The Robert Jones and Agnes Hunt Orthopaedic Hospital
NHS Foundation Trust

Oswestry

Shropshire

SY10 7AG

Chairman & Chief Executive's Office

Tel: 01691 404394

Mr Adam Hodson
Assistant Coroner for Birmingham and Solihull
50 Newton Street
Birmingham
B4 6NE

24 June 2025

Dear Mr Hodson

Re: Regulation 28 Report to Prevent Future Death - Peter Anzani Inquest

Thank you for your Report to Prevent Future Deaths (hereafter "PFD report") dated 1 May 2025 concerning the death of Peter Anzani on 24 November 2024.

In advance of responding to the specific concerns raised in your PFD report, I would like to express my deep condolences to Peter's family and loved ones. The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust (hereafter "the Trust") is keen to assure the family, and the Coroner, that the concerns raised about Peter's care have been listened to and reflected upon.

I am advised that the Trust was not initially recognised as an Interested Person (IP) to this inquest nor provided with a copy of the statements and documentation from other IPs ahead of the inquest. I understand that the Trust was recognised as an IP following a verbal application made by the Trust's legal representative during the inquest hearing.

As a Trust, we fully recognise the importance of addressing the concerns raised by your PFD report to prevent similar instances in future. I have set out the concerns outlined in your PFD report below and the relevant work the Trust has undertaken.

1. I considered evidence from a [redacted] who indicated at paragraphs 20-21 of his statement, *"I did not see any record of his pulse, blood pressure or oxygen. The normal practice is to complete these observations, and I would expect this to be done, especially with him presenting with chest issues. However, I am unable to comment why this was not recorded of confirm that these were carried out. (21) This is a learning point for the department, and I have taken steps to ensure this learning is taken forward by the Trust. I*

have alerted the Sister in charge of the Spinal Injuries Outpatients' Department and requested that adequate measures are taken to ensure that all observations made are recorded in the outpatient forms…"

2. It was unclear whether this was a single one-off event involving human error or indicative of a wider and systemic issue involving a lack of learning. There was no evidence before the court that this "learning point" had been actioned or that any adequate steps had been taken to ensure proper and accurate recording of records by staff.
3. There is a real risk of future deaths occurring where staff do not have adequate training and that patient records are not being properly completed.

Immediate actions

Following receipt of the PFD report, the Trust took immediate action to address the issues identified, specifically relating to timely and accurate recording of patient observations.

Clear and visual notices have been placed in relevant clinical areas to remind staff of the importance of recording patient observations promptly and accurately. Also, additional observation machines have been made available to ensure staff have immediate access to appropriate tools for carrying out vital sign monitoring. In addition, the importance of accurate observation recording has been communicated directly to staff both via verbal briefings and written email communication.

Also, a re-audit was completed on 21 June 2025 in relation to 20 patient who attended the clinic between 16 – 19 June 2025. The results show that a full set of clinical observations was recorded for 100% of patients, including those undergoing procedures. A copy of the audit has been provided in the Trust's PFD response bundle.

Digital record keeping system

The Trust has undertaken a review of how our current systems and processes to support accurate and timely clinical documentation.

One of the key tools supporting this work is implementation of our new electronic patient record system called Apollo, which is used Trust wide to facilitate consistent, legible and auditable documentation of patients' clinical notes. The Outpatient Observation Form now includes all baseline observations, and this essentially follows the process used in the Trust's Main Outpatient Department. A paper format will be utilised during any period of digital downtime, when access to the digital system is limited, or not available.

In addition to the above, the Trust recognises that it needs to be able to record patient observations taken in the outpatient setting on Vitals (this is a digital platform for recording clinical observations). This is currently in development with the digital team and implementation date is anticipated to be March 2026, although the timeframe is restricted by the external digital company called System C. In the meantime, the Outpatient Observation Form will be the primary source for recording clinical observations for patients attending outpatient appointments.

Standard Operating Procedure

A new Standard Operating Procedure (SOP) has been developed and is in the process of being implemented to provide a clear, visual guide for clinical staff working in outpatient settings. The SOP includes a flowchart to ensure ease of understanding and practical application across all relevant clinics. It outlines mandatory baseline observations for all outpatient appointments. The SOP is scheduled to be approved at the next Patient Safety Meeting on 08 July 2025.

The SOP further specifically requires completion of pre- and post-procedure observations in higher-risk outpatient procedures, including Baclofen, Fertility, Botox and Suprapubic Catheter (SPC) clinics.

We consider these actions are essential to ensure patient stability before and after interventions that may involve medication administration, sedation, or procedural risk.

Quality Accreditation Programme

The Trust has adopted a local Quality Accreditation Programme (QAP), and we are using this as a structured and sustainable mechanism to drive improvements across all clinical areas.

As part of the QAP, all wards, units and departments at the Trust will aim to achieve the highest level of quality accreditation to improve efficiency, productivity, patient outcomes and to enhance patient and staff experience. This underpins the goals of the Trust's Nursing and Allied Health Professional Strategy, the Trust's Quality Strategy and wraps a framework around demonstrating regulatory compliance and best practice.

The objective and focus of this work are to align the QAP to CQC's key principles of Safe, Effective, Caring, Responsive and Well Led. I have provided within our PFD response bundle the QAP audit in relation to documentation and record keeping. Where compliance was found to be less than 100%, the Trust has recommended steps to ensure increased compliance.

Moreover, the quality accreditation process has helped guide Trust's quality improvement priorities for the year. Some of the core objectives of the Trust's quality improvement priorities include improvement of documentation and record keeping related to falls risk assessments and management plans. The Trust has also prioritised measures to improve the use of fluid balance charts across the Trust.

The measures agreed to achieve these objectives are focused on improved compliance with completion of risk assessments, management plans and fluid balance charts (via tenable audits).

A copy of the Trust's Quality Priorities has been provided in the PFD bundle.

NEWS2 compliance audit

To evaluate adherence to national standards for the National Early Warning Score (NEWS2) system, a compliance audit was carried out by the Trust's Patient Deterioration & Resuscitation Committee in January 2025.

The objective of this audit was to review whether the Careflow Vitals (formerly VitalPAC) e-observation NEWS2 track, and trigger system supports prompt and appropriate escalation for a physical review by an appropriate competent clinician. The review involved a retrospective audit of NEWS2 clinical observations and escalation, which included a review of 565 observation datasets from 112 patients.

The audit report highlighted the National Institute of Clinical Excellence's (NICE) clinical guideline entitled *'Acutely ill patients in hospital: recognition of and response to acute illness in adults in hospital' (NICE clinical guideline 50).* As outlined in the Trust's audit report, one of the key recommendations in the NICE guideline is that as a minimum physiological observation such as heart rate, respiratory rate, systolic blood pressure, level of consciousness, oxygen saturation and temperature should be recorded at the initial assessment.

The audit report has made appropriate recommendations and actions for better outcomes, which has been provided in our PFD response bundle.

I confirm that a repeat audit has been scheduled for April 2026.

Deteriorating patient compliance audit

The Trust also undertook a compliance audit in January 2025 pertaining to deteriorating patients, which involved a review of monitoring and escalation of patient care. This was a retrospective audit of 113 2222 medical emergency calls and cardiac arrests.

This audit similarly refers to the NICE guideline referred to above and recommendation relating to recording of physiological observations. The audit makes mention of a report from the National Patient Safety Agency (NPSA 2007), which evidenced failure to recognise and act upon deterioration in 15% of serious incidents resulting in death reported on the national reporting and learning system (NRLS). The sub-themes identified were a failure to measure basic observations of vital signs, a lack of recognition of the importance of worsening vital signs and delay in responding to deteriorating vital signs. Accordingly, the Trust's audit (amongst other recommendations) has emphasised learning around the global assessment of patients *"including review of the patient's baseline physiological trends and not solely upon the NEWS2 score".*

I confirm that a repeat audit has been scheduled for February 2026.

I hope the above offers you reassurance of the Trust's ongoing commitment and work being undertaken, specifically relating to the issues raised in your PFD report.

The following documents are included in the PFD disclosure bundle.

- The NEWS2 compliance audit (appendix 1)
- Deteriorating patient compliance audit (appendix 2)
- The latest MCSI observational audit of 21 June 2025 (appendix 3)
- Quality Priorities 2025-26 (appendix 4)
- Quality Accreditation Programme – Documentation and Record Keeping (appendix 5)

Thank you for bringing these important issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,

[redacted]

[redacted]

CHIEF EXECUTIVE OFFICER

Appendix 1 - Clinical Audit Report Template

NEWS 2 compliance audit

Craig Lammas
Jan 2025

Contents

Date of final report	January 2024	**Division & Department**	Trust wide/Corporate
Priority Level		**Driver**	CQC Fundamental Standards Regulation 12: Safe Care & Treatment
Background	The Royal College of Physicians made recommendations for the national early warning score to be updated in December 2017. NHS England mandated for the newly revised NEWS2 to be adopted by ALL NHS Trusts by 2019.		
Aim and Objectives	To review whether the Careflow Vitals (formerly VitalPAC) e-observation NEWS2 track and trigger system supports prompt escalation for physical review by an appropriate competent clinician		
Methodology	Retrospective audit of NEWS2 clinical observations and escalation		
Standards	**Criteria and Standard:** Acutely ill adults in hospital: recognising and responding to deterioration NICE Clinical guideline [CG50] Published date: July 2007 1.10 A graded response strategy for patients identified as being at risk of clinical deterioration should be agreed and delivered locally. It should consist of the following three levels. **Low-score group:** Increased frequency of observations and the nurse in charge alerted. **Medium-score group:** Urgent call to team with primary medical responsibility for the patient. Simultaneous call to personnel with core competencies for acute illness. These competencies can be delivered by a variety of models at a local level, such as a critical care outreach team, a hospital-at-night team or a specialist trainee in an acute medical or surgical specialty. **High-score group:** Emergency call to team with critical care competencies and diagnostic skills. The team should include a medical practitioner skilled in the assessment of the critically ill patient, who possesses advanced airway management and resuscitation skills. There should be an immediate response. 1.11 Patients identified as 'clinical emergency' should bypass the graded response system. With the exception of those with a cardiac arrest, they should be treated in the same way as the high-score group. 1.12 For patients in the high- and medium-score groups, healthcare professionals should: initiate appropriate interventions assess response Formulate a management plan, including location and level of care. 1.13 If the team caring for the patient considers that admission to a critical care area is clinically indicated, then the decision to admit should involve both the consultant caring for the patient on the ward and the consultant in critical care.		
Key Results	**565 observation datasets from 112 patients reviewed** 94% were low risk tier (News2 scores = 0-2) 5.5% were medium tier (News2 scores = 3-6) 0.18% were HIGH risk (news2 score >7) 0.35% met NEWS2 escalation response criteria **Only 1 patient actually needed an escalated trigger response** 97.9% had observations that were within or met the minimum 12hourly **66.2% were ON time and compliant to the prior identified observation frequency** 20.3% were completed but overdue the prior identified frequency 13.4% were considered to 'breach' prior identified timeframe		
Feedback	Deteriorating Patient / Resuscitation Committee		
Actions	Explore options to better and readily promote identified frequencies to increase compliance rate Consider Divisional daily/weekly/monthly audit reviews		
Improvement / Outcomes	The required escalated response time vs actual response time remains difficult to determine and audit due documentation (written and digital) being retrospective to the action(s) taken place. A deterioration sticker (rolled out 2024) was not noted within the records of the 1 escalated patient. Please consider within the digital priorities timeline the integration of careflow connect as means to escalate calls from/via careflow vitals e-observation software.		
Contact	**Craig Lammas**		

Introduction

The National Confidential Enquiry into Patient Outcome and Death (NCEPOD 2005) identified the prime causes of the substandard care of the acutely unwell in hospital as being delayed recognition, and institution of inappropriate therapy that subsequently culminated in a late referral. The report found that on several occasions these factors were aggravated by poor communication between the acute and critical care medical teams.

It is well recognised that abnormal physiology is associated with adverse clinical outcomes. A multicentre, prospective, observational study (Kause et al. 2004) found that the majority (60%) of primary events (deaths, cardiac arrests and unplanned ICU admissions) were preceded by documented abnormal physiology, the most common being hypotension and a fall in Glasgow coma scale. In the NCEPOD report (2005), the majority (66%) of inpatients who had been in hospital for more than 24 hours before ICU admission exhibited physiological instability for more than 12 hours. Another study (Goldhill and McNarry 2004) found that mortality increased with the number of physiological abnormalities ($p < 0.001$), being 0.7% with no abnormalities, 4.4% with one, 9.2% with two and 21.3% with three or more.

In aim to address and improve the care of Adult patients in acute hospital care settings the National Institute of Clinical Excellence (NICE) published the short clinical guideline *'Acutely ill patients in hospital: recognition of and response to acute illness in adults in hospital' (NICE clinical guideline 50)* and outlined evidence based recommendations upon the measurement of a set (see table 1) of physiological observations linked to a 'track and trigger' system to support both appropriate observation frequency and the timely physiological review of a deteriorating patient by the most appropriate clinician.

Key recommendations

Recommendation 1.2.2.2

As a minimum, the following physiological observations should be recorded at the initial assessment and as part of routine monitoring:

- heart rate
- respiratory rate
- systolic blood pressure
- level of consciousness
- oxygen saturation
- temperature.

Recommendation 1.2.2.3

Physiological track and trigger systems should be used to monitor all adult patients in acute hospital settings.

- Physiological observations should be monitored at least every 12 hours, unless a decision has been made at a senior level to increase or decrease this frequency for an individual patient.
- The frequency of monitoring should increase if abnormal physiology is detected, as outlined in the recommendation on graded response strategy (recommendation 1.2.2.10).

Recommendation 1.2.2.4

Track and trigger systems should use multiple-parameter or aggregate weighted scoring systems, which allow a graded response. These scoring systems should:

- define the parameters to be measured and the frequency of observations
- include a clear and explicit statement of the parameters, cut-off points or scores that should trigger a response.

By weighting the abnormal physiological observations within the track and trigger the appropriate clinician can be identified and determined. A recommendation (1.2.2.10) for a 3tier graded response was outlined.

- **Low-score group**

  Increased frequency of observations and the nurse in charge alerted.

- **Medium-score group**:

  Urgent call to team with primary medical responsibility for the patient.

  Simultaneous call to personnel with core competencies for acute illness. These competencies can be delivered by a variety of models at a local level, such as a critical care outreach team, a hospital-at-night team or a specialist trainee in an acute medical or surgical specialty.

- **High-score group**:

  Emergency call to team with critical care competencies and diagnostic skills. The team should include a medical practitioner skilled in the assessment of the critically ill patient, who possesses advanced airway

management and resuscitation skills. There should be an immediate response.

Onward from the NICE clinical guideline much debate has arose upon the specificity and sensitivity of such track and trigger systems and therefore a task group established (NEWSDIG) by the Royal College of Physicians (RCP) reviewed various MEWS (modified early warning score) in operation and made recommendation for the national adoption of what they deemed the 'best' multi-parameter track and trigger system, which became known as the National Early Warning Score (NEWS)

Royal College of Physicians NEWS2 score tier response

NEW score	Clinical risk	Response
Aggregate score 0–4	Low	Ward-based response
Red score Score of 3 in any individual parameter	Low–medium	Urgent ward-based response*
Aggregate score 5–6	Medium	Key threshold for urgent response*
Aggregate score 7 or more	High	Urgent or emergency response**

* Response by a clinician or team with competence in the assessment and treatment of acutely ill patients and in recognising when the escalation of care to a critical care team is appropriate.
**The response team must also include staff with critical care skills, including airway management.

The RCP additionally suggest that where NEWS scores >7 are observed a transfer to a higher dependency area is usually necessary.

Using the e-Observation application careflow vitals (formerly known as vitalPAC) the Trust operates a graded response and escalation pathway triggered by the NEWS2 score (see appendix)

Aims & Objectives

To determine compliance to NEWS2 observation frequency and escalation standards

To identify baseline patient acuity and activity against the NEWS2 tier

Methodology

A randomised retrospective audit of 4 patients per month per ward across the months of September, October, November and December was undertaken where feasible. The inputted observation data and data listings being correlated from vitalPAC clinical, VitalPAC administrator and vitals reporting (VOR)

In keeping with compliance reporting methodology adopted by the careflow vitals software, observations were categorized as compliant, overdue or breached with each carrying the following time allowances

Compliance - time allowances

Frequency compliance	Criteria
On time	Less than 10% over the due time
Overdue	10% to less than 33% over the due time
Breached	33% or more over the due time

Scores were grouped into NEWS2 tiers (LOW, MEDIUM, HIGH). Clinical records of those with triggered score values were reviewed to determine if a clinical review was needed and what actions were taken (see appendix for graded response)

Results

565 physiological datasets from 113 patients were captured.

Observation Status	Percentage
Completed on time	**66.2%**
Overdue / delayed	20.3%
Breached required frequency	13.4%

Table 1 - NEWS2 score - Tier Distribution

Tier group	Total triggers	Total %
Low	533	94
Medium	31	5.5%
High	1	0.18%

26 of the medium risk (News score 3 to 6) triggers correlated to an accumulated non-triggering NEWS2 score of 3, and NOT a single (3) parameter trigger that may have necessitated an escalated response and increased observation frequency.

There were only 4 (0.7%) instances of NEWS2 triggers meeting the escalated response criteria (see appendix)

The instances related to ***only 2 patients***: -

Patient 1, consecutive news scores of 7,6 and 4 (with single parameter 3 trigger) recorded. Within this period correct adherence to observation frequency was observed, escalations to both the on-call medic and outreach had been made and physical reviews had been timely completed.
(No deteriorating patient sticker compiled)

Patient 2, single isolated NEWS score 5 (with single parameter 3score trigger for systolic blood pressure). In this instance, observation frequency was correctly increased to 1hourly, with further repeat observations being

undertaken 1hr 11mins later where a non-triggering NEWS score of 3 was recorded. No escalation was undertaken; it was determined that the single trigger score of 3 for blood pressure was within the patient's normal range, and no new clinical signs suggested a need for escalation. The patient remained stable, and subsequent NEWS scores did not indicate triggering.

Recommendation 1.2.2.3 12hourly minimum standard

80 datasets had modified observation frequency (frequency reduced to 8 or 12hrly)

Observation Frequency	Total datasets	Total datasets Exceeding frequency
8hourly	21	5
12hourly	59	16

The 16 datasets observed to exceed the 12hourly minimum standard, correlated to 12patients, 11 of which were ***none acute*** spinal rehabilitation patients.

Discussion

The audit revealed notable adherence to observation protocols, with a significant majority of the observations being timely. Specifically, 66.2% of the observations were recorded 'on time' within the prior identified observation frequency. Conversely, 20.3% of the observations were categorized as delayed, and 13.4% breached the required frequency for observations.

Modified observations

The dataset analysis showed most modified observation frequency adjustments matched patient stability and clinical needs. The pragmatic modifications sensibly optimized resource allocation and patient monitoring, ensuring that higher scoring patients received timely and frequent observations, while stable patients were monitored at a sustainable frequency. This approach not only aligns with best practice guidelines but also enhances overall patient care and safety. This also highlights the importance of including clinical judgment in determining the appropriate observation frequency, particularly in cases where the NEWS2 score may not fully capture the patient's condition. For example, in instances where low blood pressure or other parameters could trigger false alarms, the responsible nurse's clinical judgment should also play a crucial role in deciding the care pathway.

Spinal Rehabilitation

The NICE guidance relates to acutely unwell adults and therefore consideration to the use of other identified and documented monitoring plans should be considered for use within spinal rehabilitation, where the Trust's largest grouping of delays exceeding the 12hourly acute care minimum

standard is observed. Arguably the specialist spinal nursing staff have used their own judgement and discretion (exceeding the 12hourly minimum) to ensure their patients onward physical rehabilitation program/regimes (i.e. gym or other OT/Physio/psychological therapies) are not being impacted by un-necessary NEWS protocols demands, which the Royal College of Physician's actively acknowledge do not necessarily appropriately work or recognise the altered physiology of the spinally injured patient.

Digital platforms

The recording of the NEWS2 data via careflow vitals and other digital program provided by System C allowed for many datasets to be reviewed within a relatively short period of time. The digital EPR also provided quick access to readily legible timed and dated notes in contrast to the paper records which were often difficult to collate.

Whether digital or written what was difficult to determine was the time to clinical response as most notes upon actions taken were retrospective entries and the deteriorated patient sticker rolled out in 2024 could not be found compiled in the nursing records.

CONCLUSION

The audit underscores the need for a balanced approach that incorporates both systematic observations and clinical judgment to ensure optimal patient outcomes.

The audit demonstrated a compliance rate of 66% this figure is comparable to compliance rate (70%) observed within a separate deteriorating patient antecedence audit.

Recommendations

Explore options to readily promote increased daily/weekly/monthly surveillance of compliance to identified frequencies

Divisional oversight to promote and encourage improvement

Continue to encourage and educate around the global assessment of the patient including review of the patient's baseline physiological trends and not solely upon the NEWS2 score.

Encourage staff to use their own clinical judgment alongside the use of NEWS 2 and careflow vitals to trigger early and appropriate escalation of care where they have *'worry and concern'.*

Continue to encourage additional and early use of other clinical decisions tools like the Sepsis screening tools and integrate into careflow vitals.

Continue with expansion of the careflow suite of digital products to include careflow connect and the use of smartphone technology for escalation messaging to be via digital applications and easily auditable time-stamped push notification as opposed to existing telephone and bleep messaging which get referenced in retrospect.

Action Plan

This improvement plan should be drawn up when all the recommendations have been agreed. It is intended to show what will be done and when, and who will be responsible for ensuring that the actions are carried out. It should also include a review date by which time all actions should have been completed and a re-audit date agreed.

Area Requiring Improvement	Actions Required	By Whom	By When	Comments
Graded response	Review escalation & clinical response	Patient deterioration & resuscitation committee	Q4 2026	The vitalPAC software would need to be updated by System C to support display of the clinical response. A testing phase would need to be undertaken to sanity check the revised new software for faults and stability before full installation – this would likely fall to Q4 2026 given present delayed delivery and limited functionality of the anticipated Digital EPR and Careflow Connect integration anticipated Q3 2024
Response times difficult to determine	Time stamps for primary concern, referral and actual clinician response	I. Escalation sticker – HDU admissions ii. digital escalation	i. Q4 2025 ii. Q4 2026	i.Deteriorating Patient sticker & SOP sieve/audit on ward transfers to HDU. Though sticker was approved and introduced in JAN 2024 no sticker was located in the 1 patient requiring escalated response in this audit. Digital integration of Careflow Connect originally proposed for Q2/3 2024

Re-audit Date	Project Lead	Group	Comments
01/04/2026	Craig Lammas	Patient deterioration & resuscitation committee	

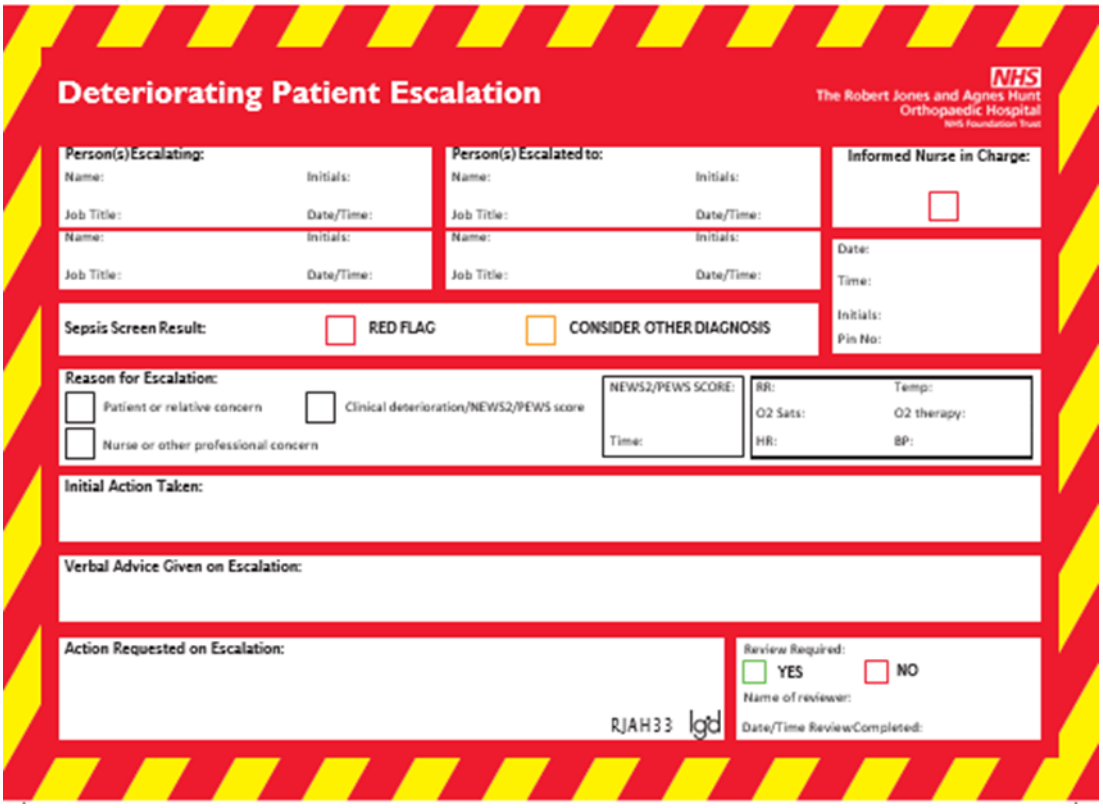
Appendix

RJAH News2 Escalation and graded response

NEWS2 Escalation Pathway			
NEWS SCORE	**FREQUENCY OF MONITORING (Minimum)**	**Doctor Response**	**Clinical response**
0	Minimum 12hrly	Nil unless specific concern	Continue routine NEWS2 frequency *unless specific clinical concern (i.e chest pain)
1 **2**	6hrly	Nil unless specific concern	Inform Nurse in charge who must review patient and determine monitoring plan
3 **4**	4hrly	Nil unless specific concern	Inform Nurse in charge who must review patient and determine monitoring plan **If signs of RED or Amber Signs of Sepsis commence Sepsis Screening tool** **Consider calling Outreach if concerned**
5 **6**	1hrly	Review within 1hr	Inform Nurse in Charge to review patient **Call Doctor on call and Outreach to assess patient within 1hr** Inform admitting Consultant Consider oxygen, IV access & fluids Consider 12 lead ECG & venous blood sampling
7 **8**	1hrly	**Review within 15mins**	Inform Nurse in Charge to review patient **Call Doctor on call and outreach to assess patient within 15minutes** Inform admitting Consultant Consider oxygen, IV access & fluids Consider 12 lead ECG & venous blood sampling
9 +	**Every 30mins**		

EXTREME VALUE			
Trigger score 3 in single parameter	1hrly	Nil unless specific concern	**Inform nurse in charge to review patient and determine monitoring plan.** **Does the patient have clear target oxygen saturation range and oxygen therapy prescription?** **Consider if trigger meets one of the RED FLAG sepsis criteria, use the Sepsis screening tool to cross-check.** **Contact Outreach (bleep 155) if concerned**

Deteriorating Patient Sticker



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Appendix 2 - Clinical Audit Report Template

Deteriorating patient compliance audit

Craig Lammas
Jan 2025

Contents

Date of final report	February 2025	**Division & Department**	Trust wide/Corporate
Priority Level		**Driver**	CQC Fundamental Standards Regulation 12: Safe Care & Treatment
Background	.		
Aim and Objectives	To review monitoring and escalation of care surrounding patient deterioration		
Methodology	Retrospective audit of all in-patients 2222 medical emergency/cardiac arrest calls		
Standards	**Criteria and Standard:** Acutely ill adults in hospital: recognising and responding to deterioration NICE Clinical guideline [CG50] Published date: July 2007 1.10 A graded response strategy for patients identified as being at risk of clinical deterioration should be agreed and delivered locally. It should consist of the following three levels. **Low-score group:** Increased frequency of observations and the nurse in charge alerted. **Medium-score group:** Urgent call to team with primary medical responsibility for the patient. Simultaneous call to personnel with core competencies for acute illness. These competencies can be delivered by a variety of models at a local level, such as a critical care outreach team, a hospital-at-night team or a specialist trainee in an acute medical or surgical specialty. **High-score group:** Emergency call to team with critical care competencies and diagnostic skills. The team should include a medical practitioner skilled in the assessment of the critically ill patient, who possesses advanced airway management and resuscitation skills. There should be an immediate response. 1.11 Patients identified as 'clinical emergency' should bypass the graded response system. With the exception of those with a cardiac arrest, they should be treated in the same way as the high-score group. 1.12 For patients in the high- and medium-score groups, healthcare professionals should: initiate appropriate interventions assess response Formulate a management plan, including location and level of care. 1.13 If the team caring for the patient considers that admission to a critical care area is clinically indicated, then the decision to admit should involve both the consultant caring for the patient on the ward and the consultant in critical care.		
Key Results	1 cardiac arrest call (Jan – Dec 2024) 113 2222calls received 49 emergency calls correlated to adult in-patients 1 case had persistent NEWS2 >5 and met RCP criteria considered for HDU transfer 70% of observations were compliant to NEWS2 frequency standards		
Feedback	Deteriorating Patient / Resuscitation Committee		
Actions	Additional ward manager/divisional matron NEWS2 audits need to be conducted to promote increased NEWS2 frequency compliance.		
Improvement / Outcomes	NEWS2 observation frequency compliance needs to be promoted and improved		
Contact	**Craig Lammas**		

Introduction

In some instances, patients who are, or become, acutely unwell in Hospital receive sub-optimal care as their deterioration is not recognised, appreciated or acted promptly upon. Within the NCEPOD Report 'An Acute Problem' (2005) suboptimal ward care and subsequent delays in transfer to critical care were evidently shown to contribute to increased hospital mortality.

The National Patient Safety Agency (NPSA 2007) also evidenced failure to recognise and act upon deterioration in 15% of serious incidents resulting in death reported on the national reporting and learning system (NRLS). Upon categorising the incidents 3 sub themes became apparent

1. Failure to measure basic observations of vital signs;
2. Lack of recognition of the importance of worsening vital signs;
3. Delay in responding to deteriorating vital signs

To address and improve the care of Adult patients in acute hospital care settings the National Institute of Clinical Excellence (NICE) published the short clinical guideline *'Acutely ill patients in hospital: recognition of and response to acute illness in adults in hospital' (NICE clinical guideline 50)* and outlined evidence based recommendations upon the measurement of a set (see table 1) of physiological observations linked to a 'track and trigger' system to support both appropriate observation frequency and the timely physiological review of a deteriorating patient by the most appropriate clinician.

Key recommendations

Recommendation 1.2.2.2

As a minimum, the following physiological observations should be recorded at the initial assessment and as part of routine monitoring:

- heart rate
- respiratory rate
- systolic blood pressure
- level of consciousness
- oxygen saturation
- temperature.

Recommendation 1.2.2.3

Physiological track and trigger systems should be used to monitor all adult patients in acute hospital settings.

- Physiological observations should be monitored at least every 12 hours, unless a decision has been made at a senior level to increase or decrease this frequency for an individual patient.
- The frequency of monitoring should increase if abnormal physiology is detected, as outlined in the recommendation on graded response strategy (recommendation 1.2.2.10).

Recommendation 1.2.2.4

Track and trigger systems should use multiple-parameter or aggregate weighted scoring systems, which allow a graded response. These scoring systems should:

- define the parameters to be measured and the frequency of observations
- include a clear and explicit statement of the parameters, cut-off points or scores that should trigger a response.

By weighting the abnormal physiological observations within the track and trigger the appropriate clinician can be identified and determined. A recommendation (1.2.2.10) for a 3tier graded response was outlined.

- **Low-score group**

  Increased frequency of observations and the nurse in charge alerted.

- **Medium-score group**:

  Urgent call to team with primary medical responsibility for the patient.

  Simultaneous call to personnel with core competencies for acute illness. These competencies can be delivered by a variety of models at a local level, such as a critical care outreach team, a hospital-at-night team or a specialist trainee in an acute medical or surgical specialty.

- **High-score group**:

  Emergency call to team with critical care competencies and diagnostic skills. The team should include a medical practitioner skilled in the assessment of the critically ill patient, who possesses advanced airway

management and resuscitation skills. There should be an immediate response.

Onward from the NICE clinical guideline much debate has arose upon the specificity and sensitivity of such track and trigger systems and therefore a task group established (NEWSDIG) by the Royal College of Physicians (RCP) reviewed various MEWS (modified early warning score) in operation and made recommendation for the national adoption of what they deemed the 'best' multi-parameter track and trigger system, which became known as the National Early Warning Score (NEWS)

Royal College of Physicians NEWS2 score tier response

NEW score	Clinical risk	Response
Aggregate score 0–4	Low	Ward-based response
Red score Score of 3 in any individual parameter	Low–medium	Urgent ward-based response*
Aggregate score 5–6	Medium	Key threshold for urgent response*
Aggregate score 7 or more	High	Urgent or emergency response**

* Response by a clinician or team with competence in the assessment and treatment of acutely ill patients and in recognising when the escalation of care to a critical care team is appropriate.
**The response team must also include staff with critical care skills, including airway management.

The RCP additionally suggest that where NEWS scores >7 are observed a transfer to a higher dependency area is usually necessary.

Using the e-Observation application careflow vitals (formerly known as vitalPAC) the Trust operates a graded response and escalation pathway triggered by the NEWS2 score (see appendix)

Aims & Objectives

Determine/identify whether there was any antecedence within NEWS2 clinical observations or other physiological decline prior to identified 2222 medical emergency.

Methodology

Utilising the clinical e-observation system (care-flow vitals -formerly VitalPAC) and the electronic patient records (EPR) clinical notes and observation data from the preceding 24hour period prior to an in-patient 2222 emergency call was retrospectively reviewed.

Results

Across 2024 (Jan to Dec) there were 113 2222 call activations across the Trust.

*2 cardiac arrests occurred, only 1 of these related to an in-hospital patient.
* 1 member of the public driven to the hospital, already in cardiac arrest upon arrival and despite staff and ambulance service attempts sadly was pronounced deceased.

49 of the 113 emergency calls correlated to adult in-patients of these 6 were excluded from the review. (5 HDU as not on NEWS2 and 1 spinal patient with anaphylactic response to CT contrast with no known prior allergies)

Only 1 of the 43cases reviewed had NEWS2 score triggers preceding. The first being a NEWS score of 7 approximately 8hrs 40minutes before the time of the 2222call. This trigger was correctly and promptly escalated as per escalation response (see appendix) and physical reviews undertaken by the Medic on-call and the outreach service. However, despite interventions the NEWS scores continued to remain between 5-7, no decisions upon escalating care, ceiling of treatment or resuscitation status were considered during this timeframe. Days prior to this incident the patient had already been identified as very frail and unfit for surgery.

The 1 cardiac arrest incident had NO prior NEWS2 triggers, signs or reported symptoms prior. The last observations (News=0) had been conducted 8hrs 22mins prior, with frequency modified to minimum 12hourly post. At time of the cardiac arrest the patient had been discharged and imminently about to leave the hospital, the due repeat of the physical observations would not have been required for further 3hrs 22mins later

3 cases had been escalated through nurse concern NOT NEWS2. 2 of which were specifically due to pyrexia (38°c & 38.2 °c) and onward escalation correctly undertook sepsis screening.

1 case did not meet the *minimum* 12hourly standard, the frequency had been modified to 24hourly, there was no noted senior level decision or rationale for this. On scrutiny of the e-observation software, the frequency had been modified by ward 'agency' login (0208hrs) and all onward observation data inputted by RJAH staff had not rectified or amended this modification.

3 cases had the observation frequency modified to the minimum 12hourly standard.

Observation frequency compliance - Time delays

8 cases had NEWS2 observation frequency delays of <30mins
13 cases had NEWS2 observation frequency delays >1hr
(The figures above include 4cases which had time delays of both <30mins and >1hr noted)

9 cases related to immediate post-operative observations and not NEWS2. Of these 2 cases post-operative frequency had not been correctly maintained.

Discussion

Only a temperature of 35°c or less will trigger a ***single*** parameter 3 activation of NEWS2. Pyrexia is permissively allowed within NEWS2 with even temperatures >39.1 only being awarded 2pts.

NEWS2 scores were not an evident predictor

The observation frequency delays within 13 of the 43 cases reviewed would indicate a NEWS2 frequency compliance of 70%

Recommendations

Continue to encourage and educate around the ***global assessment*** of the patient including review of the patient's baseline physiological trends and not solely upon the NEWS2 score.

Encourage staff to use their own clinical judgment alongside the use of NEWS 2 and careflow vitals to trigger early and appropriate escalation of care where they have *'worry and concern'.*

Continue to encourage additional and early use of other clinical decisions tools like the Sepsis screening tools and integrate into careflow vitals.

Ward managers and Matrons to conduct monthly NEWS audits to monitor and encourage compliance to NEWS2 frequency standards.

Action Plan

This improvement plan should be drawn up when all the recommendations have been agreed. It is intended to show what will be done and when, and who will be responsible for ensuring that the actions are carried out. It should also include a review date by which time all actions should have been completed and a re-audit date agreed.

Area Requiring Improvement	Actions Required	By Whom	By When	Comments
Compliance to NEWS2 frequency	Monthly auditing needs to be conducted to both police and encourage compliance to NEWS2 frequency	Ward Managers & Matrons	monthly	Trust to consider utilizing and interrogating data capture from e-observation software to lessen onerous on clinical staff to conduct additional audits when data already captured.

Re-audit Date	Project Lead	Group	Comments
01/02/2026	Craig Lammas	Patient deterioration & resuscitation committee	

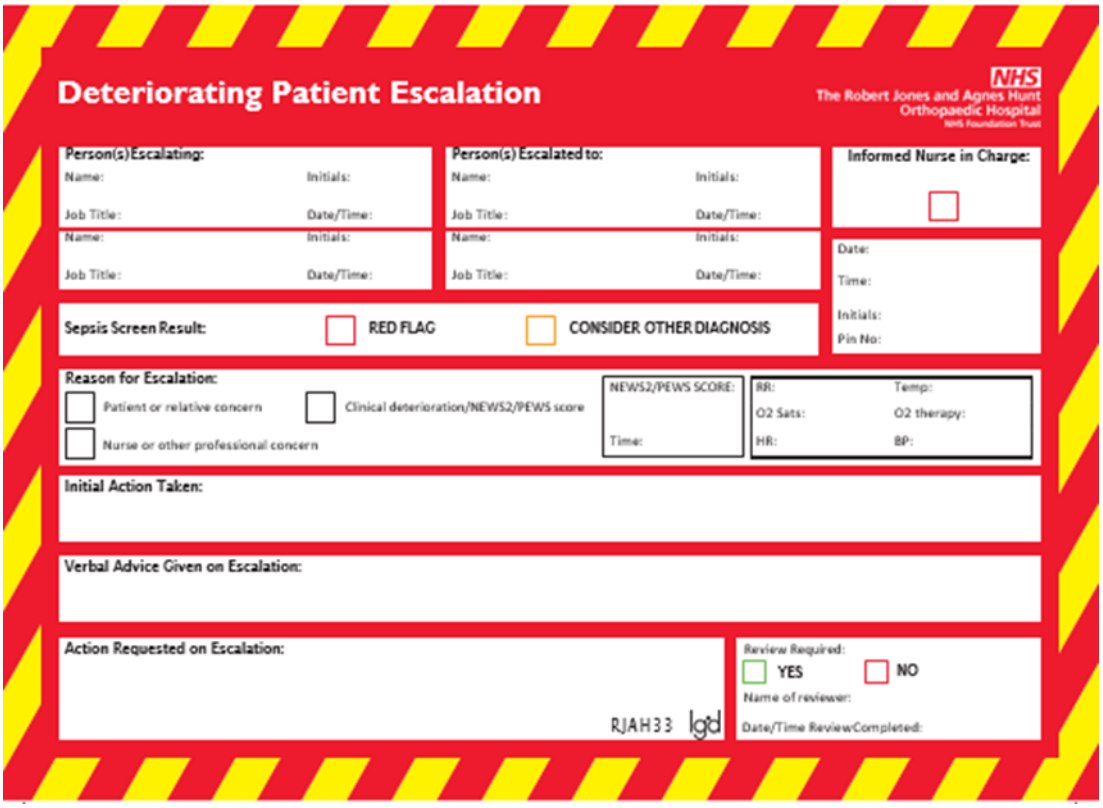
Appendix

RJAH News2 Escalation and graded response

NEWS2 Escalation Pathway			
NEWS SCORE	**FREQUENCY OF MONITORING (Minimum)**	**Doctor Response**	**Clinical response**
0	Minimum 12hrly	Nil unless specific concern	Continue routine NEWS2 frequency *unless specific clinical concern (i.e chest pain)
1 **2**	6hrly	Nil unless specific concern	Inform Nurse in charge who must review patient and determine monitoring plan
3 **4**	4hrly	Nil unless specific concern	Inform Nurse in charge who must review patient and determine monitoring plan **If signs of RED or Amber Signs of Sepsis commence Sepsis Screening tool** **Consider calling Outreach if concerned**
5 **6**	1hrly	Review within 1hr	Inform Nurse in Charge to review patient **Call Doctor on call and Outreach to assess patient within 1hr** Inform admitting Consultant Consider oxygen, IV access & fluids Consider 12 lead ECG & venous blood sampling
7 **8**	1hrly	**Review within 15mins**	Inform Nurse in Charge to review patient **Call Doctor on call and outreach to assess patient within 15minutes** Inform admitting Consultant Consider oxygen, IV access & fluids Consider 12 lead ECG & venous blood sampling
9 +	**Every 30mins**		

EXTREME VALUE			
Trigger score 3 in single parameter	1hrly	Nil unless specific concern	**Inform nurse in charge to review patient and determine monitoring plan.** **Does the patient have clear target oxygen saturation range and oxygen therapy prescription?** **Consider if trigger meets one of the RED FLAG sepsis criteria, use the Sepsis screening tool to cross-check.** **Contact Outreach (bleep 155) if concerned**

Deteriorating Patient Sticker



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Appendix 3 - MCSI Outpatient Department Clinical Observations Re Audit Report

Report Date: 23rd June 2025
Prepared by: Hannah Cheesman (Matron)

Background

Following a retrospective and prospective audit of clinical observations within the MCSI Outpatient Department, a new Observation Form was developed and implemented in the Apollo system. A corresponding Standard Operating Procedure (SOP) was introduced, requiring that a full set of observations be recorded for all patients attending the clinic.

In particular, the SOP specifies that patients undergoing invasive procedures- such as suprapubic catheter (SPC) changes or baclofen refills- must have observations completed both pre- and post-procedure.

Re-Audit Summary

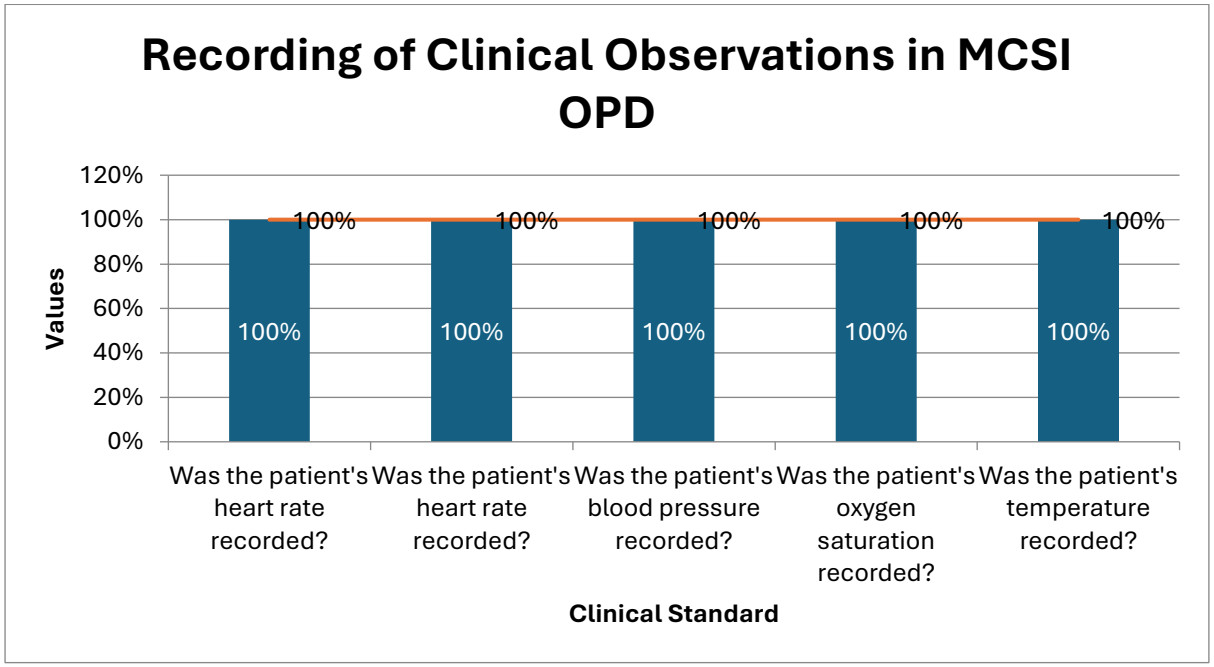
A re-audit was conducted on 20 patients who attended clinic between 16th June and 19th June 2025. The results show that a full set of clinical observations was recorded for 100% of patients, including those undergoing procedures.

Conclusion

The re-audit demonstrates full compliance (100%) with the updated SOP and use of the Apollo observation form.

Next Steps

To ensure continued adherence to the SOP, a further audit will be carried out in three month's time (scheduled for 23rd September 2025).



Appendix 4 - Quality Priorities 2025/26

Committee / Group / Meeting, Date

Council of Govenors, 14 May 2025

Author: **Contributors:**

Name: Kirsty Foskett
Role/Title: Assistant Chief Nurse and Patient Safety Officer

Report sign-off:

Name: Sam Young
Role/Title: Interim Chief Nurse and Patient Safety Officer

Is the report suitable for publication?

Yes

Key issues and considerations:

Each year the Trust sets out several quality priorities that focus on improvements relating to patient safety and patient experience.

Last year the priorities aligned to that of the Trusts Patient Safety Incident Response Plan, recognising that the introduction of the new Patient Safety Incident Response Framework (PSIRF) was change in how we respond to patient safety events and was a key focus for the organisation.

During 2024/25 the Trust launched the Quality Accreditation Programme for all wards and departments. The outputs of theses quality assessments along with learning insights through PSIRF, we have used this information to inform what the quality priorities will be for 2025/26.

The quality priorities for 2025/26 will be

- Inpatient Falls
- Managing the Deteriorating Patient
- Improving Information Sharing
- Introducing a complex care pathway

Strategic objectives and associated risks:

The following strategic objectives are relevant to the content of this report:

Trust Objectives		
1	Deliver high quality clinical services	✓
2	Develop our veterans service as a nationally recognised centre of excellence	
3	Integrate the MSK pathways across Shropshire, Telford and Wrekin	
4	Grow our services and workforce sustainably	
5	Innovation, education and research at the heart of what we do	✓

This report relates to the following Board Assurance Framework (BAF) themes and associated strategic risks:

Board Assurance Framework Themes		
1	Continued focus on excellence in quality and safety	✓
2	Creating a sustainable workforce	

3	Delivering the financial plan	
4	Delivering the required levels of productivity, performance and activity	
5	Delivering innovation, growth and achieving systemic improvements	
6	Responding to opportunities and challenges in the wider health and care system	
7	Responding to a significant disruptive event	

System partners in Shropshire, Telford and Wrekin have identified four strategic objectives for the integrated care system. The following objectives are relevant to the content of this report:

System Objectives		
1	Improve outcomes in population health and healthcare	✓
2	Tackle inequalities in outcomes, experience and access	
3	Support broader social and economic development	
4	Enhance productivity and value for money	

Recommendations:

The group is asked to note the quality priorities for 2025/26.

Quality Priorities 2025/26

Patient Falls		
Key Objectives	**Measures for Improvement**	**Leads**
• To improve documentation and record keeping in relation to Falls risk assessments and management plans. • To Improve the use of visual aids that highlight if a patient is at risk of falls. • To introduce the new post-fall toolkit	• Improved compliance with completion of risk assessments and management plans. • Improved compliance with the use of visual aids.	Linda Head, Falls Lead and Rachael Flood, MSK Matron. *Supported by the Quality Improvement Team*

Managing the Deteriorating Patient		
Key Objectives	**Measures for Improvement**	**Leads**
• To introduce a deteriorating patient simulation study day, to improve the early recognition and management of the unwell patient • To improve the use of fluid balance charts across the Trust	• Reduction in the number of patient safety reviews requested due deterioration • Uptake of simulation training amongst clinical staff • Improved compliance (through Tendable audit) in the completion of fluid balance charts	Nicki Bellinger (Critical Care Nurse Consultant), Craig Lammas, Resuscitation Officer Lowri Mansell, Critical Care Manager & Donna St John, Simulation Education Lead. *Supported by the Quality Improvement Team*

Improving Information Sharing		
Key Objectives	**Measures for Improvement**	**Leads**
• To introduce bedside nursing handovers • To introduce visual Quality Dashboards in ward/departmental areas • To review the effectiveness of safety huddles in the ward environment • To review the effectiveness of "Link Nurse" meetings • To introduce new patient bed boards across the trust	• Improved communication with staff in understanding ward (quality) performance • Reduction in incidents relating to communication in ward area • Improved scores through Well-led of the quality accreditation assessment	Unit ACNs and Matrons and Hayley Gingell, Quality Assurance Lead *Supported by the Quality Improvement Team*

Introduction of a complex care pathway for patients with mental health, Learning Disability and/or Autism		
Key Objectives	**Measures for Improvement**	**Leads**
• Improving the experience of those patients with LD&/or A or mental health needs	• Reduction in communication incidents • Reduction in complaints	Geraint Davies, AHP Consultant, Rachael Flood, MSK Matron and Kirsty Foskett, ACN *Supported by the Quality Improvement Team*

Appendix 5 -Quality Accreditation Audit Elements Related to Documentation & Record Keeping

Domain	Section	Question	Current compliance across all completed assessments (21)	Gaps in Assurance	Steps being undertaken to enhance compliance.
SAFE	Patient Observations / Clinical Records	• NEWS charts are completed on time • Falls risk assessment and management plan completed • VTE assessment has been documented and reviewed within 24 hours • Is the patient's mobility status recorded above the bed?	88%	Incomplete NEWS charts on Ludlow ward in assessments 1&2. Falls documentation and visual cues incomplete. VTE documents completed but unsigned and misfiled.	Falls risk management has started in SSU, with clear coordination and handover updates. Daily communication reinforces expectations for ongoing compliance.
	Medication Safety and Documentation	• Patients' prescription charts are legible and medication given on time as prescribed • Food allergies and intolerances recorded • Drug allergy status is recorded	86%	Allergy status recorded but patients not wearing allergy bands	
	Catheter Care Documentation	• Is catheter in use and documented in patient notes? Is the size of catheter documented in the pathway document? • Is the mls of water documented in the pathway documentation?	90%	Catheter bags not labelled or dated	Training is embedded into SSU rolling programmes, with huddles and emails reinforcing key messages. Shift checks support consistent practice and compliance.
EFFECTIVE	Patient Pathways (Documents Completed)	Are the following documents completed in 3 patient pathways? • Purpose T / Waterlow • Bed rails assessment • Medication records • Nutrition documentation • Moving & handling plan • Confirmation of personal details	95%	Incomplete bed rail assessments	**Bed Rail Policy Review** Collaborative work with Linda Head to revise policy for paediatrics. Links made to related compliance areas like VTE, falls, mobility status, etc.
	Documentation Standards (NMC & HCPC Code of Conduct Compliance)	Check 3 patient records to ensure documentation: ○ Is dated ○ Is timed ○ Is signed ○ Is legible ○ Avoids jargon ○ Non-registered staff entries are counter-signed by registrants	100%	No Gaps	
	Daily Wellness & Fluid Records	• Have daily wellness checks been undertaken? • Are fluid balance charts completed accurately?	71%	Fluid Balance charts not completed	

	Safety & Communication Records	• Are safety huddles undertaken and documented? • Is the handover documentation adequate for holistic patient care?	95%	Handovers conducted, but staff report inconsistent safety huddles.	
	Discharge Documentation	Is the discharge checklist completed?	100%	No Gaps	
CARING	Staff Induction & Access Records	• Have staff received local induction? • Have staff received Apollo & Careflow login?	100%	No Gaps	
	ADRT & ReSPECT Documentation	• Has the patient been asked if they have an Advance Care Directive? • ReSPECT form has been completed fully and dated (where appropriate)	95%	ADRT & Respect pathways not completed.	Communications have been shared with relevant clinical teams to support timely completion of key documentation.
	Communication and Patient Identification	Are patients called by their preferred name? (#CALLME – check bed board and wristband)	100%	No Gaps	
	Discharge Information	Do discharged patients feel they have enough information, equipment, and know who to contact if they have concerns?	100%	No Gaps	
	Referral & Signposting	Are patients and relatives referred or signposted to appropriate services, such as: o Patient Advice & Liaison (PALS) o Spiritual advice / chaplaincy o Safeguarding o 'Call for Concern' facility	100%	No Gaps	
	Consent & Care Involvement	• Is consent for clinical intervention requested? • Are patients consulted and involved with their care?	100%	No Gaps	
RESPONSIVE	Freedom to Speak Up (FTSU)	Are Freedom to Speak Up posters displayed on the ward?	72%	No Freedom to Speak Up posters displayed in some areas during Assessment 1, and staff were unaware of the champions.	Compliance with poster display has increased for ongoing assessments. Posters featuring FTSU champion information have been developed for display in designated areas.
	Feedback & Complaints Records	• Are staff aware of any compliments? • Are staff aware of any complaints? • Do staff know what their Friends and Family Test / IVQA results are? • Is patient feedback shared and used for improvement?	95%	Staff unaware of IVQA results	Work is underway to implement a digital ward metric screen for display in ward areas, which will include IVQA results. Works tracked through the Quality Priorities action plans
	Notice Boards	• Are notice boards up to date? • Are all notices compliant with IPC (Infection Prevention & Control)?	100%	No Gaps	
	Internal Communication (These assess the availability and awareness of documented internal communications.)	• Do staff have access to Percy (internal platform)? • Are staff aware of the latest communication bulletins?	100%	No Gaps	

WELL-LED	Staffing, Schedules, and Records	• Are rosters published 6 weeks in advance, and are staff aware? • Is staff sickness/absence managed according to policy? (Ward Manager only) • Are appraisals in date? • Are 6-monthly reviews undertaken for new starters? • Is CPD (Continuing Professional Development) identified during PDR? • Has CPD been completed within the time frame identified?	100%	No Gaps	
	Performance, Risk & Accreditation (These items involve awareness of key documented metrics and risk records, which must be maintained and communicated regularly.)	• Are staff aware of the ward's performance quality metrics? • Are staff aware of the staff survey results and any improvements taken? • Are staff aware of the last Quality Accreditation Assessment award • Do staff know the Top 3 risks in their area? • Are staff aware of the risk register?	81%	Staff unaware of ward performance quality metrics and top three risks in their area.	Work is underway to implement a digital ward metric screen for display in ward areas, which will include IVQA results. Works tracked through the Quality Priorities action plans **QI Training for Band 6 Staff (Alice)** e-learning completed by all band 6s. Band 6 staff booked onto QI course.
	Equipment & Safety Checks (Implies a formal daily log of safety-critical equipment – a vital documentation process.)	Is the resuscitation equipment checked daily and equipment in date?	100%	No Gaps	
	Business Continuity & Emergency Preparedness (These are formal documented plans and protocols essential for emergency response.)	Shift lead or manager should be able to provide/identify o The business continuity plan o The response required during a major incident o Relevant action cards o Major incident management response principles (Silver/Gold/Bronze framework)	72%	There was a lack of understanding of Business Continuity Plans in areas during their initial assessment; however, compliance improved significantly in follow-up assessments.	The Quality Accreditation and Business Continuity systems are integrated, enabling the Trust Business Continuity Lead to monitor low compliance and target training and awareness needs. **Business Continuity Awareness** Plans are being developed to familiarise shift leaders with business continuity procedures. This area has been identified as a compliance gap with progress anticipated