SR

Wrightington, Wigan and Leigh NHS

NHS Foundation Trust

[redacted]

8 September 2016

Chief Executive's Office
Trust Headquarters
Royal Albert Edward Infirmary
Wigan Lane
Wigan
WN1 2NN

Tel: 01942 822196
[redacted]

Simon D A Jones
HM Assistant Coroner
Manchester West
HM Coroner's Office
Paderborn House
Howell Croft North
Bolton
BL1 1QY

Dear Mr Jones

Regulation 28 Response: Margaret Mary Gleeson (Deceased)

Thank you for your Regulation 28 Report dated 15 July 2016.

I understand that an inquest relating to the death of Mrs Margaret Gleeson concluded on 22 June 2016. I have been fully advised of the circumstances relating to Mrs Gleeson's death and having read your report, I am grateful to you for bringing these concerns to my attention.

Since the conclusion of the inquest Wrightington, Wigan and Leigh NHS Foundation Trust ("the Trust") has been working to ensure lessons have been learnt from the events surrounding Mrs Gleeson's death. I would like to take the opportunity to advise you of the actions already undertaken by the Trust and the proposed action to be taken in the near future.

The review has addressed the following:

1. At the weekend the on call team had to do the job of 4 teams and that it was not possible to provide patients with the care they deserve. In the circumstances I consider that staffing levels should be reviewed.

2. The scoring of the MEWS tool on the medical charts had been done in accurately, and the use of the MEWS tool did not appear to be clearly understood. It would appear that refresher training would assist.

The information below forms the Trust's response in relation to our duty under Regulation 29 of the Coroners (Investigations) Regulations 2013.

Staffing Levels

During the inquest evidence was heard that at weekends the surgical on call team were extremely busy which led to patients, on occasions, not always receiving the standard of treatment they should expect. The Directorate of General Surgery recognised the variation in patient care that existed between weekends and weekdays, and action has been taken accordingly.

Please find enclosed a copy of the updated Action Plan in respect of the Trust's Investigation Report into Mrs Gleeson's death. Within that Action Plan you will note that the Surgical Division has now allocated a middle grade surgeon to undertake a 4 hour ward round for elective patients during weekends. This means that a middle grade clinician (such as a clinical fellow or surgical registrar) will

now perform additional duties at weekends to check on patients who have undergone elective surgery. These middle grades will review the patients and report any concerns to their on-call Consultant. These changes have been made to ensure that the surgical rota for doctors is robust, and also to ensure that these patients receive a daily senior review.

By making these changes elective surgical patients, such as Mrs Gleeson, are guaranteed to be seen by more experienced clinicians at weekends, thereby allowing junior doctors more time to undertake their other duties.

To ensure there are sufficient clinicians to cover the additional ward rounds, the Trust is in the process of recruiting 2 clinical fellows. One appointment has already been made, and it is hopeful the second appointment will be filled in the upcoming weeks.

The changes brought about by the additional weekend working is being monitored through the Trust's Surgical Clinical Cabinet. The Cabinet is chaired by the Trust's Acting Medical Director and is attended by senior representatives of the Surgical Division responsible for implementing these changes.

MEWS Tool

In addition to the above, it was evident at inquest that staff did not appear to understand how the MEWS chart should be scored, and additional training for nursing staff would be required.

Since the conclusion of the inquest in June 2016 the Trust has provided extensive training programmes both in the accuracy and recording of MEWS and fluid balance, but also in recognising and responding appropriately to the early signs of deterioration in patients, including sepsis. The enclosed Action Plan provides extensive evidence of the teaching sessions held to date, and those sessions will continue on a monthly basis for all Trust staff involved in patient care.

Firstly, with regards to training of the MEWS tool this has been led by the Trust's Critical Care Outreach Lead, [redacted], through the QUEST programme. This programme trains nursing staff on the use of the MEWS Tool, and highlights the importance of accurate scoring. A dedicated Critical Care Outreach Nurse also undertakes monthly audits of compliance with MEWS standards. Copies of these audits are embedded within the enclosed Action Plan and the results are fed back to Ward Managers and Heads of Nursing for action to be taken, wherever necessary. They are also monitored through the Trust's Harm Free Care Board.

In addition to this, the Trust's Director of Nursing, [redacted], has established since the inquest, and is currently chair of, a dedicated Task and Finish Group to oversee the use of the MEWS Tool. The Group meets on a monthly basis to discuss the audit findings and to monitor compliance and accuracy of scoring.

Secondly, extensive training programmes have also been held in recognising and responding appropriately to early signs of deterioration in patients, including sepsis, which was relevant in Mrs Gleeson's case. This training has been led by the Trust's dedicated Sepsis Specialist Nurse, Ms [redacted], through attendance at the Trust's Sepsis Study Day. Evidence of staff attendance at this programme is contained within the enclosed Action Plan, and arrangements are in place to make this training mandatory for all nursing staff.

[redacted] has also conducted a number of Sepsis 'Drop-In' sessions specifically for nursing staff on Swinley Ward where Mrs Gleeson was being cared for. These sessions have focused on sepsis recognition, understanding the sepsis screening tool and sepsis management.

In addition to the above, the Trust also has in place the Acute Illness Management (AIMS) course that focuses on the recognition of the acutely unwell deteriorating patient, and how they should be managed. Training on sepsis is also contained within this course.

Management of sepsis is audited on a monthly basis and the results are contained within the attached Sepsis Dashboards. [redacted] has confirmed that these audits show improvements in sepsis screening, and also with the use of the Sepsis Six pathway within the Trust's A&E Department.

Continued Monitoring

The above actions will be monitored via the Trust's Quality and Safety Committee which is chaired by a Non-Executive Director and attended by several members of the Executive team, including the Director of Nursing. Every month updates will be provided to the Committee on the actions listed above.

I hope the above response is testament to how serious the Trust has dealt with events surrounding Mrs Gleeson's death. The welfare of our patients is paramount and we will continue to ensure lessons are learnt.

If you have any comments or suggestions in relation to the proposed actions above, I would be only too pleased to hear from you

Yours sincerely

Andrew Foster CBE
Chief Executive