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Miss J Robertson
Assistant Coroner for Greater Manchester North
Coroner's Service
Phoenix Centre
L/Cpl Stephen Shaw MC Way (formerly Church Street)
Heywood
OL10 1LL

Dear Miss Robertson

Re: Patricia Norfolk (Deceased)

Response to Regulation 28: Report to Prevent Future Deaths to Pennine Acute Hospitals NHS Trust.

Please find below the response of Pennine Acute Hospitals NHS Trust following the inquest into the death of Patricia Norfolk and the Regulation 28 Report which you issued on 5 July 2017.

Your concerns were set out in the Regulation 28 Report as follows:

1. *That patients, such as the deceased, were not being receiving a daily senior clinician review. I have been appraised of the developments that the Trust is aspiring to in relation to senior daily reviews and decision making and recognise the steps the Trust is taking to recruit appropriate staff to undertake such reviews. However, I remain concerned regarding what happens to patients in the interim period pending recruitment and appointment*.

Response of Pennine Acute Hospitals NHS Trust

Whilst not considered as contributory to Patricia Norfolk's death, the necessity for daily senior clinical review did form part of the recommended actions to be taken by the Trust following its Root Cause Analysis (RCA). As outlined in the directive of Professor Makin (dated 15 March 2017), a paper on medical staffing in general and acute medicine within the Trust was prepared with a view to improving seven day standards for daily senior clinical review. This directive was provided to you under cover of a letter dated 15 March 2017.

Having considered the content of the letter and its enclosures, including the directive of Professor Makin, you subsequently highlighted that no corresponding timescale was attached to the stated *aspiration* of the Trust to deliver daily senior clinical decision making and sought further information. This information was provided within an email dated 26 May which provided you with a timescale for the implementation of improved daily senior clinical decision making, namely following the completion of the recruitment process of two new substantive consultant posts, estimated at that time to be September 2017. The precursor to these posts being Trust Board agreement to the paper prepared by Professor Makin and provision of funding for the two new substantive posts.

No acute Trusts in the country are in a position to deliver a seven day clinical review to all patients. Adding to this burden is the significant number of patients who are 'medically optimised', awaiting placement or packages of care. Recent figures for the Trust are in the region of 150 (or at least 5 wards). We also know that such patients decompensate because of the hospital environment.

Ultimately improved medical staffing will achieve seven day clinical review albeit the numbers required currently will be lessened with improvement in patient flow. Recruitment into posts is on-going and a Diabetologist, a Chest Consultant and a Geriatrician will start this year, with further interviews planned. £10 million of funding for new consultant posts has been agreed by our Salford Group colleagues.

To bridge the gap between the present situation and when medical staffing is optimised, the Trust has put in place a huge service improvement piece, led by Salford Royal, on the care of the deteriorating patient. It has involved entire ward teams & further details can be shared if needed. We have implemented the National Early Warning Score as a result of this and there has been training in recognition and escalation of the deteriorating patient.

The deteriorating patient collaborative will ensure that seven day clinical review will be available to those patients medically requiring of it. Mirroring the approach adopted by our Salford Group colleagues during their successful improvement collaborative in 2008, a full cycle of learning as regard to the methodology of the change package will be completed in November 2017 following which a cohort of Innovation Wards will be selected to represent a range of divisions and specialities across the organisation. These Innovation Wards will become the early adopters of the change package and will inform as to its spread and sustainability which will in turn inform the Trust-wide roll out of the successful interventions.

The Trust has sought to address your concern by actively progressing the recommended action as detailed at page 21 within the RCA in relation to daily senior clinical review. The improvement by way of improved medical staffing will be implemented in September 2017. As stated previously the Trust is not unique in its position of being unable to deliver this standard which is a well-known national problem. As identified within the paper prepared by Professor Makin, the driver for improvement in this regard hinges on medical staffing. The Trust has confirmed that it has sought to recruit four new substantive consultant posts at the Royal Oldham Hospital site thus increasing capacity to deliver on seven day standards. The recruitment process of such posts has proceeded as quickly as practically possible.

The Trust is therefore limited in its ability to respond to your Regulation 28 Preventing Future Deaths Report as it has previously provided you with the information relevant to the steps it

is able to take to achieve daily senior clinical review. This is an issue that it identified independently and has progressed in the absence of your Report. Whilst your comments have been taken on board, decisions around the process by which the Trust addresses this concern are a matter for the Trust to consider.

The Trust acknowledges that the action as per the RCA report for 'all patients to receive a daily senior clinician review' was, with hindsight, more aspirational than realistically achievable due to circumstances outside its control, as detailed above. This has been fed back to those responsible for the action plan, for reflection when considering future actions.

By reference to the Chief Coroner's Guidance No.5 (paragraph 5):

"*…reports should be intended to improve public health, welfare and safety… They should be clear, brief, focused, meaningful and, wherever possible, designed to have practical effect."*

The use of your PFD Report has not had any meaningful practical effect on the improvement of public safety given the actions within the Trust's power to take have already been taken and communicated to you in advance of you issuing your PFD Report. Furthermore, the PFD Report's practical effect is questionable given the date for the Trust's response loosely coincides with the date originally envisaged for the implementation of improved medical staffing.

By reference to paragraph 7 (1), Schedule 5 Coroners and Justice Act 2009 you must send your report to:

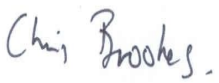
"*A person who the coroner believes may have power to take such action"*

Whilst the Trust has taken steps to address this within its locality, as previously indicated, this is a national issue and consequently any steps to address your concern as to daily senior clinical review in the absence of recruitment such as that undertaken by the Trust would more appropriately addressed to The Rt Hon Jeremy Hunt MP, Secretary of State for Health.

I hope that this response provides assurance to you and Mrs Norfolk's family that Pennine Acute Hospitals NHS Trust has worked hard and continues to focus on ensuring that lessons have been learned and improvements have been made.

Please do not hesitate to contact me if you require any further information in relation to our response.

Yours sincerely



Dr Christopher Brookes
Chief Medical Officer