East Midlands Ambulance Service NHS
NHS Trust

Emergency Care | Urgent Care | We Care

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Mrs L. Brown
Assistant Coroner
The Town Hall
Town Hall Square
Leicester
LE1 9BG

11th December 2015

Dear Mrs Brown

Re: Report to Prevent Future Deaths in the case of Caroline Elisabeth Robey

Thank you for your Regulation 28 Report to Prevent Future Deaths, dated 16th October 2015, bringing to my attention the Coroner's concerns arising from the inquest into the death of Mrs Caroline Elisabeth Robey.

I would like to assure you that within the East Midlands Ambulance Service (EMAS) all matters related to patient safety are taken extremely seriously. The delivery of high quality, evidence based care is at the heart of the Trust's clinical strategy. This work is continuous, however, I trust you will take assurance from the measures outlined in this response which are pertinent for the time-frame from the date of Mrs Caroline Elisabeth Robeys' death to the present day.

The concerns defined in the Prevention of Future Death notice pertaining to the inquest into the death of Mrs Caroline Elisabeth Robey:

> *1. No Sepsis Screening tool was used by the community health providers, and so opportunities were lost to consider the diagnosis of sepsis and refer as an emergency for hospital admission and treatment.*
>
> *2. A patient safety alert was issued on the 2 September 2014 by NHS England clearly sets out the resources available in the provision of a UK Sepsis clinical tool kit, but this has not be recognised or adopted by health care providers in this case.*
>
> *3. Inadequate note was made of the number of different attendances Mrs Robey had initiated despite previous good health, and there is no suggestion that she was a frequent attender or had ever sort medical attention inappropriately.*

LEICESTER CITY &
SOUTH LEICESTERSHIRE
CORONERS DISTRICT
17 DEC 2015
RECEIVED

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Background

East Midlands Ambulance Service (EMAS) serves a resident population of 4.8million across the East Midlands region (Derbyshire, Leicestershire and Rutland, Lincolnshire (including North and North East), Northamptonshire and Nottinghamshire), across 6,425 square miles. Each year we respond to over 616,000 emergency and urgent calls.

Sepsis screening tools

In March 2015 EMAS introduced an updated sepsis screening tool (both adult and paediatric) based upon the Sepsis 6 red flags and NHS England Safety Alert (2014) (appendices 1a and 1b). Prior to this EMAS had in place a generic sepsis screening tool based upon the same features as the updated tool but did not have specific paediatric element included (appendix 2).

In addition to the Sepsis screening EMAS has in place the Paramedic Pathfinder Triage tool (PP). The PP Triage tool is a pre hospital assessment guide based around the widely used and validated National Early Warning Score. This is an objective screening tool which is based upon both physiological parameters and clinical presentations to allow for safe See and Treat care and also to ensure the early recognition of the sickest patients requiring Emergency Department admission. . Since its introduction in April 2014 94% of staff have completed training. The application of this tool in this case would have required Emergency Department conveyance based upon the presenting symptoms. A copy of the PP tool can be found in appendix 3.

Communication and Education

As a part of our annual education programme for 2014/15 Sepsis assessment and management was included for all clinical staff and continued into the 2015/16 plan to allow for all staff to undertake this education. The educational material for this is found in appendix 4. In addition to educational material, awareness of staff has been promoted via clinical bulletins issued over the period of the last four years. Following this incident a further clinical bulletin has been issued to highlight the learning gained from this incident and other cases where Sepsis management could have been improved (appendix 5).

In addition to our allocated annual education programme Paramedic Pathfinder has been delivered as an additional face to face education session to all clinical staff from 2014. This tool was primarily launched for Paramedics but has now been extended to include other qualified clinicians within EMAS.

As with any patient safety incident or incident investigation learning is taken both organisationally and at an individual clinician level as required. In such cases, as a part of the investigation process, the EMAS organisational learning team is utilised to develop support programmes for any member of staff noted to have a linked educational need or support. It is essential that learning is taken across all levels; this ensures that responsive changes to practice are achieved. In this case a supportive programme was provided to the clinician both as a supportive and developmental measure. This process is supported by a number of key policies within EMAS such as the Supporting Capability Policy.

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I trust that the measure and safeguards cited above and evidenced in the appendices provide you with the appropriate level of assurance in relation to the commitment and planning of EMAS in relation to patient safety and the management of suspected sepsis.

Yours Sincerely

Sue Noyes
Chief Executive

NHS
West Leicestershire
Clinical Commissioning Group

CCG Headquarters
55 Woodgate
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Leicestershire
LE11 2TZ

Tel: 01509 567 700
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From the office of: [redacted]
Telephone:
Your ref: CEM/GA/00705-2015

11 December 2015

H.M Coroner
For Leicester City and South Leicestershire
The Town Hall
Town Hall Square
Leicester
LE1 9BG

Dear Mrs Mason

Re: Caroline Elisabeth Robey – Regulation 28 Report

I write further to your report made in accordance with paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013.

As outlined within your report, it is considered that action should be taken to prevent future deaths and that NHS West Leicestershire CCG has the power to take such action. I am now in a position to provide you with the following information.

I would firstly like to clarify that NHS West Leicestershire CCG is the commissioner of the Loughborough Urgent Care, with Central Nottinghamshire Clinical Services (CNCS) providing the clinical services from the Loughborough Urgent Care Centre. This response has been jointly prepared by both the CCG and CNCS.

I can confirm that the matters raised Mrs Robey's care has been formally reported as a Serious Incident (SI) and is being managed through the CCG's SI process.

I will now respond to each of your specific requests for information in turn.

No sepsis screening tool was being used by the community health care providers, and so opportunities were lost to consider a diagnosis of sepsis and refer as an emergency for hospital admission and treatment

Please see the enclosed action plan developed by the Loughborough Urgent Care Centre. As you will note, an organisational sepsis policy has been developed and during April and May 2015 all staff at the Loughborough Urgent Care Centre completed a training course in sepsis recognition. In addition, work is currently ongoing at the Loughborough Urgent Care Centre to implement the sepsis6 pathway.

A patient safety alert issued 2 September 2014 by NHS England clearly sets out resources available in the provision of a UK sepsis tool kit, but this had not been recognised or adopted by the health care providers involved in this case

I would again refer you to the enclosed action plan developed by the Loughborough Urgent Care Centre. As you will note, an approved system to review and implement patient safety alerts at the Loughborough Urgent Care Centre will be developed by January 2016, with regular assurance reports subsequently provided to the Clinical Governance Committee at CNCS on the implementation of all relevant Patient Safety Alerts.

In addition, the CCG's Head of Infection Control has arranged for an email to be circulated to all GPs within Leicester, Leicestershire and Rutland (LLR) entitled 'Managing Sepsis' as follows:

> *In September 2014 NHS England issued a Stage Two Patient Safety Alert relating to the prompt recognition of sepsis and the rapid initiation of treatment. This alert was sent out to all GP's by NHS England via the CAS system on 3 September 2014. The aim of the alert was to raise awareness of sepsis and signpost GP's to a set of resources developed by the UK Sepsis Trust, and others, to support the prompt recognition and initiation of treatments for all patients suspected of having sepsis. Following a Coroner's case the CCG has re-issued the alert reminding GPs of the need to ensure staff have access to both adult, paediatric and infant sepsis screening and action tools that can be used for patients presenting on first attendance or developing suspected infection. Staff are reminded that the resources should now have been introduced into clinical practice, in particular the administration of antibiotics within one hours of suspicion of sepsis. The UK Sepsis Trust Toolkit: General Practice management of Sepsis guidance is available at: http://sepsistrust.org/wpcontent/uploads/2015/08/1409322498GPtoolkit2014.pdf*

I can further confirm that a WLCCG Board GP, Dr Chris Barlow, has a meeting arranged with Dr John Parker, a Critical Care Consultant at the University Hospitals of Leicester (UHL), on 15 December 2015; as UHL have successfully implemented a number of quality improvement projects for sepsis in UHL, they have offered to meet with the CCG with the aim of sharing their experience/materials and to provide support in ensuring that staff have a developed understanding of the management of sepsis.

Following the above meeting, a Protected Learning Time (PLT) event will subsequently be arranged to further raise awareness of sepsis within primary medical care.

Inadequate note was taken of the number of different attendances Mrs Robey had initiated despite previous good health, and there was no suggestion she was a frequent attender or had ever sought medical assistance inappropriately

I would again refer you to the enclosed action plan developed by the Loughborough Urgent Care Centre. As you will note, a clinical newsletter was circulated in July 2015 to alert clinicians at the Loughborough Urgent Care Centre to key learning points from the case of Mrs Robey. In addition, the Loughborough Urgent Care Centre are in the process of developing a Local Operating Procedure for multiple attendances, which is to be approved and implemented by February 2016.

It is my understanding that the CCG's Chief Nurse has liaised with the Head of Quality at NHS England regarding the actions of the specific GPs involved in Mrs Robey's care and has received assurances that Dr Khokar has been referred to their Professional & Practice Information Gathering Group (PIGG) to review their individual performance as a practitioner.

Dr D Youseff has been confirmed as a Foundation Year 2 GP, and therefore this matter has been referred to Health Education East Midlands (HEEM).

I trust that the above information is of assistance, but please do not hesitate to contact me if you require any further information.

Yours Sincerely,

Ket Chudasama
Assistant Director – Corporate Affairs
t: 01509 567702