Northampton General Hospital
NHS Trust

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Private and Confidential
Mr Dixey
Assistant Coroner
The Guildhall
St Giles' Square
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Dear Mr Dixey

Mr Leslie Hurwood Inquest: Regulation 28 Report

I write to formally acknowledge receipt of the above Regulation 28 Report issued to this Trust and to provide a response detailing the actions we have taken.

You have highlighted concerns regarding insulin not being administered to diabetic inpatients at the appropriate time, which could compromise its effectiveness and pose a risk to patient safety. Additionally, you have raised concerns that the training provided does not always ensure correct practice is followed.

We have reviewed these issues thoroughly and appreciate the opportunity to address your concerns. We are committed to ensuring safe and effective diabetes management and are taking necessary steps to strengthen both clinical practice and training provisions.

Immediate actions:
The senior nursing team immediately visited ward areas to reinforce the importance of administering specific types of insulin before meals and to identify any immediate concerns regarding the management of patients with diabetes.

To strengthen communication and awareness, all wards conduct shift huddles, providing staff with an opportunity to raise patient safety concerns and share essential updates. In response to this issue, a dedicated huddle sheet was created, outlining insulin administration best practices and key safety information. These huddle sheets were used throughout the week to ensure all staff received the information, with signatures collected to track engagement. The information was also shared with the Multidisciplinary Team to ensure alignment across care teams.

To assess current practices and identify areas for improvement, the Trust immediately conducted an audit of all patients receiving insulin. This ensured that medication was being administered correctly and allowed for the targeted deployment of dedicated diabetes training where needed.

To sustain improvement, a poster and screensaver campaign has been launched, displaying key insulin safety reminders in ward areas.

Ongoing actions

A multi-disciplinary meeting was convened to review issues raised in your report, together with the formation of dedicated improvement groups to target further areas of quality improvement. The meetings also allow for organisational oversight of the concerns raised to ensure adequate improvements are made.

- Training

Staff training is being reviewed to ensure that the content is appropriate and that the timings of insulin administration forms part of the fundamental training provided to staff. The role specific and mandatory training is also being reviewed and insulin administration considered for inclusion. We are in the final stages of securing an insulin safety e-learning package which will be validated through regular audit data.

- Oversight

As described above, the senior nursing team has developed a comprehensive audit to review insulin administration, which will be integrated into our established regular ward safety audits. The audit findings will be accessible to ward leaders, senior nursing leadership, the patient safety team, and Diabetes Specialist Nurses to ensure ongoing monitoring and continuous improvements in safe insulin administration. These results will also be incorporated into the safety dashboard, which is reported through the Trust's governance framework for oversight and accountability. Additionally, the Diabetes Specialist Team will conduct an additional monthly audit to provide specialist oversight and further assurance.

To enhance collaboration and oversight, the Diabetes Team's fortnightly safety meeting has been expanded to include senior nurses from each Division, Pharmacy, and the Patient Safety Team. Furthermore, the Medicine and Urgent Care Division will actively participate to support and drive quality improvements, ensuring a multi-disciplinary approach to diabetes care and patient safety.

- Documentation

The Trust is implementing a new Electronic Prescribing Medication Administration System (EPMA) in May 2025. The Diabetes team are involved in the development of this system to ensure that there are inbuilt safety features for insulin administration.

Whilst we await implementation of EPMA, paper-based drug charts have also been reviewed to ensure that the time of administration of insulin can be clearly documented in order to support the audit mechanisms introduced.

- Policy

Whilst not a contributory factor in Mr Hurwood's case, we have decided to review our policy relating to the self-administration of medication It is recognised that diabetic patients who can self-administer their insulin should be encouraged and supported to do so.

- Protected Mealtimes

Mealtimes are protected within our hospitals. This is a period where all ward-based activities stop, where clinically appropriate, to enable staff to assist patients with their nutritional needs. This will be re-launched to include ensuring the administration of insulin at this time.

I hope this provides you with assurance that the Trust has taken, and continues to take, proactive steps to improve insulin care for our inpatients. These actions are on track to be completed and will be monitored by reports to the Insulin Oversight Group and reported up to Patient Safety Committee and by exception to Quality and Safety Committee in Common.

Finally, I would like to express my apologies for the issues identified in your Report and to reaffirm our commitment to continually work to improve patient safety.

Yours sincerely

[redacted]

[redacted]
Medical Director