NHS
Wye Valley
NHS Trust

Trust Head Quarters
County Hospital
Union Walk
Hereford
HR1 2ER

[redacted] [redacted]

13th June 2023

Dear Mr Bricknell,

Please consider this letter a formal response to the prevention of future deaths report received by Wye Valley NHS Trust on the 18th April 2023 concerning the inquest into the death of Mr Keith Hodson. The Trust would like to offer the family of Mr Hodson our sincerest condolences.

As an organisation we have considered the concerns detailed in the Regulation 28 report with the utmost seriousness. This is an opportunity to learn and improve the service for the people of Herefordshire and the surrounding areas. The concerns have been investigated fully and hopefully will provide reassurance of the improvements made.

I will address the issues you have raised in turn:

1) **Concern that an appropriate triage system is not always used in the Emergency Department**.

Initial assessment of patients attending the Emergency Department (ED) is considered critical by the Trust.

The ED at Wye Valley Trust (WVT) utilises clinical streaming, as recommended by NHS England and the Royal College of Emergency Medicine for patients attending the department. This consists of a rapid assessment by a senior clinician within 15 minutes of the patient presenting and has two objectives. Firstly, to identify patients who are unwell and require immediate clinical input (similar to that of traditional triage). Secondly, to commence an appropriate plan and determine the best location for ongoing specialty care when required. This secondary objective reduces the time taken to provide urgent care to those critically unwell and is an improvement on the traditional triage model. At times of very high demand, however this aim cannot always be met and therefore as a clinically acceptable backstop the nurse based, Manchester Triage system is used. This is a nationally recognised tool that is built into our departmental electronic patient record and is used to safely manage patient flow. A record of the triage status of all patients in the department is recorded, and visible, on the department electronic tracking system. As a second safety measure, the Band 6 nurse in charge routinely checks the triage status of patients in the department and diverts clinical resource to those patients who have not yet been triaged.

In relation to this specific incident involving Mr Hodson, an ED trained; agency nurse was employed for this shift and attended to Mr Hodson. Because of Mr Hodson's potential infectious

illness, he was taken directly to a cubicle for assessment. A full National Early Warning Score (NEWS) assessment was undertaken but unfortunately triage did not take place for reasons we cannot establish. In addition, the Band 6 triage check on the electronic tracking system was also not undertaken leading to Mr Hodson not undergoing full triage and for which we are sorry.

We would like to provide you with a full written triage and escalation policy (which are currently being reviewed in any case as part of our normal processes) by Friday 14th July 2023 if you would find that acceptable.

2) Without an effective triage system, escalation of care cannot meaningfully take place.

We hope that the answer to (1) addresses this point.

3) **On occasion appropriate senior oversight does not occur, this is required to identify when a patient has not been appropriately assessed**.

We have addressed this in (1) above but please find below a more detailed explanation.

The Trust has a departmental electronic patient record, which is a visual tool that can be reviewed by senior staff both on site and remotely. This highlights the patients NEWS (National Early Warning Score), triage, streaming status amongst other information and can be seen by all staff with access to the tool. During the day there is consultant cover in the ED from 08:00 until 19:00. After the hours of 19:00, there is an on-call function and there are clear instructions for staff to follow if they require the on-call consultant. Band 7 senior sisters/charge nurses provide ED support from the hours of 08:00 until 20:30. Overnight the department is overseen by a Band 6 Nurse in Charge and middle grade doctor cover. Since this case, the senior doctor rota has been amended leading to an increase in substantive staff on duty. Specialty doctors have received enhanced training on departmental oversight and leadership and this is repeated in their rolling training programme. Furthermore, we have increased the establishment of Band 6 nurses who are employed substantively to provide more consistent senior leadership and support to the department.

4) SI reports are not signed off in a timely fashion by a responsible individual

The Trust takes the investigation and production of serious incident reports very seriously. The length of time the investigation takes depends on multiple factors such as complexity, the number of clinicians involved and whether an independent opinion is required. The Trust endeavours to have all reports completed in a timely fashion and apologise if this is not always the case. SI reports have a designated investigating officer who is responsible for collating information, collecting statements or speaking with staff and writing the report. This involves collating the learning points to avoid similar incidents in the future. This report is then sent for divisional sign off by the divisional leads. Once the division approve the report this is then sent for executive sign off. This is signed off by either the chief medical officer, deputy chief medical officer or the chief nursing officer. Once the report is signed off, it is then sent to the ICB for their review and final sign off. SI reports are reportable externally to the ICB and only once the ICB have signed off the report is it considered complete and closed.

The Trust would like to stress that the SI process is designed around learning lessons from unfortunate events and not apportioning blame. This extends to the sign off process, the ownership of which is held jointly by the Trust and the ICS and no one individual.

With the implementation of the national patient safety strategy, the SI process will change significantly and we will be engaging with you to discuss these changes during the next month.

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5) Communication with the next of kin appears not to have happened in a timely fashion

Duty of candour is a priority and is highlighted to staff whenever an incident is raised. Upon the commencement of an SI investigation family should be informed and thus duty of candour completed. In this case the investigation was initially commenced by a consultant in ED, he did not find any failings in the medical care and handed the review over to the nursing team. During this stage of the review, the Band 7 Nurse found failings in the nursing care. This nurse erroneously believed duty of candour had previously been exercised. This miscommunication should not have happened and we apologise for the delay in speaking with the family.

We trust this response satisfactorily addresses the concerns raised in your letter, please do not hesitate to get in touch if further clarity on any point is required.

We will submit the triage and escalation policy by 14 July 2023 and ensure the meeting relating to the changes to the serious incident process is arranged in due course (we believe dates are currently being sourced).

Yours sincerely,

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Managing Director

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