The Shrewsbury and Telford Hospital NHS

NHS Trust

17 OCT 2014

Mr J P Ellery, Senior Coroner for Shropshire
Telford and Wrekin Area
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Your ref: [redacted]
Our ref: [redacted]

Date: 10 October 2014

Dear Mr Ellery,

Regulation 28 following an Inquest into the death of Martin Rowland Hill

Thank you for your letter of 6 August, 2014, setting out the matters of concern found following the death of Mr Hill. As you are aware, when a "serious incident" has occurred within the Trust, the Trust undertakes an investigation into the incident. One of the categories for a serious incident is if it caused or contributed to an unexpected or avoidable death. From the Post Mortem report and subsequent addendum letter, we were led to believe that the care provided at the hospital had been appropriate and therefore no serious incident investigation took place. Following evidence during the Inquest, we have now begun a high-risk review into Mr Hill's death. Our investigation is ongoing at this time.

In addition to the investigation currently being carried out, we have also reviewed the areas in which you have raised concern within your letter and I will address each of these in turn.

Concerns over the review and actioning of x-ray reports within the Accident & Emergency Department

There is a currently a piece of work ongoing within the Trust to improve electronic reporting systems. The Trust is looking towards utilising a system called "Order Comms" for radiology. This system will allow referrals for radiographic examinations to be sent electronically to the Radiology department. This electronic request will, if accepted, automatically populate the RIS (Radiology Information System). This reduces the turnaround time for requests received. It also provides an audit trail for when a request was sent to the department. The second half of this system covers reports sent out. With the new system, the Accident & Emergency department will be able to monitor if a report has been read and then actioned. There will be a requirement for all referrers to click a button to say that the report has been read and actioned. If a department is not undertaking this action, we will be able to flag this up as a clinical governance issue.

Given that this system will not be in place imminently, we have also reviewed the processes within the Accident & Emergency department and a more robust process of checking x-ray results and actioning abnormal reports has been developed and approved by the department. This system ensures that the x-ray results are checked regularly within the department and actioned where necessary. This should prevent recurrence of what happened in Mr Hill's case. I attach a copy of this process for your assurance. I would like to add that GP practices are able to electronically access the x-ray reports from the hospital and can access these at any time.

Mr Hill was discharged without any medications

Mr Hill was transferred from the Accident & Emergency department to the Clinical Decisions Unit ("CDU") prior to discharge. He was therefore discharged from the CDU and not the Accident & Emergency department. There is a process in place on the CDU with regard to patient discharges. If a patient requires a prescription that is not in stock or is not available, the staff will ensure that a community prescription (FP10) is given to the patient/carer to take away with them so they can obtain their medication following discharge. It appears that on this occasion, unfortunately, Mr Hill was not given his community prescription to go home with. I can only apologise for this omission and can assure you that all staff have been reminded of the importance of ensuring that they follow the process in place.

In addition, the Pharmacy department have recently updated their Medicine Codes Policy which includes a clear flowchart on how to deal with patients who are discharged outside of Pharmacy hours, as was the case in Mr Hill's care. I attach a copy of the process which should be followed by all clinical areas to ensure that patients will be discharged with either medication or a suitable prescription for them to obtain medication from a community pharmacist. The Matron responsible for the CDU has now ensured that the staff on working within the CDU are familiar with this flowchart and will refer back to the same when arranging for a patient to be discharged.

Concern over GP not receiving the discharge summary

I note that you have asked for some reassurances surrounding the current discharge process. I can confirm that the current process within the Accident & Emergency department on discharge summaries is that once the doctor in the department has written the letter to the GP, it is then transcribed by the coding staff. This is then sent either electronically by email, or if the GP practice is not on the electronic system, it is posted or faxed. This process is carried out within 48 hours.

The process for discharge summaries with patients from the CDU is slightly different and, at the present time, the discharge summaries on the CDU for Accident & Emergency department patients are handwritten. A copy of the summary is handed to the patient and a GP copy is generated. The GP copy is then either given to the patient to give to the GP or is sent in the post. This process is currently under review and it is anticipated that the CDU will soon be utilising the electronic discharge summary process that the other wards in the hospital use. This will, however, require training and is therefore not yet in place.

I was pleased to hear that the GPs at the Inquest noted that they usually receive their discharge summaries which they said were promptly received following discharge of patients from the hospital.

I hope I have been able to offer you assurances that the Trust has taken action to prevent further recurrences of the problems that were encountered by Mr Hill prior to his death.

Please do contact me if you require any further information.

Yours sincerely,

[redacted]

Peter Herring
Chief Executive