Guy's and St Thomas'
NHS Foundation Trust

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Dear Madam

Inquest touching the death of Daniel Williams

I am writing on behalf of Guy's and St Thomas' NHS Foundation Trust ('the Trust') further to the Regulation 28 Report to Prevent Future Deaths ('PFD report') dated 24 September 2019 in relation to the above inquest. I will detail the Trust's formal response below.

The Trust is grateful to the Court for granting an extension in time for the provision of its response to 26 November 2019 following receipt of the PFD report on 1 October 2019 (by post rather than email).

Within your PFD report, you expressed your matters of concern as follows:

1. Following surgery Mr Williams was left with a wound which was challenging to nurse and vulnerable to infection. Having initially been nursed on ITU/HDU, Mr Williams was stepped down to a general nursing ward.

2. The nursing care which Mr Williams received on this general gastrointestinal ('GI') ward was found - by an internal Trust investigation which took place sometime after Mr Williams' death following a request by you - to be "*deficient in delivering the fundamentals of care*".

3. Whilst still on this general GI ward, Mr Williams deteriorated and was transferred back to the HDU unit. The day following that transfer a stool sample taken tested positive for clostridium difficile ('c-diff').

4. Although you found at the conclusion of the inquest hearing that the presence of c-diff was not relevant to how Mr Williams ultimately came by his death, you indicated that you have residual concerns with the potential under investigation of c-diff cases within the Trust. You noted that this derived from what you were told during the hearing about the process which is triggered on discovering the presence of c-diff.

5. You noted that during the inquest hearing you were told that a c-diff infection is a potentially fatal infection. Consequently, it is a regulatory requirement that hospital trusts carry out a clinical case review whenever c-diff is found in order to determine whether it was linked to any "*lapses of care*" in the care and treatment of hospital patients.

6. You indicated that you were told that what should happen following the collection of a positive c-diff sample is that an alert is sent to the infection control nurse who then distributes the mandatory infection control data collection form to, inter alia, the ward on which the patient is currently. That ward — and that ward alone - then investigates, focussed on identifying "*any significant deviations from best practices...*" including in the following categories: deficiency in environmental cleaning, deficiency in hand hygiene and/or deficiency in antimicrobial stewardship. You noted that what is not done, however, is if the respective patient has recently been transferred from another ward, the investigation does not extend to the conditions on the transferring ward.

7. It was noted that in this case it was the transferring ward where there were found to have been failings in delivering the fundamentals of care and about which the family had raised significant concerns at the time. You observed that the only reason these failures were highlighted was that an investigation was undertaken following a pre-inquest review on 26 September 2018 at which Mr Williams' family raised concerns that he had died as a result of a c-diff infection contracted as a result of poor nursing care. You noted that the extent of the Trust's investigation was limited as it was conducted significantly after the event.

I have liaised with both the Gastrointestinal Unit at St Thomas' Hospital and also the Trust's Infection, Prevention and Control Team ('the IPC team') in order to coordinate the Trust's formal response to your concerns. I will deal with the information received from both areas in the sections below.

The Trust's Gastrointestinal Unit

The Gastrointestinal ('GI') Unit is based at St Thomas' Hospital. It is currently a 51 bedded unit which comprises of 2 wards: Page Ward and Northumberland Ward. Page Ward provides care for patients who are undergoing complex GI surgery following both of the Trust's elective and emergency pathways. Patients within these pathways have a variety of conditions which include: oesophageal cancer; bowel cancer; intestinal failure and inflammatory bowel disease.

Concern 1: Following surgery Mr Williams was left with a wound which was challenging to nurse and vulnerable to infection. Having initially been nursed on ITU/HDU, Mr Williams was stepped down to a general nursing ward.

The patients who we care for on Page Ward are some of the most complex patients within the Trust and many of them have significant comorbidities. In recognition of this, and following the Trust's investigation into the care and treatment received by Mr Williams, the Trust has reviewed its Education and Training Programme which is provided to the nurses who work on the GI unit. This programme includes education related to wound care and training on how to work in collaboration with our tissue viability nurses. In addition, the Trust's specialist nurses within the stoma team work closely with the nurses on Page Ward in order to educate and support them, on an on-going basis, to deliver specialised wound care to patients with complex abdominal wounds and often multiple stomas. The stoma team is also utilised to support our patients and the nurses within the critical care environment.

The Trust has created and delivered a specialised induction programme for all our new starters assigned to the GI unit. This programme is led by a practice development nurse to ensure that all new nurses on the GI Unit receive the support and supervision required to deliver expert nursing care. As part of the GI unit nursing team's continual development, the Trust provides a Band 5 nursing development programme and a development day for the GI unit's nursing assistants. This is specific to the Trust's GI speciality and includes a session with the stoma team which focuses on wound and stoma care.

To note, any decision to 'stepdown' or transfer patients to the GI unit from a critical care setting is a multi-disciplinary team decision. A decision such as this will involve the intensivist in charge of the patient's critical care and the surgical team with the overall responsibility for the patient. Once a decision is made to 'stepdown' a patient to the GI unit, the Site Nurse Practitioner is alerted who will then allocate the patient to a bed within either Page Ward or Northumberland Ward. In these circumstances, upon arrival to the relevant ward the patient will be reviewed by the Critical Response Team ('CRT') within 4 hours of the 'stepdown'. This allows the CRT to assess the patient's condition and provides them with an opportunity to liaise with the ward staff to check if they have any concerns about their ability to safely deliver care to that patient. The Trust's expectation is that ward staff are empowered to raise a concern if the clinical condition of the patient deteriorates at any time or in circumstances where they require any additional support. It is the Trust's expectation that the patient will be reviewed again by the CRT after 24 hours on the ward and also reviewed by the surgical team within 12 hours of their transfer to the ward. Nursing staff are able to contact the CRT or the surgical registrar if they require advice or if one of their patients requires urgent attention; this includes if the patient National Early Warning Score (NEWS) increases.

Concern 2: The nursing care which Mr Williams received on this general gastrointestinal ('GI') ward was found - by an internal Trust investigation which took place sometime after Mr Williams' death following a request by you - to be "*deficient in delivering the fundamentals of care*"

The Trust launched its Fundamentals of Care standards ('the standards') in April 2018. Following its inception, members of staff at the Trust have received training on the standards and I am satisfied that they are now embedded into the nursing practice on both Page Ward and Northumberland Ward. All new members of staff at the Trust receive education and training in relation to the standards as part of the Trust's specialised induction programme. Staff are also required to complete a competency assessment document which includes assessments around hygiene; infection prevention and control; fluid management and nutrition. All nursing staff on the GI unit, as part of their ongoing development, are required to complete competencies which include getting the basics of the care correct and delivering excellent fundamental care. Our registered nurses who carry out the Nurse in Charge role on a given shift also receive education and training in order to sufficiently equip them to recognise circumstances when a member of nursing staff might be struggling to deliver effective nursing care and to support them accordingly.

The Trust's Directorate Management Team ('DMT') is committed to ensuring that fundamental care is the cornerstone of our practice; this is not just within nursing care but also across the wider multi-disciplinary team. Quality rounds take place weekly which are led by the Clinical Director and Head of Nursing; these endeavour to review both patient safety and patient experience on all wards in the Gastro Medicine and Surgical ('GMS') Directorate. The Trust has found that engaging with the clinical teams in this way enables its DMT to clearly interact with staff members and offers a forum for staff to voice any concerns they hold. In addition, it allows the Trust's DMT to support staff with challenging situations (e.g. an operational issue, a staffing issue or a patient with complex needs) that require escalation.

Both Page Ward and Northumberland Ward's quality and performance is reviewed on a monthly basis via Trust scorecards. Page Ward's scorecard for the period October 2018 - September 2019 has no reportable c-diff or MRSA infection within it. Ward's hand hygiene audits are monitored on a monthly basis; the audits are compiled by a ward link nurse and are also independently reviewed by the Infection, Prevention and Control (IPC) team. For October 2019, compliance with hand hygiene standards was at 91.7%. The average compliance over the last year currently stands at 85%. Where scores fall below the Trust's expected standard which is RAG rated, Red <70%, Amber >70%, Green >90%, an action plan to improve compliance for a ward area is put in place.

An essential component in the delivery of high quality and effective fundamental care is for the Trust to ensure that it has the correct number of nurses allocated to its wards with the appropriate skills to deliver care there. Staffing on Page Ward is measured twice daily through the Trust's safe care system. This measures the dependency and acuity of the current patients on the ward and aligns this with the number of registered and unregistered nurses on duty. This system enables staff to identify any staffing risk by raising a 'red flag'. A 'red flag' is escalated in real time to the ward's Matron and Head of Nursing who are expected to mitigate any staffing risk by either providing support for the ward or by moving staff from another area to work on the ward. The ward's Matron also visits the ward daily to support staff and review any complex patient issues. Out of hours, the Site Nurse Practitioners monitor and respond to any 'red flags' that are raised. In addition to the daily staffing review by the Matron, the Head of Nursing reviews staffing numbers on a weekly basis to identify any shifts where there is a poor skill mix or where the nursing vacancy has not been filled with bank or agency staff; this seeks to mitigate any gaps in staffing in advance rather than on the day.

A Trust wide establishment review takes place twice a year to determine whether the current staffing levels meet the needs of our service. Workforce Key Performance Indicators are considered (such as: vacancies, sickness and statutory and mandatory training) as well as planned staff numbers against actual staff numbers. The workforce establishment review in 2018 highlighted the need to increase the numbers of senior nursing assistants on Page Ward in order to support the effective delivery of fundamental care. These posts have now been recruited into and the staff are now in place on Page Ward. Staffing has therefore increased by 1 whole time equivalent senior nursing assistant on both the day and the night shift on Page Ward.

The Trust's IPC Team

The Trust has an established comprehensive programme for the prevention and management of c-difficile. This programme follows best practice guidance from the Department of Health, NHS England and NHS Improvement.

Data from the Public Health England 'Data Capture System' (the official reporting portal for c-difficile and other reportable infections) indicates that the Trust has the lowest number of cases and the lowest rate of c-difficile amongst its peer organisations. These organisations make up the Shelford Group which is a collaboration between ten of the largest teaching and research NHS hospital trusts in England. The Trust is generally seen as a leading NHS Trust in this area.

For the current reporting year to date (1 April 2019 to 30 September 2019), the Trust has reported 20 cases of healthcare-associated (as nationally defined) c-difficile. This is compared with a range of 42 to 135 cases amongst our peer organisations. In terms of rate per 100,000 bed days, the Trust's rate for the current reporting year is 6.09. This is compared with a range of rates of 10.57 to 35.67 amongst our peer organisations. For the current reporting year, the Trust has not identified any "lapses in care" (formally defined as a significant failure of antibiotic stewardship or a proven transmission of c-difficile between two patients). Where there is more

than one case of c-difficile in the same clinical area within a 28 day period, this is defined nationally as a 'Period of Increased Incidence" and, within the Trust, this would result in a formal investigation. In addition, within the Trust, all c-difficile isolates are sent for molecular typing to assess for relatedness, i.e. likely transmission. To note, the Trust has not had any evidence of transmission in Mr Williams' case or any other case for this reporting period and for some considerable time before it (at least two years). There have been no outbreaks of c-difficile within the Trust for at least four years.

Concerns 3 – 7 regarding clostridium difficile ("c-diff")

The Trust's c-diff Action Group, under the chairmanship of Dr Simon Goldenberg, has reviewed the Trust's c-diff investigation process as a result of Mr Williams' death.

The c-diff investigation process has been subsequently revised. It now includes a stage whereby an assessment is made to check whether the mandatory infection control data forms need to be sent to another ward in addition to the ward where the patient is currently located. This is a formal assessment of the need to include a prior ward stay in the c-diff investigation process and to direct the investigation (and the mandatory infection control data forms) appropriately to a previous ward. The revised process now applies to any ward or clinical area on which a c-diff patient has been an inpatient in the seven days prior to the c-diff specimen being obtained or the onset of symptoms of c-diff. This will now ensure that in scenarios where a patient has recently been transferred to a ward from another ward, the c-diff investigation has the opportunity and flexibility to extend to the conditions of the transferring ward.

A copy of the revised protocol is appended to this letter as **Appendix 1**.

The Trust remains committed to improving patient care and learning from incidents such as Mr Williams' death.

Yours Sincerely

Dr Ian Abbs
Chief Executive & Chief Medical Officer
Guy's and St Thomas' NHS Foundation Trust