NHS England

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2 December 2022

Dear Ms Harrold

Re: Regulation 28 Report to Prevent Future Deaths – Mr Stephen Wells who died on 04 October 2021

Thank you for your Report to Prevent Future Deaths (hereafter "Report") 05 September 2022 concerning the death of Mr Stephen Wells on 04 October 2021.. In advance of responding to the specific concerns raised in your Report, I would like to express my deep condolences to Stephen's family and loved ones. NHS England are keen to assure the family and the Coroner that the concerns raised about Stephen's care have been listened to and reflected upon.

I am grateful for the further time granted to respond to your Report, and I apologise to the family for the delay.

Following the inquest, you raised concerns in your Report due to the lack of follow-up by an Oncologist after Stephen's liver surgery on 3 August 2020, resulting in a gap of one year in providing Stephen with any further chemotherapy, or other treatment or monitoring, which would not have been curative but would have prolonged his life. To summarise, you queried whether additional guidance or refresher training would be appropriate (for GPs when raising concerns about patient hospital / tertiary treatment, and for hospital doctors regarding using Datix), and you raised several concerns about the communication between the two Trusts, particularly when there is an inter-provider transfer (IPT).

NHS England can advise that it is routine practice in primary care to have local systems in place to monitor cancer cases among patients. By September 2023, every local risk management supplier including Datix will need to connect to the Learn from patient safety events (LFPSE) service. The reporter can log the incident as occurring elsewhere by completing the question: "Under which organisation's care did the incident occur". NHS England's Regulation 28 Working Group will notify regions and ICB (Integrated Care Board) quality teams / ICB patient safety specialists of any incident of concern occurring outside of primary care, so that this can be escalated to the other organisation. The Royal Surrey County Hospital NHS Foundation Trust (RSFT) have assured us that all consultants undertake yearly mandatory training, which includes the use of the Datix system and the expectation for Datix reporting of incidents.

Prior to the inquest, the Surrey and Sussex Healthcare NHS Trust (SASH) and RSFT conducted a joint review of the Service Level Agreement (SLA). The Trusts have been

working to ensure that the SLA has been reviewed and renegotiated, and that the learning from this inquest process and the concerns raised as a result have been incorporated into the new SLA.

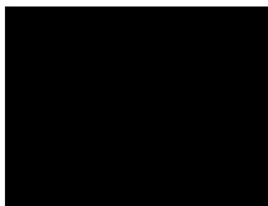
RSFT have advised that they have developed a proforma letter to use at the point when a patient's care is due to be transferred to another organisation. This letter is due to be ratified by the Oncology department and will then be used for all patients where care is being transferred from RSFT to other referring hospitals. Patients will receive a hard copy of this letter in person at their final face to face visit, which should avoid any issues with the letter being lost or delayed in a postal process, and ensure that the patient is clear on how and who to contact should they have concerns following their transfer of care. The letter will then be copied to the patient's GP and to the Clinical Nurse Specialist at the receiving Trust, who will be taking on the role of the nominated point of contact for that patient.

RSFT and SASH have confirmed that the firewall problem between both Trusts has now been resolved and electronic data connections can be seen between both RSFT's and SASH's E-Tertiary system. It is hoped that the transfer and tracking of patient care can be monitored during December 2022. The system will go live in January 2023 for all hospitals referring into and receiving patients from the RSFT cancer services. Both Trusts have agreed to ensure that the transfer of information for all cancer patients should be in line with the 'Cancer Waiting Times: Inter Provider Transfer Policy'. The policy has been developed by the NHS Wessex Cancer Alliance. This policy has been developed over the time period including Stephen's inquest, and the lessons and concerns identified during this inquest have been considered during the development of the policy. A copy of the policy is enclosed with this response for your information.

I would also like to provide further assurances on the national NHSE work taking place around the Reports to Prevent Future Deaths. All reports received are discussed by the Regulation 28 Working Group, comprising Regional Medical Directors and other clinical and quality colleagues from across the regions. This ensures that key learnings and insights around events, such as the sad death of Stephen, are shared across the NHS at both a national and regional level, and helps us to pay close attention to any emerging trends that may require further review and action.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,



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