NHS
Royal Berkshire
NHS Foundation Trust

HM Assistant Coroner Alison McCormick
Coroner's Office
Blagrave Street
Reading
RG1 1QH

Trust Head Quarters
Royal Berkshire Hospital
Level 4, Main Entrance
London Road
Reading
Berkshire
RG1 5AN

[redacted]

29th April 2024

Dear Ms. Alison McCormick

Thank you for your regulation 28 report dated 13 February 2024 concerning the death of Michael James Nye who died on 15 November 2022. I would like to take this opportunity to express my deepest condolences to Michael's parents, wife and child. The Royal Berkshire NHS Foundation Trust (RBFT) is committed to learning from deaths and improving patient safety.

Please find below the trust's response in relation to the prevention of future deaths report, addressing each point in turn.

a. Delays in blood tests being completed at night at the Royal Berkshire Hospital, and notification to clinicians on the Electronic Patient Record of abnormal results which are being reviewed.

A quality improvement project at the trust has focussed on the turnaround times for blood results being reported to ED. This focusses on shortening the time between ED booking in, and the blood result being returned and available to clinicians to inform decision-making. There are elements around processes in ED, elements in the transport of the sample to the lab, and also elements around the laboratory processes that we are working to improve.

There is also an upgrade to the laboratory information management system (LIMS) taking place in April. Consequently, the reliability of result reporting is expected to improve, with much reduced connectivity challenges expected to follow this. Please see appendix A[i].

b. The burdensome and time consuming out of hours system for clinicians requesting CT scans from an external provider;

The trust currently holds a contract with Everlight (a Radiology provider) which includes a KPI around the availability of the Everlight Service Desk to answer incoming calls:

Availability of Everlight Service Desk staff to answer incoming calls	• 85% of calls answered within 60 seconds • 90% of calls answered within 240 seconds

We are sent a Monthly Client Performance Overview report which includes performance against KPIs, discrepancies etc.

These reports feed into the formal quarterly review meetings, where any specific issues are discussed. When we're made aware of a particular problem or delay, we notify this to Everlight who follow up with an investigation report from their end.

In addition we are undertaking a quality improvement project, as part of our improving together approach, focused on time from request to reported results of CT scans for patients in the Emergency department. Currently 78% of all ED CT scans are completed and reported within 3 hours of the request.

c. The lack of contemporaneous record keeping in the Emergency Department;

In order to improve performance with regards to contemporaneous record keeping we have repeatedly discussed this with all levels of nursing and medical staff at the twice daily Emergency Department huddles. New members of staff receive education around the EPR systems and the alerts in place to highlight the NEWS scoring system and prompts for when observations are due, which is all included in their written record of induction.

d. The lack of a specific night time Internal Escalation Policy. A number of the general Internal Escalation Policy measures are not effective at night;

Following this inquest hearing, the trust's senior urgent care group leads across ED, ICU, the Critical care outreach and the hospital out of hours team, are working towards writing a revised night time Internal Escalation Policy. This currently has a completion date of August 2024 by which time, it will have gone through the trust's governance process and signed off by key stakeholders. A copy will be shared with HM Assistant Coroner via their office by 13 September 2024.

e. The need for training of all Intensive Care Unit clinicians at all levels, both existing Intensive Care Unit clinicians and new joiners, in the policy that a "just to let you know" call should result in an Intensive Care review of the patient;

This has now been included in all induction training on ICU, which is held face to face, and in the induction material that is sent prior to commencing on the unit. This has been actioned and is implemented through each induction cycle.
In relation to the lapse in communication, this case was discussed at the ICU Mortality and Morbidity meeting in March 23 and following the SI investigation was discussed at the ICU clinical governance meeting in July 23 emphasising the learning around communication. It has been further discussed at the ICU clinical governance meeting and consultant meetings in March 24 following the inquest and the issuing of the PFD notice. We are confident there is now a consistent approach across the wider team, including existing clinical staff.

f. The need for training and education of all clinicians on atypical presentation of sepsis and the need for a high index of suspicion for sepsis, particularly in the presence of a high lactate

The trust's Lead Nurse for Sepsis has delivered focused training in the areas with high prevalence of Sepsis - with teaching sessions in ED as well as discussion at Critical care outreach service (CCORS) and ICU governance meetings. Please see Appendix B[ii].

I trust this has provided some assurance in some of the changes that are being implemented in ED in order to improve patient safety. Please do not hesitate to contact me should you need any further information.

Yours sincerely

[redacted]

[redacted]
Chief Medical Officer

---

[i] Pathology Test results returned from lab within reduced time compared to arrival at ED (Target: reduction of 15 minutes)

[ii] Sepsis Action Plan 2024