INDEPENDENT DESK TOP REVIEW

SERIOUS INCIDENT NUMBER 2023/5237

NOVEMBER 2025

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INTRODUCTION

NHS England commissioned an independent desk top review into the care and treatment received by the patient[1] whilst an inpatient in Hull university Teaching Hospital (HUTH) and the investigations undertaken. The patient had been admitted via the Emergency Department on the 21st November 2021 to a medically fit for discharge ward; they died, as an inpatient, on 7th December 2021.

An investigation panel was formed in order to undertake this independent desk top review, and is referred to, throughout the report, as 'the panel'. It comprised three individuals, two of whom are experienced incident investigators and one of whom is a clinical specialist of relevance to the patient's medical condition during their inpatient stay; all three panel members have substantial senior NHS experience.

The panel were provided with documentation as described in Appendix I to this report. They did not access email (or notes of telephone) correspondence; nor some of the material provided by the family to the incident investigation led by the Integrated Care Board (ICB).

Both HUTH and the ICB have had sight of a draft copy of this report and were invited to inform the panel of any factual inaccuracies, and/or clarify any misunderstandings. Both organisations have responded, and the panel met with HUTH to review some clarifications. The panel has made a few adjustments which are contained in this final report.

The Terms of Reference for this desk top review are laid out in Appendix II to this report.

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[1] For the purposes of maintaining the individual's confidentiality, we refer throughout this report to 'the patient'.

TO UNDERTAKE A DESK TOP REVIEW AND CRITICALLY EXAMINE THE HUTH REPORT AND THE ICB COMMISSIONED INVESTIGATION INTO THE PATIENT'S CARE AND TREATMENT TO DETERMINE SUFFICIENCY OF ENQUIRY, WHETHER TERMS OF REFERENCE AND KEY LINES OF ENQUIRY WERE ADEQUATELY EXPLORED AND ADDRESSED.

The internal investigation report

1. The Hull University Teaching Hospitals NHS Trust (HUTH) investigation report was written in response to a formal complaint raised by the patient's family on 31st March 2022. There is no completion date on the report, but it was sent to the family under a covering letter dated 27th July 2023. The letter apologises for the delay in completing the investigation due to the police refusing permission for staff to be questioned until 28th January 2023. It is important to note that there was some confusion for the panel regarding the sequencing of decisions made by HUTH, and therefore their intent when writing the complaint investigation. This was then clarified by the Trust. In brief, a meeting with the family was held in August 2022; a decision was then made around December 2022 that it would be advisable – given the Trust's troubled relationship with the family – for the ICB to undertake the investigation, and the ICB became the principal vehicle for responding to the family's concerns. However, the Trust sought to ensure regulatory compliance by addressing the family concerns and providing a summary of the evidence considered, without duplicating the ICB investigation. We return to this issue later in this section of the report.

2. The family's complaint letter comprised a detailed chronology of the patient's hospital stay from their perspective, and a number of questions.

Good practice

3. The investigation report is written in clear, concise language, which minimises medical terminology and is easy to read and understand.

Areas for improvement

4. The complaint investigation did not appear to be conducted fully in line with the Trust's complaint policy at the time (CP003):
    - A period of 180 days lapsed between the permission to proceed with speaking to staff (from the police) and issuing the report to the family. The Trust's gold standard is 25 days, but in complex cases, this can extend to a maximum of 60 days. The Trust subsequently clarified for the panel that they had told the family (in July 2022) that they would require 120 days because of the complexity of the complaint. However, they acknowledge that they did not

meet their deadline, and that communication with the family about this delay could have been improved.

- It is not clear from the documentation whether or not the family were offered a resolution meeting shortly after their complaint was received by HUTH. The Trust subsequently confirmed that a meeting with the family was held in August 2022.

- The panel acknowledges that responding to complaints and investigating incidents are two different – albeit complementary - frameworks, representing two ways in which a family's concerns can be explored. The panel considered that although the complaints investigation report may have been compliant with regulatory standards, it could have been improved, and its purpose clarified, in the following ways:
    a. The report is titled 'Investigation Report' and is written in a formal style. This implies a full investigation and does not convey the more informal or humane tone that can be achieved by a letter that sets out the concerns and responses. The Trust has subsequently confirmed that the latter approach has now been adopted by them, which we support. It is unfortunate that nowhere in the report or the covering letter does the Trust highlight that the ICB is undertaking the full incident investigation, as this would have helped clarify the situation to the family.
    b. The response did not summarise the full nature and substance of the complaint from the family, nor did it describe the investigation. It did summarise its conclusions and provide details of the right to refer the complaint to the Parliamentary Health Service Ombudsman. The panel accepts that a number of the family's questions were leading and emotionally laden, and not appropriate for a direct answer. Nevertheless, there were a number of points raised regarding the behaviour and attitudes of staff, their communication with the family, and the clinical documentation, that were not addressed in the complaint.
    c. Given that the investigation report was written by a member of the corporate services team, it would have been helpful to know to whom the investigator spoke to complete what was a fairly complex set of complaints about clinical care, and whether any staff were independent of the immediate clinical team caring for the patient[2]. Furthermore, the Independent Investigation Report highlights that the HUTH investigation was a 'desk top review' only (for example, page 31 of the report), although the internal report states that information was obtained from 'Trust Staff'. Two people are mentioned – 'Consultant caring for the patient at the time, and the Clinical Lead for Medical Elderly'. There is therefore confusion as to what extent staff participated in the investigation.

5. The report references that the Serious Incident Framework (SIF) 2015 supports the Trust decision not to report the alleged fall as a serious incident. Furthermore, the Trust subsequently clarified with the panel that their decision not to declare a serious incident was based in large part upon the findings of the first two post-mortem reports. The panel accepts the Trust's initial decision-making; however, when this did not satisfy the family, in our view there was scope for flexibility,

[2] Although the panel agree that there was no need to name specific staff.

and an incident could have been declared. Section 1.3 SIF states, *'Serious incidents identified (or alleged) through the complaints route, or any other mechanism, must be treated in line with the principles in this Framework to ensure that it is investigated and responded to appropriately. If the investigation reveals that there were no weaknesses/problems within health's intervention which either caused or contributed to the incident in question, the incident can be downgraded.*

Managing complaints and investigations when there is police involvement.

6. HUTH were in a difficult position in relation to the police investigation and the instruction not to interview staff in response to any complaint/incident investigation. The panel has experience of this occurring in other Trusts and has concerns that this embargo – which can be inconsistently applied – interferes with a Trust's duty to provide safe care and improve services. Importantly, lengthy delays also cause unnecessary additional distress to grieving families. Our experience is that it is necessary for there to be liaison between the Trust executive team and senior leadership in the police in these situations, and this can resolve the situation more quickly.

7. Recommendation: we suggest that the Trust work with the police to agree protocols/communication channels, should such a situation occur in future. It may also be helpful for guidance to be provided in this regard at a national level, given that this particular difficulty occurs fairly regularly.

8. We refer more broadly to the question of working with families, and whether the family's concerns met the criteria for a serious incident investigation in the sections later in this report.

The independent incident investigation

9. The Integrated Care Board (ICB) declared a serious incident and put the matter on Steis in March 2023; the family were then content for the independent investigation to proceed. The Terms of Reference were finalised the same month. Initially the police refused permission for the ICB investigator to interview staff, but this permission was then granted in May 2023. The final report is dated 27th November 2023. The lead investigator was a senior clinician from the ICB, and specialist advice was provided by a Consultant in Metabolic Bone and Nephrology from another ICB.

Good practice

10. The report writer sought independent views where necessary (for example, discussions with the Sara Stedy manufacturer).

11. The inclusion of the social care record – relevant to the events triggering the patient's admission to hospital – provided extremely helpful contextual information.

12. The panel's view is that the investigation was conducted in an exhaustive manner, drawing on all possible information. This is particularly commendable given the lengthy delays incurred since the family first made a written complaint to HUTH.

Areas for improvement

13. The panel identified three areas for consideration.

- **Terms of Reference (ToR)**. It is not easy to marry the very detailed ToR for the independent investigation with the report findings. Best practice suggests that the ToR should be very clearly identified in the body of the report.

- Our panel has reviewed the ToR and does not have concerns that any substantive questions were left unanswered. However, there were some questions where the answers were implied rather than directly answered: for example, the question: '*was the division of available nursing experience appropriate for night shift particularly the most senior member of the nursing staff of minimum acceptable level on that evening of 23/11/21 to ensure the patient was safe?*' This was addressed in the chronology on page 31 but is not explicitly answered as to whether it was a safe level of staffing or not. Following further clarification from the ICB report author, we accept that this area of inquiry was fully addressed, albeit not clearly articulated as an opinion in the report.

- The panel recognises, however, that if the ToR are going to include numerous detailed questions, this can lead to a very fragmented set of findings that does not facilitate a clear narrative.

14. We would like to make the following suggestions:
    - Questions that are merely factual are addressed in the chronology and do not necessarily need to be itemised in the ToR; if they are itemised, then the reader could be signposted to the chronology for the response.
    - Core, high level questions need to be replicated in the reports' findings. In this case, ToR 2 questions a) to d).
    - Detailed questions requiring a judgment from the investigator could be answered within the above sections, or could be signposted (that is, indicating in the ToR in the Appendix, where these questions are answered).

15. NOTE: none of these comments about the ToR detract from the thorough approach taken by the independent investigator.

16. Occasionally, **summarised findings** drawn out in the concluding section of the report **were not always well evidenced in the body of the report.** For example, the report concluded that the use of *'international nurses*' was not a factor that affected the care received by the patient, but the main body of the report did not make any reference as to how this had been investigated. Similarly, whilst the panel agrees with the conclusion that a safeguarding alert should have been raised regarding the family's allegation of a fall at HUTH, the report did not contain information

from interviewees as to why this was not done. Following further clarification from the ICB report author, we accept that differential competence in international nurses was considered, and no differences were found (although not explicitly stated in the report).

17. **Behaviour and attitudes of staff, as questioned by the family**. There is no explanation in the report as to why some questions from the family were included in the ToR but not others. As we have already commented, some of the questions were not conducive to a learning approach for the investigation. However, our panel considered whether it would have been appropriate to include concerns from the family regarding behaviour and attitudes of staff as an area of inquiry. We also note that there is no reference or response to the family's concern that some staff on the ward may have lied in order to cover up an incident.

18. However, we do note that the investigator makes substantive comments regarding the breakdown in the relationship between the family and HUTH in the findings. It would have been helpful to have incorporated these comments into a section that was clearly labelled in such a way as to represent a response to the family's concerns regarding behaviour and attitudes. Following further clarification from the ICB report author in relation to paragraphs 18 and 19, we accept that addressing complaints regarding the behaviour and attitudes of staff is a highly sensitive area with the potential to further enflame the distress of all parties. Nevertheless, we remain of the view that it is possible to be supportive to all parties, and important to demonstrate transparency. This need not necessarily involve highly detailed inquiry, but could, for example, include an explanation as to which questions posed by the family would be investigated and which would not and why not.

19. We also note that the investigator reported that two members of staff had been reported by the family to the General Medical Council (GMC) and the Nursing & Midwifery Council (NMC), and that both organisations had found that there was no case to answer. The panel suggests that it may have been helpful to reference the NHS Improvement guidance '*A Just Culture Guide: Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents*' which was in place at the time of the investigations, but has since been replaced by the '*Being Fair Tool*' (*https://www.england.nhs.uk/patient-safety/patient-safety-culture/being-fair-tool/*). These tools are used to aid decisions and to explain these to all parties when the investigation of an incident begins to suggest a concern about an individual staff member's actions.

BASED ON EVIDENCE PROVIDED BY THE TRUST AND ICB TO EVALUATE THE IMPLEMENTATION OF RECOMMENDATIONS AND ACTIONS FROM THE TRUST AND ICB INVESTIGATIONS

21. HUTH has been through substantial changes since the patient's death, including the launch of PSIRF in April 2023, the appointment of a new Trust CEO in August 2023, and the move towards group working with North Lincolnshire & Goole in April 2024; this led to a full executive restructure and subsequent care group structure with a significant reorganisation of senior staff.

22. The investigation panel was provided with a copy of the HUTH action plan, along with some evidence. We have taken the high level action plan provided, and added comments, both in terms of the evidence provided, and suggestions for further assurance. This can be found in Appendix III of this report.

23. Overall, it was clear to the panel that the Trust has worked hard to put in place new governance structures and updated policies and procedures that are comprehensive and relevant to the ICB investigation's recommendations. However, for a number of recommendations, assurance was not provided in relation to the impact that these updated structures and procedures may have had on aspects of patient care and family/carer experiences that are relevant to the findings of the investigation report.

24. It is our recommendation that over the next 12 months, HUTH builds their assurance evidence, to be shared with and reviewed by the Integrated Care Board.

TO CROSS REFERENCE THE ABOVE INVESTIGATION REPORTS AGAINST THE CLINICAL RECORD, ORGANISATIONAL POLICIES AND NATIONAL GUIDANCE RELEVANT TO THE PATIENT'S CARE

Confirm the accuracy of the facts and chronology of the patient's care and treatment

26. The panel can confirm that the independent investigation report provides an accurate and detailed account of the facts and the chronology of the patient's care and treatment between 16th September 2021 and 7th December 2021. It is positive that the timeline incorporates the period of the patient's stay at the care home, immediately prior to her admission to hospital.

Determine the appropriateness of the treatment of the patient in the light of any identified health and social care needs, including a review of the medicine management during her inpatient stay, and identifying both areas of good practice and areas of concern.

27. The independent investigation concluded that the patient,

28. *'Had multiple co-morbidities and frailty making her susceptible to further health issues such as infection. The clinical consensus was that she had some underlying level of confusion as normal for her and that her confusion became worse by being in a different environment, having an infection and the impact of the fractured sternum. **** (the patient) did not comply easily with therapy intervention and along with her condition, would have become deconditioned in hospital, increasing her frail state.'*

29. The panel agree that this summary reflects the patient's state of health accurately.

Nutrition

30. The patient's nutritional intake was poorly assessed, monitored and managed.

31. On admission to hospital, she underwent a nutritional assessment. Key factors of Chronic Obstructive Pulmonary Disease (COPD) and suspected infection were not completed on the assessment, which meant that she was incorrectly categorised as moderate rather than high risk. This meant that she was not reviewed by a dietician, as the Trust policy requires for high-risk patients.

32. Although The patient's nutritional state was assessed daily, the possibility of infection continued to be missed. The independent investigation identified that this may have been because staff believed that infection would only be counted if the patient was on intravenous antibiotics. This is not in line with Trust policy which talks about infection / suspected infection and not the mode of administration of antibiotics.

33. Additionally, The patient was not weighed on admission, which is a requirement for all patients and of particular importance to those with frailty.

34. The lack of a recent baseline weight meant that potential weight loss could not be monitored accurately. When she was eventually weighed on 01/12/21, some 11 days after admission, it was noted that the patient had lost 4.05kg since she had been last weighed in the care home 25 days previously but it could not of course be determined how much of that weight she had lost whilst in hospital. Although intentional rounding[3] documentation indicated that drinks were regularly available at her bedside, food and fluid intake was often poorly recorded on the monitoring charts. Nor were records kept of any nutritional supplements offered/taken until these were formally prescribed on 04/12/21.

35. Given her poor nutritional intake, reduced mobility and prescribed opioid analgesia The patient was at increased risk of constipation. She already regularly took a laxative prior to admission. The intentional rounding document records bowel movements but shows only one for the patient on 27/11/21; nevertheless, there is no record of any concern about potential constipation until 05/12/21 when a consultant requested a per rectal examination and prescribed additional laxatives/suppositories. These actions appear not to have been undertaken. After 05/12/21 the intentional rounding documents continue to record *'no'* against bowel movements but the skin assessment, in contradiction states '*doubly incontinent'*.

36. The independent investigation identified all these shortcomings in relation to the patient's nutritional needs. There was limited exploration of why staff did not work in line with policy and expected practice, but recommendations were made in relation to practice, policy, auditing and training.

Acute kidney injury

37. The initial acute kidney injury (AKI) suffered by the patient was likely the result of dehydration and infection. The drug charts indicate that the Candesartan[4] was withheld initially, restarted on the 27th of November for three days then stopped again when the creatinine[5] had risen from 86umol/L (on the 22nd November) to 94 umol/L on 29th November. This does not fulfil the diagnostic criteria for AKI but it was sensible to withhold the Candesartan at this stage. The subsequent rise to 111 umol/L and 117umol/L on 3rd and 5th of December respectively do fulfil the criteria for AKI stage 1. At this time there was evidence of infection and possible dehydration which would be more than sufficient to explain this. The Alendronic[6] acid, which was

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[3] **Intentional rounding** is a structured process whereby nurses carry out regular checks on patients using a standard protocol to address such issues as positioning, skin, falls prevention, toileting, nutrition and hydration.
[4] Candesartan is a medicine widely used to treat high blood pressure and heart failure.
[5] Creatinine is a waste product produced by the body from muscle metabolism, primarily excreted by the kidneys.
[6] Alendronic acid is a medicine used to treat osteoporosis.

administered on 2nd December, a day before the creatinine of 111umol/L making it unlikely that the Alendronic acid was solely to blame. The patient was in the high-risk group for AKI though given that she was frail, elderly and with a degree of pre-existing kidney dysfunction; but in all probability, given her other conditions, her kidney function was getting worse prior to the administration of the Alendronic acid. The subsequent rise to 117umol/L two days later was not particularly worrisome and in clinical practice unlikely to warrant any other interventions. Such changes in kidney function are seen frequently in patients with infections and dehydration and are usually treated with supportive measures such as rehydration and antibiotics.

38. It is not clear as to the need to administer the alendronate during an acute illness. Typically, although biochemical changes are seen within days of administration, reduction in the fracture risk is not seen for many months so there was no imperative to act then. This treatment could have been deferred till later.

Pain management

39. The patient's pain appears to have been actively treated. She was prescribed regular buprenorphine patches on admission with regular analgesia along with oxycodone liquid as required for breakthrough cover. After 24 hours the co-codamol was stopped and replaced with regular paracetamol. Regular oxycodone was started a few days after admission and the dose adjusted. Also, codeine and MST[7] were used at various times. These changes in drugs and doses suggest that active pain management was taking place during the admission.

Review the adequacy of risk assessments and risk management, including the investigation findings regarding the knowledge and experience of staff in the use of equipment used during her inpatient stay.

Moving and handling

40. It is difficult from the clinical records alone to determine whether or not practice was in line with Trust policy and safe or unsafe in relation to the moving and handling of the patient. This is primarily because staff did not routinely record how she was moved but also because staff used differing terminology for equipment. We can see that what was documented in the moving and handling plan was a '*hoist and slide sheet'* because of a high risk of falls but that staff used a Sara Stedy device with two staff instead. This latter method was confirmed as safe and appropriate when a specialist Therapy assessment was subsequently undertaken.

41. Taking into account the family's concern that the patient had been '*dropped*' by nursing staff, it was positive that a very thorough examination of policy, practice, training and equipment was

[7] Morphine sulphate tablets.

undertaken as part of the independent investigation, including extensive interviews with clinical staff, consultation with manufacturers and a clinical expert in another hospital.

42. The independent investigation found a wide range of different practice and confusing use of differing terminology in relation to moving and handling. For example, many staff seemed, incorrectly, to believe that a patient should remain in bed until after a Therapies assessment had been undertaken. Whilst others understood the Trust policy correctly in that moving a patient should not be delayed whilst waiting for a formal Therapy assessment and that nurses should undertake their own assessment of risk and needs and incorporate this into the care plan at the earliest opportunity.

43. On the day/night that it is alleged by the family that the patient was '*dropped*' the panel can see from clinical records and the two investigations, that two moving and handling events occurred where the movement did not go as planned. In the afternoon during a physiotherapy assessment of her ability to move from sitting to standing assisted by two staff and the Sara Stedy, the patient experienced a panic attack and sat back down in the chair *'erratically'.*

44. Later that evening, the patient asked the nurse undertaking the medication round to put her to bed. The nurse told the independent investigator that she came back later to do this. She did not know what the patient's care plan was in relation to moving and handling, and after asking the patient if she was steady on her feet, she attempted to move her from the chair to the bed alone by lifting her under the arms. The nurse recounted that it was immediately obvious that the patient could not weight bare as her feet began slipping, so she quickly sat her back in the chair. After asking for assistance from another member of staff, the nurse recalls the patient was moved into the bed with the aid of a Sara Stedy without incident. The independent investigation found that the reason the nurse who moved the patient on her own was not aware of the moving and handling care plan was that such plans were not routinely handed over at shift changes.

45. The panel saw in the independent investigation that a thorough review of training was carried out, which concluded that training had moved from face-to-face into online training predominantly as a result of the COVID-19 pandemic; and that specific training in the use of the Sara Stedy was not recorded or monitored although some staff recall undertaking it.

46. The independent investigation also found that a smaller '*compact*' Sara Stedy was manufactured specifically for the use of children and small adults which may have suited the patient's stature, but it was unclear if this was available in the Trust at the time and many staff were not aware of the two versions.

47. Appropriate recommendations about moving and handling were made by the independent investigation.

Falls

48. The patient had presented at hospital following a fall and she had a history of falling. On admission, a nurse undertook a '*Falls Risk Assessment bundle*'. Although the assessment gave contradictory information about the patient's level of confusion, it correctly categorised her as at high risk of falling. At the time, an assessment of high risk automatically indicated that a '*Hoist and slide sheet'* was the only equipment which could be safely used for high-risk patients. This is contradictory to clinical assessment at the time. The panel also found it is contradictory to the manufacturer's guidance and the advice of the expert consulted in the independent investigation. This meant that whilst the use of the Sara Stedy for the patient was clinically appropriate, there was a mismatch between actions pre-documented in a care plan following assessment and clinical assessment/opinion.

49. The independent investigation also noted that whilst ward audits were undertaken routinely, they did not pick up these discrepancies.

50. In line with the independent investigation the panel found no evidence that the patient's sternal fracture happened while she was in hospital. We agree that on the balance of probability, taking into account specialist opinion and post-mortem findings, this injury is likely to have occurred before hospital admission and become displaced through normal handling and care provision at HUTH.

51. Appropriate recommendations about falls prevention were made by the independent investigation.

NEWS2 and Sepsis Screening

52. The panel agree with the independent investigation that there were three aspects of practice in relation to caring for a potentially deteriorating patient that could have been improved in the patient's case.

53. Firstly, documentation was not always clear or consistent in relation to whether she had ''*new*' or '*worsening*' confusion. This is important as confusion is often caused by both infection and constipation. The independent investigator did not comment but the panel believes one of the factors contributing to this confusion may be the multiple different places where staff are required to comment on level of confusion. We note that the Trust is implementing a new electronic assessment of the fundamentals of nursing care which may assist in improving this situation.

54. Secondly the version of NEWS2[8] for people with COPD was appropriately used for the patient. The panel agree with the independent investigation that although the deteriorating patient

[8] NEWS is a tool developed by the Royal College of Physicians which improves the detection and response to clinical deterioration in adult patients and is a key element of patient safety and improving

policy was not always triggered when her NEWS2 score was elevated, she was reviewed each day by medical staff and more frequently when her condition deteriorated. The patient was correctly treated with appropriate antibiotics, one that covered chest and urine on admission and then a change in antibiotics once her condition changed. This meant her deteriorating condition was appropriately managed despite the policy not being triggered.

55. Thirdly The patient was admitted with a likely infection and later deteriorated. Despite suspecting a urine or chest infection, no urine sample (MSU) was ever sent for microbiology culture sensitivity (MC&S). The independent investigation found the rationale appeared to be that samples are not taken because ward C9 was a discharge ward and this was not something they did. Later when the patient's condition significantly deteriorated an MSU was requested, and this was still not taken despite being requested by medical staff. This is not in line with the Infection and Sepsis Screening and Management Guideline for the Trust which states if sepsis is suspected treat as sepsis and *'all patients with suspected sepsis should have a chest x-ray and urine sample sent for MC&S at the earliest opportunity'.*

56. Appropriate recommendations about NEWS2 and sepsis screening were made by the independent investigation.

Examine the extent and quality of involvement of the patient and her family in developing and implementing her care plan.

57. It is important to acknowledge that there is a significant difference of view between HUTH and the family regarding the quality of the family involvement in her care – and by implication – the quality of HUTH's response as the family became concerned about her care on the ward. There are also some omissions from the clinical record when conversations between staff and the family are said to have taken place[9].

58. When covid restrictions were tightened and visitors more restricted, it was positive that the ward phoned the patient's family as promised at the end of each shift to update them.

59. The nursing notes start to note the length of telephone conversations with the family as from 1/12/21; it is not clear from the reports whether this is policy as the Covid visiting restrictions were enforced, or specific to the patient's family. Certainly, from this early stage it appears that the relationship is difficult between some of the ward staff and the family. The impact of Covid restrictions is not discussed in the reports, but it is our panel's view that these may have aggravated the deteriorating relationship between the ward and the family, as it was a highly anxiety-provoking time for both relatives and staff.

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patient outcomes. In December 2017, an updated version of NEWS, NEWS2 was published which is more specific for the use of people with COPD.

[9] From the independent investigation, the first of these undocumented conversations appears to have taken place on 23/11/21 when the physiotherapist spoke to family members.

60. Following the patient's death on 7/12/21, the family were apparently in contact with the Patient Advice and Liaison Service (PALS) raising concerns about the patient's care and visiting protocols. This was followed by formal and written complaints, as described above. In October 2022, HUTH instructed a solicitor to write to the family requesting agreement to a behaviour charter and informing the patient's daughter that she is not to attend Trust premises unless for a prearranged medical appointment. Meanwhile, at unspecified points in time, the family referred a number of nurses and one medical consultant to their professional regulatory body.

61. The panel agrees with the independent investigator (pages 83-85) who suggests that a serious incident could have been declared on the Steis system, and that the family could have been handled more sensitively, with HUTH's executive team involved in decision making.

62. Our panel would go further and would suggest that when family members are not assured by the response of staff to their concerns, it is important to escalate matters in a timely fashion. Arranging a meeting with a Divisional Director or the Chief Medical Officer or Chief Nurse can sometimes enable families to feel properly heard and for any specific care concerns be addressed, if appropriate. Such meetings should ideally take place well before a family feels the need to make a complaint in writing.

63. In a similar vein, although we understand HUTH's reasoning regarding the NHS England 2015 serious incident criteria, in our view it would have been reasonable to respond to the family's continuing concerns by logging the patient's death as an alleged serious incident where acts or omissions may have occurred that led to an avoidable death. This could then have been de-logged following an investigation should no failure in care have been identified.

Identify any gaps or omissions in the patient's care not adequately addressed within the two investigations.

64. The investigation panel did not identify any further gaps or omissions in the patient's care not already identified.

65. The panel made one observation when reviewing the documentation, not already included in previous reports. That is, we were struck by the onerous and fragmented nature of paper-based form filling required by the nursing staff on the ward. These processes necessarily drew staff away from direct patient care and held the potential for information to be missed.

CONCLUSION

66. The investigation panel have independently reviewed the previous Trust (HUTH) and ICB commissioned investigations, the findings and recommendations. The panel concluded that there were a number of learning points identified from the HUTH complaint investigation. The ICB investigation report was extremely detailed, with a number of good practice points identified.

67. The Trust leaders, in clarifying factual inaccuracies with this investigation panel, clearly demonstrated their own learning in relation to the handling of the complaint from the family; the panel supports their views as to what actions might have brought greater clarity to the situation.

68. The panel identified some learning points in relation to the ICB commissioned investigation report but, when reviewing the care provided to the patient, they did not identify gaps in care that had not already been picked up by the ICB report. Overall, the panel reached the same conclusions regarding HUTH's care of the patient as did the ICB investigation report: these conclusions were in line with best practice, national guidance and organisational policies.

69. The panel considered that there was learning for the Trust in terms of their handling of the family's concerns, both before and after the patient's death. The patient's admission to hospital took place during the pandemic, a time during which both staff and families were under considerable pressure. Nevertheless, the panel agreed with the ICB report investigator, that there were opportunities for a more sensitive approach from the Trust, including more timely intervention by clinical executive team members.

70. HUTH, in collaboration with the ICB, provided an updated action plan for the panel. It was clear that there had been a number of changes to governance structures and the executive team within the Trust since the patient's death. Considerable work has taken place to develop policies and procedures relevant to the ICB investigation findings. The panel suggest that there is now a need for the Trust to provide more assurance in relation to the embedding of new procedures and evidencing the positive impact that these have had. This assurance should be shared with and reviewed by the ICB.

RECOMMENDATIONS

71. The panel suggest that the Trust work with the police to agree protocols/communication channels, should such a situation occur in future. It may also be helpful for guidance to be provided in this regard at a national level, given that this particular difficulty occurs fairly regularly.

72. The panel suggest that there is now a need for the Trust to provide more assurance in relation to the embedding of new procedures and evidencing the positive impact that these have had. This assurance should be shared with and reviewed by the ICB.

APPENDIX I : DOCUMENTATION

Date	Documents
	The complaint
31/3/22	Family's complaint
27/7/23	Complaint investigation report (HUTH)
27/7/23	HUTH cover letter for the complaint
	HUTH Policies (* denotes versions at time of incident & now)
	Deteriorating Patients Policy*
	Nutrition and Hydration Policy
	Patient Falls Prevention and Management Policy*
From Jan 22	Sternal Fracture Management
	Health & Safety Policy
	Incidents Policy*
	Complaints policy*
	Being open when patients are harmed*
	All clinical records, HUTH, including
	Nursing shift notes
	Care plans
	Food record & hydration charts
	Medication charts
	Doctors' notes
	Assessment unit forms
	Observations
	Medical investigations
	Action plan updates and evidence
	ICB investigation
27/11/23	Final version of report
	Appendix 1: questions from the family
March 23	Appendix 2: final terms of reference
	Appendix 3: Datix web report
	Appendix 4: consultant radiologist (HUTH) reviews images
	Appendix 5: timeline of events
	Appendix 6: timeline of key events
	Appendix 7: history of falls from family
29/6/23	Appendix 8: email confirming account from family
	Appendix 9: mother describes fall/mother confirms fall
	Appendix 10: images of pre & post fracture from family
1/12/21	Appendix 11: Dr ** recording
	Appendix 12: Sara Stedy pictures

21/12/21	Appendix 13: first post mortem report
1/4/22	Appendix 14: second post mortem report

APPENDIX II: TERMS OF REFERENCE

Independent Desk Top Review into the Care and Treatment received by The patient whilst an inpatient in Hull University Teaching Hospital and the investigations undertaken.

Background to the Investigation

The patient was admitted via the Emergency Department on the 21st November 2021 to a medically fit for discharge ward. Later a fractured sternum was diagnosed, with accompanying chest pain. She was diagnosed with hospital acquired pneumonia, declining renal function and passed away on the 7th December 2021.

Purpose of the Independent Investigation

- To independently review the robustness of the previous Trust and ICB commissioned investigations, the findings and the recommendations.
- To consider the quality of the care and treatment provided to The patient against best practice, national guidance, and organisational policies, based on a desk top review of relevant evidence already collated from the previous investigations.
- To independently review evidence for the implementation of the actions and recommendations from both the investigations.

Terms of Reference

To undertake a desk top review and critically examine the Hull University Teaching Hospital report and the ICB commissioned investigation into The patient's care and treatment to determine sufficiency of enquiry, whether terms of reference and key lines of enquiry were adequately explored and addressed.

Based on evidence provided by the Trust and ICB to evaluate the implementation of recommendations and actions from the Trust and ICB investigations.

To cross reference the above investigation reports against the clinical record, organisational policies and national guidance relevant to The patient's care in order to:

- Confirm the accuracy of the facts and chronology of The patient's care and treatment.
- Determine the appropriateness of the treatment of The patient in the light of any identified health and social care needs, including a review of the medicine management during her inpatient stay, and identifying both areas of good practice and areas of concern.
- Review the adequacy of risk assessments and risk management, including the investigation findings regarding the knowledge and experience of staff in the use of equipment used during her inpatient stay.
- Examine the extent and quality of involvement of The patient and her family in developing and implementing her care plan.

- To identify any gaps or omissions in The patient’s care not adequately addressed within the two investigations.

Timescale
The investigation process starts when the investigator receives the Trust documents and ICB commissioned investigation documents, and the investigation should be completed within 6 months thereafter.

Initial steps and stages
NHS England will:

- Arrange an initiation meeting between the Trust, ICB, investigator and NHS England.

Outputs

- NHS England will require monthly updates from the investigation company.

- The Investigation company will provide a full findings written report to NHS England that includes, if required, measurable (SMART) and sustainable recommendations for the Trust, Integrated Care Boards and NHS England as appropriate.

- Provide a Full Findings Report and summary versions as required that may be published, that is easy to read and follow with a set of measurable and meaningful recommendations that have been coproduced with the effected organisations, having been legally and quality checked, proofread, and shared with participating organisations (NHS England style guide to be followed and the principals of GDPR observed).

- At the end of the investigation, to share the report with the Provider, ICB, Region and NHS England to explain the findings of the investigation.

- If required presentation of the investigation report to NHS England, ICB and Provider Boards and to staff involved in the incident. Delivery of learning events/workshops for the Provider, staff, and commissioners if appropriate.

APPENDIX III: TRUST ACTION PLAN

HUTH ACTION	ACTION EVIDENCE	INVESTIGATION PANEL UPDATE	FURTHER ACTIONS/ASSURANCE REQUIRED?
NUTRITION/HYDRATION			
Standards need to be improved with regards to actions required to ensure nutrition and hydration is optimal for patients and this includes, all the pathway from assessment, weighing patients, care planning, implementation of actions, completion of food and fluid charts and a revisit of referral pathways for additional specialist support.	Managed as part of Nutrition and Hydration Steering Group (NSG). To review referral pathways to dietetics & ensure staff awareness. Assessment against 8 nutritional and hydration standards ongoing. Task and finish group established re feeding patients. Fundamental standards HUTH.	The new ACE 'ward to board' assurance process includes a monthly audit on nutrition and hydration, containing all of the elements in this recommendation	None
Ward documentation audits need to be designed that they pick up issues that the investigator has raised in terms of variation in approaches and non-adherence to some aspects of the policy	Weights are expected to be monitored twice weekly including on the NCTR wards, in line with the Nutrition Risk Assessment. The Assurance Nutrition Audit performed monthly by the wards asks if weights are recorded every 72 hrs; this is completed on 5 patients monthly.	As above	
Poor completion of food/fluid charts - supplements not prescribed/given regularly till late in admission, lack of escalation to medics	Ward Sisters and Matrons to monitor in areas and ensure compliance	As above	None
Oral health poorly recorded	Oral hygiene assessment is now on nerve centre and must be completed every 72 hrs.	The new nutrition and hydration policy, updated May 2025, also includes an Oral Support Care Pathway.	None

Training and support for staff to better understand why hydration, nutrition and constipation is important to the care of their patients and how when not managed appropriately, this can contribute to the deterioration of people in their care	Nutrition training in place currently. NSG reviewing.	This is a Trust priority and that training is mandated for 4,000 staff across the Trust. Compliance is currently above 85%.	None
Improvements in the prevention and management of constipation needs attention and a plan developed to address issues raised in this report.	Bowel function should be monitored as part of the individual care and care planning for a patient with any issues being discussed with the MDT and appropriate actions and care instigated.	It is not sufficient to say what should be done. The documentation provided to us made no reference to any changes implemented by the Trust in relation to the prevention and management of constipation, although we did note that hydration monitoring and food fluid input/output recording is audited as part of the new ACE assurance programme.	Assurance should be provided showing what has changed in the prevention and management of constipation. Supported by audit evidence to ensure the changes are effective.
FALLS/MOBILITY			
A cross check needs to take place with the new electronic system put in place since the patient's admission, for assessments and care planning in order to be sure discrepancies have been ironed out.	Electronic system now fully embedded into practice with further flags & prompts built into the safety information serving as a base for the ward safety huddles and communication. Trust wide Falls group and weekly falls meetings with all B7 Sisters implemented, reviewing all areas.	We were assured that a completely new electronic record system has been implemented, and that the Falls Matron leads weekly meetings with clinical leaders, which is a forum where any discrepancies in the new system can be flagged.	None
Consideration needs to be given to understand if a falls scoring system is serving patients well and if more emphasis and support needs to be provided for good clinical assessment and positive risk taking in line with therapy staff approaches.	Work undertaken in Falls work programme, AHPs part of the strategic and operational groups.	From the information provided to us, we found no evidence that the new electronic systems have been checked for consistency in how they assess confusion.	The Trust could add to its assurance bundle an explanation on how they have checked that the new electronic record is consistent in how it assesses confusion.

Ward documentation audits need to be designed that they pick up issues that the investigator has raised in terms of variation in approaches and non-adherence to some aspects of the policy.	Work undertaken in Falls work programme. Falls fundamental audit tool also devised and commenced.	The new ACE 'ward to board' assurance process is comprehensive and designed with input from specialist teams in its design.	None
L&S BP not recorded on or during admission	Work undertaken in Falls work programme, also now built into the electronic systems and included in the ward fundamental falls audits.	The new ACE 'ward to board' assurance process includes checks for consistent practice in relation to falls, such as checking lying and sitting BP and if a recent falls risk assessment/care plan is in place.	None
The Mobility and Falls Prevention Care Bundle needs reviewing to ensure that the score reflects the tools (equipment) to be used for a patient.	Work undertaken in Falls work programme. The mobility assessment pulls through to the patient's nursing evaluation so all staff will be able to view it easily. This must be completed on admission and is reviewed as part of the falls risk assessment.	The Trust has ensured the mobility assessment pulls through to the patient's nursing evaluation automatically on the electronic system, but the evidence provided to us does not say how this ensures that assessments direct staff to use the most appropriate equipment. None of the assurance documents provided to us refers to this.	The Trust should add to its assurance bundle an explanation on how it has ensured current assessment tools direct the clinician to the most appropriate equipment to use for patients in falls prevention.
Clear documentation of how transferred in daily nursing records	Work undertaken in Falls work programme. Patients are also reassessed within 6 hrs of transfer.	The new ACE 'ward to board' assurance process includes reassessment within 6 hours after transfer.	None

Trust need to be clear that devices purchased broadly meet the needs of pts and staff are aware and competent in their use	During Moving and Handling training, all staff are given instructions in the use of equipment and of the requirements to risk assess the patient prior to moving them with the aid of any device. They are taught to ask physios if they have any queries and to refer to the daily physio records for patients. In 2022, there was no one in post for Moving and Handling for the Trust. There was a gap during covid and the new manual handling lead, however there is over 100 link moving and handling staff. The new moving and handling lead oversees the training of all IEN nurses with university students being trained by the University (with assurance that the training was consistent). Videos of equipment use were also available on PATTIE. Existing staff who had previously been trained were asked to complete online training in terms of updates. The Trust confirms that all moving and handling training incorporates use of equipment.	The Trust inventory shows that they have one compact Sara Stedy within the Trust. Although we are assured that there are local moving and handling link staff and a new Trust lead has the responsibility to ensure appropriate equipment is available, there is no description of how this is done.	The Trust should add to its assurance bundle an explanation on how the Trust Lead ensures the most appropriate equipment to use for patients in falls prevention is available.
Nursing staff to better understand their responsibilities for assessing a patient to mobilise prior to physio assessment	RNs (other healthcare professionals including all registered staff) are accountable for patient care and appropriate assessment and decision making. Work undertaken in Falls work programme	Uptake of training in relation to falls and moving and handling is monitored, and attendance is good. There is a clear statement that training should be in-person in the first instance but update training can be undertaken online. It is also positive that the Trust now have regular falls meetings attended by clinical leaders, where incident themes and shared learning can be identified. Audit of completed paperwork in relation to falls risk assessment is also being monitored.	None

Asset register for clinical areas to record specific equipment used given confusion over sara steady hoist	The last audit of equipment at HUTH was in 2021. During Covid, equipment was moved/displaced/scrapped but no one individual to oversee this. Arjo Huntleigh did use teams to complete regular audits for equipment asset registers. However, on commencing the role in 2023, JR determined that equipment registers and assets were out od date and subsequently Arjo ceased their audits too. The asset register is being refreshed but is likely to take a significant period of time and is not fully reflective of current provision. This is planned to be completed by the end of May 2024.	The up to date asset register is now in place using consistent terminology.	None
Full participation of the Trust should be in place for the Falls Collaborative that has been commissioned by the ICB by AQUA (Advancing Quality Alliance)	Trust already committed to be part of this work	We were assured that the Trust has a comprehensive audit and monitoring process in relation to falls, which is recorded and shared on the Audit Management & Tracking (AMaT) system.	None
Good handover practice standards need to be in place and audited to ensure they are embedded.	SM leading Trust wide piece of work re handovers and safety huddles	This recommendation relates to inconsistency in ward handover practices in relation to falls risk. The evidence provided to us does not relate to ward handover practice. For example, the clinical handover policy and SOP provided relate to transfers between wards and not to the transfer of information between shifts on an individual ward. Equally, no evidence was provided in relation to auditing ward handovers.	The Trust should provide evidence that it has developed good handover practice standards and audited to ensure they are embedded in practice.
<u>NEWs 2 AND SEPSIS SCREENING</u>			
Poor completion of VIP scores re cannula	Now built into the electronic systems, ongoing monitoring through the fundamental audit reviews, future ACE programme.	The new ACE 'ward to board' assurance process includes this.	None

Improvement needs to be made to ensure nursing assessments accurately reflect patients who have infections, and this should be audited as part of the programme of documentation audits	Part of NEWs and assessments. Work ongoing with the Sepsis team Trust wide.	It is unclear from the information provided to us how the Trust has acted to ensure staff are recording 'new' confusion (as a possible indicator of infection) consistently, as this is not outlined in either the sepsis policy &tools or NEWS2.	The Trust should provide clear evidence of how they have ensured staff are recording 'new' confusion consistently.
Urine samples for MC&S must be collected and sent in line with medical plans and in line with policy	These are part of the board/ward round decisions within a ward and monitored by the medical and nursing teams during these processes	It is positive that the new sepsis policy is clear on the requirement for urine testing and chest x-rays, and that, attendance at training on sepsis is mandatory. However, we found no evidence that adherence to this particular aspect of the policy (undertaking urine testing) had been audited.	The Trust should provide evidence of auditing which demonstrates they are taking urine samples in line with the Trust policy on sepsis
Confusion not accurately assessed or recorded as part of NEWs	Part of NEWs and assessments.	It is unclear from the information provided to us how the Trust has acted to ensure staff are recording 'new' confusion (as a possible indicator of infection) consistently, as this was information from other assessments not NEWS2.	The Trust should provide evidence of how they have ensured staff are recording 'new' confusion consistently.
Staff must heed intelligence from families about their loved ones particularly descriptions of them not being their usual self and more confused than normal. This would also be in line with Martha's Law recently announced nationally	Good communication and listening to family members is essential and promoted. Wards encouraged to operate 'relative clinics' with nursing and medical teams.	Although some of the work is in its early stages, we were assured that the Trust is taking a robust approach to listening to patients and their families in relation to the deteriorating patient with the introduction of Martha's rule, including a SOP to assist staff understanding, an agreed dashboard of metrics and additional funding.	None
ZOLEDRONIC ACID			

The Trust should develop a protocol for the administration of IV bisphosphonates in an inpatient setting.	This is now in place: Guideline for Use of Intravenous zoledronic acid 5mg in patients with metabolic bone disease Reference number: CG782	In the panel's view, the policy is comprehensive and covers both outpatient and in patient administration with appropriate adjustments of the protocol for each. It provides references to relevant other sources and includes items like the prescription charts etc. management committee.	The panel did not have sight of any assurance as to how adherence with the policy is going to be monitored. This could be done for instance with audits run out of pharmacy as they will have a record of each time IV Zoledronic Acid is prescribed. Such audits could be presented at a Quality and Safety or Medicines
DoC & SERIOUS INCIDENT MANAGEMENT			
The investigator believes attention needs to be given to roles and responsibilities, accountability and responsibility regarding the consideration and declaration of serious incidents. The investigator believes this should be at executive level only	Serious incidents discussed at Weekly Patient Safety Summit (WPSS)led by the Site Medical Director supported by the Patient Safety team.	HUTH's weekly patient safety summit meeting is an appropriate forum to address this recommendation.	Minutes of the meeting could be provided to evidence attendance and discussion. In line with our comments below, it would be helpful to provide data on those incidents and complaints, where early intervention is required by the nurse or medical director (in line with the panel's recommendation in the main body of this report), and/or early resolution meetings are held; and where there are uncertainties as to whether an incident should be reported to NHS England.

That the Trust Board should have close oversight of those serious incidents which are considered, the reasons why an SI is not declared, and those declared so it can be open to scrutiny and challenge	The Trust board, CNO, CMO were closely involved and did have oversight of the case.	Further to our comments above, it was not clear to the panel - when reading the ICB investigation report - that an executive member of the team had direct contact with the family around the time that their concerns were being repeatedly raised, either before or after the patient's death. The panel has suggested that it is good practice for senior clinical involvement in situations where patients and their families repeatedly raise concerns that are not assuaged by the local team's response.	As above.
With the move away from the serious incident framework to PSIRF (the Patient Safety Incident Response Framework) the Trust need to be absolutely sure that PSIRF will provide a change in the culture and behaviours of staff to be appropriately supported and trained to consider, investigate and involve families in incidents.	Involvement of the family and patient is an integral part of the PSIRF process and this has been built into the PSIRF processes. PSIRF was introduced in HUTH During April 2023, policies and processes aligned to PSIRF Policy CP453	The PSIRF and related policies and procedures provided to the panel by HUTH are appropriate and in line with national expectations.	Once HUTH has had the opportunity to establish PSIRF practice across the trust, it will be important to audit adherence to the policy. The panel suggests that in response to this particular recommendation, it would be extremely beneficial to engage with PSIRF lived experience workers and with those families who had been involved in investigations, to gather feedback and develop the service further.

In line with the Serious Incident Framework 2015 the Trust must have mechanisms to ensure that actions from recommendations in this report have actions which are monitored until implemented and there is evidence of whether or not the action plan has resulted in the practice / system improvement anticipated. This should include oversight of implementation by organisation leaders	Action plan devised from the ICB response and will be monitored by the HUTH Deputy Chief Nurse, PSIRF Policy CP453	The information provided by HUTH to the panel highlights a significant amount of work that has been completed in relation to updating policies and procedures, as well as new governance structures. As our comments in this action plan highlight, there is now a need to evidence the embedding of these processes and improved impact in terms of patient/carer experience.	None
The new Trust Chief Executive is reviewing the executive appointments and the approach to clinical governance which is welcomed	Organisational restructure of all areas including governance underway	Evidence of the new governance structure was provided to the panel.	None
This case should be considered as part of any future review of the governance/clinical governance arrangements at the Trust	RC fully cited on this case and leading on restructure of organisational governance depts.	The investigation panel has had sight of the new group structure and the associated governance arrangements.	None

The approach by HUTH to the non-declaration of a serious incident and subsequent investigation, only exacerbated the family's grief and anger and if handled more pragmatically and sensitively may have averted what came after. The SI could have been de logged if following investigation there was found to be no evidence of an event giving rise to an SI. It was impossible for the Trust to have led an investigation which was trusted by the family in these circumstances. It is also a key point that the length of time since the patient's death and the Trust complying with the independent investigation meant that staff's recall of events was not as good as it would have been if the investigation had occurred close to the date after the patient died.	HUTH did deal with the case sympathetically, fairly and followed guidance re SI declaration.	The ICB comment is framed more as an observation or conclusion rather than as a recommendation, and this makes it more challenging for HUTH to respond. However, the investigation panel agree with the ICB report conclusions and do not support HUTH's response in the action plan.	The panel has highlighted a number of ways in which HUTH could provide assurance that both complaints and investigations - with associated data on local resolution, re-opened complaints, and audit/survey results - are associated with an improved culture of responsiveness to families and flexibility in relation to incident reporting.
When allegations made by the patient and her daughter that described being dropped on the floor were made, the Trust did not refer to internal safeguarding under the 'allegations made against staff' policy nor did they report internally on Datix even if this then turned out not to be evidenced.	KH Lead for Safeguarding to include this in the new face to face safeguarding training which is being developed in collaboration with NLAG SG team. Will also include as part of the ongoing safeguarding supervision sessions. Will share and discuss the case and relevant findings at both the DDSG and Safeguarding steering group.	The panel has been provided with data on safeguarding training compliance, and examples of the training slides that relate to potential allegations against staff. The action plan update also acknowledges that 'additional weight around this aspect of training would be beneficial', with which the panel agrees.	Given events - albeit relatively rare - in recent years that have attracted national interest relating to inappropriate and abusive behaviour by NHS staff, the panel agrees that many trusts should review whether or not this aspect of safeguarding training has been addressed sufficiently.
OTHER - Additional HUTH Actions			

Missed fracture discussed at radiology discrepancy group	Check with Radiology - emailed MN 10/4/24. 25/4/24 further discussion with MN, no clinical indication to do lateral view of sternum on admission so any old fracture will not have been identified. Not able to confirm if was discussed at the MSK discrepancy meeting as no records or minutes maintained of the meetings.	There is now a new Care Group Director of Allied Health Professionals which includes Radiology, and they have implemented a new governance structure across the group. A comprehensive list of processes was provided to the investigation panel; these were in line with national recommendations and include documentation of discussions and decisions. Furthermore, an audit of structured reporting for chest X-rays was undertaken in 2024.	Further assurance could be provided by the group reporting on the rate of inaccuracies and discrepancies identified, to ensure that this rate is in line with national expectations.
Flexibility re visiting for dementia/delirium pts	Significant work undertaken by KH Safeguarding Lead re Johns' Campaign, Essential Caregivers and incorporated into HUTH's Visiting Policy. Carers Information Support Service (CISS) has been introduced into HUTH to independently support the carers of patients admitted to the hospital. A member of the team is present in the hospital every Wednesday and carers can contact the service for support 24/7. The Alzheimer's Society have launched a pilot role supporting the discharge pathway with the 13th floor. Based in the hospital, the dementia advisor will work and support patients from admission through to discharge, offering an additional 6 week post-discharge care and support plan.	The family's ability to visit the patient was specific to the new visiting restrictions that were in place due to Covid. The panel can confirm that HUTH has an appropriate set of guidelines for patient visiting. We note that visiting hours have been extended.	The panel has not had sight of any assurance to confirm that family members and carers are satisfied with the visiting arrangements. HUTH could report on any complaints/PALS concerns and incidents that relate to this area of patient experience. The absence of any such concerns being raised would provide some assurance.

Pain management in dementia/delirium pts	The Abbey Pain scoring tool is now within the corporate policy for pain assessment and treatment. Caroline Weetman and team (supported by Quality Improvement team) shared a robust action plan following the notification from NAD that HUTH are a national outlier for pain assessment for patients who are non-communicative and have a diagnosis of dementia. There are no audit results available but it is suggested that it is a similar picture for all cognitively impaired patients (including those with delirium). Dr Nagandran, Pharmacy and KH are looking at how we can utilise ePMA to gain oversight on medication provision to the dementia/delirium patients (including anti-psychotics and potentially analgesia) but this is in the early stages.	There has been progress in this area. The panel were provided with robust assurance, via copies of the monthly digital pain audits.	It will be helpful to monitor progress over the next year, both in terms of the use of ePMA to gain oversight on prescribing for dementia/delirium patients, and also in terms of converting the Abbey pain assessment to a digital format.