Integrated Governance Unit
Silver Springs
Tameside and Glossop Integrated Care NHSFT
Ashton Under Lyne
OL6 9RW

Tameside and Glossop Integrated Care NHSFT
Fountain Street
Ashton Under Lyne
Tameside
OL6 9RW

27th September 2022

Private and confidential
To be opened by the addressee only
HM Coroner, Miss A Mutch
Via Email

Dear Miss Mutch

I am writing further to the inquest touching upon the death of Earnest Bacon (who died on 17th January 2022) which concluded on 26th July 2022 and the subsequent Regulation 28 Notice issued to the Trust. I hope to be able to build upon the issued raises within your report, and set out below my response. I have outlined these in order of the concerns raised.

In response to the concerns raised, the Trust instigated an immediate strategy meeting with all the Divisional Directors to collaborate, assess and understand the actions required to address the issues raised.

Concern 1:-
The inquest heard evidence that there staffing numbers of doctors and a reliance on junior doctors to cover wards at the weekend was part of the national staffing model.

On Sunday night 16th / 17th January 2022, the night when Mr. Bacon's condition sadly deteriorated, the level of junior doctor cover for the medical wards overnight exceeded that set out in national guidance by the Royal College of Physicians (2018). The actual number of doctors on call at that time were three Tier 1 doctors and one Tier 2 doctor covering non-covid medical beds. At the time that Mr. Bacon died the Trust were experiencing a significant increase in clinical activity as they were responding to the Omicron Covid wave.

Medical staffing is continuously monitored and is reported to the Trust wide bed meeting, which occurs 6 times per day, this includes weekends. Any known shortfalls in the rota are known, and proactive action is taken on these to provide cover.

Whilst the Trust does acknowledge that the junior doctor rota meets national guidance it does need to be strengthened further to support increased activity and acuity in the ward areas. The Trust is currently progressing a business case to increase the level of junior doctor provision which also aims to reduce reliance on locum and agency doctors.

disability confident EMPLOYER
Everyone Matters

Concern 2: -
As a result of the availability of the doctors Mr Bacon was not reviewed face to face but via a telephone call. His notes were not viewed and the seriousness of his condition was not recognised.

Please may I refer this point to the narrative which we have provided for concern 3, where I have described the improvement work and on-going actions to support the recognition of sepsis across the Trust.

Concern 3:-
The Trust policy required that Mr Bacon be treated for Sepsis, but he was not placed on the Sepsis pathway and a further reviewed did not take place until another doctor was asked to review him, despite his NEWS score continuing to trigger for sepsis.

Immediately following the inquest touching the death of Mr. Bacon the Trust completed a retrospective root cause analysis investigation into the clinical care of Mr Bacon, and in particular the response to his raised National Early Warning Score (NEWS) and recognition of sepsis. This was also retrospectively reported on the Trust's incident reporting electronic system. A number of learning points were identified as a result of the investigation and the findings have been used to support a Trust wide sepsis improvement plan.

The sepsis improvement project is being led by the Head of Nursing for Professional Standards and Assurance and the Trust Medical Lead for Patient Safety. The improvement plan builds on previous actions taken by the Trust to support the early detection and application of the Sepsis 6 care bundle. The comprehensive plan includes a number of workstreams which will support improvement on:

- Recognition of sepsis
- Application of the Sepsis Care Bundle
- Prescribing of antibiotics
- Blood Cultures
- Medical assessment of deteriorating patients.

The Trust has had a Trust wide a focus on World Sepsis Day which was held on the 13th September 2022. The Trust's Safer Care team have held a focus on sepsis week which took place over the week of 12th -18th September 2022. The objective of the week was to raise the profile of sepsis throughout the organisation and to reiterate recognition and management of suspected sepsis. During the week results of the sepsis audit and a detailed action plan on the sepsis improvement work was shared at the Trust's Grand Round and the Managing Deteriorating Patient Group. In addition to this, 7-minute briefings on recent sepsis incidents have been developed and are being shared across the Trust. The Safer Care team have also created sepsis related scenarios to engage teams in identifying red flags for sepsis and encourage adherence to the use of sepsis care bundles.

Throughout September the Safer Care team has been visiting the wards and community bases to carry out interactive tool box talks. Information regarding the use of the sepsis care bundles and the use of the sepsis trolley (for inpatient clinical areas) has also been shared with clinical teams. Clinical teams have been participating in sepsis scenario sessions, which supports the identification of red flags for sepsis.

disability confident EMPLOYER
Everyone Matters

The key messages for the Trust wide project are:

- 'Think could this be sepsis'
- Identification of sepsis
- Implementation of sepsis care bundle
- The sepsis six

To provide internal assurance spot check audits have been implemented to specifically look at compliance with the sepsis pathway. The audits have commenced and include a review of 10 patients each month. Where compliance with the pathway has not been present, an incident form will be completed contemporaneously.

The sepsis improvement work has also been reported to the Trust's Quality and Governance Committee, which is chaired by a Non-Executive Director. As a direct action following this meeting additional nursing posts were agreed which will specifically support clinical teams in sepsis identification, training and compliance across the organisation.

Concern 4:-
The nursing team recognised that Mr Bacon was triggering for sepsis but the notes were not flagged and the failure to follow the Sepsis policy was not escalated in accordance with Trust Policy. The reason for non-escalation was unclear.

As explained in the narrative answering point 3, a retrospective investigation was completed following Mr. Bacon's inquest. The investigation report identified that whilst the nurse who conducted the set of clinical observations at 19:50 hours on 16th January 2022 recognised and acted upon his raised early warning score (which was scoring 7), by inserting a cannula and performed blood tests, they did not recognise that Mr. Bacon was displaying two red flags for sepsis. As the nurse had not recognised the fact that Mr. Bacon had sepsis, then the sepsis care bundle was not initiated. Had the red flags been recognised, the sepsis care bundle could have been implemented at an earlier point, it is also likely that this information would also had been relayed to the on call doctor, which may have led to a timelier response. It is hoped that the Trust wide improvement plan and actions that the Trust have taken so far would reduce the risk of this occurring again.

Along with the sepsis improvement project, the Trust has also been reviewing the NEWS scoring system and how this is recorded. The NEWS score is a well established physiological scoring tool which was introduced at the Trust many years ago. The NEWS tool has an established training package in place for clinical staff and compliance with the tool is part of the regular Trust audit program. Compliance with the tool is monitored via the Deteriorating Patient group which reports directly into the Executive Lead Service Quality Assurance Group.

When clinical observations are performed as part of NEWS the staff in the Trust are required to manually calculate and record the score. The Trust acknowledge that manual calculation and recording can be open to human error, therefore significant work has been undertaken to improve this and I can confirm that the Trust is currently at the Pre-Market Stage of procuring a new Electronic Patient Record (EPR) to replace Dedalus Lorenzo in March 2025.

disability confident EMPLOYER
Everyone Matters

Whilst the new EPR may provide a long term electronic NEWS solution in 2025, in the interim the plan is to deliver an inhouse electronic solution. The Trust has an embedded electronic NEWS application currently in use across our Emergency Department (eNEWS). The agreed proposal is a pilot of the eNEWS application across our surgical wards with a view to improving the accuracy and speed of data recording, and to eliminate errors in early score warning calculation. We are aiming to commence the pilot prior to December 2022.

At the time of Mr Bacon's death, the delay in recognising and treating his sepsis was not reported on the Trust's electronic reporting system. As a result of your concerns outlined above in relation to incidents, the Trust's incident trigger lists have been circulated widely throughout the organisation with a reiteration of the importance of incident reporting.

In addition to this, there has been a Trust wide focus on incident reporting throughout the month of September 2022. This work has been underway across the organisation and is being led by the Assistant Director of Integrated Governance throughout, culminating in the Trust's Patient Safety Conference on October 6th 2022. This programme of events and activities seeks to engage staff at all levels and focusses on identification of incidents or near misses, incident reporting, acting on and learning from incidents.

I hope you will feel that the Trust has taken appropriate action as a result of your findings, however should you wish to discuss any aspect of this or seek further assurance please do not hesitate to contact me through the Legal Services Team

Executive Director of Nursing and Integrated Governance

Acting on and behalf of , Chief Executive Officer

disability confident EMPLOYER

Everyone Matters