Wirral University Teaching Hospital NHS
NHS Foundation Trust

David Allison
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Alan Wilson
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22nd July 2014

Dear Mr Wilson,

Re: Regulation 28 report issued 2nd June, following inquest into the death of Jennifer Morrison

I am writing in response to the report to prevent future deaths, which you issued on 2nd June 2014. This letter forms the Trust's response to the two issues cited in the report and I hope that it will assure you regarding the effectiveness of our processes, the actions that we have taken since Mrs Morrison's death in January 2013, and the further steps that we are planning to take.

Your report identified two issues of concern – missing documentation in Mrs Morrison's medical records, and a failure to align staffing resources during the first week of January 2013 with an increase in patient numbers and clinical activity following the Christmas holiday period. I will respond to each of these issues in turn.

Missing Documentation
The inquest heard that documentation was missing from the patient's medical records, relating to observations which were undertaken during the afternoon prior to the patient's death (Medical Early Warning System and fluid balance charts). We have been unable to locate these documents and it remains unclear why they were not included in the notes in this instance. However, I can outline our process for managing medical records and how we obtain assurance that it is operating as it should.

The Trust has a Health Records Management Policy which describes the process for creating, filing, storing and retrieving records, and defines the standard of record-keeping that the Trust expects from its staff. One of these standards is that every page of the notes should include the patient's full name, their medical records number and their NHS number, in accordance with

guidance issued by the National Patient Safety Agency. In practice this is usually achieved by affixing a pre-printed sticker containing these details to the top of each sheet. This ensures that if a sheet is misfiled, or becomes detached from the notes, it can be re-filed in the correct set of notes. Every three months, we carry out an audit against the health record keeping standards. The audit has a sample of approximately 800 sets of notes, drawn from the full range of clinical specialties. In the most recent audit, covering January to March 2014, 98.1% of records had the patient's full name on every page.

If any documents have been misfiled, they should be sent back to the person who should have filed the document for them to re-file it. If a sheet of paper falls out of the notes in Medical Records, they will put it back in the correct place. In practice, this is very unusual thanks to the 'Mediclip' fixtures which are used nowadays to hold the notes together, but is more likely to occur with older sets of notes. If Medical Records receive a set of notes containing loose papers, they will return the notes to the previous user with an instruction for the filing to be completed correctly.

The Medical Records Department provides a comprehensive training programme for their own staff, and for staff elsewhere in the organisations who handle case notes such as ward and clinic clerks and medical secretaries. This training is delivered to staff on induction to their roles, with an update every three years thereafter. The training emphasises that the notes are essential for safe patient care and that they are legal documents which can be referred to in inquests or litigation. The main topics covered include filing in the notes and using the tracking function on our patient information system so that the notes can always be located. At the end of the session, participants must complete a questionnaire to test their knowledge. Medical Records also provide a range of ad-hoc training which can be delivered in other departments of the Trust or on a one-to-one basis.

Going forward, the Trust is implementing the Cerner Millennium electronic patient record. This is already in use in much of the Trust, and it is to be implemented fully in the rest of the hospital from mid-November 2014. Although existing sets of paper case notes will be retained, Millennium will be used to record care provided from November onwards and this electronic record will supersede paper notes. This should eliminate problems associated with misfiling or detached sheets of paper, as paper documentation will be obsolete.

Staffing and Workload Planning

The report states that *"I was concerned that the Trust could do more to ensure that the care afforded to patients was not jeopardised due to staffing levels being unable to cope with a spike in the numbers of patients waiting until after the New Year to visit hospital".*

In responding to this concern, I would like to outline the processes that the Trust has in place to balance staffing and activity levels, and to ensure that sufficient beds are available. I will cover both Trust-wide policies and processes, and initiatives in the Division of Surgery (and specifically in the Surgical Assessment Unit, where Mrs Morrison was a patient).

The Trust has an Escalation Policy, the purpose of which is to deal effectively with variations in demand and adjustment to bed capacity, to ensure safe patient flow, and to manage clinical risk

within acceptable limits. The policy defines thirteen 'trigger points' in terms of emergency department activity levels and bed capacity, and includes clear criteria for prioritising patients for allocation to beds. There are four states of alert: red, amber, yellow and green; and when a trigger point is breached, the hospital moves to a higher state of alert. At higher states of alert, the frequency of bed management meetings increases and they are attended by more senior personnel, along with colleagues from other organisations in the local health economy. Escalation areas are put into use if needed, and patients are identified who may be suitable for early discharge. This policy was recently reviewed in the light of experience and a new version came into force in June 2014.

Although levels of activity in the hospital can vary unexpectedly from day to day and week to week, there are generally seasonal patterns of demand for services, with demand peaking in winter. Every year, the Trust produces a Winter Operational Plan to manage these demand pressures. This is developed well in advance, and the 2014/15 plan is being drafted at the time of writing. Each year's plans take into account lessons learned from previous years' experience. An outline of this particular case has been shared with those involved in producing the plan.

During the winter months, the level of elective work is controlled in order to accommodate the expected influx of non-elective patients. The Trust uses an electronic rostering system which allows nursing cover to be planned and viewed far in advance. All Consultants must give at least six weeks' notice of their annual leave.

The Trust is taking action to ensure safe staffing levels throughout the year, not just in winter. The nursing establishment (the number of funded nursing posts in the organisation) has been reviewed, and investment made in areas – including the Surgical Assessment Unit – which did not meet the required nurse: patient ratio. Monthly reports are produced for the Director of Nursing which show the nurse staffing levels on each ward. This reflects the emphasis which was placed on staffing levels by the Francis Inquiry, the Keogh reviews of hospitals with high mortality rates, and Professor Don Berwick's report on the state of the NHS. We are actively managing sickness absence through our Attendance Capability Policy. There has been a steady decrease and at the end of the 2013/14 financial year the level of sickness absence was 4.68%. Our target is to reduce this to 4.00%. Departments which have persistently high levels of absence, or which are not complying with the Attendance Capability Policy, are subject to special measures.

Within the Surgical Division, there is now a daily management meeting to review staff levels on each of the wards. This was introduced approximately six months ago.

Surgical Assessment Unit

Mrs Morrison was a patient on the Surgical Assessment Unit (SAU). Earlier this year the SAU was the subject of a 'Listening into Action' project. Listening into Action is an initiative which brings together multi-disciplinary groups of staff at all levels to identify what a good service looks like, what they hope to achieve within six months, and a list of high-impact short-term actions which will help the service to get there. The actions arising from the project included increasing the junior doctor presence, introducing twice daily on-call consultant rounds and regular staffing reviews to ensure sufficient staffing levels. The unit has been re-named the

Emergency Surgical Assessment Unit (ESAU), emphasising that it is not a standard inpatient ward on which patients would be expected to remain for long periods of time; your report mentioned the amount of time that Mrs Morrison had spent on the SAU.

I hope that this letter provides you with assurance that the Trust is implementing robust measures to prevent such an incident from happening again. If you require any further information, please do not hesitate to contact me.

Yours sincerely

David Allison
Chief Executive