

2nd February 2016

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Ms Selena Lynch
Senior Coroner
The Coroner's Office
St Blaise Building
Bromley Civic Centre
Stockwell Close
Bromley
BR1 3UH

John Goulston
Chief Executive
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RESPONSE TO REGULATION 28 CORONER'S REPORT TO PREVENT FUTURE DEATHS

Dear Ms Lynch

Re: Madhumita Mandal (Deceased)

I write to you in my capacity as Chief Executive for Croydon Health Services NHS Trust ("the Trust").

This response is made on behalf of the Trust. This response follows a Prevention of Future Death Report ("the Report") commissioned by you, dated 08 December 2015.

The Report was commissioned in relation to the inquest into the death of Ms Madhumita Mandal who died on 11 September 2013. The inquest into Ms Mandal's death concluded on 23 September 2015.

Thank you for sharing the Report with the Trust and I note that the subject matter of this Report, as set out at paragraph 4, relates to the events in the Urgent Care Centre on 7 September 2015.

I understand that the Report has been sent to the Trust, Virgin Care Wandle LLP and the Croydon Clinical Commissioning Group.

Your concerns

The Trust is mindful that consideration must be given to this report and any response. In considering this report I have consulted with the clinical lead in the Trust's emergency department and the Trust's Medical Director.

The Trust's relationship with the Urgent Care Centre ("UCC")

I understand from paragraph 5 of your Report that your concerns relate to the 'streaming' of adult patients arriving at the Trust's emergency department through the Urgent Care Centre ("UCC").

The Croydon Clinical Commissioning Group ("CCG") awarded the contract for delivery of urgent care services to Virgin Care Wandle LLP. Virgin Care Wandle LLP controlled the steaming of adult patients who arrived in the Trust's Emergency Department at the time of the incident. The functionality and review of the streaming model at the time of the incident is accordingly the responsibility of Virgin Care Wandle LLP.

The Trust respectfully submits that it is therefore not in a position to comment on the streaming model implemented by Virgin Care Wandle LLP nor the appropriateness of the triage assessment undertaken by the urgent care receptionist. The Trust does not consider it is in a position to

comment on any actions or proposed timescales for any actions by Virgin Care Wandle LLP arising as a result of this inquest, save for those that relate to the working relationship between the UCC and the emergency department.

Actions taken on behalf of the Trust

As set out above, the Trust considers that the subject matter focus of your report will require a response from Virgin Care Wandle LLP or their insurers given the venue of your concerns. However, I note the contents of paragraph 3 of your Report and as a Trust we recognise the need for continual review and improvement of our health care services.

Having consulted with the emergency department's clinical lead and the Medical Director, I can confirm that since September 2013 there have been changes made to the interface between the UCC and the Trust's own emergency department.

1. Medical observation reviews in UCC

The streaming model currently in place between the UCC and the Trust's emergency department is now delivered by band 6/7 (senior) emergency department nurses.

2. Formalisation of the handover process from the UCC to the emergency department

Patients received by the resuscitation team are received and assessed by an emergency department consultant or registrar. It is now standard practice for the Consultant in charge of the department on each shift to undertake a formal handover from the resuscitation area before starting the ward round, as opposed to relying on verbal feedback; this change was implemented immediately after Ms Mandal's death.

The 'handover' process in which patients are transferred from a UCC practitioner to the emergency department has been formalised in that on acceptance of a patient to the emergency department, both clinicians involved in the handover must sign and time-stamp a document to ensure the exact timing and approval of the handover are documented. This helps to ensure that an appropriate care/treatment plan is devised and reviewed by more senior medical staff, and assists in the timely delivery of treatment.

3. Fortnightly governance review meeting

There is now a fortnightly review of governance and process issues between the UCC and the emergency department; this has allowed us to work more closely with our UCC colleagues and recognise and deal with potential problems more quickly. We have used the forums to refine the streaming and handover processes thus ensuring patients get to the correct clinicians in a safe and timely fashion.

4. More emergency care nurses /paramedic practitioners in resus area

We now have a well-established team of Emergency Care Nurses and paramedic Practitioners within the resus area who all have extended skills. This team has dramatically improved the quality and consistency of care we offer patients in the resuscitation room. They offer great support to the doctors but are also empowered to make autonomous decisions to escalate to more senior staff when the need is required.

Conclusion

Following the changes to the practice both in the UCC/Trust's emergency department interface and in the Trust's Emergency Department, I note there have been no similar incidents since Ms Mandal's death.

The new streaming model between the UCC and the Trust's emergency department is more suitable in terms of patient safety and I understand this is the same model that most UCC's and emergency departments use across the country.

Ms Mandal's sad passing has highlighted the importance of team work and communication and I firmly believe the changes we as a Trust have implemented has demonstrated that we have learned from the incident and have taken steps to ensure the health and wellbeing of our patients is upheld.

I understand a copy of this response will be sent to the Chief Coroner.

If you have any other concerns or queries arising out of this response, please do not hesitate to contact me.

Yours sincerely,

A handwritten signature in black ink that reads "Goulston". The signature is written in a cursive style with a large initial 'G'.

Mr John Goulston
Chief Executive