East Kent Hospitals University NHS
NHS Foundation Trust

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Our Ref: [redacted]

07 May 2015

From the Interim Chief Executive, [redacted]

Dear Ms Redman

Re: Kelly Patrick WILLIS (deceased)

Following the conclusion of the Inquest hearing touching upon the death of Kelly Willis on 25th March 2015 and pursuant to Paragraph 7, Schedule 5 of the Coroners and Justice Act 2009, and to Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013, I set out below the actions and considerations taken by East Kent Hospitals University NHS Foundation Trust in respect of your findings.

1. Follow up of documented actions

There are regular, daily handover sessions between the separate clinical and nursing staff when there is a change over in shift pattern of staff covering the hospitals' sites. During these handover sessions it is expected that staff inform those coming on duty of any outstanding actions to be taken in respect of the individual patients on the wards. This includes informing staff of the importance of following up any actions which remain outstanding at the time of handover. In addition, clinical staff are expected to review the more recent entries within a patient's healthcare record at the time when they attend to a patient, in order to ensure that they are aware of the pre-existing documentation within the patient's healthcare records and to assist in informing future clinical decisions which may need to be taken. At the time when reviewing the healthcare records, and where it is observed that an action is outstanding, consideration is given as to the appropriateness of furthering the action in view of the patient's current clinical condition. Where there is concern as to the appropriateness of following up a documented action, it is my expectation that the individual's concerns are escalated to a senior member of staff for further consideration/discussion. Any revisions to action plans should be clearly documented within the healthcare records to not only record the care decided upon and given, but also to inform future decision making and on-going treatment plans.

2. Prompt Contact with Tertiary Referral Centres

The Trust recognises that earlier contact should have been made with [redacted] at St Thomas' Hospital following Mr Willis' admission to the William Harvey Hospital, particularly because his diagnosis was unconfirmed. It is not uncommon for patients to undergo treatment at tertiary centres and for their care to subsequently be referred back to that of the Trust either as a direct referral or following readmission to hospital from the community setting, as in Mr Willis' case. It is not

appropriate or necessary for contact with tertiary centres to be made for all patients who subsequently return to our care, but it is appropriate in circumstances where patients suffer rare complications of procedures which they have undergone, such as in the case of Mr Willis. I fully understand that had timely contact been made with [redacted] Mr Willis may have been offered further treatment for his condition and whilst the prognosis of long term survival would have been poor, he may have received alternative clinical care and management.

In order to bring your concerns to the attention of the clinical and nursing staff within the Trust an article will be included in the regular publication produced by the central Risk Management Team entitled Risk Wise. This publication is disseminated electronically to all members of Trust staff and is produced on a quarterly basis. The article will include reminders to all staff of the importance of ensuring that requested actions which are either documented within the healthcare records or advised of during handover sessions, and which appear to be outstanding at the time of review are reassessed with a view to subsequent completion. The article will also inform the reader of the importance of considering the need to make contact with tertiary treatment centres for further guidance and patient management, particularly where a patient has already received treatment from that centre. A copy of the published bulletin will be sent to you in due course.

I would like to take this opportunity to thank you for your letter and to reassure you that we have taken your comments on board and will continue our commitment to deliver a safe and effective service to our patients.

Yours sincerely

[redacted]

[redacted]
Interim Chief Executive