Central London
Community Healthcare
NHS Trust

Private and Confidential

Our reference: MAD M-070220-2

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15 May 2020
Dear HM Coroner

Re: Prevention of future death report following inquest into the death of Mrs Anita Loi

I am writing in response to the Regulation 28 report to Prevent Future Deaths that was received on 6 March 2020. I understand that you began an investigation into the death of Anita Loi on 28 November 2019 which concluded at the end of the inquest on 20 February 2020. Firstly I would like to offer my sincere condolences to Mrs Loi's family for their loss.

I would also like to express my regret that the Trust was not invited to participate in the investigation, or the inquest on 20 February 2020.

I will respond to each concern raised in turn:

(1) The Tissue Viability Nurse and District Nurses are a part of the same community team but no steps had been taken to attend to the management of Anita Loi's leg wound despite repeated referrals by the GP and a call to the community team by the family.

Our Tissue Viability and District nurses received referrals from the GP, but unfortunately there was a delay by the GP surgery in providing sufficient clinical information on the initial referral to aid safe triage and a lack of timely responsiveness to follow-up requests for information. We also acknowledge a communication breakdown by our teams that contributed to a delay in care.

The Trust's Single Point of Access Team (SPA) was contacted by telephone on 7 May 2019 by Dr [redacted] GP at Morden Hall Medical Practice referring Mrs Loi to the Tissue Viability Nurse (TVN). The referral was forwarded to the TVN and triaged on 8 May 2019. The TVN called the GP to request an updated doppler scan as the one on record was outside of the 3-6 month timeframe. The Single point of access team (SPA) team also contacted the GP practice on 9 May 2019 with regard to the doppler report and followed up with an email as requested by the GP practice on the same day. A subsequent attempt was made to request the scan from the GP on 10 May 2019. The GP responded to confirm that the doppler report was from September 2018. There was a lack of timely responsiveness to follow up requests made by the SPA for information, which led to a delayed triage; the referral was rejected on 16 May 2019 and the GP was advised that this was because no further doppler or duplex scan was provided.

A doppler scan within 3-6 months report is necessary for triage as it is important to ascertain the vascular status for patients with lower limb wounds. This assists with identifying any vascular issues which require prompt referral of the patient to the secondary care vascular team for their input. We acknowledge that the request for a doppler assessment should have been secondary to the assessment of the clinical presentation of Mrs Loi. Additionally, when the referral was rejected by the TVN team, Mrs Loi should have been internally referred to the District Nurses for care and treatment and I am very sorry that this did not happen.

The GP made a referral to the District Nurses team on 31 May 2019 requesting a doppler assessment, the triage nurse spoke to Mrs Loi's son who reported that her legs were swollen. The triage nurse advised that there was a waiting list for doppler assessments, as there was no clinical assessment which indicated the urgency of the referral; the referral was not prioritised. Mrs Loi's son was advised that he would contact the GP practice with regard to going there instead. The triage nurse contacted Mrs Loi's son again on 3 June 2019 and he advised that he was still waiting for a response from the GP Practice; he advised that his mother did not have any wounds that required dressing. With this information the triage nurse assessed that it would be safe to wait for the doppler or to request that it is carried out at the surgery. The triage nurse discussed with Mrs Loi's son that the community nursing referral would be rejected.

A further referral was received on 20 June 2019 to both the District Nurses and TVN service. The TVN triaged the referral and noted that there was reference to a burn wound which was reported to have been on the foot for 6 weeks which previous referrals did not indicate. When the TVN triaged the referral it was mistakenly identified as a duplicate as a referral had also been made to the District Nurse Team and unfortunately this delayed the assessment. The District Nursing documentation advised that a visit would be carried out and the TVN service would be updated, However, there was a delay in follow up, for which I am sorry and I have followed up with the team to ensure processes are strengthened.

The District Nurses operated on a business continuity basis quite often which meant that patients had to be prioritized and visits delayed on occasion. In this instance Mrs Loi was not sufficiently prioritized, based on the information contained in the first two referrals. The prioritisation process did not appear to be risk based and there were communication issues between the TVN team and DN team which resulted in each team assuming that the other was visiting Mrs Loi.

(2) On 11 December 2019 the GP invited the District Nurses Team and Tissue Viability Nurses Team to attend a meeting at the surgery with the practice clinicians to review unexpected deaths and to discuss this case. Neither team attended the meeting and to date have not engaged with the GP in relation to this death despite a chasing letter.

clinical operations manager was contacted on 18 November 2019 by Business Manager for Morden Hall Medical Centre, to attend a 'Significant Event' Case Review Incident. advised that he was bringing some information together to enable them to review the case of Mrs Loi who passed away at St Helier Hospital in July having been admitted following a cardiac arrest. advised that Mrs Loi had been seen for treatment of her diabetes and had also been referred to the Trust for treatment of leg ulcers. requested details of the teams involved and clinical notes. advised that or a member of her team would be welcome to attend, however it was not mandatory. replied on 20 November 2019 advising that she would be unable to attend on that date as she would be on annual leave, however, she would enquire whether another manager would be able to attend in her place. informed that she would be unable to share the clinical records with him as there was no information sharing agreement in place with the GP practice at that time however information would be shared by the person attending the meeting.

On 8 December 2019, emailed to reiterate that she would be unable to attend as she was on annual leave, and unfortunately the appropriate deputy was also unable to attend due to sickness. However, requested that she be updated with the outcome of the meeting and to be advised if she could help further. There was no further communication following this.

I'm sorry that we missed the opportunity to engage in this meeting as a result of the issues outlined above. We acknowledge that engaging in this meeting would have been a good opportunity to review Mrs Loi's care and we will put measures in place to ensure improved engagement with such meetings going forward. The Merton Community Service continue to attend practice meetings and will be strengthening the communication between the GP practices to ensure that discussions are held whenever there is any confusion surrounding a patient's care or unexpected death.

(3) Whether there are appropriate policies, procedures, protocols in place for the referral of patients to the service, and the response to such referrals.

We have updated our Triaging Standard Operating Procedures to ensure a robust process for the management and response to referrals. The procedure now ensures that Triage nurses check if patients are open to other CLCH services. If the referral received is for more than one service on the same day the triage nurse must make contact with that other service to initiate joint working and ensure that visits are allocated appropriately. When a referral is received by more than one service, a meeting is held to ensure that the patient's referral, clinical history is reviewed jointly and a plan of action on how best to manage the patient's care is determined.

We have now also undertaken a serious incident investigation and identified areas requiring improvement and put measures in place to ensure such events do not re-occur as outlined below:

1. We have undertaken an urgent review and are improving the referral processes from primary care into DN & TVN teams.
2. We will commence work on our electronic patient record system to strengthen the reminder capability in EMIS Health, (Egton Medical Information Systems), to ensure that referrals are effectively managed and responsiveness is maximised.
3. We have urgently reviewed the referral form to provide clarity on clinical information required by TVN to make informed clinical decision.
4. We progressing work to ensure urgent escalation processes if there are delays to requests from GPs for further information to inform triage.
5. We will establish clear processes to be in place to review jointly as part of an MDT all people referred who are know to multiple teams to ensure timely joined up responsiveness.
6. Where referrals for doppler are made incorrectly to the TVN team we will put the patient at the centre of the care and work to avoid delays in care by; liaising with the appropriate team to see if the required assessment can be undertaken to aid clinical decision making.
7. We will clarify to the GP information required in a referral including a detailed clinical assessment and indication of urgency for patient.
8. Further to the poor communication between TVN & DN teams. The Merton DN/TVN team are to make urgent contact with the Trust accredited service in Harrow, to see what learning can be shared about providing a seamless service between these teams and the arrangements in place to managing joint referrals.
9. The Team will urgently review how known medical history is being used to inform clinical decision making.
10. We will urgently review the caseload prioritisation process for a doppler in the DN service to ensure it is risk based.

I am sorry our communication and management of referrals was below our expected high standards which led to delays in care. I am confident that the steps we are undertaking will ensure that each patient referred is reviewed in a collaborative, systematic way and care provided at the correct level. As well as continuing to review the actions we have implemented, we will also be sharing learning from this investigation with other teams across the Trust.

I hope our approach to learn from this assures you. Please do not hesitate to contact me or [redacted] the Divisional Director if you require any further information.

Yours sincerely

[redacted]

Director of Nursing & Therapies (Quality & Safety)
Central London Community Healthcare NHS Trust