Tameside Hospital NHS
NHS Foundation Trust

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27th November 2015

Your ref: JSP/GB/01246-2015

Mr John Pollard
Senior Coroner for Manchester South
The Coroner's Court
1 Mount Tabor
Stockport SK1 3AG

Dear Mr Pollard

Inquest: Hilda Haughton

I write in response to your Regulation 28 Report dated 29 October 2015, issued at the conclusion of the inquest touching upon the death of Hilda Haughton, which took place between 26 and 27 October 2015.

In your report you have raised one concern with Tameside Hospital NHS Foundation Trust about a fall which occurred on 6 May 2015 on Ward 41 at Tameside General Hospital. Your concern is that there was a "lack of candour" by the hospital staff in respect of that fall.

I hope this response provides you with the reassurance you require to this concern. I hope that your concern can be addressed firstly with specific reference to the incident referred to on 6 May 2015, as well as by explaining to you the Trust's attitude and culture regarding openness and candour.

Incident on 6 May 2015

I wish to take this opportunity to make it clear that the incident on 6 May 2015 did not invoke the Statutory Duty of Candour under Regulation 20 (2) of the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014. An unwitnessed fall occurred on or around 04:50 on 6 May 2015. The medical records demonstrate that following this Mrs Haughton was given a head-to-

The Trust's attitude towards candour

The Trust has been very proactive in relation to ensuring Duty of Candour, Trust policies have been reviewed and consideration continues to be given regarding statutory obligation when reviewing and updating policies and procedures.

The Trust was comprehensively inspected by the CQC in May this year and they commented in their report that they were particularly pleased with the progress the Trust had made with candour and with the governance processes put in place to support this.

I along with my leadership team have a strong leadership ethos regarding candour and believe that leading by example is key in demonstrating the Trust's commitment in relation to candour. My Director of Quality and Governance and I both regularly meet with families and patients to discuss their experiences and to apologise when things go wrong.

During February and March 2015 the Trust ran several workshops which were delivered by external facilitators and were attended by a wide range of staff which focused on investigations, Root Cause Analysis and incorporated communication and supported the culture of reporting and openness. We trained over 75 staff in this and Being Open and Duty of Candour was central to the training.

In order to ensure the Trust is transparent and learns from incidents, complaints and claims we have commissioned a significant number of independent expert reports to ensure transparency and openness with our patients, relatives and carers which we share with them and with our staff for learning.

The Trust's processes for openness and candour encourage local meetings with medical and nursing and support staff with patients, families and carers to discuss management plans and promote effective communication and early resolution of any questions or concerns.

The Trust has commissioned a number of patient experience films with our patients and their relatives to ensure that their perspective and their experiences are shared with staff and that we learn from these. One of the consistent messages in these is the importance of communication and how this effects the patients and families perception and how this influences their view of the Services in relation to openness and candour. These are available on the Trust intranet and public internet and focus on both the negative