remit is to support training around enhanced care supported by the Falls team. The first round of training is planned for March 2024.

Falls investigation

The circumstances of Mr Eggleton's fall was investigated immediately at the time and a 72-hour investigation report was completed on the 27 January 2023.

The falls report was reviewed at the Divisional Falls round table as an MDT approach on the 01/03/23 led by the Deputy Medical Director to ensure a robust investigation and identify any learning outcomes. Other contributors were the Ward Manager and Matron for the area, the Falls team, Radiology and the Governance team.

The report was signed off by the Division on 20 March 2023 and presented at the Trust's Incident Review meeting (IRM) on 27 March 2023. There was a delay reporting this as a Serious Incident and it was uploaded on STEIS (Strategic Executive Information System). The investigation outcome was presented to Serious Incident review meeting on 12 December 2023. The Trust is reviewing how falls with harm are investigated and reported to ensure there is no delays going forward.

Falling and the harm from falling is one of the quality indictors the Trust monitors closely and is reported through the Integrated Performance Report to Trust Board. Falls and the falls prevention actions are part of the regular nursing audit programme and this helps ensure the effectiveness of actions are monitored.

The overall trend of falls is reducing however there has been a theme of falls with harm or patients having multiple falls. Therefore it has been agreed that falls is one of the top 5 quality improvement

priorities under the Patient Safety Incident Response Framework and will therefore continue to have focus and support for improvement.

Conclusion

I hope this letter reassures you that we are taking the learning from this sad case very seriously and will ensure that we continue to develop our approach to enhanced care to support patients that require additional support.

Finally, I would like to reiterate my sincerest condolences to Mr Eggleton's family and apologise for the distress this process may have caused.

Yours sincerely

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Acting Chief Executive

CC: CQC