George Eliot Hospital
NHS Trust

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6 March 2023

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PRIVATE & CONFIDENTIAL

Ms L Lee
Assistant Coroner for the Area of Warwickshire
Coroner's Office
Warwickshire Justice Centre
Newbold Terrace
Leamington Spa
CV32 4EL

Dear Ms Lee

RE: Regulation 28 Report - MRS CAROL ANN WELCH. DoB: 20/03/1975 DoD: 01/05/2022

Thank you for your Regulation 28 report dated 11th January 2023 relating to the inquest of Mrs Carol Ann Welch. I was sorry to read of you outstanding concerns at the conclusion of the inquest and hope the following information will provide you with further reassurance.

Following receipt of your report, the Trust convened a working group to review the concerns raised within your report and to reappraise the findings in the Root Cause Analysis (RCA) presented during the coroner's investigation. For ease we have taken the liberty of providing an overview under relevant themes.

Training and Assessment of Doctors Who Qualify Abroad (ref points:2 & 5 of Regulation 28 report)

Doctors who practice medicine in the United Kingdom (UK) need to hold a licence to practice along with a suitable type of registration for the work that they will be doing. A licence to practice is provided by the General Medical Council (GMC) which allows them to carry out certain activities such as prescribing medicines and treating patients.

The GMC is an independent body with responsibility for regulating doctors in the UK and its legal purpose is to protect, promote and maintain the health and safety of the public by making sure doctors meet the stringent standards for good medical practice.

Your concern was that the middle grade doctor in this case had trained overseas, and it was not clear to you how his familiarity with Royal College Guidance had been assessed.

When the Trust receives an application from a doctor our People and Recruitment Department will check the official GMC registration to ensure the doctor is appropriately registered and holds the relevant qualifications and license to practice in the UK. The doctor in Mrs Welch's case was registered with the GMC in April 2020. In addition, this doctor became a member of the Royal College of Emergency Medicine before they started working at this Trust in September 2020. Accordingly, the doctor will have been assessed as competent by the Royal College as part of their registration and accreditation process in exactly the same way a UK trained doctor would be assessed. This accreditation includes an assessment of familiarity with relevant Royal College guidance.

In short, the requirements for Royal College accreditation for overseas qualified doctors are identical to, and as robust as, those required of UK qualified doctors.

Each junior and middle grade doctor within the Trust has an assigned Clinical Supervisor who is appropriately trained and responsible for overseeing the junior/middle grade doctors' clinical work. The Clinical Supervisors at the Trust are always at a consultant level. The Clinical Supervisors have monthly meetings where they discuss each doctor to review their clinical work, ascertain how well they are doing and whether they require additional support or training in certain fields. In addition, all junior and middle grade doctors also have appraisals undertaken by a trained Appraiser on an annual basis where their performance including training is monitored to ensure they are compliant.

Shared Learning (ref points: 3, 4, 7 & 8 of Regulation 28 report)

There are robust processes in place across the Trust including the Urgent and Emergency Care (UEC) Directorate to ensure staff awareness, participation, and dissemination of learning is completed to support the safe delivery of care for our patients.

It is important to highlight that when an incident is reported the senior leaders within the directorate are given oversight and supportive conversations take place with key staff involved in the care to understand their part and to obtain their views on making sustainable improvements. This may entail, but is not exhaustive, of personal reflection, self-directed learning or creation or amendment to process or policy as an immediate action to learn from the events; this was the case regarding Mrs Welch.

Any incident classified as having resulted in moderate or above harm is presented at the Trust's Review of Harm Meeting which occurs on a weekly basis. The incident is also presented in detail at the preceding month's directorate governance meeting, chaired by the clinical director and attended by all levels of medical and nursing staff and discussion ensues with attendees about the detail known of the events at that time.

There are further opportunities for staff to contribute to collaborative and human factors driven conversations within our tabletop review exercises to determine how the incident occurred and what system driven actions need to be made to mitigate further reoccurrence. This is followed by the opportunity for key staff to support with the content of the written report and any actions created. There is always senior medical and directorate leadership support oversight and approval of the written reports.

Once a thorough review has taken place and the exact learning identified, the UEC Directorate has a plethora of means to ensure staff are aware of the learning. The incident is discussed again and the report shared at the directorate governance meeting to ensure the outcomes from the review are discussed and to offer debate and prompt further opportunities for sustainable improvements. This is complimented by further meetings amongst our different work groups within the department (medical, nursing and administration) and these meetings are another chance to cascade learning and reach a wider forum. There are daily departmental safety huddles and medical and nursing handovers that allow for incidents, patient feedback and learning to be discussed and shared in a more practical forum.

The directorate also considers other ways individuals may digest information and to attract interest in learning they have a department messaging group, a monthly electronic newsletter and a highly visible display area deliberately placed outside the staff room to ensure maximum attention is captured from poster or other visual aids. The content of the posters cover not just feedback from specific cases but also include information on the most common themes of incidents, complaints and risks to support staff learning.

The directorate has a robust governance process in place to ensure that actions are monitored and completed. This happens through oversight and support within the directorate incident management group which links into our governance and management meetings and the Trust's Operational Quality and Safety Group and Finance and Performance Executive meetings.

Unfortunately, it is not possible for all members of the UEC Directorate to attend meetings where learning from incidents are shared due to the clinical demands of the department. However, minutes and learning are shared via email and through using the aforementioned methods so that all members of the team are informed even when they are unable to attend the meetings due to annual leave or other commitments.

It is recognised that if an individual wishes to access reports or written material on learning in their own time that at the time of this incident these documents were kept within a restricted folder on our Trust server. To ensure that meeting reports are accessible to all staff for the purpose of learning the directorate is exploring a shared drive on its server and a shared area on its staff intranet platform, so these are easily accessible as the documents do not hold any patient identifiable details.

In Mrs Welch's case, to support staff awareness of the incident a poster was created providing a summary, the findings and learning identified. The poster was displayed in a visible location within the Emergency Department (ED) and was shared within the department messaging platform which is accessed by staff of all professions. To ensure wider dissemination the case was discussed at the consultant meeting and medical handover as well as the governance meeting in June 2022, after the incident was reported and again in August 2022, once the investigation had been completed. The case was also shared at the Trust's Serious Incident Group on 1 September 2022.

The aid memoire provided to the court was an example of key learning that was shared as part of a comprehensive induction and following learning from Mrs Welch's case. The aid memoire captured essential information and was not in order of priority. In consideration of your comments regarding the aid memoire, this has been reviewed and revised to ensure all clinically essential information is at the top.

Guidelines (ref points: 6 & 8 of Regulation 28 report)

There are hundreds of guidelines available to doctors working in UEC and as part of their induction they are informed how and where they can access the guidelines through the Trust intranet. It is recognised that the UEC directorate cover several specialties and each speciality

have Royal College Guidelines and NICE Guidelines applicable. Hyperlinks to both of these websites are easily accessible on the department's bespoke intranet page. The Trust has proactively considered asking every clinician to sign to confirm that they have read each guideline but at this time believe that due to the high volume of applicable guidelines it would be impractical to achieve and worse still it could turn into a tick box exercise.

The Trust has, however, noted that the middle grade doctor in question did not follow the appropriate guidance of referring to a consultant if a patient returns to the department within 72 hours with the same clinical condition. The Trust is currently working with its Information Technology Department to add an alert to the Clinical Portal used by UEC to flag/highlight if the patient reattends within 72 hours and mandate that the doctor should seek advice from a consultant prior to discharging the patient from the department. We believe this additional safety measure would prevent future harm in this group of patients who are at higher risk.

UEC are in the process of conducting an audit to review patients that have reattended within 72 hours to see whether they were referred to a consultant prior to discharge. The outcome of this review will be shared within UEC and will also be presented at the Trust Wide Audit Day.

I hope this information demonstrates that we have thoroughly reviewed existing processes and have implemented additional measures to prevent future harm.

If I can be of further assistance, please do not hesitate to contact me.

Yours sincerely

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Chief Executive Officer