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M E Voisin
Senior Coroner for Area of Avon

Dear Ms Voisin

Re Elizabeth Rose Curtis

Thank you for the Regulation 28 letter dated 11 January 2019 and sent to us via email with a cover letter dated 14 January 2019. I am replying on behalf of NHS Improvement. I am grateful to you for sharing your findings from the inquest with us and highlighting that action could prevent future deaths. In preparing this reply I have sought advice from the Royal College of Physicians and colleagues at NHS England to ensure we have identified all possible opportunities to do so.

We are grateful to you for putting us in touch with [redacted], who has kindly shared documents related to the mobility score she has developed. [redacted] also spent time talking to my teams about the mobility score and how they plan to use it within Royal United Hospital Bath NHS Foundation Trust. We have shared with [redacted] some issues it would be important to consider whilst locally testing the mobility score, including considering a format that does not use numbers and plus signs to reduce the risk of it being unintentionally added to the National Early Warning Score (NEWS2) and ensuring presentation helps ensure most recent mobility is not confused with required safe mobility. [redacted] will link to her local NHS Improvement Patient Safety Collaborative for their support in assessing the impact of the initiative in her trust and for their support in potential future spread to other hospitals.

The Royal College of Physicians, who lead on the National Early Warning Score (NEWS2) are very supportive of the need to assess, monitor and act on a range of other signs and symptoms and test results that indicate a patient is either not improving as fast as expected or is getting unexpectedly less well. They believe this is best done by comprehensive assessment and review tailored to patient specialities alongside NEWS2, rather adding a mobility score as an additional field on NEWS2 charts nationally; but we will keep them updated on any significant findings from the work at Royal United Hospital Bath NHS Foundation Trust.

Whilst we are not yet in position to use the local mobility score nationally, we are taking forward action to prevent future deaths related to the prescribing error that affected Mrs Curtis. Safe prescribing of haloperidol in acute hospital care can be challenging, as the doses that are appropriate for an older person with a lifelong history of a psychotic disorder differ from those appropriate to someone with delirium, and the dose that may be appropriate for using once to manage an emergency is different from a continued dose given regularly over days. This means that the standard limits within electronic Prescribing and Medication

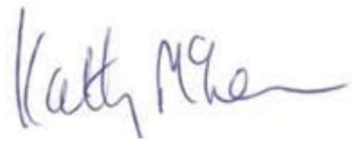
Administration (ePMA) systems* currently do not effectively block prescriptions that would be unsafe for a frail older person. However, the increasing sophistication of these systems means there is potential to do more to design out combinations of dose and duration that are outside prescribing guidelines for older people. We have asked our colleagues at NHS England and NHS Digital to work with the manufacturers of these systems and the trusts configuring them to consider building in prescribing limits that use a combination of dose and duration rather than dose in isolation, require an active decision to re-prescribe after 48 hours, and potentially restrict prescription of any repeat doses in older patients without authorisation from a senior or specialist member of staff. All hospitals within the NHS are moving towards the use of ePMA systems so this is likely to be the most effective route to ensure safer prescribing in the rare circumstances where haloperidol is needed to reduce distress from delirium.

Some of our wider initiatives will also help improve the safety of older patients with similar needs to Mrs Curtis. Our Patient Safety Collaboratives support the development and sharing of best practice in identifying deteriorating patients, and they will support further improvement activities related to medication safety for older people in the coming year. Initiatives to encourage non-medical prescribing mean that specialist nurses, after appropriate training, can directly prescribe the medication they recommend, avoiding the risk of communication error when a doctor is asked to prescribe the recommended dose. Our quality improvement incentives for reducing risk of falls in hospital include avoiding prescription of medication like haloperidol in older patients unless strictly necessary. The NHS Long Term Plan describes how we will improve the care we provide to people with dementia and delirium and frailty, whether they are in hospital or at home.

We appreciate that at the inquest you were made aware of additional local safety actions taken forward by Royal United Hospital Bath NHS Foundation Trust. Those including changes to prescribing systems, providing additional information for junior and locum doctors on the appropriate use of haloperidol, and review of consultant rotas and medical staffing levels. The regional team at NHS Improvement will continue to support the trust as it carries through these local actions.

I hope you will be able to share my reply with Mrs Curtis' family. I am very sorry indeed that these errors occurred when she became acutely ill and needed hospital admission, and I appreciate this must have been particularly distressing to her family when they had provided excellent support to enable her to live at home for so long. I hope it will give them some small comfort that we are taking steps to prevent future deaths, and I thank you for giving us the opportunity to do so.

Yours sincerely



[redacted]

Executive Medical Director and Chief Operating Officer

NHS Improvement

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* *Electronic Prescribing and Medication Administration (EPMA) refers to computer systems that guide safe and effective medication prescription and administration.*