Department of Health

From the Rt Hon Jeremy Hunt MP
Secretary of State for Health

Richmond House
79 Whitehall
London
SW1A 2NS

Tel: 020 7210 3000
Mb-sofs@dh.gsi.gov.uk

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Mr Andrew Walker
HM Senior Coroner
Northern District of Greater London
North London Coroners Court
29 Wood Street
Barnet
EN5 4BE

11 FEB 2014

Dear Mr Walker,

Thank you for your letter about the inquest into the death of Grace Mary Bates.

On 21 April 2013, Mrs Bates died as the result of complications from poorly managed diabetic episodes following admission to Barnet Hospital. The medical cause of death was complications of diabetes mellitus.

Your report summarised the circumstances regarding Mrs Bates' death, noting in particular, the poor management of blood sugar levels and the absence of a specialist diabetic nurse over the weekend.

All registered nurses (RNs) are accountable for and have skills in blood glucose monitoring. Their skills include monitoring blood glucose, recording findings, evaluating whether each reading falls within an expected range and taking the necessary action. This is the most elementary level of care.

In more specialist areas, such as endocrinology wards, which may have a higher concentration of people with diabetes, it is usual for RNs to have developed their competence in titrating medicines in response to blood glucose readings. In this situation, the Trust should apply clinical governance mechanisms to enable this to take place safely and effectively.

The National Institute for Health and Care Excellence (NICE) quality standard on diabetes states that people with diabetes admitted to hospital should be cared for by appropriately trained staff and be provided with access to a specialist diabetes team. These standards provide an authoritative definition of good quality care and should be used as a basis for best practice.

Local organisations are best placed to assess the needs of their populations, and to commission and deliver high-quality, safe and comprehensive diabetes services; including appropriate nursing staff and I expect local healthcare organisations to do their utmost to deliver care against NICE standards as part of a general duty to ensure continuous improvement in quality.

The wider issue of patient outcomes and weekend admissions has been recognised as a matter of national significance. NHS England has assessed the considerable evidence which has emerged over the last ten years, linking the reduced level of service provision at the weekend to poor outcomes for patients admitted to hospital as an emergency.

The NHS Services Seven Days a Week Forum, established by the National Medical Director Sir Bruce Keogh, has developed ten clinical standards describing the standard of urgent and emergency care that all patients should expect to receive on every day of the week. Their delivery should reduce the risk of morbidity and mortality following weekend admission in a range of specialties including diabetes, and provide consistent NHS services, across all seven days of the week.

The Forum has not attempted to specify the roles and grades of staff that should be present at weekends, except in the case of medical consultants where there is good evidence about the effect of absence of senior decision makers. The standards describe how quickly admitted patients should be seen and assessed on every day of the week by a suitable medical consultant, defined as 'one who is familiar with the type of emergency presentations in the relevant specialty and is able to initiate a diagnostic and treatment plan'.

The clinical standards are attached for your convenience and further information about the work of the forum can be found at
http://www.england.nhs.uk/ourwork/qual-clin-lead/7-day-week/

NHS England's ambition is for all the clinical standards to be adopted in every community in England by the end of 2016/17. With a number of our key strategic partners, we will use a range of incentives, rewards and sanctions, including the NHS Standard Contract, to support the change.

I do hope that this information is helpful and I thank you for bringing this important issue to my attention.

Yours sincerely

Jeremy Hunt

JEREMY HUNT