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1st November 2022

Private and Confidential

Mrs Karen Harrold
HM Assistant Coroner for West Sussex

[redacted]

Dear Mrs Harrold,

Re: Regulation 28: Report to Prevent Future Deaths following the Inquest into the Death of Stephen Wells

We are writing in response to the Report to Prevent Future Deaths which you issued to the Chief Executive Officers of both the Royal Surrey NHS Foundation Trust (RSFT) and Surrey and Sussex Healthcare NHS Trust (SASH) following the inquest touching upon the death of Mr Stephen Wells, which concluded on the 16th August 2022. Given that the concerns that you raised mainly involved the working communication and handover of care between both Trusts, and the fact that both Trusts have been working together since the inquest to address the concerns identified, we are submitting a jointly written and agreed reply addressing your concerns. We would like to thank you for investigating this matter so thoroughly and for bringing your concerns to our attention.

The Prevention of Future Deaths report identifies five areas of concern, and we will address each of these areas of concern in turn below, along with details of the discussions and actions that we have undertaken or plan to undertake to address the issues identified.

1. **Whether additional guidance may be appropriate for GPs to know where to raise concerns about patient treatment in hospital or tertiary care.**

We have carefully considered this concern and believe that this will be answered by the changes that are being put into place in response to Concern 5, discussed below. These changes will ensure that both the patient and the GP are aware of the name and contact details of the patient's nominated point of contact at all points in the patient's pathway. This point of contact will, in almost all cases, be a Clinical Nurse Specialist. Should the GP have concerns about the care of their patient they would be able to raise their concerns directly with this nominated point of contact.

When this process is ready to go live RSFT will communicate this to all of our GP partners through direct communication, our regular monthly GP newsletter and our regular monthly 'working together' meeting held between primary and secondary care clinicians. This will ensure that all of our local GPs are aware of the new process and that should they wish to raise concerns about a specific patient they can do so using the contact details provided for

the nominated point of contact. The GPs local to RSFT also know that they can raise concerns directly through the 'working together' meeting or via email directly to the RSFT Medical Director and Deputy Medical Director. Similarly at SASH, the Surrey and Sussex GP groups both have a regular primary care interface meeting with the Trust's Chief Medical Officer in which concerns can be raised or directly via email at any time.

2. Whether further guidance or refresher training is needed for hospital doctors regarding the use of the relevant Datix system.

This concern was raised following evidence heard by yourself during the inquest that the RSFT witness assisting the court on governance and risk issues did not know that the doctors had received letters from Mr Well's GP raising concerns about the lack of ongoing follow up following his liver surgery.

This incident occurred at SASH and so the Serious Incident Investigation was conducted by SASH with input from RSFT. There was therefore no Datix incident raised at RSFT and additional documentation such as these letters would have been held at SASH rather than at RSFT.

At RSFT it would not be expected that consultants upload letters such as these to Datix as this would not be our normal process. However, it would be expected that letters such as these would have been identified during a Serious Incident Investigation and certainly during the preparation for inquest. At this point these letters would have been uploaded by the governance team to the Datix system and contained within the Serious Incident and inquest files. This data would then be provided to, and be reviewed by, the Trust witness assisting the court.

The RSFT Medical Director has asked the Deputy Medical Director and the Lead Consultant for Clinical Governance to conduct a review into the RSFT processes for Serious Incident Review and preparation for Inquest. This review will include ensuring that all relevant documents, such as letters, are identified and correctly contained within Datix and the Serious Incident review documentation, all documentation should then be reviewed by any witness attending an inquest to assist the court on governance and risk issues. There is a similar process at SASH.

To provide assurance about the raising of Datix incidents when a significant problem in patient care is identified, both Trusts can confirm that all consultants undertake yearly mandatory training which includes the use of the Datix system and the expectation for Datix reporting of incidents. The consultants also attend departmental and divisional governance meetings at which incidents are discussed that have been reported using the Datix system. There is therefore a high level of knowledge and awareness across the consultant body of the requirement to report incidents using the Datix system and of how to do this. The consultants, and all other staff members, are also aware of the need to report any patient identified as potentially lost to follow up immediately and to complete a Datix incident report. Incidents reported on Datix involving consultants, and other medical staff, are also discussed at their annual appraisal as a standard part of the appraisal process.

3. The lack of progress made in reviewing / renegotiating the SLA bearing in mind the difficulties in this case were drawn to the attention of the Trusts in September 2021.

Both Trusts recognise that greater progress should have been made in reviewing and renegotiating the SLA prior to the Inquest, particularly given that the Trusts were aware of the difficulties in this case in September 2021. We would like to thank you for bringing these issues to our attention both before and during the inquest. Since the inquest 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. This SLA is now awaiting its final sign off by both organisations and we have enclosed a copy of the updated SLA with this response for your information.

Both Trusts have been discussing more broadly the provision of Oncology services between RSFT and SASH and how these may be delivered in the future. We are currently discussing a potential move to a new model of service delivery which would remove the division in care between the two Trusts and remove the need for a significant number of transfers of care between the two organisations.

RSFT are also reviewing their Cancer and Oncology SLAs with other Trusts and incorporating the learning from this event into those SLA renegotiations.

4. An ongoing firewall problem between the two Trusts as this places a current reliance on email rather than automatic electronic systems especially given the failure of emails in this case to secure a much-needed appointment.

The firewall problem has been resolved between the two Trusts and electronic data connections can be seen between the RSFT and SASH E-Tertiary systems. This data transfer is due to be further tested by the IT and Cancer teams in the week commencing the 7th November. The system will then be tested clinically as part of a planned move of Upper Gastrointestinal Oncology patients currently managed by SASH to the care of RSFT later in November when each patient will require a transfer of information.

Assuming that the testing scheduled for November is successful all RSFT cancer staff will be trained on the correct use of the E-Tertiary system and the transfer and tracking of patient care during December. The system will then go live for all hospitals referring into, and receiving patients from, the RSFT cancer services in January 2023.

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' which has been developed by the Surrey and Sussex Cancer Alliance. This policy has been developed over the time period including this 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.

RSFT is also working with all of the hospitals who refer patients into the Trust for cancer services to ensure that they also follow the practice laid out in the Surrey and Sussex Cancer Alliance policy.

5. Concerns that that there is insufficient clarity for both patients and staff as to the identity of the key contact for the patients care when there is an IPT from SASH to RSFT and vice versa.

Following the concerns identified during the inquest the Trusts have been working on an agreed pathway that will ensure that patients themselves receive a letter at the point when their care is due to be transferred to another organisation. This letter will contain the key contact details including a telephone number for the nominated point of contact at the receiving organisation. The patient will therefore always have the key contact details available to them. The letter will also be copied to the patients GP and to the receiving clinical nurse specialist at the receiving hospital. This ensures that the GP has access to the contact details of the nominated point of contact should they need to raise any concerns or otherwise make contact with the treating clinical team. The Inter Provider Transfer process will continue to be conducted in accordance with the Surrey and Sussex Cancer Alliance policy described in Concern 4.

RSFT 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 RSFT Oncology department on the 4th November and will then be used for all patients where care is being transferred from RSFT to our referring hospitals. Patients will receive this letter in person at their final face to face visit, this will 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 taking on the role of the nominated point of contact for that patient.

On behalf of both Trusts we would like to take this opportunity to offer our sincere condolences to Mr Wells' family for their loss. We hope that the actions outlined above assure you that we are committed to identifying learning and improving the quality of care for our patients.

Yours Sincerely

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[redacted]

Chief Executive Officer
Royal Surrey NHS Foundation Trust

Chief Executive Officer
Surrey and Sussex Healthcare NHS Trust