Stockport NHS
NHS Foundation Trust

Oak House
Stepping Hill Hospital
Poplar Grove
Stockport
SK2 7JE

Telephone: 0161 483 1010
Fax: 0161 487 3341
E-mail: [redacted]

Our ref. AB//CM/PR_letter To HM Coroner P Pattison
Your ref. JSP/KN/00238 2014

23 July 2015

H. M. Coroner
Greater Manchester South District
Coroner's Court
Mount Tabor
Mottram Street
Stockport
SK1 3PA

Dear Mr Pollard

Re: Pamela Pattison (Deceased)

Thank you for your letter dated 18 March 2015 in which you write pursuant to Regulation 28 of the Coroners (Investigation) Regulations 2013 following the inquest into the death of the above named person; we this received by email from your PA on the 18 June 2015. As always, I am grateful to you for highlighting your concerns and for providing me with an opportunity to respond.

I shall address each of your concerns in the order in which you raised them:

1. **Nurse training on M4 and A11 with regard to diabetes care was deficient leading to a failure to escalate care appropriately.**

   The issue of nurse training was highlighted in the Patient Safety Investigation into the care of Mrs Pattison and actions were developed which I understand were shared with you at the inquest.

   One of our most important actions was the internal commissioning of a "Task and Finish Group" whose remit was "to review the current situation regarding diabetes care to ensure safe and effective care for all patients with diabetes in hospital". This was chaired by [redacted] Head of Risk and Customer Services, and included senior medical staff, experienced diabetes specialists (both nursing and medical) and senior nurses from across the Trust. I understand the action plan from this group was also shared with you during the inquest.

   I am now in a positon to update you on the progress of those actions:

   a. The Trust Training Needs Analysis (TNA) has been amended to include diabetes training as an essential requirement for all nurses and doctors (see below).

	Method of delivery or access	Nurses/Midwives/Allied Health Professionals, Assistant Practitioners, Clinical Community Professionals (See key below)	Health Care Assistants, Trainee Assistant Practitioners, Clinical Support Staff, Community Support Staff	Consultants, Associate Specialists and Staff Grades	Medical staff in training
Diabetic training for staff that are involved in Diabetes and associated insulin process Commencing April 2016	Delivered on Essentials and eLearning	Covered on Essentials for all. Registered Nurses and Midwives and all APs also to complete module 'Safe use of insulin' 3 yearly Tool box training by link nurses - annually	POCT training for glucometer delivered in work place or on care certificate for nursing support staff	On Essentials training and complete eLearning module for 'Safe use of insulin' every three years	On bespoke induction and complete eLearning module for 'Safe use of insulin' every three years
Diabetes management advanced	Bespoke training session	Hospital and night nurses and those undertaking professional cover	N/A	N/A	N/A
Prescribing training including insulin prescribing	Pharmacy taught session	N/A	N/A	Specialist Registrars on commencement	On commencement
Diabetes management and insulin prescribing	Taught by Diabetes nurse	N/A	N/A	Specialist Registrars on commencement	On commencement

b. An E-Learning module has been purchased by the Trust (one recommended by NHS England) completion of which is included in the TNA.
c. Bespoke training has been delivered to nursing staff on both M4 and A11 in the care of diabetic patients.
d. 'Essentials' training (that which is mandatory for all staff every three years) now includes a session on diabetes and insulin management.
e. Link Nurses have been identified for each ward and area and they are receiving specialist training to facilitate local training on all wards.
f. Bespoke training has been designed for senior nurses at night and out of hours and the process for delivering this is commencing.
g. All medical staff on commencement receive specialist training regarding prescribing of insulin and diabetes management.

2. Doctors not being aware that they should not omit long standing insulin

Ensuring that all doctors are aware of the appropriate management of diabetes has been addressed both by training (see above) and by an improved "Diabetes Microsite" and improved availability of Diabetes Specialist Nurses.

3. No access to specialist outreach nurse on surgical wards

Since this incident there has been a merger of community and hospital teams and the appointment of a further Diabetes Specialist Nurse and a Diabetes Practice Educator, who support the whole Trust.

The Trust has also implemented an electronic inpatient referral form for patients needing review, which provides a more robust method for all ward areas to request help or support in managing patients with diabetes.

4. A requirement for additional consultant cover for Diabetes

An agreement was reached to expand the consultant cover within Diabetes & Endocrinology in July 2014. This subsequently went out to advert but unfortunately we have failed to recruit on

several occasions. The Trust therefore approved an agency locum consultant to be brought in whilst we try to recruit to the post. The locum started in February 2015 and the team have now moved to a 'Consultant of the week' model, to provide more specialist inpatient time.

5. **No plan for sickness cover for the specialist outreach nurse**

   This planned sickness had been identified and the manager recognised the need for additional cover and backfill for this post. A plan had been put in place to commence on the 27th January 2014, which is sadly the day Mrs Pattison died.

   The plans referred to in point 3 will help ensure that this does not happen again.

6. **Lack of equipment and understanding of how to use equipment:**

   a. **Ketone dipsticks**
   As discussed at inquest it was apparent that there was some confusion regarding the monitoring of ketones by nursing staff and this issue is now covered in all delivered training, making clear the process for monitoring ketones.

   b. **Cardiac monitors/ward defibrillator**
   Cardiac monitors are available on the diabetes speciality ward. It is accepted that there were none available for the orthopaedic ward; staff on these wards are not trained to interpret the output from a cardiac monitor so the most appropriate course of action would be to transfer those patients requiring cardiac monitoring to a ward where staff are trained to interpret and respond to the output from a cardiac monitor. In this instance the plan was to move Mrs Pattison as soon as possible; unfortunately this was not as timely as I would have hoped. This matter should then have been escalated through the appropriate out of hours' management structure to ensure that her move was facilitated as soon as possible.

7. **Delay in moving the patient to a medical bed when one was required**

   Following investigation into this incident there is no documented evidence of the time that the bed was requested. I can confirm however that during this period there was a high volume of 4 hour breaches partially due to capacity being limited.

   During this period the bed management team were prioritising Emergency Department (ED) admissions to prevent overcrowding and maintain patient safety within the ED.

   However the bed management team are aware that they need to balance priority of bed allocation based on clinical needs of all patients regardless of their location and any concerns could have been raised through the appropriate out of hours' management structure. The Trust is in the process of reviewing its Capacity and Flow Escalation Policy which will reflect the bed allocation prioritisation process.

8. **General under resourcing within the Trust for care of patients with Diabetes**

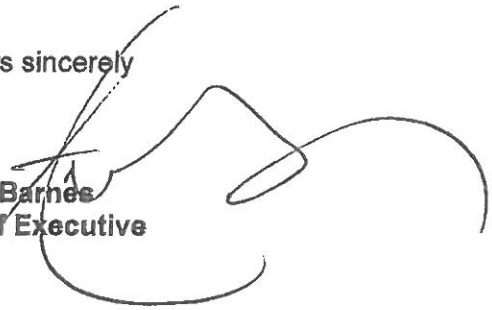
   As I have mentioned the Trust recognised there were some areas of concern in regard to the management of patients with Diabetes and in response to this commissioned a "Task and Finish" group. This group has met a number of times and a robust and thorough action plan was developed and approved at the Quality Governance Committee. A plan is in place for an audit in relation to the impact of those actions to be undertaken in September and October 2015 the results of which will be shared at Board level through the Quality Assurance Committee.

   Evidence to date is that there has been a reduction in serious incidents related to patients with diabetes and there is clear evidence of a good uptake of training.

I hope that this response answers your concerns and provides you with the assurance that the Trust is committed to improving the quality of care we give to all our patients.

Please do not hesitate to contact me if you have any further questions regarding this matter.

Yours sincerely



Ann Barnes
Chief Executive