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Ms Selena Lynch
Senior Coroner – London South
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BR1 3UH

29 January 2016

Dear Ms Lynch

Regulation 29 Response further to the Regulation 28 Report to Prevent Future Deaths in respect of the Inquest touching the death of Mrs Madhumita Mandal

We are providing this letter in response to the Coroner's Regulation 28 report dated 8 December 2015.

By way of background, Virgin Care Wandle LLP (Virgin Care) was commissioned to provide the healthcare services within the Urgent Care Centre (UCC) based within Croydon University Hospital (CUH) Accident and Emergency Department in March 2012 by Croydon Primary Care Trust (succeeded on 1 April 2013 by the Clinical Commissioning Group) (the CCG).

We now address the specific concerns which the Coroner has required Virgin Care's response to in respect of her Regulation 28 report. We note that there are three issues that the Coroner has identified as a matter of concern. We have listed the Coroner's concerns and have responded to each of these as follows:

1. ***Mrs Mandal was taken to Croydon University Hospital by her husband. Virgin Care was contracted by the Croydon Clinical Commissioning Group to provide urgent care services, and to stream adult patients arriving at the emergency department. A streaming model was followed by a receptionist who had no medical training and who performed no medical observations. This led to a delay of about an hour before Mrs Mandal was seen by any qualified healthcare professional, by which time her condition was critical.***

   From April 2012 until November 2015, when a patient presented at the joint reception in the A&E department at CUH, in line with the contractual service specification from our healthcare commissioners, the receptionist completed a record with administrative details and, using the condition specific criteria, *streamed* the patient to await assessment at either the UCC or the Emergency Department (ED) which is operated by CUH staff (see **Appendix 1** – Adult Streaming Operational Policy and **Appendix 2** - Streaming Index). Adult patients streamed to the UCC waited in the joint reception area to be seen by an UCC clinician (employed or contracted by Virgin Care). Adult patients streamed to the ED waited in the joint reception area to be seen by the ED triage nurse (employed by CUH) on duty. Once an ED patient had been triaged, they could either be asked to move to ED or return to the joint reception area. In addition, both UCC and ED staff were jointly responsible for surveillance of the waiting room to identify potentially deteriorating patients.

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Receptionists were instructed to speak to a clinician if they were unsure about a patient's condition or if they had any concerns about a patient. Receptionists were trained to carry out the streaming process and a record of this is attached at **Appendix 3** (One to One Training), which has been redacted appropriately to maintain confidentiality. The receptionist who booked in Mrs Mandal had received such training in October 2012.

In September 2013, (after Mrs Mandal's death) the Vitalpac Early Warning Score (ViEWS) protocol was implemented as part of ongoing improvements discussed and agreed with our commissioner. After a patient has been streamed to the UCC, a Healthcare Assistant undertakes the ViEWS assessment within 20 minutes of arrival and this includes taking full observations. We attach the 'ViEWS Algorithm' at **Appendix 4**. Based on a number of physiological parameters the healthcare assistant inputs the observations into the clinical system and an automatic score is generated. This system aims to provide a clinically objective score and is an additional tool to determine the acuity of a patient's presentation to help ensure the patient is seen by the most appropriate clinician as soon as possible.

From November 2015, interim changes have taken place to the way patients are directed to the UCC or ED while the redevelopment of UCC and ED is underway. This means that the ED is now providing 'clinical streaming' i.e. one nurse viewing all patients as they enter the department to determine presenting condition. This is not a triage system. This decision was made by the CCG, CUH and Virgin Care as the two departments are no longer co-located. Virgin Care is working closely with both the CCG and CUH to ensure patient safety is maintained during the redevelopment. It is anticipated that the redevelopment will last until March 2017 at the earliest. As a committed provider of safe care for our patients, we will continue to liaise and work closely with our commissioners and CUH in relation to the UCC and ED and any improvements that can be made to the services commissioned by our commissioners. We confirm that representatives from the UCC and the ED meet regularly for joint governance meetings where clinical issues and incidents are raised and discussed.

The Coroner has stated that there was *"a delay of about an hour before Mrs Mandal was seen by any qualified healthcare professional, by which time her condition **was critical**"*. We note that during the Inquest hearing, this was not confirmed by any of the witnesses on the day including the expert, Dr Soni. He stated that *"At 8.20 she is in extremis and has got a prominent problem, the nature of which was uncertain at that point in time, so I think it is likely she was already in extremis at 7.20"*. Dr Soni also went on to say *"the probabilities say that it is more likely that she would have died despite the best efforts"*. We are therefore concerned that a conclusion has been drawn by the Coroner that as a result of the actions by the receptionist, Mrs Mandal's condition was rendered or became critical, despite the lack of evidence at the inquest on that point. We respectfully invite the Coroner to re-consider this statement.

2. ***The streaming model had been approved and commissioned in the contract as recommended by an NHS body called the Emergency Care Intensive Support Team. The system at Croydon has changed since Mrs Mandal's death but concerns remain about the level of qualification for assessment of patients, and there may be lessons for other Trusts who contract out the provision of urgent care.***

As the learned Coroner has correctly identified, the "streaming model" followed by Virgin Care has been approved and commissioned in our contract by the CCG as recommended by the

Emergency Care Intensive Support Team (ECIST), an NHS body, affiliated with NHS Interim Management And Support.

When the services commenced in April 2012, the UCC was required, under the contract and conditions of the commission, to assess patients using a process based on the Manchester Triage System (MTS). Due to the nature of patient flows within the services, the MTS process resulted in delays in treatment for both the UCC and the CUH ED. Delays were resulting in four hour breaches in the ED and prolonged waits in patients being seen by a clinician in both services, which was an agreed significant patient safety cause for concern by both services. At busy times clinical staff were taken from treatment duties to assist with the MTS. This meant there were fewer clinicians treating people which in turn added to delays. The UCC had already identified triage as a bottleneck and had strengthened the process by replacing nurses with General Practitioners (GP) to carry out the MTS.

The Emergency Care Intensive Support Team (ECIST) was invited by Virgin Care to review the processes between the UCC and CUH. We attach at **Appendix 5** a letter dated 15 August 2012 to Jacqui Smart, previous Head of Operations at the UCC, from ECIST, which outlined their recommendations and reasoning ('ECIST Report').

The ECIST recommendations challenged the concept that triage provided a clinical safety net for patients with serious injuries or illnesses. ECIST stated that non-clinical reception staff could be trained to "identify red flag conditions" and have those patients seen by a clinician immediately. They also pointed out that the delays caused by triage were "inherently dangerous". Our understanding is that long delays for triage had occurred in the ED in the past.

Virgin Care adopted most of the recommendations of the ECIST review after consultation with CUH and the PCT (now the CCG). 'Streaming and See and Treat' was commissioned and introduced on 9 October 2012 in order to replace the MTS triage. The process specified non-clinical receptionists streaming adult patients to the UCC or ED in accordance with strict criteria.

The development of the streaming model involved senior staff and clinicians from Virgin Care, CUH ED (including Dr Kathryn Channing, Clinical Lead) and the PCT. We attach at **Appendix 6** a copy of the 'Emergency Recovery Board Meeting Minutes' of 4 October 2012 which confirm that both clinical teams were "very happy" with the proposed model of care which they had "worked up together" at the request and with the involvement of the commissioner.

The condition specific criteria for streaming decisions (the 'Adult Streaming Operational Policy' and the 'Streaming index' as attached at Appendix 1 and 2) were all **jointly agreed** by Lorraine Walton, ED Operations Manager at CUH and Caroline Bampton, Service Manager at Virgin Care and their teams. These processes and policies were jointly signed by CUH and Virgin Care.

Receptionists were trained to carry out the streaming process and a record of this is attached at Appendix 3 (One to One Training). Receptionists were instructed to speak to a clinician if they were unsure about a patient's condition or if they had any concerns about a patient. The receptionist who booked in Mrs Mandal had received such training.

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3. ***Mrs Mandal's death also raises questions about the use of ambulance services. A difference in assessment of patients based upon their mode of transport to the emergency department may encourage patients to err on the side of calling an ambulance.***

   There is a process for patients brought to CUH via ambulance services to be seen and treated within the UCC similar to those walking into the UCC. Patients are not assessed differently based upon their mode of arrival, except in the case of blue light ambulances where this group of patients would be seen immediately by an ED clinician due to the serious nature of the clinical condition.

We trust the information we have provided is of assistance to the learned Coroner when making her recommendations and the Coroner is satisfied that relevant actions have been taken and no further actions are necessary.

Yours sincerely

Sangita Bodalia
Legal Counsel
For and on behalf of Virgin Care Wandle LLP

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- Appendix 1 – Adult Streaming Operational Policy
- Appendix 2 - Streaming index
- Appendix 3 - One to One Training
- Appendix 4 - ViEWS Algorithm
- Appendix 5 - ECIST Report
- Appendix 6 - Emergency Recovery Board Meeting Minutes