NHS
Kent and Medway

[redacted]

Private and confidential

Central and South East Kent Coroners
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ME16 8AE

The Office of the Chief Executive
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[redacted]

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Tuesday 30th April 2024

Dear Ms Wood,

NHS Kent and Medway Regulation 28 Response re Kerri Louise Mothersole

Thank you for your Prevention of Future Deaths Report dated 28 February 2024 sent pursuant to paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 concerning the death of Ms Kerri Louise Mothersole on 20 August 2022.

I understand that during the course of the inquest you heard evidence that you felt needed to be addressed by the Integrated Care Board (ICB) to prevent future deaths. I will address your concerns, which are as follows:

> (1) The two reports from HEM Clinical Ultrasound Ltd on 28 June 2021 and 1 July 2021 and any images associated with the reports were not provided to any of the deceased's treating clinicians. Only the second report from 1 July 2021 was sent to her General Practitioner and not the first report from 28 June 2021. Neither report was uploaded to her clinical notes at Medway Maritime hospital or Maidstone hospital. Had the images and the reports been available to her treating clinicians then a more urgent referral would have been warranted by her General Practitioner and she may have been investigated and treated at a much earlier stage.
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> (2)The court heard that most of Kent have a system whereby imaging taken can be seen at more than one Trust and is even linked to tertiary referral centres in London. The system used was referred to as the PACS system. Clinicians told the court that they could look up images for their patients taken at another hospital and this would

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impact on their decision making for a patient. Images taken in the community by private providers are not uploaded to the system but can be requested however this relies upon knowing that there were any images to access in the first instance.

(3) The managing partner at HEM Clinical Ultrasound Ltd gave evidence that she had been requesting that the imaging they took be made available on the central system. She was unable to explain why this had not been requested or set up or commissioned by the Integrated Care Board. All gave evidence that the lack of imaging being available meant that issues could be missed and this created a risk to patients, which at its extreme would include a risk of future deaths.

As all three of the concerns that you have highlighted in the Regulation 28 Report appear to relate to the same issue, i.e., the inability to upload images to the Picture Archiving System (PACS) system by private providers in Kent and Medway, I will respond to all concerns together. While the ICB accepts that this is the case, it is normal practice across the NHS in England for community ultrasound services not to be directly connected to any Integrated Care System PACS solution.

For information regarding this patient's case, the ICB Patient Safety Team has requested that HEM Clinical Ultrasound complete a Serious Incident (SI) Investigation regarding the Coroner's first concern. This concern notes that there were two ultrasound reports available, only one of which was initially sent to the patient's GP. The provider has stated that that first report was inaccurate and should not have been sent to the patient's GP.

To address the concerns highlighted in the Regulation 28 Report, we can confirm that Kent and Medway have been moving away from individual PACS systems resident in each of our providers to a central PACS system. Procurement commenced in 2021, with the integration of acute provider trusts in September 2023.

Community diagnostics were introduced in the 2010s to improve access and reduce cost. However, no work was commissioned at the time to provide integration to GP or acute systems. The standard protocol is for community diagnostic providers to send reports (text-based), as opposed to the full diagnostics image, back to the GP that requested the investigation. The GP will then assess the report in the context of their holistic assessment of the patient and they make a clinical decision on whether to refer a patient to secondary care.

Notwithstanding the above, NHS Kent and Medway have taken the following actions to reduce the risk of the scenario in the coroner's report happening again in the future:

1. The ICB's Contracting Team issued a contract variation (CV) letter on 10 April 2024 to all existing community Any Qualified Providers (AQPs) that provide direct access diagnostic services for patients in the network. All community AQPs will be required to telephone the patients' registered GP within 5 days of any suspicious or incidental clinical findings noted on a diagnostic imaging report that the GP has a responsibility to act upon urgently. All community providers will be required to keep a log of the date the telephone call was made

to the patients' GP practice and the contact details of the patients GP liaised with for both audit and patient safety purposes. This process is already in place with providers and GPs where suspicious pathological findings have been identified. The ICB's Contracting Team have requested all community diagnostic providers return the signed (CV) letter by 30 April 2024. NHS Kent & Medway's Primary Care Team have also issued out communications to all member GP practices on 11 April 2024, advising them of the new process in place. This will continue to be monitored via monthly ICB Primary Care Board and Contract Monitoring meetings.

2. To provide longer term assurance, and in acknowledgment of this matter, NHS Kent and Medway will examine potential changes where appropriate relating to IT integration. To support this, we will undertake a review of how the incident occurred and determine how the risk of this re-occurring can be reduced. This will include:
    a. Mapping processes in the diagnostic imaging workflow, including manual and automated processes, highlighting where processes failed.
    b. Auditing key systems that are used to understand how patient diagnostic data is flowed and shared through the end-to-end diagnostic process highlighting where there are issues.
    c. Creating an options appraisal, identifying opportunities for improvements in process, and integrations of systems including estimated costs and timescales.
    d. Considering the Options Appraisal and the feasibility of any recommendations. It is anticipated that the production of an Options Appraisal will be delivered by the end of August 2024.

Based on the above, I hope I have provided you with the relevant assurance that Kent and Medway ICB has taken your concerns seriously and that we will continue to strive to provide an appropriate range of services to people undergoing imaging in the community by private providers, and to offer high standards of care to our patients.

Yours sincerely

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Chief Executive
NHS Kent and Medway