Heatherwood and Wexham Park Hospitals NHS

NHS Foundation Trust

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Our Ref: BC/RL/eh/EdenE-25

Your Ref: PJB Eden Reg 28

20 January 2014

HAND DELIVERED

Mr Peter Bedford
HM Coroner Berkshire
Yeomanry House
131 Castle Hill
Reading
Berkshire RG1 7TA

Dear Mr Bedford

Re: Inquest into the death of Edna Elsie Eden – v –
Response to Regulation 28 Report to Prevent Future Deaths

Thank you for your letter dated 27 November 2013.

Firstly I would like to thank you for bringing to my attention the matters raised in the Regulation 28 Report to Prevent Future Deaths. I was sorry to learn about the problems that the late Mrs Eden encountered when admitted to our Trust.

As evidenced in your inquiry and our own internal investigation it is clear to me that we failed to deliver the high standards of care that Mrs Eden was entitled to expect. Whilst I have no doubt that everyone involved in her case thought they were doing the best for her at the time, it is clear that mistakes were made and lessons will be learnt.

I have grouped my response under three headings set out below i.e. action taken before inquest, immediate action taken after the inquest and action to be taken.

Action taken before the inquest

As you know the Trust had already taken some action following its own internal investigation. You were informed of these during the inquest hearing therefore I will not rehearse them here again.

However in addition I wanted to specifically point out that a new Policy i.e. TPP 231 (enclosed) which focuses on the Management of the Deteriorating Adult Patient was introduced in August 2013. This Policy has introduced a new requirement for ensuring that the EDOD score calculation is verified by another member of staff to reduce inaccuracies as was in this case. An audit capturing the number of correctly calculated EDOD scores was carried out in July 2013 and the results of this audit highlighted very good compliance; with all standards exceeding the 90% mark and as well as showing that every patient with an increased EDOD score had the algorithm followed appropriately.

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In addition TPP 231 has strengthened the use of Situation Background Assessment Recommendation (SBAR) tool. This is a communication tool used when notifying Doctors over the phone or in person of a patient for review. The tool ensures important information is conveyed in order to allow the Doctor to paint a picture of the patient's condition and prioritise review as necessary.

Immediate action taken after the inquest

The new MSS system was introduced in the Emergency Department on 14 January 2014 and has an added function of calculating the EDOD score electronically thereby reducing the possibility of wrong calculations.

All referrals to the Hospital pass through the Emergency Department. On 14 January 2014 the Trust introduced a new Procedure for dealing with referrals to the hospital. Although some aspects of this new procedure are underway the electronic section is expected to go live in six weeks' time. The electronic system will ensure that instead of using the bleep system to notify inpatient teams that there is a patient in the Emergency Department or that there is a GP referred patient who needs to be reviewed a message will be sent via Smartphone. The Specialist Registrar receives an e-mail alert and then allocates the job within the team. On receiving the e-mail it will be the inpatient team's goal to see the patient within one hour of referral thereby ensuring no delays.

This system will eradicated issues previously identified at times with bleeps with regards to not having an audit trail. This system will also provide assurance to staff that when a message is sent to the Specialist Registrar it has been received and will therefore be acted upon.

Action to be taken in the future

The Trust has plans to introduce a 24 hours a day Central Hub system and the timescales for actions are stated in the enclosed action plan. It is envisaged the Hub will be located at Wexham Park Hospital and be equipped with IT systems and run by senior managers who will be responsible for ensuring the following:

- Tracking of all patients throughout their hospital stay;
- Manage all bleeps;
- Manage all GP and inpatient referrals;
- Review the workload of clinicians;
- Obtain formal handover throughout the Trust, 3 times a day;
- Allocate jobs to Doctors;
- Review any uncompleted tasks and reallocate as necessary;
- Redistribute work where a team is overloaded;
- Authorise employment of extra staff depending on workload;
- Escalate to the Duty Manager and On-Call Director as necessary.

Some of the work with regards to a Central Hub is already underway in that the location has been identified and at least six senior managers have been recruited so far with more to follow.

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It is my view that the Central Hub will help reduce the recurrence of the root causes identified in Mrs Eden's care namely:

- no doctor review due to lack of appropriate patient tracking system;
- no response to bleeps as tracking junior doctors caseload monitored centrally;
- better administration regarding GP referrals;
- inadequate handover;

I realise that these changes cannot change what has happened to Mrs Eden or put everything right but I hope the plans set out in this letter will reduce the likelihood of a similar incident happening again. Once again thank you for bringing this matter to my attention.

[redacted]

Medical Director