NHS
Stockport
NHS Foundation Trust

[redacted]
Chief Executive
Stockport NHS Trust
Poplar Grove
Stockport
Cheshire
SK2 7JE

[redacted]

Our Ref: [redacted]
Your Ref: [redacted]

12 August 2025

Private and Confidential
Mr C Murray
Area Coroner
1 Mount Tabor Street
Stockport
Greater Manchester
SK1 3AG

Dear Mr Murray

Re: Death of Neil John Clarke
NHS number: [redacted]
Inquest date: 1 May 2025

I am writing to you further regarding the Inquest into the death of Mr Neil Clarke which concluded on 1 May 2025 and the request for assurance in respect of the following:

- **Consideration to be given to the appropriateness, from a safety and well-being perspective, of surgical procedures involving elderly patients who may benefit from more conservative measures and the associated documentation and guidance advising patients of different treatment choices.**

Medical professionals, particularly those working with older adults, receive training and guidance on ensuring informed consent and discussing all treatment options with their patients. This training is integrated throughout a doctor's career, from medical school through ongoing professional development. Training is guided by principles and regulations from bodies such as the General Medical Council and the Quality Care Commission. Training has an emphasis on shared decision making, where the doctor acts as an expert in medical options, and the patient is the expert in their own values and preferences, which encourages a collaborative approach.

Training also highlights the importance of providing patients with all relevant information about their condition, prognosis, and available treatment options, including the option to take no action. This information must also cover potential benefits, risks, side effects, and complications associated with each option. Additionally, it is also best practice for the suitability of an elderly patient to undergo surgery to be discussed within a multidisciplinary team meeting, especially for those patients deemed at are at a higher risk. This allows for a more balanced assessment of the benefits and risks of surgery versus alternative treatments or no treatment, leading to a more individualized and patient-centered care plan. This was the case for Mr Clarke following MDT review in September 2023.

I can confirm that the Trust undertook a review of the Trust's Consent Policy in 2024 which stipulated a healthcare professional responsible for seeking consent must have received appropriate consent training.

Consent training was not originally a requirement of the Core Skills Training Framework for mandatory or role specific training, however, it is a key component of CQC assessments to ensure that we are delivering safe, effective and person centered care. Consent training provides healthcare professionals with the knowledge and skills to communicate effectively with patients; assess their capacity to give consent; understand and decide when and how to involve family members or legal representatives and how to document appropriately to meet legal and ethical compliance.

A proposal was made for the provision of consent training and to align this as essential training for clinical staff with patient facing roles to be delivered by an appropriately sourced e-learning module and adapted to align with Trust needs. The proposal was approved and Mandatory Consent Competency requirement was rolled out on 22 July 2025. All clinical staff involved in delivering patient care have the requirement attached to their position in ESR (Electronic Staff Record) and will be auto-enrolled in the relevant e-Learning packages. A timeframe of October 2025 has been set for completion by all relevant staff with a three year rolling programme.

Compliance for this training requirement would then be reported through governance processes including the Educational Governance Group, Patient Safety Group and at Divisional meetings.

- **Accuracy of hand over communications between clinical staff in respect of patients returning to the main ward from HDU.**

[redacted] Divisional Nursing Director, together with [redacted] would like to assure you that changes to process had been implemented prior to Mr Clarkes' inquest and these changes continue to be embedded throughout the Division of Surgery and the wider Trust. Examples of the changes implemented are outlined below:

1. The discharge checklist completed by ICU/HDU staff for a patient transferred to a main ward has been updated and now includes a dual signature feature, meaning that the document must be signed by both the ICU/HDU nurse and the receiving ward nurse.

2. [redacted], Matron for ICU, has been auditing the implementation of the updated checklist since February 2025. The audit has confirmed that ICU are 84% compliant with observations completed an hour before transfer (Trust target is 80%). In respect of completion of the transfer document, the audit shows that this was completed for 82% of patients, with 96% being signed and dated by ICU and 88% signed and dated by the receiving ward.

   The Division of surgery will continue to monitor this for the next six months to ensure that this improved process is fully embedded within teams.

3. In addition, as part of the joint handover, when the ICU nurse arrives with a patient who is being transferred to a ward both nurses will be in attendance for the first set of observations, which are recorded on Patientrack. Observations done at the point of transfer are being audited for our internal data capture and this remains part of the Trust's Quality Safety Improvement Strategy and will remain an ongoing audit and key performance indicator.

4. The Division of Surgery, are focused on supporting transfers within core hours, and before 17:00 hours, to ensure that we avoid any handover period on the main wards. A daily meeting has been established (Monday to Friday) at 14:00 hours where General Surgical Elective wards including ICU, HDU and theatres, together with site coordinators and manager of the day for surgery, meet to identify appropriate patients who can be stepped down from ICU care to ward level care. The expectation is that once the patient has been identified for transfer, the main ward will actively communicate once that bed has become available. The aim to is improve communication and ensure the timely transfer of patients.

5. Whilst this new process is in its infancy, we will continue to monitor and audit this after three months in respect of improved transfer times within core hours. This will be undertaken by December 2025.

We hope that the information provided above, including the implementation of consent training and its alignment to essential training for clinical staff with patient facing roles, together with the process changes in respect of handover information and documentation and our efforts to promote safer transfer of patients, assures you and Mr Clarke's family that we have taken the learning identified as part of our review of Mr Clarke's care extremely seriously. We aim to use all learning positively in order to improve services and ultimately, patient care.

I would like to assure you that communication, handover, documentation and consent processes remain a focus and a priority for the organisation, and we will continue to strive for quality and the highest standards of patient care.

Please do not hesitate to contact me if you require any additional information.

Yours sincerely

[redacted]

Chief Executive

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