Sussex Medical Chambers

10 Clive Avenue
Worthing
West Sussex
BN12 4SG
[redacted]

16/10/25

Dr Karen Henderson
Assistant Coroner
c/o Jonathan Groves
Parkside Chartway
Horsham
RH12 1XH

Dear Dr Henderson

I am writing in response to your Regulation 28 report dated 17 September 2025, following the inquest into the death of Keith James Hankin, which you conducted over the course of four days during the period 18 December 2024 to 4 July 2025.

Sussex Medical Chambers (**SMC**) was not an Interested Person in the proceedings and the first notification that SMC received from you regarding the proceedings was received on 22 April 2025, which was after you had heard three days of evidence. I responded to that letter on 20 May 2025 and SMC received a further email from your officer on 29 May 2025, to which I responded on 12 June 2025 requesting details of your specific concerns so that I could respond to your queries more comprehensively. Your officer responded on 12 June and then sent a witness summons on 26 June when we were still considering the earlier email. I therefore prepared a comprehensive statement which was sent to your officer on 27 June 2025. This statement, along with our earlier letter, responded to your questions regarding [redacted] and SMC's appraisal process.

I was then called to give evidence on 4 July 2025 during which I was asked to explain how SMC came into being, [redacted]honorary consultant post, the service specification set down by the Integrated Care Board (**ICB**), the contractual arrangements for the individuals involved in the service, clinical governance, referral processes, mortality and morbidity meetings, multi-disciplinary team meetings, SMC's review of the treatment Mr Hankin received with SMC, [redacted]ole within SMC, and learning that SMC has taken from Mr Hankin's death. Having heard my evidence, you requested further documentation, and we sent a detailed letter and bundle of documents to your officer on 1 August 2024 in which I provided:

1. Details of the qualifications and NHS positions of those involved in the Community Urology Service (**CUS**);

2. A further explanation regarding [redacted]honorary consultant position including his CV;

3. Minutes relating to CUS's Clinical Governance Minutes which incorporate the function of morbidity and mortality meetings for the last two to five years;

4. The action plan prepared by SMC following Mr Hankin's death.

In addition to providing the information you specifically requested, I also provided additional documents and information as well as explanations as to further steps taken by SMC in response to the issues you had raised or that had come to light during my attendance at the inquest on 4 July. I also asked that since SMC had not been made an Interested Person in the proceedings and had therefore not been privy to the three days of evidence that predated my giving evidence and had not had sight of any disclosure, SMC be given the opportunity to address any additional concerns you had in correspondence as opposed to by way of a Regulation 28 report. I am very disappointed that notwithstanding this request, you have issued your report, particularly since that report contains inaccuracies and requests for information and/or concerns that have already been addressed. I nevertheless set each of your concerns and supplementary comments in turn in bold below followed by my response.

1. **Lack of clinical governance of the Community Urology Service (CUS) by the Integrated Care Board (ICB) who commissioned the service and Sussex Medical Chambers (SMC) who were responsible for providing the service.**

   The Integrated Care Board contracted Sussex Medical Chambers to provide a Community Urology Service through any qualified provider in 2015 and renewed the contract through a competitive tendering process twice subsequently. The ICB used a generic contract supplied by NHS England to contract the service. Neither the ICB nor SMC were able to provide any evidence of robust clinical governance or multi-disciplinary team processes to ensure best practice of urology services from inception to date.

   Your concerns regarding how the ICB commissioned CUS will no doubt be addressed by the ICB. I strongly refute your comment that SMC has provided no evidence of robust clinical governance however. In my evidence I answered your questions about the quarterly meetings that take place between the ICB and SMC. I expanded on my oral evidence in my letter of 1 August 2025 by explaining that these are contract review meetings that are held and chaired by the ICB. I confirmed that during these meetings, metrics and performance data is reported and discussed and governance issues are addressed. I offered to request the minutes of these meetings from the ICB so that you could reassure yourself about the nature and content of our discussions, however you chose not to request these.

   I also gave evidence about the quarterly clinical governance meetings held within SMC. I provided you with the minutes of these meetings from 2020 onwards in the bundle of documents that accompanied my letter of 1 August 2025. CUS's clinical governance arrangements are reviewed and assessed by the CQC and, following our last inspection, in November 2022 it was determined that the structures, processes and systems to support good management were clearly set out and understood, leaders held regular update meetings to discuss and review the service and there was effective staff meeting structure and systems for cascading information within the organisation.

   I invite you to re-consider the evidence I have provided, and the documents submitted, which demonstrate that comprehensive governance process were, and remain, in place.

2. **Lack of Integration of the Community Urology service with NHS Hospital Urology Services.**

   The CUS provided community-based urology services with non-consultant grade urologists without any oversight or integration with hospital-based consultant led urology services. Whilst there was an opportunity for CUS to

refer more complex patients to NHS Hospital Trusts the 'silo' effect of these 2 services was such that they effectively worked independently of each other. The absence of a robust multi-disciplinary team assessment within the CUS and the lack of senior clinical oversight of community urology patients by NHS consultant clinicians leads to a concern that the urology service is fragmented and does not effectively support urology patients within the region to confirm best practice and optimal treatment.

I understand that your concern arises from [redacted] decision to refer Mr Hankin to Goring Hall Hospital (a private provider) and not to Worthing Hospital (an NHS hospital) given his co-morbidities. SMC fully accepts this concern and, as a result of this, is trialling the referral risk assessment checklist which was sent to you on 1 August 2025. This requires all clinicians working within the CUS to complete a checklist for all surgical referrals. It is designed to ensure that all patients are referred appropriately and receive optimal treatment.

Turning to your concern regarding integration with hospital-based consultant led urology services, the model at CUS is no different to other similar models. The purpose of CUS is to provide consultations, treatments and minor surgical procedures within the community. Any procedures which require a day case or general anaesthetic are referred to a secondary care setting of the patient's choice. The service ensures that patients receive prompt and appropriate treatment within the community as opposed to having to wait to be seen at hospital. The service relieves pressures on the NHS and is a popular solution for patients and GPs. There is no multi-disciplinary team assessment of patients who have been referred on a routine basis within the CUS (although colleagues regularly discuss the appropriate treatment pathway for CUS patients) but, as you heard in evidence at the inquest from a Consultant Urologist based at Worthing Hospital, there is no multi-disciplinary team assessment at Worthing Hospital either, save in relation to cancer patients.

As I confirmed in my letter of 1 August 2025, when the CUS was first established in 2011, the clinical lead was a professor in urology. The professor led the service until 2014 following which [redacted]ook over as the lead clinician. [redacted] ad been given an honorary consultant position by Western Sussex Hospitals NHS Foundation Trust in May 2009 having been accepted onto the GMC Specialist Register in April 2008 and having practised in a consultant urologist role at BMI Goring Hall Hospital from December 2008. The ICB had been provided with [redacted] CV and were fully aware of his background and experience. We do not accept that he is a "non-consultant grade urologist" as per your report. [redacted] GMC registration states he may work at any grade including consultant.

3. **Lack of appraisal and mandatory assessment of clinicians employed by CUS.**

There was an absence of any appraisal and/or mandatory assessments within the CUS or the ICB and SMC for the associate specialist clinicians who were working extra-contractually outside of their NHS work. No evidence was provided as to their experience and competency. This gives rise to a concern that their working practices are insufficiently assessed and fails to fulfil GMC's good practice guidelines. Likewise, no evidence was provided regarding regular morbidity and mortality reviews of complications by the ICB, CUS and SMC such as when patients re-present to NHS hospitals with complications arising from the CUS.

This concern conflates two issues. I shall address each in turn. Firstly, appraisals and assessments of those working within the CUS. You were provided with evidence of

the appraisal process in my statement of 27 June 2025. I confirmed in that that all clinicians employed in the CUS are employed in a primary clinical role elsewhere and work for our organisation as a secondary role. The primary role is usually within an NHS Trust but occasionally is within another regulated health care provider. Each primary organisation is required to carry out an annual appraisal which involves considering previous appraisals, checking CPD is kept up to date, ensuring all mandatory training has been completed, considering feedback and looking into serious events and complaints, as well as other internal processes. It is standard practice for the primary appraiser to ask the CUS to input into these appraisals, which we always do on request. We are provided with the primary appraisal paperwork for all our clinicians every year and we review this as part of our internal review process. In addition to receiving this information annually from the primary employer of each of our clinicians, SMC conducts an annual review with every clinician. This varies according to role and seniority, but comprises of compliance checks, making sure mandatory training is up to date, ensuring that CPD has been completed, and reviewing and discussing patient feedback. We therefore do not understand why you say that there are no appraisals or mandatory assessments within the CUS. We also do not understand why you state that no evidence was provided as to the experience and competency of the clinicians working within the CUS. You asked for the qualifications and NHS positions of all staff, and this was provided to you on 1 August 2025. In the absence of you requesting further information as to experience and competency, CUS was not in a position to address your concerns and is unable to do so in this response for confidentiality reasons.

You have also raised a concern regarding regular morbidity and mortality reviews. This is despite our providing you with the minutes for our clinical governance meetings from 2020 onwards from which you can see that the clinical governance meetings include a morbidity and mortality review. As mentioned above, metrics and performance data are also discussed during the quarterly ICB meetings for which you did not request the minutes.

4. **Practicing [sic] Privileges within the private sector.**

[redacted] set up and led the CUS under the auspices of SMC. The ICB contractually required this service to be run by a consultant urologist. [redacted] had not held a formal consultant urologist position within the NHS prior to tendering for this work. It remains unclear as to how [redacted] was provided with practicing [sic] privileges at a private hospital as a consultant and was therefore able to practice independently and without scrutiny. This gives rise to a concern that there is a lack of robust assessment and guidelines, both locally and nationally, as to how clinicians are given practicing [sic] privileges to work independently outside of the NHS to the potential detriment of patient care. It also gives rise to a concern that patients are not being fully informed of the relevant experience of such clinicians thereby breaching the statutory duty of candour responsibility of all hospitals.

As mentioned above, the ICB had been provided with [redacted]CV and were fully aware of his background and experience. We do not accept that he is not a consultant urologist.

We note that you have issued a Prevention of Future Deaths report to Goring Hall Hospital and we will therefore leave it to Goring Hall Hospital to explain its processes in relation to the practising privileges provided to [redacted] We will also leave it to Goring Hall Hospital to address the point you raised regarding duty of candour, since it references hospitals and not the SMC.

5. **Learning from Mr Hankin's death.**

The ICB did not independently review the circumstances of Mr Hankin's death to confirm if there was any learning or changes in practice to prevent further deaths. Likewise, SMC relied on [redacted] to inform them and investigate Mr Hankin's death without considering the inherent conflict of interest in so doing. The lack of an independent review prevented any proactive learning and changes in practice following the death of [redacted] [sic]. This gives rise to a concern that the system within the ICB and SMC are insufficiently robust and could – as it was with Mr Hankin – prevent transparency and openness as to the circumstances of his death and limit any learning and or necessary changes in practice to prevent future deaths.

We will leave it to the ICB to comment on any actions it took following Mr Hankin's death. Insofar as your concerns regarding SMC's review of his death are concerned, it is incorrect to say that [redacted] ilaterally investigated Mr Hankin's death. The circumstances of his death were reviewed at a clinical governance meeting on 1 November 2023 at which I was present along with [redacted] who is a consultant in renal medicine at University Hospitals Sussex NHS Foundation Trust, [redacted] (Director), [redacted] (Operations Managers). We discussed the events leading up to Mr Hankin's death and the fact that Goring Hall Hospital was conducting its own investigation into Mr Hankin's care. We wrote to Goring Hall Hospital offering to input into their investigation, as is usual when treatment spans multiple providers.

Since that time, the inquest has taken place, and we have reviewed Mr Hankin's care again while responding to your requests for information. [redacted] has also self-referred to the GMC as a result of the concerns you raised in relation to his clinical decision making. We therefore wrote to your officer to request recordings of the four days of inquest in order that we could review the circumstances of Mr Hankin's death in greater detail. We also obtained Goring Hall Hospital's serious incident review report to further assist our consideration of the learning to be taken.

As I set out in my letter of 1 August 2025, we have drawn up and implemented a Communication Improvement Plan which I sent to you. This was drawn up specifically to address the concerns that you raised regarding referral pathways and what you considered to be siloed working. It also addressed your concerns that SMC did not have a formal process in place to follow up clinical incidents in conjunction with other agencies. It includes a Referral Risk Assessment Checklist to ensure that every patient is referred to the appropriate secondary provider.

In addition to the Communication Improvement Plan, SMC has implemented a Managing Clinical Incidents Plan. This plan includes provision for reinforcing policies, strengthening incident reviews and increasing confidence and learning. It was sent to you on 1 August 2025 along with our three action plans which will be reviewed in January 2026.

6. **Management of Mr Hankin at Goring Hall Hospital.**

   This concern is for Goring Hall Hospital to address.

Yours sincerely,

[redacted]
Managing Director
Sussex Medical Chambers