Department of Health & Social Care

From Nadine Dorries MP
Minister of State for Patient Safety,
Suicide Prevention and Mental Health

39 Victoria Street
London
SW1H 0EU

[redacted]

Your Ref: [redacted]
Our Ref: [redacted]

Mr Christopher Morris
HM Area Coroner, Manchester South
HM Coroner's Court
1 Mount Tabor Street
Stockport SK1 3AG

27 January 2021

Dear Mr Morris,

Thank you for your correspondence of 28 September 2020 to the Secretary of State for Health and Social Care about the death of William McKibbin. I am replying as Minister with responsibility for hospital care quality and patient safety and I am grateful for the additional time you have allowed for my response.

I was saddened to read the circumstances of Mr McKibbin's death and wish to offer my sincere condolences to his family and loved ones. Your investigation of Mr McKibbin's death provides important learnings to improve patient safety across the NHS and I am grateful to you for bringing your concerns to my attention.

In preparing this response, my officials have made enquiries with NHS England and NHS Improvement (NHSE/I), to understand the action taken locally by the Manchester University NHS Foundation Trust (the Trust), and with the Care Quality Commission (CQC), as the independent regulator of care quality.

I am advised that the Trust, of which Trafford General Hospital is a part, has apologised unreservedly for the failings in Mr McKibbin's care and the standard of the investigation conducted into Mr McKibbin's fall, as well as the quality of communication with Mr McKibbin's family.

I am further advised that the Trust has provided assurance in its response to you, that it did not seek to deliberately mislead or withhold information from Mr McKibbin's family, or indeed your investigation into the circumstances surrounding Mr McKibbin's death.

I will not repeat the detail of the Trust's response to you. However, I note that the Trust has said that it has taken significant learning from its reflections on the investigation carried out into Mr McKibbin's fall that will inform its investigation process and that the learning has been widely shared across the Trust's hospitals, Board of Directors, its Governors and local commissioners, and to the CQC. Further learning, incorporating the

findings of the inquest into Mr McKibbin's death and the concerns identified, have been shared within the Trust, with future learning events and opportunities planned.

I note your residual concerns as to the prevailing culture at the Trust, and by extension, within the NHS with regard to the Duty of Candour.

The Duty of Candour Regulations[1] came into force in November 2014 for the NHS, which ensure that providers of NHS services are open and transparent with people who use services and their representatives in relation to care and treatment, when something goes wrong that appears to have caused harm or could lead to significant harm.

The Regulations, set out specific requirements that providers must follow when things go wrong with care and treatment, including informing patients and their families about the incident, and providing reasonable support, truthful information and an apology.

The CQC has the power to prosecute for failures to comply with Duty of Candour, however this has not been done to date. The Duty of Candour for NHS providers was introduced, alongside other measures, to cultivate a culture of learning to enable lessons to be learned quickly and patients protected from harm in the future.

My officials have been informed that the Trust has a Duty of Candour policy in place and that internal Trust monitoring shows 95 to 100 per cent compliance from staff. In 2018, the CQC inspected these arrangements and rated them 'Good'.

To support NHS Trusts to learn from mistakes in order to reduce risks to future patients and avoid tragedies from happening in the first place, we introduced the Learning from Deaths programme in April 2017. The Programme was established in response to the CQC's 2016 report Learning, candour and accountability: a review of the way NHS trusts review and investigate the deaths of patients in England,[2] in which the CQC identified that learning from deaths needed much higher priority in the NHS and that many bereaved families did not experience the NHS as being open and transparent.

The first ever National Guidance on Learning from Deaths [3]was published in 2017 and introduced a more standardised approach to the way Trusts review, investigate and learn from deaths. Guidance is clear that Trusts must also engage meaningfully with bereaved families and carers.

From 2017-18, we have required NHS trusts to publish locally the numbers of deaths thought to be due to problems in care on a quarterly basis, and to evidence what they have learned and the actions taken to prevent such deaths on an annual basis in their Quality Accounts. This new level of transparency is fundamental to a culture of learning and ensuring the safety of NHS services.

In March 2019, the CQC published a review of NHS trusts' implementation of National Guidance on Learning from Deaths. It showed that trusts are at different stages of

[1] https://www.gov.uk/government/publications/nhs-screening-programmes-duty-of-candour/duty-of-candour#duty-of-candour-regulations
[2] https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf
[3] https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf

implementation but included case studies to demonstrate significant progress being made on Learning from Deaths.

You may also be interested to note that a new Patient Safety Incident Response Framework[4], to replace the Serious Incident Framework, is being developed by NHSE/I to facilitate examination of a wider range of patient safety incidents in the NHS and to improve the quality of patient safety incident investigation and how organisations can learn and change as a result. The Trust, in its response to you, sets out specific actions it has taken with regards to 'red flag' warnings and other actions.

Finally, with regards to falls prevention, the National Institute for Health and Care Excellence (NICE) has published a clinical guideline on *Falls in older people: assessing risk and prevention* (CG161[5]) that includes guidance on preventing falls in older people during a hospital stay. The guideline says:

> *1.2.2.1 Ensure that aspects of the inpatient environment (including flooring, lighting, furniture and fittings such as hand holds) that could affect patients' risk of falling are systematically identified and addressed*

This recommendation would apply to wards, toilets and other parts of the hospital. The guideline recommends that for patients at risk of falling in hospital, an assessment of the patient's individual risk factors should be conducted and where necessary, appropriate intervention put in place. NHS trusts are expected to take account of NICE guidelines when planning care.

I have been assured that the Trust's falls investigation template has since been updated to include more detailed guidance around immediate action, including the requirement for an immediate check and documentation of the environment of a fall, including an unwitnessed fall. This includes changes to the Intentional Rounding Checklists in use at the Trust.

In relation to the matter of concern about notification requirements in relation to the deaths of service users and the information that is required of providers within a specified time period, I am aware that the CQC has written to you explaining the process for the reporting of deaths, or incidents of 'severe harm', to NHSE/I's National Reporting and Learning System (NRLS) and STEIS (the strategic executive information system), and the way in which the CQC can review, request and assess information relating to reported incidents.

You will also be aware that the CQC reviewed the NRLS/STEIS incidents in relation to Mr McKibbin's death and considered that sufficient information was provided by the Trust in order to fulfil its regulatory duties. Importantly, I note that the CQC is satisfied that current reporting processes, through NRLS/STEIS reports, are adequate to enable it to fulfil its regulatory responsibilities. However, the CQC will review its existing notifications guidance in light of the findings from Mr McKibbin's death, to determine if further clarification is required.

I trust this response is helpful.

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[4] https://www.england.nhs.uk/patient-safety/incident-response-framework/
[5] https://www.nice.org.uk/guidance/cg161

Yours sincerely,

NADINE DORRIES

MINISTER OF STATE FOR PATIENT SAFETY, SUICIDE PREVENTION AND MENTAL HEALTH