PARTNERS [redacted]

SALARIED DOCTORS [redacted]

PRACTICE MANAGER [redacted]

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Date letter typed: 20 May 2025

[redacted]

Mrs Samantha Goward
Area Coroner for Norfolk
Norfolk Coroner Service
County Hall
Martineau Lane
Norwich
NR1 2DH

Re:
Mr Derek Cole
[redacted]
DOB - 06 Jan 1943

Prevention of Future Deaths Report

Dear Mrs Goward,

I am writing on behalf of the Attleborough Surgery in response to the matters of concern raised in your Prevention of Future Deaths Report dated 26 March 2025 relating to our patient, Mr Cole in order to provide you with information regarding the steps we have taken to ensure that there is no recurrence.

1. When secondary (hospital) services ask the practice to perform tests, the practice should notify them of the results if they are abnormal, confirm that a follow up appointment is in place and consider if the abnormal results should lead to a request for a more urgent review.

The abnormal, GP-generated PSA results should have been notified to the hospital in order for them to confirm or expedite their proposed review appointment. They were not notified as they should have been because the practice understood from hospital correspondence that a review appointment was taking place soon although no date had been confirmed. The hospital have access to the test results requested by the GP but they should have been notified by the practice as this would have prompted them to arrange and possibly expedite the review appointment.

Cont'd...

The practice has had a clinical meeting to discuss responsibility for notification of GP-generated results to the hospital. Routinely when GPs request tests which are abnormal or relevant to their patient's treatment by secondary services, any abnormal results are communicated effectively and in a timely matter. When secondary services ask the practice to perform tests the practice should be provided with a hospital-generated ICE form. This ensures that the tests requested by the hospital are clearly set out and that they are notified directly of the results. Where no hospital form is provided for a requested test, the GP actioning an investigation requested by the hospital becomes responsible for acting on the result.

Informing the hospital immediately of the abnormal results and clinical update would have enabled them to review and expedite the next appointment and his treatment.

The practice has discussed and circulated a new policy to ensure that all clinical staff are reminded of their responsibilities to communicate any abnormal test results to the hospital whether requested by the hospital or the GP. All results received are reviewed by a GP who makes a clinical decision about whether or not any further clinical update needs to be provided to the hospital with the abnormal result.

A protocol specifically for investigations requested by the hospital has been developed and introduced which requires:

- When the hospital requests investigation for a patient under their care, Reception should ensure that the patient has a hospital generated form when booking practice-based tests on behalf of the hospital. This will ensure that care remains appropriately with specialist hospital services, who will then receive results back directly, review and decide next steps for care planning. Where this form is not available, the practice should contact the hospital to request a hospital-generated request form.
- However, any tests should be proceeded with in the meantime with a practice-generated form if there is any urgency.
- The responsibility for managing a practice- generated result in this circumstance will rest with the practice:

Results where the patient is under the care of the hospital should be prioritised by the clinician receiving them so that clinically significant results are dealt with appropriately. With the forwarding of straightforward results, the clinician will ask reception to inform the hospital.
With any results needing the sharing of updating clinical information / requesting further advice, this should be dealt with by the clinician directly. In Mr Cole's case, the hospital should not only have been given the results but also a clinical update.

Following these discussions, we identified that the issue of the hospital failing to provide blood forms for their own monitoring has been a problem for other patients at our practice.
I have therefore spoken to [redacted], Executive Officer at the Norfolk & Waveney Local Medical Committee on behalf of the practice and made him aware of this issue. He confirmed the LMC raises such contract breaches with the Integrated Care Board on a regular basis and he advised me to raise the issue with the NNUH Medical Director Dr Bernard Brett, which I have done.

Cont'd...

2. Mr Cole's case should have resulted in an SEA at several points including:
    - When it was clear that there was a delay in secondary care receiving the abnormal results.
    - When it became clear that there was a resulting delay to important treatment for Mr Cole. When the practice was asked for a statement by the Coroner.

The SEA took place on 16.04.25.

As a result, the SEA protocol has been amended and circulated to all clinicians. There is clarification that it is the responsibility of the clinician involved in the patient's care to report to the Practice Manager and Practice PA, but any staff member who identifies a concern should also have a low threshold for reporting to them as well. Similarly, any staff member with a concern that a significant/critical event could have taken place should have a low threshold for discussing the case with a colleague.

In addition, the SEA and reporting of deaths protocols has been amended to specifically include any delay in care and/or any near miss which did not cause harm but could do so if it happened again.

Training for GPs and all staff is planned for 04.06.25 to cover the new protocols, which have already been circulated.

The surgery plans an audit of all deaths over the next 3 months to measure how many are being referred appropriately for a SEA, according to the amended protocol. The audit will then be presented for discussion at a clinical meeting at the practice.

I wish to make clear how seriously I and the practice take the issues that you have raised and hope you are reassured by the steps the practice has undertaken and has planned to prevent future recurrence.

Yours sincerely

[redacted]

[redacted]