Oxford University Hospitals
NHS Foundation Trust

PRIVATE AND CONFIDENTIAL

John Radcliffe Hospital
Headley Way
Headington
Oxford
OX3 9DU

18 December 2023

Mrs Heidi J Connor
Senior Coroner for Berkshire

[redacted]

Dear Mrs Connor

Following the death of Mr Frances Osborne Barnes (Barney), and subsequent inquest on 17-19 October 2023, I write as CEO of Oxford University Hospitals NHS Foundation Trust (OUH), which is the host Trust for the Thames Valley Vascular Network (TVVN), to provide a response to your Regulation 28 Report dated 27 October 2023.

I would like to start by expressing to Mr Barnes' family how sorry I am for their loss. Mr Barnes underwent elective inguinal hernia repair on 12 March 2022 at The Spire Dunedin Hospital, Reading. During the procedure his external iliac artery was transected. The surgeon called an off-duty vascular consultant colleague who attended in his private capacity and repaired the damaged artery with a bypass graft. The patient was transferred to the Intensive Care Unit of Royal Berkshire NHS Trust.

The Royal Berkshire Hospital (RBH) intensive care team subsequently contacted the on call Vascular Surgical Consultant at OUH as the Vascular Surgical Hub for the TVVN. The OUH Vascular surgical consultant contacted the off-duty vascular consultant who had repaired the iliac artery for further information about the case and then provided verbal advice to the RBH intensive care team regarding the vascular management of the patient.

Notably, the usual process for escalating vascular surgical emergencies within the TVVN was not followed at the time of the initial vascular injury, whereby the on-call consultant for the TVVN should be contacted to arrange either the transfer of the patient to OUH or the dispatch of a vascular consultant with the appropriate graft and equipment to the referring hospital.

You recorded a narrative conclusion as follows: "*Mr Barnes suffered a rare and significant complication of surgery. This was likely to have been the biggest factor contributing to Barney's death. If Barney had been transferred to Oxford University Hospital, consideration would have been given to a thrombectomy and/or amputation. It is likely that, if amputation had been needed, this would have happened sooner. This delay contributed to Mr Barnes' death.*"

The cause of death was:
1a) Multiple Organ Failure
1b) Femoral Artery Injury during Elective Inguinal Hernia Repair
2) Ischaemic Heart Disease

You have set out three concerns:

1. Clarification of vascular surgery pathways – i.e. working with others in the Thames Valley Vascular Network to consider how patients should be efficiently referred to the vascular team, wherever that patient is physically based (including in the private sector).

2. Consideration of an electronic referral system (such as OARS). You note that OARS was set up by the Oxford Trust itself, and is already in operation in a neurosurgery context, and indeed even for some vascular surgery patients.

3. Consideration of how the Oxford Trust responds to and learns from deaths.

In addition, you raised concerns regarding our engagement with other hospital partners and our approach to investigating this tragic incident.

Our normal processes of engaging with clinical governance teams at local hospitals were followed. In this case we contacted the Governance lead for Spires Hospital on 23 March 2022 providing details of whom to contact in OUH Divisional Clinical Governance. We requested an NHS number of the patient and a chronology of the events so that we could provide input into their investigation. We also shared a draft statement to the Coroner by three vascular consultants with the Clinical Governance team at the Royal Berkshire Hospital (RBH) on 9 February 2023. This described the involvement of the OUH clinicians in this incident. This was again shared on 15 March 2023 with RBH Patient Safety Team with a request to contact us again if further input into their investigation was required.

We have also reviewed these points raised by your report and have documented our response below:

1. Clarification of vascular surgery hub pathways

1.1 Following this inquest, a concise procedure for contacting the Vascular Team at OUH has been developed and approved by the TVVN which clearly sets out the referral process for patients who have a vascular emergency within the Network. This will be sent to all NHS and private providers in Thames Valley and provides details on how to contact the on-call Vascular SpR and on-call Vascular Consultant.

1.2 The principle of granting operating and access rights for OUH surgeons to NHS and Private hospitals in TVVN area has been included within this procedure. It also clarifies that the on call vascular surgeon is responsible for providing any specialist vascular surgical equipment required.

2. Consideration of an electronic referral system

2.1 We have appraised several options in relation to the TVVN referral process, including potential electronic referral systems, and documentation of advice and guidance given by on-call vascular consultants in the TVVN.

2.2 The TVVN have agreed that all vascular emergencies should continue to be referred by telephone to the on-call vascular surgical team at OUH. No electronic referral system would ensure as timely and effective a response to vascular emergencies.

2.3 Options considered to record referrals from centres within TVVN included:

2.3.1 The use of a Microsoft 365 Form which will enable all referrals to be documented in real time including a record of the patient's name and NHS number. This does not require the patient to have an existing OUH medical record number (MRN) and so allows documentation of referrals of patients who are not currently under the care of OUH. This Form is currently used by the vascular surgical team to track patients from around the region who are awaiting discussion at the Multidisciplinary Team meetings. The data is stored within the OUH server on Sharepoint.

2.3.2 A clinical audit and research system is currently used to document every inpatient encounter and vascular operation within Vascular Surgery in OUH. It could be used to document referrals to the vascular service; however, it is dependent on the patient having an existing OUH Electronic Patient Record (EPR) and so would not be suitable for documenting referrals from across the TVVN.

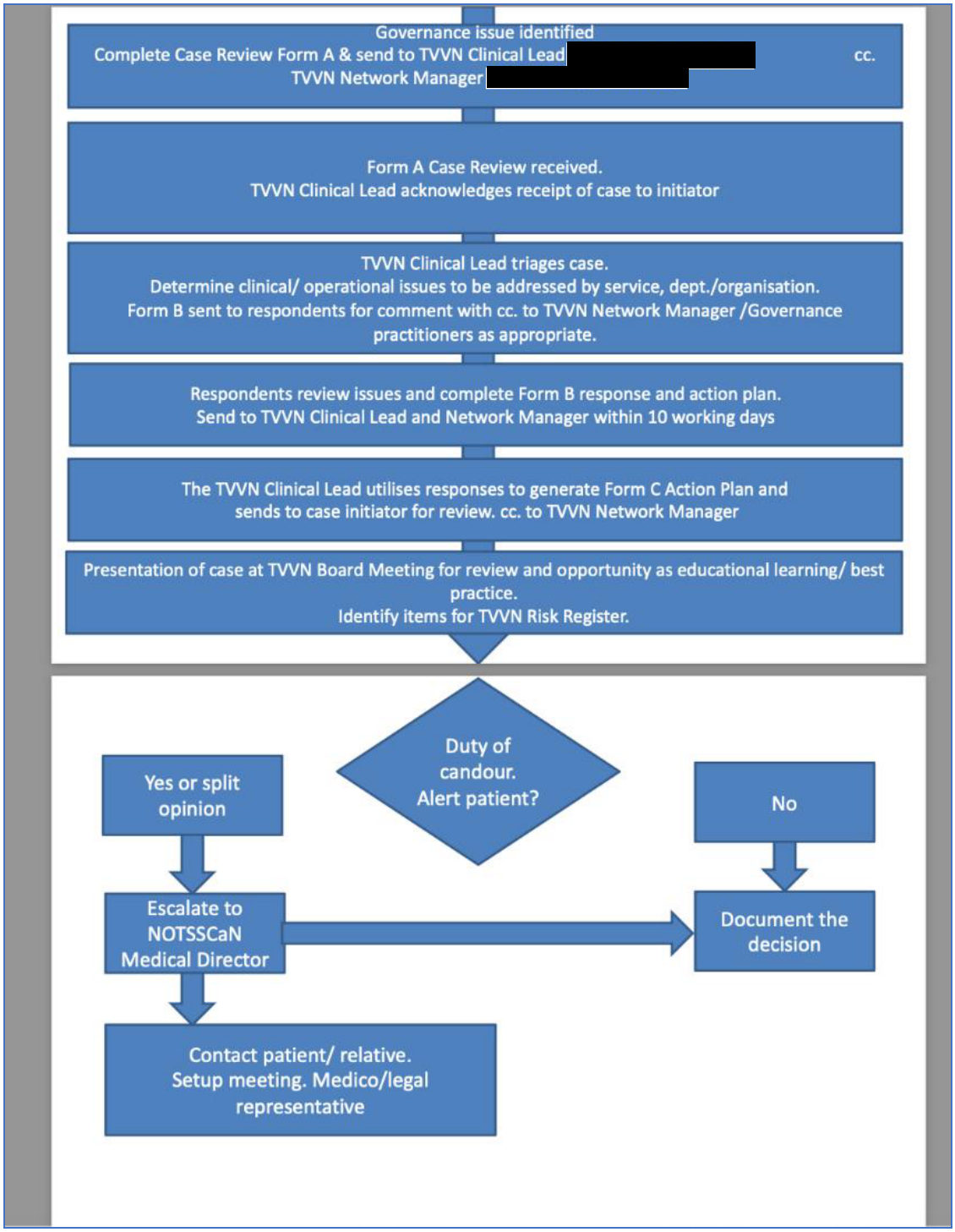
2.3.3 The Online Acute Referral System (OARS) is currently used for urgent but not emergency referrals from outside OUH to vascular surgery, plastic surgery, and neurosurgery. Time-critical, emergency referrals to neurosurgery and plastic surgery must be supplemented by a telephone call to the on-call team. For vascular surgery, the system is currently only used to capture non-emergency referrals of patients with carotid artery disease and acute DVT.

2.4 Following this options appraisal, the Microsoft 365 Form has been agreed to be the most effective method of documenting emergency referrals by the OUH vascular consultants and will be implemented from 1 January 2024.

3. Consideration of how the Oxford Trust responds to and learns from deaths

3.1 Future Governance of cross-organisational incidents within TVVN

3.1.1 Following this incident, all vascular related deaths within the TVVN where there is a clinical concern and opportunity for learning will be discussed and minuted at the quarterly TVVN morbidity and mortality (M&M) meeting. The minutes will be shared with clinicians and Clinical Governance teams of all organisations within the Network. This will enable learning from all deaths, not just those that occur within OUH, to be disseminated across the Network. This process is summarised below:



3.1.2 The M&M documentation will include three new forms which will require completion whenever there is a vascular surgery-related concern raised about a patient death in the Thames Valley region.

3.1.3 These forms will be shared with the Medical Examiners in the hospitals within the Network. They will be asked to raise any deaths where there is a clinical concern and opportunity for learning.

3.1.4 The OUH Vascular Surgery monthly M&M meeting currently reviews all vascular deaths that occur within OUH. This meeting will be amended to discuss non-OUH vascular related deaths to enable learning to be disseminated within OUH.

3.2 How OUH responds to and learns from deaths

3.2.1 OUH is committed to accurately monitoring and understanding its mortality outcomes. Reviewing patient outcomes, including deaths, is important to help provide assurance and evidence that the quality of care is of a high standard and to ensure any identified issues are effectively addressed to improve patient care.

3.2.2 The OUH Clinical Governance team regularly coordinates contributions to investigations at partner hospitals for patient safety incidents involving one of our networked services.

3.2.3 OUH introduced the Medical Examiner (ME) office in June 2020. This is to provide greater safeguards for the public by ensuring proper scrutiny of all non-Coronial deaths. Currently 100% of Trust deaths are reviewed by the ME office who feedback any concerns directly to the Learning from Deaths team (part of the Clinical Governance team). Any concerns and compliments are also fed back to clinical teams for action.

3.2.4 OUH ensures a high level of mortality reviews across all Divisions. In 2022/23 of 2719 total deaths, 2625 (97%) of deaths were reviewed within 8 weeks. Of these reviews, 1273 underwent a level 2 review (47%) and 53 had a structured review (2%). The remaining 94 cases were also reviewed, but outside the 8-week target. The total number of mortality reviews within 8 weeks for the first Quarter of 2023/24 were 628 (99%) out of 634 deaths. Of these 285 (45%) were conducted at level 2 and 6 cases (1%) underwent a structured judgment review.

3.2.5 All system investigations involving OUH are reviewed and approved at Divisional meetings and signed off via the Patient Safety Team by the Chief Medical Officer's office. This process mirrors that of our internal investigation sign off and learning process. System wide investigations may include meetings between the BOB ICB, OUH patient safety team, and patient safety colleagues from other trusts. These are documented and the results of the investigation are fed back to the Divisional teams and learning is shared across the Trust.

3.2.6 There is a cross organisational approach to Duty of Candour (DOC), with evidence of coordination and ownership of responsibility regarding which organisation will complete DOC and feedback once it has been completed (see flow diagram in 3.1.1).

3.2.7 We have reviewed our organisational responses to concerns highlighted by other organisations in the light of your concerns. The available evidence, including from recent cases, confirms early active engagement and collaboration with partner organisations. We would be happy to provide further details if required.

3.2.8 In response to this inquest several new processes have also been introduced:

3.2.8.1 The OUH Mortality Review Policy has been updated to include an appendix on cross-system learning responses and how these are managed across the Buckinghamshire Oxfordshire Berkshire West and Frimley Integrated Care Board (BOB ICB). This section is also contained within our Patient Safety Incident Response Framework procedure for the management of non-mortality incidents.

3.2.8.2 A weekly Patient Safety meeting with Buckinghamshire, Oxfordshire and Berkshire West (BOB) Integrated Care Board (ICB) has been established for Patient Safety Teams to plan and liaise on the progress of multi-organisational Patient Safety Incidents. Ad-hoc arrangements can also be made in the event of significant Patient Safety incidents that require urgent planning and response.

I hope that this response will reassure you that we have taken your concerns very seriously and implemented appropriate actions as a result of this inquest.

Yours sincerely

[redacted]

Chief Executive Officer

Enc. TVVN Emergency Contact Details
TVVN M&M forms