Office of the Managing Director
[redacted]

Worcestershire Acute Hospitals NHS Trust

[redacted]

22 March 2024

Mr D D W Reid
HM Senior Coroner
Worcestershire Coroners Court
Martins Way
Stourport on Severn
Worcestershire
DY13 8UN

[redacted]

Dear Mr Reid

Re: Paul William Bradley deceased
Regulation 28 Report to Prevent Future Deaths

Please accept this letter in response to your Regulation 28 Report to Prevent Future Deaths sent on 29th January 2024, following the Inquest touching on the death of Mr Paul Bradley.

In your Regulation 28 report you identified the following matters of concern relating to the Worcestershire Acute Hospitals NHS Trust (WAHT)

1) *It was a mistake to have tried to arrange this appointment by telephone, and that it should have been conducted in person.*
2) *After the Urology appointment in March 2021 was missed, there is no evidence that letters seeking to rearrange it were sent to either Mr Bradley or to his GP*
3) *There is no evidence that the vascular team wrote to Mr Bradley or to his GP about those missed scan appointments.*
4) *There is no evidence that either team contacted the other about Mr Bradley's missed appointments; nor did the vascular team update the urology team about the appointments which Mr Bradley did not attend.*

I was therefore satisfied that:

a) *The Trust's Urology team had no clear system in place to try to ensure that a patient who missed an important urology appointment could be followed up, and his treatment targets met.*
b) *Where, as here, more than one team was involved in a patient's care, there was no clear system in place to ensure that the teams involved communicated with each other about the progress they were making with the patient, and about any appointments missed by the patient*

Responding to the concerns raised:

A significant amount of work has been undertaken by the Trust Patient Experience team over the past 12 months, to raise awareness of how better to support patients with a hearing impairment (appendix 1). This should enable patients to access support that they require more easily and also raised awareness in staff of the most appropriate methods of providing care for patients with hearing impairments.

Both patient facing and staff facing British Sign Language flyers have been developed to raise awareness (appendix 2,3).

To address points 2 to 4 and concerns a and b, the Trust held a Round Table review of Mr Bradley's case on 1st March 2024. The meeting was attended by members of the Urology Team, Cancer Services Team and Patient Safety Team and was multidisciplinary. The purpose of the review was to turn themes identified in to actions and assign them to the appropriate people to make the necessary changes and improvements.

The following actions were agreed with named individuals responsible for their delivery: -

- Streamline and standardise Urology MDT processes to facilitate appropriate time to discuss cases fully.
- Develop a Standard Operating Procedure for the monitoring of potentially cancerous lesions, including transfer of information between teams.
- Develop clear process for the handover of patients from Cancer services to Departmental teams if moved off an active cancer tracking process.
- Cancer Alert on the Patient Administration System to remain active for the lifetime of the patient
- Develop Risk Stratification process within clinical teams for patients who cancel appointments/do not attend.

The above actions have varied timelines due to the complexity of some of the issues but will be monitored through the newly developed Improving Safety Action Group, held monthly and chaired by the Chief Nursing Officer/Chief Medical Officer, with first review date scheduled for mid-April 2024.

Appendix 1	Appendix 1 Our Approach.docx
Appendix 2	BSL Flyer- patient facing.png
Appendix 3	BSL Flyer- staff facing.png

I trust that the foregoing has adequately addressed the Regulation 28 report issued subsequent to the inquest into the death of Paul Bradley.

Should you require any further information in relation to this matter, please do not hesitate to ask.

I confirm that I have not forwarded a copy of this response to any other Interested Person and would therefore be grateful if you could do so, as appropriate.

I also confirm that the Trust is content for both the regulation 28 report and the response to be released or published should the Chief Coroner wish.

Yours sincerely

[redacted]

[redacted]
Managing Director

Appendices
1. Our Approach
2. BLS Flyer Patient facing
3. BLS Flyer Staff facing