Nuffield Health response to the Regulation 28 report to prevent future deaths issued by HM Area Coroner Claire Welch for Cheshire on 8 October 2019 following investigation and inquest into the death of Mary Jane Chapman.

Nuffield Health: Introduction

Nuffield Health is the UK's largest healthcare charity and as an organisation with no shareholders, we invest all our income back into our vision to build a healthier nation. We do this through services in our family of 31 hospitals, 112 fitness and wellbeing clubs, healthcare clinics and emotional wellbeing services.

We operate as a responsible charity and are proud of our commitment to our flagship programmes to widen access to our services. This includes improving the lives of hundreds of children with cystic fibrosis through free exercise classes; pioneering the world's largest research project into how exercise can help men recovering from prostate cancer and working in partnership with schools to provide thousands of pupils with free timetabled programmes to improve their health and wellbeing.

Within the DNA of our charity is our values framework. We put our patients, customers and colleagues at the heart of everything we do because we CARE: this reflects our ethos: Connected, Aspirational, Responsive and Ethical.

Background to the Regulation 28 Report

HM Coroner Claire Welch, Area Coroner for Cheshire, held an inquest into the death of Mary Jane Chapman on 25-27 September 2019.

**Throughout this report, we shall refer to the patient as Mary, consistent with the terms of reference agreed with the family at the inquest.*

Mary underwent an elective right total knee replacement at the Nuffield Health Hospital Chester ("the Hospital") on 13 February 2018 and was discharged home 3 days later. During her pathway of care, she had a low platelet count and at the time of discharge, had a platelet count of 74. Due to a combination of reasons relating to the discharge process, an intended blood test by the GP approximately one week post-discharge was not undertaken.

Mary was admitted to the Countess of Chester NHS Hospital on 28 February 2018 and despite intensive medical treatment, she sadly died on 4 March 2018. The cause of death was a large myocardial infarction due to a left descending coronary thrombus, the underlying cause of which we now understand to be Catastrophic Antiphospholipid Syndrome (CAPS). Antiphospholipid Syndrome (APS) is a naturally occurring autoimmune condition; the trigger for this developing into CAPS could not be ascertained.

Coroner's concerns:

Although HM Coroner concluded that the apparent failure to ensure the follow-up blood test was undertaken in a timely manner did not cause or contribute to Mary's death, it was her opinion that

ongoing uncertainties in the Hospital's discharge process presented an ongoing risk to patient safety, in the absence of further action being taken. It was for this reason that a (Regulation 28) report to prevent future deaths was issued to Nuffield Health with a requirement to respond by 3 December 2019.

Matters of concern:

1) Although the Nuffield Health Discharge Policy was revised in 2018 as a direct consequence of learning following the internal investigation into this event, the document was considered by HM Coroner to be lengthy, unwieldy and generic. HM Coroner was particularly concerned that the policy did not give sufficient clarity to who is responsible for doing what, or when, as part of the discharge process.

2) A lack of policy or guidance for arranging critical post-discharge investigations.

3) In respect of 1) and 2) above there was no evidence at the inquest to give assurance that clinical and nursing staff are now aware of their roles and responsibilities in the discharge process. Equally, there was no evidence that such changes (as have been implemented) have improved the quality, accuracy and robustness of discharge communications.

4) Despite reinforcing the need for doctors to document fully their intended plan for follow up investigations in the medical records, there was no evidence to demonstrate that this resulted in improved record keeping or more robust and accurate discharge communications.

5) There was no document or policy to guide the multi-disciplinary risk assessment of patients with low platelet counts. There was no evidence of how such an approach should work in practice nor evidence to demonstrate the approach has improved the risk assessment of such patients.

6) As consultants working at Nuffield Health come from a variety of hospitals with different practices, and acknowledging clinical judgment will inform individual discharge plans, the responsibility for ensuring clear and unambiguous procedures sits with Nuffield Health.

Nuffield Health's response to HM Coroner's Regulation 28 findings

Immediate Actions:

Upon receipt of the Regulation 28 report to prevent future deaths, Nuffield Health's CEO, Steve Gray, tasked the Clinical Director and Chief Nurse, [redacted] to lead the response keeping him, the Executive Board and Governors routinely updated on progress at their monthly Board meetings. [redacted] sent a letter of acknowledgement to HM Coroner the day following receipt of the report.

Immediately following a period of annual leave [redacted], Hospital Director at Chester Hospital sent a letter of acknowledgement to Mary's partner on 21 October 2019. In this, he gave assurance as to how seriously the Regulation 28 report is being taken and explained that a copy of our response will be shared with her once complete. [redacted] also advised that [redacted] will make arrangements to meet with her to discuss the actions and changes, if she feels this would be helpful.

[redacted] Quality Care Partner (QCP) Quality Improvement and therefore part of the Clinical Directorate senior leadership team co-ordinated and implemented the action plan involving the Medical Director, clinical subject matter experts and senior leaders at hospital level as required.

A copy of the action plan as of 30 November 2019 is attached; Appendix A.

Subsequent Actions: For clarity, the number assigned to each of the actions listed below correlates with the number of the concerns listed above:

1) The revised Nuffield Health Policy (Appendix B) is rewritten paying particular attention to clarity of role and responsibilities associated with different professionals within the multidisciplinary team, with regard to the patient discharge process. The process itself has greater clarity and considers all scenarios that may present for patients using Nuffield Health services.

2) The revised Nuffield Health discharge policy includes the process for arranging critical post-discharge investigations.

3) The role & responsibilities of all professionals working within the multidisciplinary clinical team are clear within the revised policy and an audit process, which is currently being tested, will be used across all hospitals to monitor the efficacy of the process and the patient experience. This audit is on our electronic Quality Management System (QMS). The list of questions that make up the audit are attached at Appendix C but please note that this does not show the on-line format which is user-friendly with clear headings. Section 7 onwards of the audit is of particular relevance

4) Every medical practitioner working within Nuffield Hospitals received a communication:

(i) Consultants

Within 4 working days of receiving the Regulation 28 report to prevent future deaths the Medical Director for Nuffield Hospitals issued a communication for all consultants with practising privileges reiterating their responsibilities in relation to contemporaneous documentation and their communication with nursing staff & GP's in relation to the discharge of patients. A copy of this communication went to every Hospital Director (Registered Manager) and Matron (Appendix D).

(ii) Resident Medical Officers (RMO's)

Within 5 working days of receiving the Regulation 28 report to prevent future deaths an urgent tele- conference was held with the Chief Executive and Medical Director of NES Healthcare (provider of RMO's to Nuffield Hospitals), the Nuffield Health Quality Care Partner for North & Midlands (clinical contact) and the contract lead from Nuffield Health's procurement team.

Actions agreed and completed within 4 weeks were:

- All RMO's received a copy of the correspondence sent to consultants.
- All RMO's received a case study based on this event to reiterate their responsibilities in relation to communications with consultants, contemporaneous documentation and their communication with nursing staff & GP's in relation to the discharge of patients (Appendix E).

- Within the communication sent to RMO's, it is made clear that they must escalate all abnormal investigation results to the consultant and clearly document this in the patient's medical records. In addition, and further to learning from this event, information, clinical criteria & resource regarding antiphospholipid syndrome (APS) was also included.
- To provide robust and ongoing communications to this relatively transient workforce, NES Healthcare reviewed the RMO job description and strengthened the emphasis on responsibilities regarding escalation and communication of abnormal results to consultants and contemporaneous documentation (Appendix F). All current RMO's have received a copy of the new job description, as will all future appointments.
- The clinical team at Nuffield Health reviewed the RMO Induction and Handbook to strengthen the emphasis on the above responsibilities (Appendix G (1 and 2)).

(iii) Hospital teams

Further to these communications, the Medical Director and Clinical Director/Chief Nurse sent a joint communication to all Hospital Directors (HD's) & Matrons to reiterate the learning and actions taken following the inquest. This outlines the actions required at local level. (Appendix H).

5) The Admissions Policy for Nuffield Health Hospitals is being updated and in final draft. As an appendix to the policy, hospital teams will attach their local standard operating procedure (SOP) outlining inclusion and exclusion criteria for patients attending pre-operative assessment (POA) for elective surgery. This will be based upon the facilities at each hospital and service provision. Further to the learning from this event, it is recommended that should a patient present with a known diagnosis of APS, the admitting consultant must seek advice on a case-by-case basis from a consultant Haematologist before proceeding with treatment (Appendix I).

With regard to abnormal platelet counts in the event of no known diagnosis of APS, we know from the investigation that the nursing team correctly escalated the low platelet count noted at POA, which is consistent with Nuffield Health Policy. For ongoing assurance, our established audit programme includes monitoring anaesthetic records to ensure abnormal results are highlighted.

The consultant must be informed of any abnormal blood results noted during the patient's stay; blood results are issued to the relevant clinical area from which the nursing team and / or RMO will receive and read them. The communications issued following this event to all medical personnel, with Matrons copied (for sharing with nursing teams) highlights this requirement and for the respective practitioner to make a contemporaneous medical record.

Summary

Mary's unknown APS led to a very complex, unexpected and highly unusual clinical situation. The hospital team, and indeed the wider Nuffield community, have been very saddened by this tragic event.

Immediately following Mary's death, a local investigation took place at the Hospital with significant changes to mitigate future risk. This included the introduction of an additional step in Nuffield's

protocol, this is to contact GP's by telephone (in addition to sending the discharge summary) when there is an urgent action required of them. This in turn was included in the revised national discharge policy.

Another key development in the Hospital was the introduction of electronic issue of discharge summaries via a secure portal, to give heightened assurance that information is received into GP surgeries within 48hrs of patient discharge. This system is in place in a small number of Nuffield Hospitals and we are looking to extend across all 31 locations. We now recognise further opportunities to improve quality and consistency of the discharge process through standardisation of systems, process and collaborative working with GP's, which we are taking forward in our Quality Improvement Plan.

The national policy originally developed in response to this event, included features intended as risk mitigation factors. The experience and outputs from the inquest have demonstrated the value of testing such documents with individuals and teams detached from (in this case the discharge) process to determine how clear the protocol really is to individuals less familiar with Nuffield Health systems and processes. This was a key piece of learning we shall apply to future policy developments. Reviewing the document with fresh eyes has, we believe, produced a more succinct policy with much greater clarity.

This experience further highlights the complexity of multi-disciplinary working within the healthcare environment, and the critical nature of key fundamentals; verbal and written communications, for which all registered professionals, are individually accountable. The steps we have taken to reiterate this across all disciplines are hopefully clear within this response and the evidence provided. To gain assurance of ongoing standards and quality these aspects, along with other key indicators associated with the discharge process, are now more robust within our audit framework. Importantly, this involves not only a retrospective review of medical records, but also the patient's experience.

We sincerely hope that our response and the actions outlined in this report demonstrate and provide assurances to HM Coroner and Mary's family that Nuffield Health have taken on board and acted upon the concerns raised in the Regulation 28 report to prevent future deaths.

[redacted]
Clinical Director and Chief Nurse
Nuffield Health

01 December 2019