Department of Health

POC 1031054

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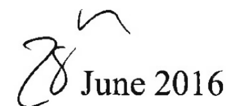 June 2016

Thank you for your letter of 20th April 2016, following the inquest into the death of Helen Patton. I was sorry to hear of Mrs Patton's death and wish to extend my sincere condolences to her family.

Your report concerns the performance of mini Tracheostomy procedures. You raise a number of points:

- the continuing risk of mortality, where mini tracheostomy procedures are not undertaken within theatre conditions or ultrasound guided;
- that mini tracheostomy procedure is undertaken regularly on a national level without ultrasound guidance or in theatre conditions;
- the absence of any national guidance in respect of mini tracheostomy procedures to minimise the risks associated with them, particularly the risks of conducting such procedures outside of an operating theatre and without ultrasound guidance.

I have consulted the Royal College of Surgeons (RCS), the Faculty of Intensive Care Medicine (FICM) and the Royal College of Anaesthetists (RCOA) in preparation of this response.

FICM and RCOA have reviewed your Regulation 28 report and provided a joint response to the issues you raise (enclosed). They confirm that routine use of ultrasound is not mandated prior to mini tracheostomy as it is not currently feasible to do so for a number of reasons. The Intensive Care Society and FICM are developing ways to standardise ultrasound access training in order to make it more accessible.

However, FICM and RCOA point out that ultrasound is largely limited to pre-procedure planning and anatomic landmark identification as the size and shape of most available probes makes real-time scanning impractical. They also point out that bleeding can occur with or without prior use of ultrasound.

With regard to carrying out a mini tracheostomy procedure, FICM and RCOA confirm that an appropriately equipped critical care unit is and would be a suitable setting.

The reasoning and evidence for these views is in their full reply.

Various reviews and professional guidance have been published for England concerning the safe use of Tracheostomy and the care of patients undergoing this treatment:

- The National Institute for Health and Care Excellence (NICE) has produced interventional procedure guidance [IPG462] on Translaryngeal tracheostomy which makes recommendations on the safety and efficacy of this procedure. This guidance acknowledges that Tracheostomy is commonly carried out for patients in intensive care and although this may be performed surgically, anaesthetists and intensive care physicians usually perform the procedure using a percutaneous technique under endoscopic guidance. NICE reports that the translaryngeal tracheostomy technique may lead to lower rates of bleeding, trauma and infection to the tissues surrounding the insertion area, compared with surgical and other percutaneous techniques. It may also avoid the risk of damage to the posterior wall of the trachea and tracheal rings, because of a lack of external compression during insertion.

- The National Confidential Enquiry into Patient Outcome and Death (NCEPOD) has published a report, On the Right Trach? (2014). The report reviews the care received by patients who underwent a tracheostomy and includes comprehensive key findings and recommendations. As a result of the NCEPOD report, the National Tracheostomy Safety Project (NTSP) published a comprehensive best practice guide, *Comprehensive Tracheostomy Care - the NTSP Manual*, in 2014.

- In addition, the Royal College of Anaesthetists (RCOA) has published Anaesthesia services for head and neck surgery 2015. These guidelines include advice on support and care for tracheostomy patients and recommend that all Trusts should have a protocol and mandatory training for tracheostomy care.

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All of these guidelines were developed following consideration of the risks associated with tracheostomy procedures and therefore incorporate best practice advice and support. They all clearly indicate that it is routine practice to carry out an emergency tracheostomy in a critical care unit. What is of vital importance however is the level of competency of the individual carrying out the procedure, the availability of senior support and access to appropriate resuscitation equipment.

I hope that this reply is helpful and I am grateful to you for bringing the circumstances of Mrs Patton's death to my attention.

Yours sincerely,

BEN GUMMER