NHS
Brighton and Sussex
University Hospitals
NHS Trust

Your ref: VHD/ST/Whittington
Our Ref: RS/INQ/18/68

3 May 2019

Miss Veronica Hamilton-Deeley
HM Senior Coroner for Brighton & Hove
The Coroner's Office
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Brighton
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NHS Trust
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Dear Miss Hamilton-Deeley

The Late Kenneth Whittington

Thank you for your letter of 14 February 2019 enclosing your Regulation 28 report, Record of Inquest, and for sharing your concerns. We have acted on your concerns, have learnt from Mr Whittington's inquest, and I am pleased to say we have made improvements to our services which I will summarise below.

Firstly I wish to offer my heartfelt condolences to Mr Whittington's family and friends.

The findings from the inquest have been shared widely within the Trust and have been discussed at the Safety Huddle attended by the Medical Director and Nursing Director, the Serious Incident Review Group meeting and the Division of Surgery's governance meetings. This has ensured senior ownership to review the systems and processes in place, make the necessary changes, and ensure the learning is filtered through to all levels of staffing within the Trust.

The investigation producing the learning and improvements following the inquest have been led by [redacted], Chief of Service for the Division of Surgery, [redacted] Consultant Governance Lead for Surgery, and [redacted] Directorate Lead Nurse. [redacted] has been in contact with Mr Whittington's family as part of the process and will continue to provide them with support and information.

There was no junior doctor present at the pre operative assessment appointment to see Mr Whittington. This resulted in his atypical antibodies not being identified and therefore the surgery did not take place on the original date planned. For this I apologise. A General Medical Council (GMC) and Health Education England Kent Surrey and Sussex (HEEKSS) Deanery review of the Digestive Diseases Directorate in the Trust was undertaken. This review was critical of our use of junior doctors in pre-operative assessment processes and they recommended that these tasks should be nurse delivered as is the case in most NHS Trusts now. A Working Group was convened to change the pre operative assessment process and a new model is being developed. Nursing Staff are responsible for flagging pre operative abnormal blood test results. Mr Threlfall is in contact with the Pre Operative

Assessment Manager and the Perioperative Directorate Lead Nurse and this work is on-going to maximise efficiency and safety.

The documentation in Mr Whittington's records was not to the level we would expect. As a result, [redacted] has led on a piece of work to ensure the general surgeons will use an electronic system (Bluespier) for recording operations. The sections of the operation note mandated by the Royal College of Surgeons can be easily filled in on the computer to generate a typed operation note in clear, legible print. A section for post-operative instructions is included on Bluespier. This means the operation note and post operative instructions are recorded electronically making it easier for all staff to access and read. This can be printed and added to the paper records.

In addition, the Division of Surgery have reviewed the Enhanced Recovery Programme booklet and have amended this to include a section on the management of post operative urinary catheters. An order for the amended booklets has been placed with the printers. When the new booklets have been printed we will roll these out for use.

To strengthen awareness and recording, the daily ward round sheets now include a pre printed prompt on urinary catheters. An audit is underway of documentation in surgery measured against National Guidelines[redacted] is leading on this audit.

Our practice has changed and Nursing staff no longer remove urinary catheters on the Surgical wards, without clear documented instruction in the records from the doctors to do so.

The Senior Nurses are also conducting an audit to focus on the quality of the Level 9A nursing documentation, these results will be shared with the Clinical Governance meeting in the Division of Surgery for action as necessary dependent on the results.

Wendy Caddye, Nurse Consultant for Pain Management, has reviewed and revised the Trust's Epidural Policy to provide robust and clear guidance for all staff on the management of disconnected and failed epidurals. A section has been added to the policy titled epidural failure. To supplement this, all Level 9A nurses have attended, or are in the process of booking to attend, an Acute Pain Study Day which includes specific training on epidural management. All nurses in charge of a shift on the ward are fully epidural trained.

We do operate a system of a consultant surgeon being the consultant for the week, this allows us to ensure our patients are seen by a consultant each day. To improve continuity of care and ensure the team are aware of each patient on the ward, on 25 February 2019 we introduced mandatory Board Rounds to take place in the morning, before the ward rounds, on all wards and in all specialities to facilitate improved communication between ward teams (doctors, nurses and allied health professionals). The principles of the Board Round are to confirm the patient acuity (how unwell they are), have they had any test results which require review, do they need any tests to progress their care, what interventions/actions need to be taken and when e.g. removal of catheter. The meeting occurs every morning. Actions are recorded on an Electronic Whiteboard and are followed up by the Nurse in Charge that day. Feedback from staff about the daily Board Rounds indicates that this has facilitated improved communication between all healthcare professionals at all levels on Level 9A. The surgical team also have a 4pm review meeting each day. The purpose of the meeting is to review and complete any outstanding actions and prepare a clear and thorough handover for the surgical team covering the night shift. The rationale for any changes in the plan will then be documented in the patient's records. I agree, the documentation in Mr Whittington's case

in this regard was not good enough. The importance of good clear record keeping has been reinforced at the Ward Huddles and at the Clinical Governance meeting. We continually strive to improve the quality of our documentation and the audit results will drive this improvement on an on-going basis.

Discharge documentation was poor in Mr Whittington's records; we have now appointed a discharge facilitator to work with the Level 9A staff and to assist with patient discharges and in turn with the documentation of discharge planning. We have also revised the two band 7 nurse roles on the ward so one of these nurses in their role will focus on discharges (and admissions) and make sure the discharge planning is on track and the accompanying discharge paperwork is complete. The discharge planner template is being revised to make it clearer and easier to use and record the key information. The documentation audits will review the quality of discharge documentation.

Where any individual nurse's documentation is found not to be the level and quality expected, the Ward Manager and Matron will address this with the individual nurse.

The above is a summary of the actions we have taken following the inquest and your Regulation 28 Report, I hope you feel assured by the improvements we have made to our systems and processes. I am confident these improvements have increased the safety of our patients and staff.

Finally, I would just like to reiterate my condolences to Mr Whittington's family and friends on behalf of the Trust.

Yours sincerely

Dr George Findlay
Chief Medical Officer and Deputy Chief Executive