Sherwood Forest Hospitals NHS
NHS Foundation Trust

Quality for all

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13 February 2017

Mrs H Connor
Assistant Coroner for
Nottingham and Nottinghamshire

By Email

Dear Mrs Connor

I am writing in response to your Regulation 28 Report dated 09 February following your investigation into the death of Mrs SS.

For simplicity's sake, I have in bold highlighted each of the concerns you raised therein and addressed them in turn in the narrative below.

Review of administrative systems for contacting and following up patients who DNA appointments – with such correspondence to be copied to their GPs.

At the hearing, the Trust was unable to provide evidence of an appointment letter for the appointment in July 2015. Since the inquest we have interrogated the appointment system, and it appears that where patients have deceased their administrative letters are no longer visible on the main screen unless certain boxes are checked; administrative staff unaware of this feature would assume no letters were created/sent.

We have now been able to determine that following referral of Mrs S to the vascular team, a letter was sent to Mrs Stokes (see **appendix 1**) on 15 July 2015; this was for an appointment on 27th July. Our Medway computer system indicates that this letter was printed on 21st July and we assume it was posted to her (see **appendix 2).**

Mrs S did not attend this appointment and this was inputted onto our system as a 'DNA' and she was to have a new appointment made (see **appendix 3**). We believe that our staff telephoned Mrs S the following day (28th July) to make another appointment for her which was for the 14th September and from the comment made, it was noted that she would like to be seen earlier if there was opportunity by reason of a cancellation (see **appendix 4**). We believe that it is likely that this date of 14

September was the next available appointment. We have looked back at the vascular clinics for the period July 2015 - September 2015, there was indeed limited capacity for patients to be seen any sooner. A letter again appears to have been sent to Mrs S on the 28th July 2015 (see **appendix 5**).

An Outpatient Improvement programme was commenced in March 2015 to address a number of issues relating to patient experience and waiting times for Outpatient appointments. Some of this work is relevant to this case.

The DNA process was re-launched in June 2016 (see the **flow chart** attached) as it was clear that there was not a consistent approach to dealing with DNAs across the Trust. This process ensures that DNAs are dealt with on the day. Clinic staff will place a DNA sticker into the patient's notes and ensure this is completed by the clinician who indicates the action to be taken e.g. further appointment within given timescale or discharge. The clinician can also highlight if there are any safeguarding concerns and request the notes to be returned to their Patient Pathway Co-ordinator (PPC) for further action to be taken.

The receptionist will input an outcome for the appointment and makes any further appointments as requested by the clinician before sending the notes to the PPC. If the patient is discharged at the clinician's request a DNA letter will be sent to both the patient and their GP to indicate the discharge has taken place. However, prior to discharging the patient a check is made to ensure that the patient was sent an appointment letter and also that the address for the patient recorded on Medway, matches that on the Summary Care Record. The reconciliation slips which indicate the actions requested by the clinician are destroyed after completion of the task. However, the DNA sticker remains within the case notes permanently and is a record of the request. The Trust is planning to commence a pilot of scanning reconciliation slips into Medway, providing a permanent record.

A number of managers involved in the Outpatient service carry out DNA audits on a regular basis to ensure that the process is being adhered to. We are happy to provide audits of this process should you require.

Another improvement initiated by the Outpatient Board is a weekly monitoring meeting with all Business Managers to review any clinic capacity issues, for patients awaiting appointments. Any capacity constraints are raised with business managers and escalated to Divisional General Managers and the Chief Operating Officer if not resolved.

System for ensuring RAD alerts are received and acted on timeously.

Mrs S underwent an ultrasound on 13 July 2015 in which the incidental finding of abdominal aortic aneurysm was noted. This ultrasound was sent urgently (using this Trust's XXXX system, please see **appendix 6**) to the referring clinician [redacted] who then made an urgent referral to the Vascular team at NUH, he also alerted the GP to the finding, and an appointment was made on 21 July 2015 for the patient to be seen on 27 July 2015, as above. Mrs S then underwent a CT scan on 22 September 2015, by which time the aneurysm was no longer a new finding of the

nature that a 'RAD alert' was required, but a timely response was of course necessary, and this is addressed in the next section of this response. The CT report was sent to the NUH Vascular team for consideration at their MDT.

A series of upgrades to the EMRAD systems are underway, which will include a facility to electronically alert clinicians via text message to mobile devices and emails simultaneously which should further enhance the alert system. This should be available to alert not just staff at this Trust but also referring clinicians from NUH and other local trusts that are part of the East Midlands EMRAD/PACs consortium. It also allows specialised reporting radiologists at one of the consortium trusts to report directly on images taken at other Trusts.

Vascular surgeons based at both KMH and NUH should consider having a clear agreed protocol for obtaining custom-made grafts – to include such matters as:

a. A clear pathway for contacting and sending scan results to manufacturers.
b. Limited no of consultants dealing with these cases.
c. Clear timetable between first contact with manufacturer and final sign off – with responsibility of a named consultant to ensure there is no delay.

The Vascular team at NUH are in the process of developing a FEVAR database. This is a database system for the recording and tracking progress of patients with abdominal aortic aneurysm who are referred to the department of Vascular Surgery, Nottingham University Hospitals NHS Trust (NUH), who will be treated with fenestrated endovascular repair (FEVAR). Unlike grafts used for standard endovascular repair (EVAR), FEVAR graft systems are complex and are custom built for each patient. Consequently, there is a significant lead-time (typically 12 weeks) before they are available for implantation. Planning, ordering, and deploying a FEVAR system involves multiple stages, independent companies that manufacture the grafts and multiple clinical teams. There is a need for an information system to help manage this process, to ensure that treatment timescales are met. The plan is for an intranet interface (using standard desktop web browser software, such as Internet Explorer or Google Chrome) to a Microsoft Access database. The interface will be similar in form to applications currently in use in NUH for the vascular surgery MDT administration, Interventional Radiology (IR) consultant diaries and for NUH IRMER documentation The FEVAR interface is intended to sit alongside that for the vascular MDT administration system.

The system will be visible across the NUH intranet, thus providing entry from any NUH networked PC (including remote laptops logged in via VPN). The system will not be visible on the open internet outside NUH.

The pathway is considered in four phases:

1) Initial MDT, initial FEVAR MDT decision, FEVAR graft planning, FEVAR MDT sign-off

2) Placement of purchase order, graft manufacture and delivery, logistics
3) Final preoperative assessment and checks, the FEVAR procedure
4) Initiation of follow-up

FEVAR MDT is intended to occur on a weekly basis.

Some patients may leave the pathway for various reasons (e.g. manufacturers determine that anatomy is unsuitable for FEVAR despite initial MDT optimism). An exit protocol will be included for these patients. In the case of those patients that are referred on to other centres, the exit protocol will record details of the onward referral and reply received, with the facility to note any follow-up that NUH is required to carry out.

Each phase will have a number of tasks and relevant data (such as expected delivery dates) associated with it. Each task should have a due-by or expiry date and the person signing it as complete should be recorded. Some tasks will always occur (such as placing an order for a graft), and will appear as default. There will be the facility to enter additional tasks relevant to particular patients.

Each phase will have a due by date. When all listed tasks are done, the phase can be flagged as complete. In cases where a patient exits the protocol, subsequent phases will be shown as excluded (see below). The person signing-off each stage will be recorded.

FEVAR timescales

Timescales are set in order that the system can indicate to users when particular tasks, or phases, are overdue. Setting timescales to short (everything becomes overdue) or too long (nothing ever becomes overdue) would serve no purpose. Timescales are not intended to be binding and actual timescales may vary in individual cases. Additionally, timescales may be adjusted, once the system has embedded, to try to achieve a practical balance. The following proposed timescales have been discussed with, and agreed by, Ms Khan, Ms Dabee and Dr O'Neill.

Phase 1 (Entry – FEVAR MDT)

Initial FEVAR MDT	VR & IR	1 week
Request copy of CD(s) following entry	VS	1 day
Print CDs	Radiology	2 days
Collect/send CDs by/to manufacturer	VS	1 days
Reply from manufacturer	Manufacturer	1 week
Second FEVAR MDT (Confirm sizes and manufacturer plan, sign order form, send to manufacturer)	VR & IR	1 week
Phase overdue		3 weeks

Note: It is hoped that direct, electronic transmission of CT data to manufacturers will become available later this year, which will obviate the need to produce CDs.

Note: If the manufacturer's plan is changed at the second FEVAR MDT, it will be returned to the manufacturer for revision and considered at again the following FEVAR MDT. Each cycle will therefore add a further week.

Phase 2 (Purchase order – FEVAR graft delivery)

Sign order form and send to manufacturer	VS	1 week
Manufacturer to obtain purchase order	Finance	
Acknowledge receipt of purchase order. Manufacture starts	Manufacturer	
Model delivery date (when required)	Manufacturer	2 weeks
Bench deployment	VS and IR	1 week
Graft delivery date		6 weeks
Phase overdue		7 weeks

Phase 3 (FEVAR Procedure)

Preoperative checks		2 weeks
Confirmation anaesthetic assessment		
Procedure date		
Phase overdue		2 weeks

Phase 4 (Follow-up)

Follow-up CT and OPD appointments	VS and IR	6 weeks
Phase overdue		6 weeks

The total time from entry to the FEVAR protocol and the FEVAR operation date is approximately 12 weeks.

Adequacy of the trust's investigation of these events – in particular the morbidity and mortality meeting discussion, which was incomplete, and does not refer to delay by the trust at all.

Further to the investigations referred to above, Mrs S' case is to be discussed at the next vascular Morbidity and Mortality meeting at NUH.

Nature and content of the witness statements provided to the coroner, which again refer only to delay by the manufacturer, which is clearly not the central issue in this case.

The legal team at Sherwood Forest Hospitals NHS FT is soon to be made part of the Governance Directorate, with offices adjacent. This will enable a greater working relationship between the legal team and the Clinical Governance Unit which it is expected will make matters requiring investigation clearer from the outset. Any insufficiency in witness evidence can be addressed at an earlier stage.

I hope this provides you with assurance that we have reviewed our systems and will continue to look for further opportunities to improve processes and the experience of patients.

Should you require any further information please do not hesitate to contact me.

Yours sincerely

Peter Herring
Chief Executive