Cambridgeshire & Peterborough Integrated Care System

NHS Cambridgeshire & Peterborough

Our ref: [redacted]
Your ref: [redacted]

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For the attention of
David Heming
Senior Coroner
Cambridgeshire & Peterborough Coronial Service
Lawrence Court
Princes Street
Huntingdon
PE29 3PA

Date: 28th May 2025

Sent via email to: [redacted]
cc: [redacted]

Dear Mr Heming

Re: Christian James Gabriel HOBBS - Date of death 26 December 2017

Thank you for your Regulation 28 Prevention of Future Deaths Report regarding Christian James Gabriel Hobbs that the ICB received on 8 April 2025. We note the content and the points raised for an ICB response.

We wish to express our sincere condolences to Christian's family and friends. We have taken this matter extremely seriously.

The matters of concern that you have raised within your report relevant to NHS Cambridgeshire and Peterborough Integrated Care Board (CPICB) are listed below together with the actions that we have or will be undertaking to prevent future deaths. We have used lettering for each point as per the Prevention of Future Deaths Report.

A. Cardiogenic Shock

The Prevention of Future Death Report noted that concerns were identified over funding availability and implementation of the key recommendations set out within the document 'Shock to Survival'

- CPICB recognises that while the recommendations within the *Shock to Survival* document have not been nationally mandated, they represent best practice and are integral to delivering high-quality care within acute NHS hospital settings. The ICB have implemented an improved contractual process where all providers have a Clinical Review Quality Meeting each month, alongside a Technical Information Finance Meeting. The ICB will seek assurance of compliance with the *Shock to Survival* recommendations through Clinical Quality Review Meetings with North West Anglia NHS Foundation Trust and other providers in the Cambridgeshire and Peterborough Integrated Care System that care for similar patient groups.

This process will be undertaken through Clinical Quality Review Meetings and is expected to be completed by 30 June 2025.

B. Echocardiography

The Prevention of Future Death Report noted that Christian had not had a transthoracic echocardiogram or focused echocardiography prior to his arrest and that this was a concerning feature of his care in the Emergency Department, given he was critically unwell and in a shocked state.

- CPICB will work with North West Anglia NHS Foundation Trust and other providers caring for similar patient groups to gain assurance that mechanisms are in place to ensure critically ill patients have 24/7 access to either transthoracic echocardiography or focused echocardiography. This process will be undertaken through Clinical Quality Review Meetings and is expected to be completed by 30 June 2025.

C. Fluid Management

The Prevention of Future Deaths Report noted that it was unclear if audits and deep dive reviews have identified the completion of fluid balance charts and the understanding of the need for acting on flags as a recurring theme.

- The ICB implemented a weekly Serious Incident Closure Assurance Panel in 2021 with the purpose of having oversight of all serious incidents reported by providers across Cambridgeshire and Peterborough Integrated Care System. This process was superseded by the nationally mandated Patient Safety Incident Response Framework (PSIRF), which changed the model for incident reporting and response.

- Under PSIRF, the ICB now only maintains direct oversight of Patient Safety Incident Investigations (PSIIs). If providers choose to use alternative PSIRF tools (e.g., after action reviews, thematic analysis), the ICB is informed of these only through themes and trends reported in quarterly submissions. Additionally, the ICB has representation at the weekly provider Patient Safety Meetings, where all incidents are reviewed.

- From analysis of patient safety data since 2017, fluid management has not emerged as a recurrent theme within North West Anglia NHS Foundation Trust (NWAFT). Furthermore, fluid balance monitoring forms part of the Trust's ward accreditation programme, which reviews wards against a range of national care standards. It is also embedded within the Trust's core matron audit programme, ensuring ongoing oversight and quality improvement. The Trust continues to hold the responsibility to ensure that it will share any emerging themes or risks to the ICB in the monthly Integrated Quality Report.

H. Critical Care

The Prevention of Future Deaths Report noted that there were concerns in relation to resources and training for this speciality and whether the Trust had acted upon any reviews of the Critical Care Unit at Hinchingbrooke Hospital. The ICB have implemented an improved contractual process

where all providers have a Clinical Review Quality Meeting each month, alongside a Technical Information Finance Meeting.

All Trusts share their key risks, emerging issues, mitigations and data with the ICB in report format prior to these meetings. This process provides the ICB with oversight and assurance.

- The East of England Critical Care Network undertook a review of Critical Care Services at Hinchingbrooke Hospital in September 2023, with a follow-up visit in June 2024. This is part of the East of England Adult Critical Care Operational Delivery Network's rolling programme to quality assure care provision across the region.

  The CPICB Quality Team were invited to join the critical care review by the Critical Care Network. Following this visit the Critical Care Network led upon review of the action plans and gaining assurance that the recommendations had been acted upon.

J. Sepsis Pathway

The Prevention of Future Deaths Report noted that there were concerns about training and auditing of the sepsis pathway

- North West Anglia NHS Foundation Trust includes sepsis data as part of its monthly Integrated Quality Report to CPICB. This data is reviewed regularly and does not currently flag as an outlier when compared to regional or national benchmarks. Within this report, providers also highlight any emerging risks and issues. To date, sepsis has not been raised to CPICB as a concern. Based on current data and provider reports, CPICB assesses the Trust's approach to sepsis management as adequate. We will continue to monitor for any changes in performance or risk indicators.

P. Patient Safety in some Trust areas

The Prevention of Future Death Report noted that it is unclear as to whether there has been a deep dive or audit/review to look at patterns/trends rather than simply looking at raw overall mortality data.

- North West Anglia NHS Foundation Trust's Quality Assurance Committee holds a monthly meeting, alternating between surveillance and deep dives on identified themes. This is attended by representatives from CPICB. The Trust's Patient Safety Incident Response Framework (PSIRF) plan outlines detailed quality improvement initiatives, and we are working with the Trust to gain assurance that progress is being made in the areas defined.

- The Quality Team recognises the forthcoming Trust's implementation of a nationally validated software system called, GENOME. This system will support improved patient safety surveillance, including ward-to-board visibility of safety themes and triangulated data.

  CPICB will have access to GENOME dashboards, which will enhance our ability to monitor assurance, track progress against quality priorities, and identify areas requiring escalation or support.

We trust the actions taken by us address the concerns raised and we will continue to work with our partners to continue improvements. Should you seek any further clarification, please do not hesitate to contact us.

Yours sincerely

[redacted]

[redacted]
Chief Medical Officer
NHS Cambridgeshire and Peterborough ICB.
MA FRCP MRCGP FFPH DTM&H