NHS
Bedford Hospital
NHS Trust

Ms Amy Street
Assistant Coroner for Bedfordshire and Luton
The Court House
Woburn Street
Ampthill
MK45 2HX

AV/ED/HMC/evans

22 November 2019

Dear Ms Street,

Re: Inquest touching the death of Pamela EVANS

Thank you for your letter of 7 October 2019 enclosing a Regulation 28 (Prevent Future Deaths) report in relation to an inquest touching the death of Mrs Pamela EVANS on 25 July 2019.

I would like to begin by expressing my condolences to Mrs Evans' family and saying how deeply sorry I am for her passing.

As you know, the trust initiated a serious incident investigation following Mrs Evans' death, the outcome of which was shared with you; and you received live testimony at the inquest. The investigation found there was a delay in Mrs Evans being reviewed by a doctor following her fall due to other clinical emergencies happening at the same time; your regulatory notice acknowledged any earlier review or intervention would not have changed the outcome for Mrs Evans.

While the hospital's serious incident investigation and your own inquest was unable to determine whether Mrs Evans suffered an event that caused her to fall, or the subsequent bleed was caused by the fall, you concluded Mrs Evans 'had been appropriately attended by nursing staff and the fall was not preventable.'

However, during the course of the inquest you heard evidence that, while accepting the fall was not preventable nor would there have been a different outcome, you believe this gave rise of sufficient concern to issue a Regulation 28 notice highlighting five issues. I am enclosing an action plan to provide you with assurance of specific actions in mitigation of your concerns, and I would also like to provide you with some context on the issues and for the sake of clarity I will address those in order.

NEWS training and escalation

Following every inquest the chief executive and I receive an update from my representatives. Whilst our commitment and expectation is to ensure all 1363 nursing staff are trained, including temporary staff, it is disappointing that one bank nurse was not able to communicate to the court her training record and understanding of implementing NEWS2. It is additionally disappointing as I understand two of my senior nursing team provided evidence in articulating the training and teaching of NEWS2 across the trust.

The Trust takes patient safety seriously and is compliant with our duties to implement national patient safety initiatives. NEWS2 was launched in September 2018 and the trust had to report compliance by April 2019 and undertook:

- Direct clinical training with all nursing staff highlighting that escalation is based on experience and professional curiosity as well as numerical scoring
- Launched a new NEWS score sticker to be incorporated into patient notes to evidence escalation.
- Communicated through hospital cascade mechanism the use and expected compliance of NEWS2

I have asked for some actions to be taken to provide assurance to myself.

Absence of evidence that staff know the routes of escalation for deteriorating patients
I apologise if at the time of the inquest Trust representatives were not able to provide you with assurance on staff knowledge regarding the routes for escalation for deteriorating patients. The trust has undertaken substantial work over the past two years on identifying and escalating deteriorating patients. Part of which has been to:

- Provide tools and mechanisms to identify patients who are deteriorating
- Being clear on routes of escalations and that clinical experience and knowledge is used as well as numerical scoring
- Use trust-wide training opportunities across the trust such as annual clinical updates, monthly shared learning sessions, patients safety update bulletins
- Capture data on training through regular ward quality huddles; daily safety huddles; regular audits of compliance
- Capture data of associated tools of measurement such as the use of treatment escalation plans (TEP) and regular clinical audits

I have asked for some actions to be taken to provide assurance to myself.

Critical care outreach team initial response
I understand from my representatives they sought to give clarity regarding the clinical experience and ability of the critical care outreach team. I am sorry if this was not clear.

The critical care outreach team is a multidisciplinary team utilising highly qualified staff, predominately nurses, who have undergone at least three years training in critical care, deteriorating patients, multi-organ failure and treatment plans. These nurses are integral to a first line response for escalation and have the skills and authority to develop treatment plans for patients, asking ward staff to closely monitor and continue to escalate for further advice. They have access to the twenty-four hour critical care medical team. In addition, all patients reviewed by the outreach team will be reviewed Monday to Friday by a designated critical care consultant.

It would be wrong to suggest the critical care outreach team response must be by a doctor in order to safeguard patient welfare. The disciplines and patient-review process of the critical care outreach team at Bedford hospital is in line with national standards for the provision of outreach services.

I am aware you highlighted a situation where a CT for a patient was needed and the critical care outreach nurse would not be able to do that. To be clear, nurses do not request scans such as CT, and any request would be escalated to an appropriate doctor. I am not aware of any patient that has been adversely affected by the critical care outreach nurses attending a patient rather than a doctor.

Calculating consciousness in NEWS2

I understand during the live evidence you heard that the NEWS2 algorithm now includes the status of 'new confusion' as an additional scoring metric and that while the notes recorded Mrs Evans had a degree of confusion , this was omitted on the scoring sheet leading to an inaccurate calculation.

This was wrong and I have asked my director of nursing to ensure all nurses are reminded of their duty to assess, score and record properly a patients overall observations . However, while you have rightly drawn to my attention the mis-scoring, the absence of the confusion score had no effect on Mrs Evans as her overall deterioration was recognised and escalated to the medical team in a timely manner.

Hospital SI report did not acknowledge or highlight these issues

Thank you for drawing my attention to these issues. As you know a serious incident report is to ensure gaps in care, root causes and learning are identified order to protect future patients and improve our practice.

The serious incident investigation reviewed in detail the actions, decision making, escalation and factors that contributed or impacted on Mrs Evans fall and subsequent deterioration.

However, for clarity, the serious investigation did consider elements of actions and decision making that may have impacted on Mrs Evans and which led to a number of recommendations in the report including:

- Ensuring assessments and patient observations are carried out
- Review of the post falls protocols and level of escalation
- Shared learning and reminder on contacting the critical care outreach team
- Using multi-channel communications to share learning from this investigation

I do not believe the investigation fell short of what it intended.

I hope you have found my points of clarity constructive and please find enclosed the trust's action plan in relation to your regulatory notice; some of which specifically refer to ongoing actions such as continual audits and training. I remain satisfied that immediate actions and learning have been completed. In addition to the recommendations from our internal investigation we have listened to the evidence from the inquest, the family's concerns, and your recommendations and I am confident this action plan does support ongoing care for deteriorating patients.

For your information to ensure ongoing patient safety learning the trust is holding monthly lunchtime learning sessions, open to all clinicians, where we present learning from serious incidents and I have asked Mrs Evans case and your concerns are highlighted at a forthcoming session. These sessions will be led by my medical director and I have asked him to ensure ongoing learning and compliance extending from this investigation and inquest.

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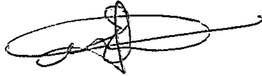
While, patient safety is a key priority for Bedford hospital and I know it to be a safe, compassionate and caring hospital with staff committed to ensuing patients are well cared for, we can always learn and I appreciate your feedback.

Please do not hesitate to contact me should you need any further information.

Yours sincerely,



Eileen Doyle
Deputy Chief Executive

CC Ms Emma Whitting – Senior Coroner for Bedfordshire and Luton