Great Western Hospitals NHS
NHS Foundation Trust

Private and confidential

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Mr David Ridley
Senior Coroner for Wiltshire and Swindon
Wiltshire and Swindon Coroner's Office
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15 December 2017

Dear Mr Ridley

Re: Regulation 28 Report to prevent future deaths
Dr Jeremy Michael Holt Marshall (deceased)

Thank you for your letter of 18 October 2017 detailing recommendations for the Trust. This letter sets out the Trust's response to your report.

In your letter you have raised concerns with elements of the care provided to Dr Marshall. Although you found that these concerns did not contribute or cause the death of Dr Marshall, we acknowledge the possibility that left unaddressed, such concerns could cause problems for other patients in the future. The Trust takes all recommendations seriously. The Trust has reviewed our Root Cause Analysis investigation action plan and in light of your recommendations has updated this. I have enclosed a copy of this with this letter. I will also endeavour to set out a summary of what actions are planned to address your concerns.

The prevention of future deaths report and recommendations has been discussed at executive level at the Patient Qualify Committee. Discussions have also been had at the preventing deteriorating patient's work stream which is one of the Trust's quality initiatives.

Expectations of F1 and F2 Doctors

In your letter you expressed the view that junior doctors should be reminded that bleeping a colleague to escalate a patient is the responsibility of the individual doctor unless this task is specifically delegated. When the task is delegated the doctor should document in the care plan / patient notes to whom this has been delegated to.

The Trust has considered your view and is of the belief there is no single solution to this. The omissions most likely stemmed from human factors rather than a systemic failing. Therefore a multidisciplinary approach is being taken strengthening personal accountability including updates to a handbook, simulation training and Adult Basic Life Support training.

The next new intake of surgical junior doctors starts at the Trust on 6th December 2017. These doctors have access to an electronic handbook containing key information including standards expected in relation to delegation of duties. The handbook is a live document and will be under regular review.

The Trust also has plans to update simulation training and the Adult Basic Life Support training. Simulation training consists of interactive training sessions relating to real life clinical situations. The Trust plans to incorporate the importance of clarity of communication (including delegating responsibility for tasks) into these sessions. Simulation training sessions which have already been held, have been found to be highly effective in developing the skills of staff.

The Adult Basic Life Support is annual mandatory face to face training for clinical staff. There is a plan to review the training provided and to update this to include scenario training on what to do in an emergency situation specifically in relation to the delegation of tasks. There is a plan to also include a section on what to do in a non-emergency situation and the importance of documenting delegation details.

I would like to take this opportunity to inform you of other ways in which support is provided to the junior surgical doctors.

- The speciality induction afternoon includes lectures on general surgical emergencies, ENT emergencies, urology emergencies, critical care outreach, and simulation session for the deteriorating patient.
- Fortnightly MRCS (royal college of surgeons) training is provided, this is well attended
- Monthly Junior doctor forum where quality improvement issues and other concerns can be discussed and raised

<u>Review point and fall-back position when no further action is forthcoming</u>

In the first part of this recommendation you suggested that for the higher acuity patient when a doctor reviews the patient they need a documented plan for follow-up. As with your previous recommendation, this will be included in the junior surgical doctor handbook. Other information included in the handbook includes clinical support and mentoring, work plans including ward rounds and guidance of specific tasks, core department guidelines and training opportunities.

As you heard at the inquest into the death of Dr Marshall, the Trust has also developed new handover documentation for high risk surgical patients to ensure that patients are followed up appropriately. This includes patient name, location, diagnosis, bloods and other results and the treatment plan.

In the second part of this recommendation you suggested that we ensure our nursing teams are confident and comfortable to escalate a situation to the on call consultant if critical care outreach is not available and no action is forthcoming from doctors.

The Trust has a continuity plan in place so that if the critical care outreach team are not available the bleep is passed to the nurse in charge of ITU or the ICU doctor. This ensures that there is always staff available to provide support when required. The system has been operational 24 hours a day since January 2017 and therefore has been in place during period of winter pressure and has proved to be an effective and beneficial resource in improving patient safety. This is demonstrated by review of ITU admissions and the latest report shows that for the unplanned admissions there is an improving trend in the medical plans being documented and appropriate escalation being undertaken. In addition the number of medical emergency team calls has reduced.

The Trust enables our nursing staff to be confident and comfortable in escalating to the on call consultant when required. As a contingency plan the Trust has an escalation process where the nurse escalates to manager/nurse in charge who would then escalate to matron or, if, out of hours to the clinical site manager. One aspect of the clinical site manager's role is to ensure timely escalation to consultants or medics in charge to highlight patient safety issues. These processes form part of the iRespond package which are available on all wards.

Recording observations in a patient's NEWS is scoring 7 or more

In your letter you felt there was no guidance regarding the frequency of documenting observations. The Trust has a 'Recognition of the Deteriorating Patient' policy and this mandates the requirements for measuring and recording of observations. The policy states that for a patient with a NEWS score of 7 or more, observations should be measured continuously and each set of observations recorded. As you heard at Dr Marshall's inquest, the Trust will be implementing electronic observations in the early part of 2018. In the meantime there is a quality improvement piece of work across the Trust to improve the recording and actions of NEWS. Audit data shows that the NEWS accuracy is consistently over 90%.

In the New Year the Trust will be installing an electronic observations IT system. For this the Trust is developing clear algorithms to enable automatic escalation to the doctors, this will be on a loop so if for example the F2 doctors do not respond, this will be escalated to the registrars and will continue through the doctor ranks up to Consultant until someone responds to the escalation alert. I have enclosed the high level roll out plan, you will see we aim to have electronic observations implemented Trust wide by May 2018.

The electronic observations system will improve the recording and accuracy of NEWS scoring and will reduce the risk of patients not being reviewed when they are unwell as escalation will be automated.

In addition to the Trust's internal learning processes, our Medical Director requested that the Royal College of Surgeons complete a review of Dr Marshall's care, this is to ensure that all possible learning opportunities are explored. The Trust received the final report this week and will now review the report, consider the Royal College of Surgeons' recommendations and develop an action plan to ensure the recommendations are acted upon.

I hope that this provides you with assurance that the Trust are working to put measures into place and will continue to make improvements to try and ensure to safety of our patients.

If you require any further information please do not hesitate to contact me.

Yours sincerely

Nerissa Vaughan

Nerissa Vaughan
Chief Executive

Encs –
Updated action plan
Electronic observation high level project plan