From [redacted]
Minister of State for Care

39 Victoria Street
London
SW1H 0EU

Department of Health & Social Care

Our ref: PFD-24-04-17-Burman

Mr David Ridley
Senior Coroner for Wiltshire and Swindon
Wiltshire and Swindon Coroner's Office
26 Endless Street
Salisbury
Wiltshire SP1 1DP

By email: [redacted]

3 July 2024

Dear Mr Ridley,

Thank you for the Regulation 28 (Preventing Future Deaths) report of 17th April 2024 in relation to the death of Margaret Avril Burman. I am replying as Minister with responsibility for dementia. Please accept my apologies for the delay in responding to this matter.

Let me begin by saying how saddened I was to read about the circumstances of Ms Burman's death. I would like to offer my sincere condolences to her family and loved ones. It is vital that we learn from incidents where we can in order to improve patient safety.

Your report raises several important issues, including appropriate staffing levels and falls mitigation in wards with people at risk of falls, in particular patients with dementia or Alzheimer's Disease. It also refers to the need for a standardised toolkit when assessing the risk of falls on hospital wards coupled with greater sharing of learning from good practice across Trusts.

I am aware that that the National Medical Director is responding to your report on behalf of NHS England and as such I do not intend to duplicate the contents of his communication with you. However, I am assured that NHS England have reflected upon the concerns raised in your report in relation to Ms Burman's care.

NHS England advise that the risk of falls is an ongoing priority for providers and continues to be an active area of developing research and evidence. The current NICE guidelines *Falls in older people: assessing risk and prevention* describes evidenced based practice, including for healthcare and other professional and staff who care for older people who are at risk of falling. These guidelines are currently being updated and due to be published in March 2025. The Royal College of Physicians also provides evidenced based guidance on preventing falls and serious injury in *Falls prevention in hospital*.

I am informed that on 8 May 2024 a formal engagement meeting was held between the Care Quality Commission (CQC) and Salisbury NHS Foundation Trust at which your PFD report was discussed. The Director of Nursing acknowledged that pre-2021, Spire Ward referenced in your report had significant staffing problems, particularly around recruitment and retention. CQC was briefed on the actions taken by the Trust since the death of Ms Burman as follows:

- Improvement programme to reduce falls, including 'bay watching' and increase in staffing, specifically on Spire Ward. This includes 'allocation on arrival' for staff so that they can be allocated to wards, such as the Spire Ward, that are short staffed.
- Additional activities for patients who are at risk of falls to improve sleep and therefore reduce activity throughout the night which could lead to a fall.
- Improved assessment on admission to highlight patients at risk of falls.
- Further education for staff on why understanding blood pressure measurements is critical, for instance that low blood pressure can lead to falls.
- A 'yellow' blanket initiative is now embedded within the Emergency Department (where a patient might be at risk of falls, a yellow blanket is placed on the bed so that staff can easily recognise a patient who might fall if they begin to mobilise).

It is reassuring to know that there has been a reduction in falls at the Trust since 2021 and that CQC continue to engage with and monitor the Trust through their usual regulation and monitoring responsibilities.

I would like to thank you for bringing these important concerns to my attention.

Yours sincerely,