University Hospitals of North Midlands NHS Trust

[redacted]

Royal Stoke University Hospital
Executive Suite
Springfield
Newcastle Road
Stoke-on-Trent
Staffordshire
ST4 6QG

[redacted]

16 June 2021

Ms Murphy
H M Assistant Coroner
547 Hartshill Road
Stoke on Trent
ST4 6HF

Dear Ms Murphy

Inquest Touching the Death of Alex Shaw

Further to your letter dated 7 May 2021, I am pleased to provide the following response to address the concerns that you raised at the inquest touching the death of Alex Shaw.

You raised a number of matters of concern to be addressed by both this Trust and Birmingham Children's Hospital. Set out below are the actions undertaken by University Hospitals of North Midlands NHS Trust in response to the issues highlighted.

1) There was poor communication of the patient's clinical condition/observations between the Registrar at the Royal Stoke University Hospital and the Consultant at the Birmingham Children's Hospital when advice was sought by telephone. There was also poor documentation of the contents of the information that had been provided during that conversation and the timing of when the call was made. The evidence of the Consultant at the Birmingham Children's Hospital was that her advice would have been different if she had been made aware of the patient's rising heart rate.

2) The evidence also revealed that it was a "judgment call" when the clinician felt that a dialogue between clinician's at a different hospital needed to be documented.

3) Consideration should be given as to how a patient's observations are communicated to clinician's between the University Hospital and the Birmingham Children's Hospital, the time, content, advice and documentation of the conversations.

Action Taken
As a result of the concerns raised, the following action has been taken:

1) The paediatric team are in the process of developing a facility on the Trust electronic Iportal System which will provide a structured note 'Paediatric Advice Proforma' to aid electronic documentation of conversations between hospitals when seeking advice on patient care; this will include prompts for important discussion points and will have mandatory fields for vital signs (such as heart rate, BP etc.) which will ensure that the clinician includes such information in conversation. Matters are currently being developed with the IT team and we hope to have a solution by September 2021.

2) In response to point 2, the paediatric team are also aiming to develop a Standard Operating Procedure (SoP) which will also refer to the need to compete the Paediatric Advice Proforma. This SoP will be relevant to discussions between hospital Trusts and will follow on from the work undertaken as per point 1. It will require clinicians to document all discussions.

3) As discussed in point 1 above, the development of the 'Paediatric Advice Proforma' will prompt clinicians to input time of conversation, content of the request, information shared and advice given / received.

In addition to the above direct actions, I am also very pleased to share that Staffordshire Children's Hospital at Royal Stoke has recently appointed a named Consultant who will be responsible for the management of all children with metabolic disease.

I sincerely hope that the above information provides you with assurance that the University Hospitals of North Midlands NHS Trust has taken the matters arising from the inquest touching upon the death of Alex Shaw seriously.

The Trust strives to provide a high standard of care to all patients and I am grateful to you for raising these concerns on this occasion.

Should you wish to discuss any aspect of this report further, please do not hesitate to contact me.

Yours sincerely

CHIEF EXECUTIVE

Enclosure: Action Plan