14 MAY 2015

Our Vision
To provide every patient with the care we want for those we love the most

Norfolk and Norwich University Hospitals NHS
NHS Foundation Trust

Trust Management Offices
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NHS Foundation Trust
Colney Lane
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Ms Jacqueline Lake
HM Coroner
Norfolk Coroner's Office
69-75 Thorpe Road
Norwich NR1 1UA

Our Ref: AD/vr/IQ.14.022

11 May 2015

Dear Mrs Lake

Nicola TWEEDY (Deceased)

Further to my letter of 23 March, I attach a copy of our response to your Report arising from the death of Mrs Tweedy. This is in table form, to ensure that we have addressed each of the issues that you raised.

I anticipate that the response will be self-explanatory, although some of the issues concerned are complex. If it would be helpful to discuss at all please let us know.

You will appreciate that the question of thromboprophylaxis following day case surgery is contentious and the evidence base on which to found best practice is limited. I should therefore make clear that the change in prescribing practice introduced by surgeons at our Trust was based on our ongoing audit of 60,000 day case patients over the last 5 years, rather than on the sad outcome in Mrs Tweedy's individual case. Rare complications will sometimes occur and there are genuine concerns that increased use of thromboprophylaxis will generate increased risks of bleeding for other patients. We will continue to monitor the position closely.

There are always opportunities to learn and, as you know, we produced an action plan in advance of your Inquest in this case. Recent external inspection has confirmed that we had implemented the actions we had identified in our plan and that this "*demonstrated that learning and improvement had taken place*".

On an administrative point, we understand that a copy of your report was also sent to the Department of Health, but it contained a different date for our response to be received. In order to avoid confusion, I can confirm that we have responded within the timeframe stated in the original report that you sent to the Hospital.

Yours sincerely

[redacted]

Chief Executive

Response to Regulation 28 Report dated 17 March 2015

Mrs Nicola Tweedy (Deceased)

	Matters of Concern Raised	Comment	Ongoing Action
1	*"Specific leaflets relating to the procedure and aftercare were not handed to the patient.* *It is understood a "tick box" has now been added to documentation recording that this is done. This will only work if forms are properly and timely completed. It is understood training and auditing of forms is now in place, but it is not clear how this is being carried out".*	Leaflets on a range of subjects are provided to patients as a standard part of the pre-assessment clinic process. This was not however documented - in the past, we have not required our staff to document that they have given the standard information to each patient – in order to avoid excessive paperwork. Following this case, we have added an additional 'tick-box' to our standard documentation so that in any future dispute there is evidence that leaflets have been given.	A recent independent external inspection found that the Trust had implemented its Action Plan (on which this action was listed) and that this *"demonstrated that learning and improvement had taken place".* We do not believe that our staff will require any specific training in completion of the revised document. We will however review this as part of our regular cycle of documentation audits.
2	*"The Thromboprophylaxis Risk Assessment form was not completed at any point throughout Mrs Tweedy's dealings with the hospital. Had the Risk Assessment been completed this would have flagged up specific risk factors relating to Mrs Tweedy well before the operation. It was noted that the Risk Assessment had not been completed following Mrs Tweedy being anaesthetised and this did start discussion between the consultant surgeon overseeing the procedure and the Anaesthetist about the risk factors*	The Consultant Anaesthetist and the Consultant Surgeon have confirmed that a risk assessment for thromboembolic risks was carried out. The assessment was not however documented. The outcome of the discussion was that it was agreed that the patient should be given Heparin and this was noted on the anaesthetic chart. It would have been helpful had the risk assessment form been completed, as this would have avoided subsequent dispute. The administration of a single dose of Heparin in this case was however in line with clinical practice in major centres across the UK. It also represented the professional clinical judgement	In light of our ongoing audit of over 60,000 day case patients, our haematologists and vascular surgeons have identified that varicose vein surgery may be an independent risk factor for thrombo-embolic events. Our surgeons now routinely prescribe 5 days of thromboprophylaxis for day-case patients undergoing varicose vein surgery. There is inevitable concern that this may give rise to increased complications of bleeding. It is important to emphasise therefore that this decision was taken on the

	and action to be taken. However at this stage in the procedure, it did not allow for a full and proper consideration of the relevant information early on when proper thought could have been given to the risks and potential risks."	in the particular circumstances of this case. It is important to repeat the information set out in the evidence, that a review of 60,000 day case patients has shown that the risks of thromboembolic events are not cumulative. It is appreciated that this may be contrary to expectation from a 'lay' perspective. The evidence seems clear however, that there is no demonstrable increase in risk in patients with several risk factors as opposed to one. The implication is that earlier discussion of the risk assessment would not have produced a different clinical judgement of the amount of heparin to prescribe.	basis of our 5-year audit data and not in response to Mrs Tweedy's individual case. We will continue to audit our outcomes in case increased bleeding complications are such that we should reverse this change in practice and reduce the amount of drugs prescribed. Our doctors have already started reporting their data at clinical and scientific meetings and we anticipate that this will form part of the underlying evidence that informs any future revision of national guidance on thromboprophylaxis. The evidence in this area is however not at all conclusive and we understand that other surgeons and other centres may adopt a different view on whether extended thromboprophylaxis is appropriate in these circumstances.
		We understand that this Trust carries out more thromboprophylaxis risk assessments than any other Trust in the country, bar one. Even so, we want to do better and we are currently implementing an electronic prescribing system in our hospital at a cost in excess of £1.5M. We expect this to make it easier for staff to complete the relevant risk assessment documentation on a consistent basis.	We are continuing to 'roll-out' our electronic prescribing system which will make VTE risk assessment mandatory and will automatically gather data on completion rates.
4	*There was no evidence that the Nurse completing the notes had actually seen*	We believe that this issue must be based on a misunderstanding as the evidence of the nurse	NFA

	Mrs Tweedy prior to discharge.	recounted a conversation with the patient.	
3 & 5	*"Nursing notes on discharge did not fully cover all the factors required to be checked before a patient is discharged."* *"The checklist Form for completion on discharge was not completed."*	In this case it was recorded by the nurses that the patient had eaten supper, had a drink and had been to the toilet before discharge. The full in-patient discharge checklist would not be expected to apply to day-case patients however we wanted to ensure that the criteria for nurse led discharge for day-case patients adequately reflected the need to assess the patient's ability to mobilise before discharge. Our Action Plan on this case explained that whilst this issue was covered by the existing Day Procedure Unit (DPU) discharge checklist the process applying to day cases patients outside the DPU was to be reviewed to ensure that this was consistent.	A recent independent external inspection found that the Trust had implemented its Action Plan (on which this action was listed) and that this *"demonstrated that learning and improvement had taken place".*