Office of the Chief Medical Officer

PA –

Divisional Medical Director:
Emergency Medicine
PA –
01905 763333 ext.39345

Divisional Medical Director:
Surgery
PA –
01527 505740

Divisional Medical Director:
Specialised Clinical Services
PA –
01905 733448

Divisional Medical Director:
Speciality Medicine
01905 733211 ext.39818

Divisional Medical Director:
Women and Children
01905 761499

NHS
Worcestershire Acute Hospitals NHS Trust

Our Ref: 2078/SAK/MLR

20th December 2017

The Coroner
G U Williams LLB
HM Senior Coroner
Worcestershire Coroner's Court
The Civic, Martins Way
Stourport on Severn
Worcestershire, DY13 8UN

Dear Mr Williams,

Ref: Regulation 28: Report to Prevent Future Deaths

Following your letter to the Chief Executive Officer, Michelle McKay, I write in response to your Regulation 28 Report issued 30th October 2017 surrounding the death of Michael Edward Giles.

You raised 4 matters of concern.

1. *You've invited the Trust to consider standardising the handover process across the hospital and to put in place a protocol whereby the identity of the person responsible for ensuring the handover takes place is clearly recognised.*

   The events surround this tragic case and your regulation 28 letter was discussed with the trainees in early November 2017. The conclusion from the trainees was that they were confident that the processes now in place were robust and they had not experienced any near misses as a consequence of inadequate handover. There is a standardised structure for handover which follows SBAR. This is an acronym for Situation, Background, Assessment, Recommendation. With reference to identifying a responsible person is a little more fraught. Handover takes place at multiple levels whilst the patient remains an inpatient. For example; between nursing staff during shift changes, from allied health professionals to nursing staff following procedures and interventions, between junior medical staff as part of a shift hand over as well as between senior medical staff as part of the transfer of care and responsibility.

   The importance of hand over in a structured manner continues to be the subject of our attention and indeed was the focus of discussion by our Director for Medical Education when he met with the trainees. To facilitate and support the transfer of clinical information the nursing staff also undertake a structured process "board round" takes place every morning on the ward between senior clinicians and the ward nursing staff.

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2. *Invited the Trust to put in place the requirement that all complex cases who are admitted onto the ward on a Friday or over the weekend, particularly where they have undergone invasive procedures, are routinely subject to a senior doctor review.*

   There is already an expectation that all patients need to be reviewed 7 days per week. For those pateients with high dependency needs the expectation is that they are seen and reviewed by a consultant twice daily (including acutely ill patients directly transferred and other who deteriorate). An audit of our practice from March 2017 shows that we were able to meet this requirement 93% of occasions. The overall proportion of patients who required a daily consultant review and were reviewed by a consultant was 68%. In order to improve this further working practice by consultants has been reorganised to facilitate a higher proportion of patients being seen at least once every 24 hours.
   In order to keep the risks to a minimum for patients undergoing invasive procedures we are already reviewing where these can be done, i.e. limiting it to where there are areas with the required expertise for care after the procedure.

3. *Invited the Trust to consider a protocol to ensure that during the crisis period of a patient's admission there is a nominated individual to take the lead and to ensure optimum care is given.*

   In all cases when patients take a turn for the worse the most senior Doctor is responsible for taking the lead in ensuring optimum care is given. It is not possible to have a protocol to identify a nominated individual because the required leadership depends on the underlying condition. Thus what is required in Emergency Department and who should take the lead might be very different to the needs surrounding a post-operative event or indeed during a period of convalescence whilst on the ward. The key to such events is identifying changes to the patient's condition in a timely manner before any event occurs. To this end, we audit all patients brought to intensive care unexpectedly or patients requiring the emergency team during the day time. We assess for the adequacy of care and the appropriateness of timely escalation prior to this. We have also started human factors training.

4. *We have invited the Trust to put in place addition training so that record keeping is consistent complete and clear.*

   We recognise the importance of good clinical record note keeping. As part of this, we have undertaken an audit to assess our baseline and thereby assess the impact of interventions to improve this. I have attached the audit which demonstrates areas of good practice as well as areas in need of improvement. We're also working with the communications team to develop a clinical records keeping video to drive up standards. I anticipate that this will be available in February. I've also attached a leaflet that will be forwarded to all in the Trust that utilise patient's notes. The attached has yet to be finalised and is merely to provide an indication of the direction of travel. I anticipate that this will be available in February 2018.

I hope that the details of the actions that we are taking, provides you with the assurance you are seeking in order to prevent future deaths.

Best wishes.

Yours sincerely,

Chief Medical Officer
Enc.

cc. Michelle McKay Chief Executive Officer