Department of Health

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Ms L Hashmi
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Dear Ms Hashmi

9th October 2017

Thank you for your letter of 19 July to the Department about the death of Ms Edith Robinson. I am responding as the Minister with responsibility for hospital care. I am grateful to you for accommodating additional time to finalise our response.

I was very saddened to read of the circumstances surrounding Ms Robinson's death. Please pass my condolences to her family and loved ones. I appreciate this must be a very difficult time for them and I am truly sorry for the failings in the care and treatment provided by the NHS.

Your Report raises several areas of concern that I will address in turn.

Firstly, on the matter of consultant review over weekends, I can assure you that it is a key commitment of the Government to work with the NHS so that seven day services are available in all hospitals.

The variation in medical staffing levels at weekends, with less frequent clinical review and decreased access to investigations and interventions, is currently being addressed by the Seven Day Services programme. The programme is being implemented across England and is jointly led by NHS England and NHS Improvement. Further information is available at the following website (www.england.nhs.uk/ourwork/qual-clin-lead/seven-day-hospital-services/).

One of the priority clinical standards specifically focusses on daily, twice daily, or delegated medical review for all patients requiring clinical input every day of the week, including weekends.
The four priority standards are:

- Consultant assessment – as soon as possible and at least within 14 hours of admission;
- Key diagnostic tests within one hour for critical patients and 12 hours for urgent patients;
- 24-hour access to consultant-led interventions (e.g. emergency general surgery, interventional radiology); and
- Consultant-led ongoing review – twice daily for high dependency patients, once daily for general ward (unless it would not affect the patient's care pathway).

The standards are being implemented across England in stages. The national ambition is for these standards to be delivered for half of the population by April 2018 and across the whole of England by 2020/21.

I am advised that the Pennine Acute Hospitals NHS Trust was identified as a Phase 1 site for the delivery of the Seven Day Service standards. The Trust continues to work towards achieving the standards and NHS England and NHS Improvement are providing ongoing support to the Trust.

In terms of ensuring appropriate medical review through weekdays and weekends, I am advised that the Trust has agreed that all patients will be reviewed daily by the medical team and that the Trust is currently looking to ensure that all trauma patients with severe systemic illness will be reviewed daily by a medical doctor. This will be monitored through Trust audits. I am informed the Trust has also sought to clarify the process around referral to orthogeriatricians and has confirmed that the orthogeriatricians will review any patient with a bone injury referred to them Monday to Friday.

Turning to concerns around the use of early warning scores (EWS), the National Institute for Health and Care Excellence (NICE) published its guideline on '*Acutely Ill Patients in Hospital: recognising and responding to deterioration*' in 2007 (www.nice.org.uk/guidance/cg50). The guideline makes recommendations on the use of a graded response strategy but does not recommend any specific scoring system, which should be agreed and delivered locally. However, the National Early Warning Score (NEWS) developed by the Royal College of Physicians in 2015 (www.rcplondon.ac.uk/projects/outputs/national-early-warning-score-news) is widely used and has been endorsed by the National Quality Board.

An EWS should always be used in conjunction with clinical judgment. Some hospitals have introduced electronic systems that automatically calculate the EWS and trigger awareness of deterioration directly to a senior clinician such as a member of a Critical Care Outreach Team. Nevertheless, it remains essential that individual ward-based clinical staff are able to record and interpret vital signs that signify deterioration, and to recognise when to seek senior support. I am advised that the Patient Safety Collaboratives across England have a new workstream specifically focussing on recognition of, and response to, acute deterioration.

There is an expectation that, under the Nursing and Midwifery Council's (NMC) Code of Conduct, registered nurses must preserve safety by being able to accurately assess signs of normal or worsening physical and mental health in the person receiving care. They must also understand that they retain responsibility for monitoring EWS even if the task of taking observations is delegated to a support worker.

You may be aware that the NMC has recently closed its consultation on education standards, including the pre-registration standards of proficiency that nurses must meet before being registered with the NMC. I am advised that the draft standards currently include specific standards relating to patient assessment and management of patient deterioration (as well as record keeping). The NMC has made its education team aware of the concerns you have expressed in your Report to feed into the education standards review.

Locally, I am advised that it is part of the Pennine Acute Hospital NHS Trust's action plan as a result of this incident to improve staff knowledge and skill in recognising and caring for deteriorating patients and ensuring that physiological observations are completed as per the Trust's policy. In conjunction with this recommendation, improved standards of documentation for both nursing and medical staff were also identified.

I am further advised that to support calculations being performed correctly, the Trust has implemented the New Early Warning System (NEWS) and is undertaking assertive work to specifically address the issues of miscalculating EWS, including staff training. A series of audits commenced in July, with standards required by the new system being continuously monitored. In addition, I am advised that the Trust will be introducing electronic recording of observations

in the coming months which should improve the accurate recording of observations.

The third area of concern in your Report is around the standard of record keeping. Both the NMC and the General Medical Council (GMC) have guidance for practitioners on record-keeping and both professions are responsible for maintaining clear, timely signed records for patients.

The GMC's guidance is contained within its Good Medical Practice guideline (www.gmc-uk.org/guidance/good_medical_practice.asp), and for nurses, standards relating to documentation is contained within the NMC Code of Conduct (www.nmc.org.uk/standards/code/). In addition, the Royal College of Physicians has recently produced standards on generic medical record keeping. The standards can be found on the Royal College's website at (www.rcplondon.ac.uk/projects/outputs/generic-medical-record-keeping-standards).

As indicated above, the NMC has recently consulted on changes to its educations standards, including record keeping and the concerns in your Report will be shared with the education standards review team.

Doctors and nurses working in managed environments (such as hospitals) should be following the record keeping practices established locally. In addition, in England, these practices must adhere to standards set out in Regulation 17 on good governance by the Care Quality Commission (CQC) (www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-17-good-governance).

I am advised that there is evidence of limited compliance across NHS trusts with recording the exact date and time of clinical review and the grade of the senior reviewing doctor. Support is being offered to provider organisations through NHS England's Sustainable Improvement Team to help improve performance in this area.

With regard to the Pennine Acute Hospitals NHS Trust, I am advised that the Trust has recognised that all staff need to improve standards of documentation and this includes compliance with mandatory health records training. The Trust has a target for 90 per cent compliance for documentation. To support this, monthly documentation audits will take place and these will be followed up at 1:1 meetings with staff who are non-compliant. In addition, the Trust has recently adopted a Nursing Assessment and Accreditation System which includes an audit that examines documentation and record keeping.

Department
of Health

Finally, I acknowledge that concerns around out of hours care and management of the deteriorating patient, including use of early warning scores, have been raised in previous Prevention of Future Deaths Reports involving care provided at the Pennine Acute Hospitals NHS Trust. As I explained recently in response to a separate report, the Trust is undertaking a comprehensive programme of improvement under the leadership of the Salford Royal NHS Foundation Trust, and progress is being closely monitored by an improvement board, involving local organisations and national regulators.

My officials have brought your concerns to the attention of NHS Improvement and the CQC.

I am advised by the CQC that the concerns you have identified are reflective of the findings it made in its inspection of the Trust in 2016. Since that inspection, CQC has been engaging with the Trust and has received regular updates on its improvement plan. It is CQC's intention to test the Trust's stated improvements, including those that touch on the concerns in your Report, during future inspections.

In addition, NHS Improvement will continue to review the implementation and embedding of the actions that the Trust has identified as a result of this case.

I hope this information is helpful and provides assurance that failings around quality and safety are being addressed at the Trust. Thank you for bringing the circumstances of Ms Robinson's death to our attention.

Yours sincerely

Philip Dunne

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