NHS
The Shrewsbury and Telford Hospital
NHS Trust

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Mr Heath Westerman
Assistant Coroner
HM Coroners Service
Shirehall
Abbey Foregate
Shrewsbury
SY2 6ND

Date: 11 September 2018

Dear Mr Westerman

Re: Regulation 28 Patricia Palin deceased

Further to my letter of 21 August 2018, I would like to once again offer my sincere apologies for the delay in responding to your Regulation 28 report. I note that the first point related to another organisation and so I will address each of the points you have set out in turn, which relate to Shrewsbury and Telford Hospitals NHS Trust.

1. **Too few Doctors were on duty in general to cover patient needs and there did not seem to be a programme in place for trying to get a third Doctor to replace the Doctor who phoned in sick.**

   The Trust does have a process in place for trying to backfill vacant shifts in the Emergency Department. At the first instance we will attempt to contact our own doctors via the Departmental Consultants or Medical Staffing representative making contact. We will also advertise via external agencies at the same time to ensure that every attempt is made to fill the gap. I attach a copy of the flow charts used to backfill vacant shifts.

   However, on occasion if the sickness is short notice, as with any organisation, it is less simple to get cover. However, we do everything in our power to ensure the shift is covered. Due to the fragility of the workforce both in the locality and nationally, we usually already have numerous requests out to agency, as well as our own staff picking up additional shifts, therefore it is not always possible to cover when staff call in at the last minute to cancel their shifts.

2. **Ertapenem was not in stock and led to some 2 hours 25 minutes delay in administration. Other suitable drugs were in stock, but not considered.**

   The Doctor prescribing the Ertapenem was not made aware that it was not available in the department, so was unable to consider an alternative. The outcomes of the Root Cause Investigation were discussed with the team for learning to ensure communication is improved in the future. Furthermore, the drug is now stocked in the Emergency Department, to avoid recurrence in the future.

3. **Whilst there was a general awareness of the dangers from sepsis from the Hospital witness evidence:**
   a) **Red flags of sepsis were missed**
   b) **Leg bandages were not removed to allow for a full top to toe examination**
   c) **Sepsis 6 care bundles were not followed in accordance with guidelines**

The Root Cause Analysis was shared with the staff involved in order for lessons to be learnt by the individuals involved in Mrs Palin's care. This was reflected by Dr Roy who attested to this in the Inquest hearing. In addition to this the Trust has carried out work on Sepsis and much more is planned through the Trust. In the last few years our organisation partnered with Virginia Mason Hospital in America, in order to improve patient safety and care. As part of this, one of the Value Streams has focused on Sepsis and improving care for patients with this condition. Some of the improvements which are being rolled out include:

- Revised Sepsis Screening Tool - a revised version was created by Surgical Assessment Unit (SAU) staff, which increased compliance to 100% in that area.
- New Sepsis Trolley – the SAU team introduced a bespoke sepsis trolley to store all of the items required to provide timely treatment for patients who are diagnosed with sepsis generating greater efficiency and reliability based on 'set up reduction'.
- Sepsis Box - the box placed all the items required in one place in order that a diagnosis can be obtained quickly (Ward 28).

The Critical Care Outreach Team have also developed a new Sepsis Web page on the Trust Intranet with information and links. On this the team will be doing a 'Spotlight' of the month to highlight good practice from various wards around the hospital to raise awareness of sepsis, this should keep sepsis awareness fresh and in the minds of everyone.

However, given that Mrs Palin's delays were based in the Emergency Department I wish to you update you on the work which has taken place and the on-going plans to improve sepsis care in ED specifically. Our Critical Care Outreach Team commenced a programme of sepsis education in both Emergency Departments, as of last week; to date 20 staff have been trained. The education is targeting all clinical staff in the department; however this is limited to availability of staff due to work load. The training sessions are taking place daily, 7 days a week. The feedback has been really positive from all staff. The areas covered within the teaching session are recognition using visual signs, as well as recognition using the Sepsis screening tool. The Team then look at the Sepsis Six pathway in detail and discuss the importance of delivering this within the one hour time frame. Finally reference cards are provided to staff to keep highlighting the sepsis six pathway and signs/symptoms.

Alongside this we are reviewing the trolleys in the department, with the possibility of trialling a trolley that will allow for us to put everything into the trolley for immediate care of the septic patient, this includes antibiotics and fluids. The existing trolley in place does not carry everything required for immediate care.

We are also developing a Patient Group Directive which will allow Senior Band 5 Nurses and Band 6 Nurses to deliver the fluids and antibiotics within the one hour required time frame in the event that a Doctor is not available to meet the demands of the one hour time frame. This is a huge step for us and one that has been welcomed by all the nursing staff within the ED. Both ED's have Practice Education nurses who will continue to ensure all staff are up to date with their sepsis training.

Sepsis Champions have also been chosen to be a link within the ED, and they will work closely with the Critical Care Outreach Team to continue the education and provide support for all staff within the ED. The Team are also in the process of working with the Medical Teams to ensure that all the Doctors are trained in Sepsis recognition and treatment.

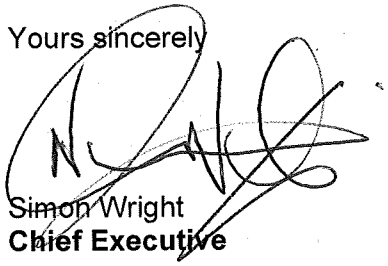
Critical Care Outreach will continue to support the education and training in these areas for as long is required.

I hope that I have been able to assure you that whilst we recognise that Mrs Palin's care was not at the standard we aspire to provide to our patients, we are taking all the necessary steps to improve the care we provide to our patients in the future.

This is not something which we can do overnight and will take some time and constant review, to ensure that the improvements we are making, are successful.

Please do contact me if you have any further questions at this time.

Yours sincerely

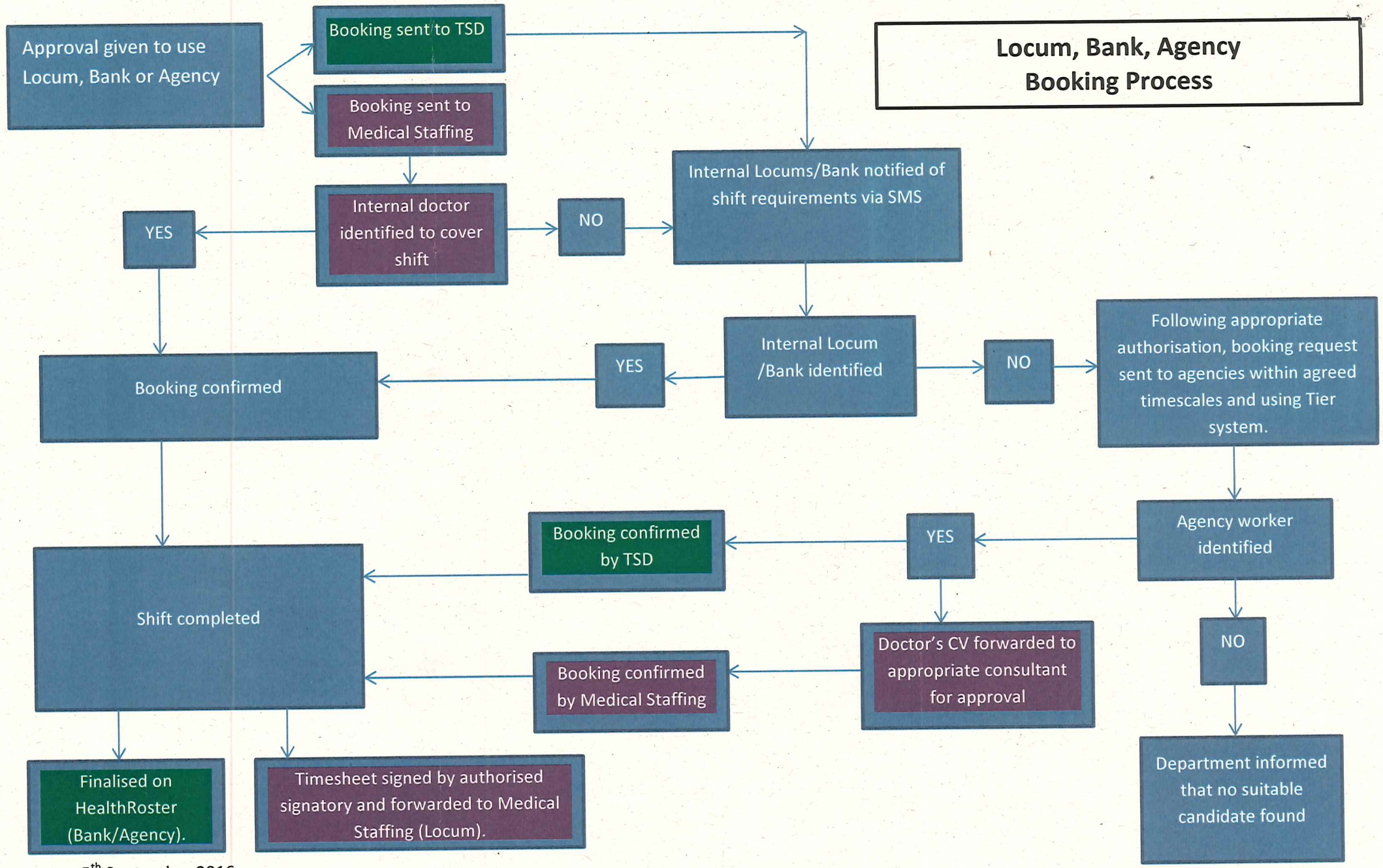


Simon Wright
Chief Executive

Enc.

Appendix D

Locum, Bank, Agency Booking Process



5th September 2016

SHROPSHIRE & TELFORD LOCAL MEDICAL COMMITTEE

Representing all General Practitioners in Shropshire and Telford & Wrekin

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IFR/klh

9th August 2018

H. Westerman
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Sir,

I am Dr Ian Rummens. I have been a general practitioner, in Oswestry, since 1983, and Secretary of Shropshire and Telford Local Medical Committee since 1986.

I am writing in response to the Regulation 28 Report regarding Patricia Violet Palin, deceased. I will respond to item 1 in the Matters of Concern. This deals with the issue of access to patient information held in the GP record by Shropdoc personnel. Similar issues apply to access of information from the GP record by staff working in hospital, particularly A&E.

In 2010 the Summary Care Record (SCR) was introduced. This is an electronic record of important patient information created from the GP record. It allows approved staff, working anywhere in the NHS, to access this information about a patient using the NHS Spine Web Portal.

The basic SCR record only contains a list of prescribed medication, previous adverse reactions to drugs and allergies. A SCR is created automatically unless the patient chooses to opt out. They are continually updated, every time the patient's record is changed by the practice, as long as the user is logged on using an NHS smartcard which is now almost invariably the case. Not every GP computer system used across

the UK is compatible but almost (and possibly all) Shropshire practices use compliant systems.

As far as I am aware, Shropdoc personnel have been able to view a patient's SCR for some time. They need to have an NHS smartcard that allows this but I don't think there is any problem with this. I assume that this applied in Patricia Palin's case.

I think the relevant issue is the addition of more clinical information by the GP practice, particularly for frail and vulnerable patients with chronic medical conditions. This allows a more comprehensive picture of a patient's problems to be obtained which can only contribute to their subsequent care. This requires the express consent of the patient and for this to be recorded electronically on the patients GP record. Once this happens, coded items and supporting free text is added. This includes:

- Significant medical history (past and present)
- Reason for medication
- Anticipatory care information (such as information about the management of long term conditions
- End of life information
- Immunisations

Sensitive information (like fertility treatments, sexually transmitted diseases) are not automatically included but any information the patient would like included can be added manually.

It seems likely that if this additional information was available to Shropdoc, and passed on to the hospital, it would have contributed to Mrs Palin's care.
From 2017, the General Medical Services contract requires GPs to identify patients with moderate or severe frailty, and promote the inclusion of additional information in those patients with severe frailty by seeking their permission to add it. In this context, frailty is defined by the electronic Frailty Index (eFI). This is a number, automatically generated by the practice computer, based on a number of indices, for example:

Moderate Frailty is defined by an eFI score of 0.25 –0.36. These will be people who have difficulties with outdoor activities and may have mobility problems or require help with activities such as washing and dressing.

Severe Frailty is defined by an eFI score of > 0.36. These will be people who are often dependent for personal care and have a range of long – term conditions/multimorbidity. Some of this group may be medically stable but others can be unstable and at risk of dying within 6 – 12 months.

Practices should have a rolling program of identifying their patients who are severely frail, interviewing them and seeking their consent to create an enhanced SCR. Inevitably, a number will not give consent. For patients lacking capacity to consent, there are GMC guidelines which can be followed, to allow a decision to be made that is in the best interests of the patient.

I'm afraid I don't have figures for the proportion of Shropshire and Telford patients with severe frailty who have an enhanced SCR. The CCGs may be able to provide these. Clearly, GPs have a responsibility to encourage uptake in this group. In addition, there seems little doubt that there are potential benefits in all patients classed as frail having an enhanced SCR, and that could be extended further. As far as I am aware, there are no plans by the Government to extend the requirement beyond those with severe frailty. GP workload and manpower issues limit the capacity of practices to do more but I will write to practices encouraging GPs to discuss the benefits of allowing an enhanced SCR with all their patients with chronic illness.

I remain, your obedient servant

I.F. Rummens

c.c. J.P. Ellery
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