NHS
University Hospitals of North Midlands
NHS Trust

[redacted]

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ST4 6QG

[redacted]

23 June 2021

Mrs M Jones
H M Assistant Coroner
547 Hartshill Road
Stoke on Trent
ST4 6HF

Dear Mrs Jones

Co-joined Inquests touching the deaths of Peter Hussey and Stephen Oakes

Further to your letters dated 19 April 2021, I am pleased to provide the following response to address the concerns that you raised at the co-joined inquests touching the deaths of Stephen Oakes and Peter Hussey.

You raised a number of matters of concern to be addressed by several organisations and we have taken the opportunity to address matters directly relating to the University Hospitals of North Midlands NHS Trust, which were highlighted by you as follows:

1. The Hospital Trust did not fully evaluate the size 14FR tube prior to replacing all previous drainage tubes (Ryles) with the carefeed 14Fr feeding and drainage tube. Feedback was generally difficult to obtain.

2. Nursing staff did not consider alternative action when the NG tubes were not adequately draining. There was no general recognition of the need to aspirate the tube.

3. There is no compulsory training of clinicians required to undertake root cause analysis.

Action Taken
During the course of the inquest, you were appraised of improvements that had already taken place across the Trust, however, in addition we are pleased to advise of the following significant improvements.

1. *The Hospital Trust did not fully evaluate the size 14Fr tube prior to replacing all previous drainage tubes (Ryles) with Carefeed 14Fr feeding and drainage tube. Feedback was generally difficult to obtain*

   Matters relating to the inquest touching upon the deaths of Mr Hussey and Mr Oakes were discussed at the Medical Device Strategy Committee (MDSC) and as a consequence, a new proforma for evaluating equipment has been designed and will be used to collect feedback from users during the initial trial period. As indicated at the inquest, the recently appointed Specialist Nurse will assist in gathering this data.

We are also looking at trialling new equipment (where appropriate) in the Trust Extended Reality Laboratory (ERL); this is a simulation facility and will assist in identifying any gross issues before implementing trial periods in the clinical areas.

2. *Nursing staff did not consider alternative action when the NG tubes were not adequately draining. There was no general recognition of the need to aspirate the tube.*

   The Trust Nasogastric Working Group, chaired by the Lead Nurse for Quality and Safety, have overseen a focused piece of work to review and update the Local Safety Standards for Invasive Procedure (LocSSIP) – Insertion of Nasogastric / Orogastric Tubes, to include 'troubleshooting' guidance regarding aspiration of Nasogastric/Orogastric tubes inserted for the purpose of drainage. Troubleshooting guidance will also be provided in both nursing and medical clinical guidelines.

   The Trust e-learning training package for the insertion and on-going management of Nasogastris/Orogastric tubes has also been updated to include 'troubleshooting' guidance on aspiration of Nasogastric/Orogastric tubes and includes the development of a competency and self-assessment document; this will ensure that all registrants involved in the management of Nasogastric/Orogastric tubes are competent to do so.

3. *There is no compulsory training of clinicians required to undertake root cause analysis.*

   The Trust continue to provide RCA training for clinicians across the organisation. Whilst training was available prior to the inquest touching the deaths of Mr Hussey and Mr Oakes, we aim to increase the number of staff who are trained in the basic principles and tools for RCA investigations. All names of staff who have undergone RCA training will be entered onto a staff database and future Investigating Officers will be selected from this list.

I have also enclosed a copy of the action plan that has been developed following the inquest and I do hope that it demonstrates our intention to improve the services provided at the Trust.

I sincerely hope that the above information provides you with assurance that the University Hospitals of North Midlands NHS Trust has taken the matters arising from the inquest touching upon the deaths of Mr Hussey and Mr Oakes seriously. The Trust strives to provide a high standard of care to all patients and I am grateful to you for raising these concerns on this occasion.

Should you wish to discuss any aspect of this report further, please do not hesitate to contact me.

Yours sincerely

[redacted]

CHIEF EXECUTIVE

Enclosure: Action Plan