NHS
University Hospitals
Bristol and Weston
NHS Foundation Trust

Trust Headquarters
Marlborough Street
Bristol BS1 3NU

10 January 2024

Ms Debbie Rookes
Assistant Coroner for Avon

PFD RESPONSE

Dear Ms Rookes,

Deceased: Calogero Di Blasi

I am writing in response to the Regulation 28 Report to Prevent Future Deaths dated 15 November 2023.

I would like to begin by extending my deepest condolences to the family of Mr Di Blasi. I hope that my response provides his family with assurance that the Trust takes their loss seriously and has taken this further opportunity to consider actions which may prevent this from recurring.

In order to respond to the matters of concern set out in your report and provide assurance to you on the actions taken to mitigate the risk of future deaths, I have sought the assistance of Chief Clinical Information Officer. In addition, I have consulted with , Clinical Chair for the Division of Surgery, who has clinical responsibility for the Colorectal and Upper GI teams, and , Clinical Chair for Diagnostic and Therapies, who was present at the inquest and has clinical responsibility for Radiology.

Matters of concern

1) **Issues arising from parallel clinical pathways**

I acknowledge your concern around the communication between specialties when a patient is on two active pathways. I recognise the importance of such knowledge, given the increasing complexity of the patient demographic we treat.

I understand that you heard evidence from the clinical team around the additional question on the pre-procedure checklist for endoscopy. A patient is now asked whether they have had any investigations within the last 6 weeks, and I was pleased to hear that this has been effective in identifying such investigations.

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I asked [redacted] and the witnesses to consider whether any further action could be taken to strengthen the pre-procedure checklist. I am advised that they have identified an additional potential change in practice. The Division of Surgery will undertake a scoping exercise to assess the feasibility of the administrative teams reviewing the patient list and identifying any patients who are on a parallel clinical pathway. The endoscopist would then be notified to review the electronic records and ICE and any relevant investigations before the procedure. Upon completion of the scoping exercise, the Division will consider whether a pilot may be offered for the endoscopy team.

As many patients are treated out of the region or in private or satellite institutions, the subsequent check by the clinician, through a discussion with the patient, provides another opportunity to identify relevant investigations, thereby ensuring there is a robust process in place.

I trust that this is striking the balance between maintaining the number of investigations for those patients on the urgent referral pathway, whilst ensuring that relevant investigations are identified for each patient.

2) The reporting timeframe on two 2 week urgent cancer pathway referral does not take into account timeframes for reporting investigative procedures or subsequent review by the referring clinicians.

As you heard in evidence, there is, regrettably, a national shortage of Radiologists. I therefore envisage that the Secretary of State for Health may wish to add to the below response from the Trust.

Firstly, I attach the guidance on diagnostic imaging reporting turnaround times issued by NHSE in August 2023. Whilst this national guidance was issued after Mr Di Blasi's death, it provides a maximum turnaround time of 3 days for outpatients on a cancer pathway.

The Trust recognises that this best practice relies upon there being full staffing available to deliver it. Furthermore, the guidance considers that adherence to the turnaround times relies upon good digital connectivity and IT infrastructure; I will turn to the Trusts' digital strategy below.

Regrettably, in parallel with a number of organisations across the country, the Trust is not meeting this timeframe. The following mitigations have been put in place:

- The Trust is actively recruiting to the vacancies for radiologists.
- Outsourcing is used to maximise the number of reports which can be achieved within the timeframe
- Locum radiology cover can be arranged.
- Additional sessions are in place for existing radiologists
- The Division is undertaking a scoping exercise to increase the resource of radiographers who could support the radiologists.

All of the above actions will increase reporting capacity and seek to enact the recommendations from the national guidance. In addition, the Radiology team have added a risk to the risk register around turnaround times. This will ensure that this remains a priority for the Division.

Secondly, the guidance confirms that local Standard Operating Procedures (SOPs) should identify 'urgent', 'emergency' and 'time critical' findings. You heard in evidence that the Trust's SOP on Incidental Findings will be reviewed, with a view to updating this to reflect the recent national recommendations of the royal colleges.

Aligned to this, I have received an update in respect of the paper reports for radiology; these will be discontinued from 1 May 2024. Results will continue to be available via the ICE and PACS electronic reporting systems. As part of the transition away from paper results, the Trust plans to set up specialty specific reporting systems within our existing digital platforms.

Alerts

I thought it important to update on the action the Trust has considered but would be unable to implement.

I understand that it was explored in evidence whether an alert could be added to the electronic records for varices. It would not be practicable to highlight chronic conditions in alerts. Notwithstanding the fact that their purpose is to identify standardised alerts, such as allergies and the need for an interpreter, expanding this to include a new diagnosis, would not be feasible. Furthermore, it may be helpful to explain that the alerts do not pop up when a clinician opens the electronic record, they must be accessed, and there is a risk that adding new alerts could increase risk.

The Trust has therefore carefully assessed this option but considers that it would not improve patient safety and would be outwith our understanding of how other Trusts are utilising alerts on electronic records.

3) **The current training for Endoscopists for JAG accreditation requires the performance of 200 endoscopies. However, these tend to focus on clinician's area of specialty and therefore there is danger that lesion recognition will be limited and insufficient to ensure that endoscopies are able to recognise less frequently occurring lesions. With the need for an increasing number of endoscopists, action should be taken.**

I note that the Regulation 28 Report was shared with the Royal College of Physicians, who I understand are responsible for the Joint Advisory Group on GI Endoscopy (JAG) and will be providing you with a response from a national perspective.

The Trust has taken further action, over and above those completed for the PSII, to address this concern:

- [redacted] operates 5 training lists each week, in his capacity as Clinical Lead. He is able to share his knowledge of lesion recognition with junior doctors, to build upon the 200 endoscopies they are required to take in their own training. The current schedule includes 10 dedicated training lists, in addition to ad-hoc training and hosting fellows in Lower GI Endoscopy and Advanced Hepatobiliary Endoscopy. The Trust collaborates with other Bristol endoscopy institutions to provide training courses on upper gastrointestinal haemostasis and colonic polypectomy, both JAG-certified courses. Trainees of all endoscopic disciplines are encouraged to attend lists where they are likely to encounter a broad range of pathology.
- Learning from this case has been shared at our pan-UHBW Endoscopy Users Group (EUG), in addition to local Gastroenterology and Hepatology education meetings.

- Endoscopists have access to an online endoscopy learning platform (GIEQs online; accredited by the European Society for Gastrointestinal Endoscopy (ESGE) and American Society for Gastrointestinal Endoscopy (ASGE)). We are able to audit uptake of the online content prior to quarterly EUG meetings. We are also collaborating with the South-West Endoscopy Training Academy (SWETA) to create a mandatory local learning resource that will form a part of the Trust statutory training for staff involved in gastrointestinal endoscopy.
- The PSII has also been shared at the Patient Safety Group, which has representation from all of the Clinical Divisions at the Trust, to ensure learning is cascaded across all specialties.

Digital Strategy

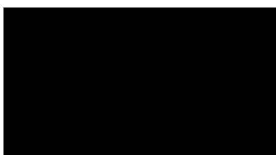
UHBW and NBT will shortly appoint a joint Chief Executive and Chair. The Chief Digital Information Officer has already been appointed across both Trusts and is in the process of launching a Digital Strategy, with the aim of converging the IT systems across the provider collaborative.

As a tertiary centre, the Trust receives referrals from across the region and recognises the importance of integrated working. The challenge of multiple systems for records is a national one. The overarching aim of the strategy will be to ensure that clinical information is digital and in one place, thereby avoiding paper records. I therefore hope that you will begin to see a united approach across the two Trusts who serve the jurisdiction. I am hopeful that the improved infrastructure will help to support the delivery of the turnaround times discussed above.

I understand that Mr Di Blasi's family requested that the learning from this inquest be shared with the Clinical Endoscopist who performed the first endoscopy, but who no longer works at the Trust. The Trust will endeavour to achieve this. Lastly, it may be helpful to confirm that the Endoscopy team is auditing photo documentation during an endoscopy as part of the recurring audit plan.

We trust that the above actions provide you, and the stakeholders you have shared the Regulation 28 Report with, assurance that the Trust has learnt from this death. We are consistently challenging ourselves to consider further action we can take to strengthen patient safety, whilst recognising that a number of the concerns raised are at a national level.

Yours sincerely



Interim Chief Executive