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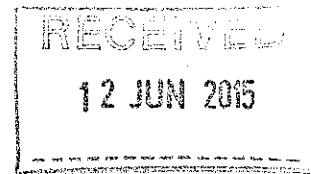
Fax: [REDACTED]

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9th June 2015

Your ref: [REDACTED]

Dr Robert W Hunter
HM Senior Coroner
Coroner's Court
5 – 6 Royal Court
Basil Close
Chesterfield
Derbyshire
S41 7SL

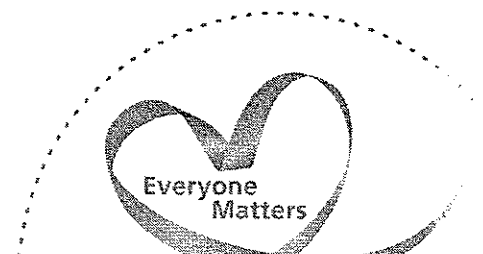


Dear Dr Hunter,

Re: Regulation 28: Report to Prevent Future Deaths following Inquest into the death of Mrs. Sheila Johnson

I am in receipt of your Regulation 28 Report to Prevent Future Deaths dated 19th May 2015. I am very sorry that you have had cause to identify concerns regarding the quality of the Trust's internal investigation process and in relation to the system for the urgent recall of patients discharged with potentially life threatening conditions. We accept in full your verdict and requirements.

It was recognised by the Keogh Review Team who visited the Trust in May 2013 that at the time of Mrs. Johnson's death the Trust fell below expected standards in relation to a number of areas associated with the governance of care and treatment. As a result, the Trust was placed in Special Measures. The Trust engaged a new Leadership team and accepted all the recommendations made by the Keogh Review and CQC which resulted in a Trust-wide review and improvement programme. The improvement plan has been extensively monitored by the CQC, Monitor, NHS England and Tameside and Glossop CCG with independent third part scrutiny



Since Mrs. Johnson's inpatient treatment, her tragic death and the 2013 investigation into the circumstances surrounding her death; considerable changes have been made both to improve the quality of the Trust's internal investigations and the process for discharging patients.

As part of the improvement programme across the Trust, a review of senior nursing staff took place, and medical staffing underwent a review with the intention of improving Senior Doctor presence within the Trust and their availability out of hours to improve quality, safety and patient care.

The Trust has implemented a programme of Leadership Development for Clinical Leaders and Ward and Senior managers to develop leadership capabilities, abilities and build a more collaborative organisational culture.

In relation to your particular concerns regarding the quality of the internal investigation undertaken at this time, the Trust's processes have been revised significantly and beyond all recognition. The current policy for the management of serious incidents including their investigation has been rewritten and implemented. The policy provides clear guidance to Trust staff in relation to incident reporting and the investigation process, with the aim of improving the quality of the Trust's investigations. We have had this monitored by the CQC and CCG and reported to external oversight groups.

All serious incidents are reviewed by Directors who assign a level of investigation and an investigation team to each serious incident, consisting either of appropriate individuals from the Trust or where relevant external independent persons. Professional advice relevant to the specialty is now obtained.

We recognise that staff undertaking incident investigations need to be appropriately trained. Since the investigation into Mrs. Johnson's death the Trust has invested significantly in additional training provided by an external facilitator. This has delivered root cause analysis and investigation training across all divisions of the Trust, the most recent training taking place in March of this year. More than 75 senior officers have been trained in RCA. This has underpinned the revised policy to ensure investigations are more robust and recommendations are acted upon and patient care and safety is improved.

A sample of serious incident investigations conducted since the training were audited during the period November 2014 and March 2015 by independent third party auditors (MIAA) and the audit demonstrated that the individuals involved in those investigations were appropriately trained.

The auditors concluded in their report dated 10th March 2015 that the serious incident processes provided significant assurance to the Trust that systems and processes were in place.

We have also introduced improvements to the process for internal review of serious incident reports. There is now an Executive led Serious Incident Review Panel which reviews all serious incident investigation reports and action plans and scrutinises and challenges them, providing feedback to the investigation teams when further clarity is required. The panel also require that responsible nursing and medical leads attend the meeting to feed back what changes have been made and what lessons have been learnt from investigations.

As part of the investigation process appropriate recommendations and actions are identified either within the investigation report or in a separate action plan to address issues that have been highlighted. The Serious Incident Executive Review Panel discusses actions arising from serious incidents and how they will be addressed by the divisions of the Trust.

The Trust has a number of improvement work streams into which the actions arising from serious incidents have been mapped, including patient safety programme work streams that are monitored and feed into the Trust's Governance arrangements which report to Trust Board. The Quality & Governance Unit has developed processes to work with the Trust's Clinical Divisions and follow-up on the implementation of actions identified and further assurances are gained through the ward accreditation process, Board leadership walk-rounds to wards and departments, and patient experience feedback.

The complaints processes, HM Coroner's Inquest processes and mortality review processes are now coordinated into one process to oversee the Statutory Duty of Candour requirement.

I also note your concern that the audit of the nursing and medical documentation undertaken during the investigation into Mrs. Johnson's care confined itself to establishing that the entries were accurately dated and timed with a legible signature.

The revised investigation process and procedure includes the requirement that incident and complaint investigations consider relevant best practice and policies and that the investigation should include whether the recommended systems and processes were followed, as well as whether record keeping

standards were adhered to. It signposts the user to the Incident Decision Tree which also includes the requirement to assess decisions made and actions taken against policies and procedures to identify whether there were failures in systems and processes or individual failures.

The Trust acknowledges your concerns and accepts them in full. The fact that there was no formal system for the urgent recall of patients discharged with potentially life threatening conditions, has been addressed by the Patient Flow Manager.

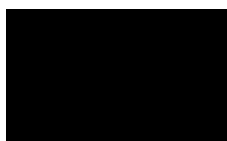
Staff will be directed to attempt to contact the patient or relatives in the first instance and contact the General Practitioner and Community staff should the patient or relatives not be contactable, if necessary staff will be directed to contact the Police and ask for a 'safe and well' check.

The procedure will be defined in a simple flowchart which signpost will staff to the correct actions and responsibilities should any staff member identify that a patient has been discharged and needs to be recalled urgently. We are closely monitoring the quality of discharges with our CCG. The process will also be included as an appendix within the Admission and Discharge Policy.

I am writing directly to the family of Mrs. Johnson extending my apologies and sincere condolences.

I hope that the above clarifies the improvements that we have made and addresses your concerns and findings in relation to Mrs. Johnsons Inquest. Please do not hesitate to contact me again if any more information is required.

Yours sincerely



Karen James
Chief Executive

cc. Monitor
CQC
Tameside and Glossop CCG