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Our Ref: YO/bb

The Leeds
Teaching Hospitals
NHS Trust

Mr Kevin McLoughlin
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Dear Mr McLoughlin

INQUEST TOUCHING THE DEATH OF THERESA MARIA BUTTON (Deceased)

I refer to your correspondence of 3rd October 2018, regarding the inquest touching the death of Theresa Maria Button and the Regulation 28 Report to Prevent Future Deaths in respect of this case.

I can confirm that the contents of your Regulation 28 Report have been shared with the relevant staff to enable us to provide you with a comprehensive response.

We have considered the contents very carefully. The Trust acknowledges that prior to the inquest Mrs Button's daughter had not proceeded with her application to access her mother's healthcare records. We hope that the responses to the concerns below, together with a review of Mrs Button's records, will allay her anxieties and show that the multi-disciplinary team that cared for her mother on ward J83 provided a good standard of care.

In your report you highlight that your matters of concern were as follows:

(1) The staffing levels on Ward J83 should be reviewed, notwithstanding that they may currently meet the minimum levels prescribed. The ward handles a challenging cohort of patients with liver disease who have complex needs which merit close nursing attention.

Staffing levels on all of our ward areas including ward J83 are reviewed daily in accordance with safe staffing requirements together with the numbers and individual needs of our patients.

The Trust recognises that safe levels of nurse staffing are essential to the delivery of quality patient care. We already have robust systems in place for determining safe staffing levels and ensuring mitigating actions are put in place where staffing is below the agreed plan or insufficient to meet patients' specific needs. This includes robust escalation processes to both the Heads of Nursing and Director of Nursing (Operations).

As I am sure you will appreciate, your observation regarding patients with complex needs applies to many wards across the Clinical Service Unit (CSU) and the wider Trust, therefore the

information that has been provided in this response in regards to staffing levels is applicable not only to ward J83 but to all other areas too.

By way of background, following discussions with senior nursing staff, three levels of staffing for their areas has been agreed and staffing rosters have been submitted to reflect the current staffing level. The three levels are:

- Optimum staffing - this is where we would like to be in the next 2/3 years; i.e. this is our ambition and would include supernumerary status for ward/department leaders, CPD time etc.
- Current staffing - based on current budgeted establishments and ability to recruit, agreed with the Head of Nursing in each CSU to maintain safe staffing ratios.
- Minimum staffing levels - this is an additional safeguard/governance level. Any ward at minimum will trigger an escalation the details of which are set of further in this response. This aligns to the National Quality Board's latest guidance, (February 2018) and has been operational in the Trust since 2012.

The Trust has been very clear that all ward staffing budgets are funded at current budgeted establishments and that this move is a further safeguard to support staff in the daily management and escalation of ward staffing concerns.

I can confirm that the Trust meets the National Quality Board 2018 guidance on safe staffing. Examples of these include:

- Use of the National Safer Care Acuity and Dependency Tool
- Professional Judgement
- Specialty/Bed base requirements (tertiary service provider)
- Embedded Clinical Metrics (Healthcheck) relating to standards of patient care
- Red/Amber/Green (RAG) ratings that determine individual ward staffing risks
- Nursing red flags for example delivery of patient observations or medications
- Care Hours per Patient Day (National requirement)

Actual nurse establishments are calculated using a range of data with staffing updates submitted nationally each month to NHS England via the Nurse Staffing Return (Hard Truths). The return incorporates data relating to both substantive Trust staff and additional temporary staff (bank and agency).

A twice yearly ward staffing review of nursing acuity and dependency levels is undertaken, which informs changes to skill-mix required and the annual updates to the roster system. Following the July 2018 establishment and skill mix review, 102 roster templates have been reviewed to ensure they align to the current staffing level plan agreed for each ward.

Where staffing is below the minimum agreed plan, or where the current staffing is assessed as not being able to meet the patients' needs, mitigation is put in place. To mitigate the risks to patients, as well as reviewing staffing at the daily operational meeting outlined above, CSUs also review staffing daily at Matron Huddles and actions agreed include:

- Proactively requesting shifts to be filled by bank and agency workers;
- CSU staff moved between clinical areas to mitigate the gaps and maintain patient safety;
- Increasing the number of Clinical Support Workers on duty;
- Deploying non-ward based clinical staff e.g. Matron or Clinical Educators, to these areas to provide care and support to the ward teams.

Individual 1:1 meetings are held with each Head of Nursing by the Deputy Chief Nurse/Director of Nursing (Operations). Where individual wards are found to be consistently at minimum levels, or where mitigations have not been possible, a summary report known as an SBAR (Situation, Background, Assessment, Review) is compiled by the CSU. This report is discussed at both the

weekly Corporate Operational meeting and the weekly Quality meeting with the Chief Nurse and Chief Medical Officer. In the event of bed closure recommendations by CSUs to support patient safety, this report is shared at the Executive Directors meeting.

The Trust has strong governance and oversight of staffing both in hours and out of hours where 24 hour support is available from a Head of Nursing, General Manager and Executive Director.

This is supported by a Trust-wide document - *Actions to be taken when the numbers of Nurses and Midwives per shift falls Short of the Agreed Roster Template*. This document was updated earlier in 2018 to reflect and meet the National Quality Board Guidance issued in February 2018. A copy of this is attached for your information.

The Trust has in place a comprehensive escalation process to support CSUs in the event of staffing shortfalls and concerns. Further to a pilot in surgical services a RAG rated nurse staffing status report has been introduced for daily reporting. This daily oversight is provided by the Deputy Chief Nurse/Director of Nursing (Operations) with any unmitigated concerns regarding individual ward areas being escalated to the Chief Nurse. A weekly Red, Amber, Green (RAG) status report is provided to the quality meeting and the Executive Director meeting.

The Trust continues to recruit band 5 registered nurses, midwives and operating department practitioners with 304 external registered band 5 staff starting in post since April 2018. 262 of the 304 new starters commenced in post in September and October 2018, in line with university out turns. Corresponding to our recruitment figures is a reduction in both registered and unregistered nursing and midwifery vacancies across the organisation. Registered Nurse vacancies have reduced from 14% in September 2018 to 11 % in October 2018, with unregistered vacancies reducing from 6% in September to 4% in October 2018.

The next matter raised in your report is as follows:

(2) *Evidence taken at the Inquest revealed concerns that treatment plans instituted by clinicians were not always fully or effectively implemented as the staff were often too busy, particularly at night. Example included not hoisting an immobile lady out of bed onto a chair before mealtimes and then having time to encourage her to eat.*

Mrs Button's nursing needs, clinical treatment and support requirements were reviewed on a daily basis. Enhanced care and intentional rounding were utilised to support Mrs Button.

The contemporaneous healthcare records show that she was regularly hoisted from her bed at mealtimes, (as well as other times during the day), and encouraged to eat; there were however a number of occasions where Mrs Button declined to be hoisted. In these circumstances, where Mrs Button would allow, the position of the bed was altered so that she was in a more upright position to enable safe eating.

(3) *In this case the deceased was frail and losing weight due to not eating. A family member witnessed her food being left on her tray whilst she was laid flat and hence unable to access it with the result that it went cold and she did not eat, despite the concern relating to her nutritional condition.*

Evidence was heard during the course of the inquest regarding the considerable challenges staff had in encouraging Mrs Button to eat. The Trust welcomes the fact that during your summing up you acknowledged that all the staff involved had made considerable efforts to increase Mrs Button's nutritional intake and encourage her to eat. [redacted] visited Mrs Button frequently during her inpatient stay to support meal choices and completion of her menu. [redacted] also bought some Ribena and TUC biscuits in for Mrs Button following discussion that this was something she enjoyed. Despite regular anti-emetic medication, she frequently complained of feeling sick and would only eat very small amounts of food, or declined meals and

supplements in their entirety. When Mrs Button did feel able to eat, assistance was provided with meals because of her right sided weakness. There was an incident when Mrs Button complained that her meal was cold when served to her and was not what she had ordered. Staff arranged for soup and toast and assisted her with her menu choices after she had finished eating. It is the Trust's view that the clinical team did their very best to improve Mrs Button's nutritional condition throughout her in-patient stay on Ward J83.

(4) Insufficient time was available for the nursing staff and clinicians to explain treatment decisions to family members. An example given at the Inquest related to a decision to prescribe anti-depressant medication without the family being informed of any psychiatric involvement.

Mrs Button's healthcare records show that there were a number of discussions between clinical and nursing staff and her daughter [redacted] regarding treatment; medication; skin care; infection control measures etc. It is clear that staff were not always available to speak with family members immediately, but that arrangements were made to follow up requests for updates/respond to queries as soon as staff members became available and Louise was also given [redacted] contact details should she have any concerns. The staff were aware that Louise was finding it difficult to cope with her mother's deteriorating condition and they did all they could to support her and keep her updated.

During the course of her in-patient stay Mrs Button became increasingly anxious and depressed which became a source of concern for those caring for her. Acting in her best interests and with the patient's informed consent, they arranged for her to be assessed by a specialist nurse with mental health training. The nurse completed the Hospital Anxiety and Depression Score tool with Mrs Button. This established that Mrs Button had an anxiety score of 21/21 (severe) and a depression score of 16/21 (severe). Mrs Button was very open with the nurse about the issues that were causing her to feel anxious and depressed. Some of these related to her physical condition and others were linked to family matters. A range of coping strategies were discussed to help manage her anxiety and depression; one of which was medication. Mrs Button wished to consider this.

Mrs Button's mood deteriorated over the following two days and there was another discussion with her about coping strategies. She consented to starting on a small dose of anti-depressant medication. The medication was prescribed to help lift Mrs Button's mood; increase her appetite and improve the quality of her sleep which were the main issues she was struggling with and were all part of the building blocks of recovery. Mrs Button had the capacity to make these decisions about her care. Regrettably, when her daughter learned that Mrs Button was taking an anti-depressant she instructed her mother not to take it because it was linked with gastric bleeding. While we understand that [redacted] was acting with the very best of intentions, there was no evidence of any link between the medication prescribed and gastric bleeding. This was explained to Mrs Button at some length along with the reasons why the medication had been prescribed, but sadly she declined to restart the medication. It is the Trust's view that staff acted appropriately and in Mrs Button's best interests.

(5) Contemporaneous nursing records were not always maintained; for example relating to food and fluid intake (even though nutrition was a matter of concern to the treating clinicians).

Prior to, and during the course of the inquest [redacted] apologised that record keeping in relation to nutrition and hydration was not to a consistently high standard. This was addressed with the ward team at the time and has been discussed subsequently.

The Trust has in place an audit process referred to as the ward/department Healthcheck. This provides a systematic overview of performance across a range of key areas that influence or reflect the standards of care, patient outcomes and experience of care delivered in the Trust. The data can be viewed at organisational, CSU and ward level, providing both a local and strategic picture. A copy of the completed Healthcheck for ward J83 over a 12 months period in relation to nutrition and hydration has been included with this letter. You will note that the ward results demonstrate a very high level of compliance across the key areas identified.

[redacted] attends morning handover on ward J83 on at least a weekly basis where she is able to highlight any concerns with the team in addition to celebrating success.

Thank you for bringing these matters to my attention. I do hope that this response has assured you that the Trust has given careful consideration to the matters of concern you have raised.

If I can be of any further assistance please do not hesitate to contact me.

Yours sincerely

Dr Yvette Oade
Chief Medical Officer
Leeds Teaching Hospitals NHS Trust