Wrightington, Wigan and Leigh NHS
NHS Foundation Trust

Mr Andrew Foster
Chief Executive
Wrightington Wigan & Leigh NHS Foundation Trust
Trust Headquarters / The Elms
Wigan WN1 2NN

Tel: 01942 82 2194
Fax: 01942 82 2158
[redacted]
Web: www.wwl.nhs.uk

Mr Walsh
Area Coroner
HM Coroner's Office
Paderborn House
Civic Centre
Bolton BL1 1QY

23 November 2015

Dear Mr Walsh

Regulation 28 Response: Harry Pryal (Deceased)

Thank you for your Regulation 28 Report to Prevent Future Deaths, dated 28 September 2015.

Within that Report a number of concerns were highlighted to Wrightington, Wigan and Leigh NHS Foundation Trust ("the Trust") following the evidence heard at the inquest of Mr Harry Pryal held on 3 and 4 September 2015.

I have been fully advised of the circumstances relating to Mr Pryal's death, and having read your Report, I am grateful to you for bringing these concerns to my attention.

Since the conclusion of the inquest the Trust has undertaken a great deal of work to address these areas of concern, and have been working alongside the 5 Boroughs Partnership NHS Foundation Trust ("5BP"), to ensure lessons have been learnt from the events surrounding Mr Pryal's death.

I would like to take this opportunity to advise you of the actions already taken by the Trust to address the concerns outlined on pages 7 and 8 of your Report, and any proposed action to be taken in the future.

1. **The provision of notes within hospital records in relation to any telephone referrals or other referrals from health professionals for advice in relation to the treatment and care of a patient. The review**

should include the retention of such notes for observation by other clinicians who may become involved subsequently to ensure continuity of advice in relation to treatment and care.

I understand the above was also raised with 5BP, as well as the Secretary of State for Health, as it was acknowledged that this was a nationwide concern.

It has been shared with the Trust's Clinical Directors for Medicine, Scheduled and Unscheduled Care, to enquire into what processes could be put in place within the organisation.

I am advised that the Trust's Medical Registrar on-call receives approximately 60 to 70 bleeps a day during his 12 hour shift. The majority of those relate to internal queries; however around 5-10% are telephone referrals from external providers, (such as 5BP, GPs, and other NHS hospitals). Often these calls are taken whilst the health professional is on a ward undertaking clinical duties, therefore making it difficult for a note to be made of that discussion, especially as these calls do not relate to patients currently being treated within the Trust.

The majority of these external referrals also relate to patients who do not have medical records, either because they have never attended the Trust before, or the medical records are held offsite in storage (making them inaccessible at the time of the discussion). This makes it very difficult for the health professional to document a contemporaneous record of the referral.

According to the General Medical Council, and Royal College guidance, there is a duty on the health professional seeking the advice to ensure a full and accurate record is kept. I note a directive has been given to clinicians within 5BP to ensure all clinical advice received is fully recorded, and for the documentation to include the health professional's name, grade and contact details.

In addition, the Trust has been working with 5BP to create a standardised proforma for use on transfers between the two organisations (please see Appendix 1). The proforma, setting out the patient's medical background, reason for referral, and any prior discussions, would be sent upon transfer and kept within the medical records. Both Trusts are looking to pilot these proformas following approval from the respective clinical committees.

As stated above, I note this matter has been raised with the Secretary of State for Health. I would be grateful if you could share his response to this concern so that we may seek to take further action, in addition to that outlined above.

2. **A review of the liaison, understanding and interpretation of the provisions of the Service Agreement in relation to Radiology for the period from the 1 April 2015 to 31 March 2016 and any subsequent years, taking account of the evidence heard at the inquest. The review should include the operation and performance of the terms of the Agreement, and should extend to the involvement of the two Trusts, particularly on the same site at Leigh Infirmary.**

   The review should also take account of any other Service Agreements in existence and entered into by both Trusts either collectively or individually.

Shortly following the conclusion of Mr Pryal's inquest, discussions were held regarding the interpretation of the Service Agreement for Radiology between the two organisations. Leading on these discussions for the Trust has been [redacted] (Associate Director of Finance) and Andrew Beatty (Radiology Directorate Manager), with [redacted] (Contract Manager for 5BP).

A further meeting was held on 18 November 2015 where a joint review was undertaken of the Service Agreement for Radiology to ensure patient safety is now at the heart of the specification. [redacted] and Andrew have also presented to the Trust's Quality and Safety Committee on what lessons have been learnt following Mr Pryal's death.

It is acknowledged that there are a number of other Service Agreements the Trust has in place with 5BP, which relate to pharmacy, anaesthetics, domestics, psychology, counter fraud and estates. These Agreements have also been discussed and work is being undertaken to review the terms to ensure a consistent approach by both organisations.

In addition to the above, the Trust's Standing Financial Instructions (SFI's) have also been updated in respect of the process for sign off for Service Agreements (please see Appendix 2). The attached document will be used as a sign off sheet, and is now required for every new Service Agreement the Trust enters into. The revised SFIs have been approved at Trust Board level.

The Service Agreement will be owned by the operational manager ("Responsible Officer") within the department which it relates to. It will be their responsibility to send out the sign off sheet to all those named seeking approval, and thereafter to cascade it down to those who provide the service (i.e. the health professionals) to ensure it is complied with.

The Divisional Accountant will remain responsible for the financial aspects of the Service Agreement, and the document itself will sit with the Trust Board Secretary.

3. **A review of the electronic systems, which allow access by 5BP to network connections in relation to WWL systems, particularly to allow web viewing of x-ray examinations in accordance with the Service Agreement.**

Following discussions with 5BP, it was agreed that the Trust would grant secure web based viewing for all diagnostic reports via a secure system which can be accessed by an agreed username and password. It will be decided by 5BP which of their health professionals has access to this system. This is an interim measure until further developments can be made via the Trust's HIS system which is due to be implemented next year.

The Trust is aware that not all health professionals at 5BP have the expertise to identify and interpret diagnostic reports. Therefore in addition to the above, the Trust has a 24/7 "on call" Radiologist who is able to assist in interpreting x-rays, scans etc, if the health professionals are unable to do so. This has been communicated to 5BP who in turn will share this information with their staff.

4. **A review of the reporting times for x-ray examinations with particular reference to triage to identify any urgent or unexpected significant clinical findings, which will need to be communicated to the referring clinicians at the earliest time.**

In the case of Mr Pryal, the x-rays undertaken by 5BP at Leigh Infirmary were treated the same as if he were based at an out-patient facility. It is acknowledged that there was a lack of understanding by health professionals at the Trust that Lakeside Unit is an inpatient facility. Mr Pryal's x-rays should have been reviewed as if he was an inpatient, and then they would have been reported sooner.

Discussions have been held at the Radiology Governance Meeting on 22 September and 15 October 2015 reminding all health professionals that patients at Lakeside Unit are to be treated as in-patients. The Radiology Information System (CRIS) has also been updated to reflect this, to prevent a similar delay occurring.

Within the Emergency floor at the Trust there is a "red dot" system in place so that if Radiographers have any concerns, an * is put on the CRIS system to alert the referring clinician that they may be an untoward finding. This is something that is currently being considered to be used throughout the organisation, and ongoing discussions at being held within the Governance meetings.

"Hot reporting" has also been in place since early 2015 during week days. This means that x-rays are reported "as close to immediately as possible following the x-ray being undertaken" (unless the referring clinician is able to review and interpret them directly). This is currently not in place at weekends due to lack of resources. However reporting radiographers are currently being trained to interpret chest x-rays. One has already been trained and funding is in place for another.

Due to Mr Pryal's x-ray request including a chest x-ray it meant, at the time, that it had to be reported by a radiologist. Due to New Year and bank holidays, there was no radiologist available to report plain films, which led to the delay. The risk of this delay happening again has been reduced by the introduction of Specialist Radiographer chest x-ray reporting.

Finally consideration is also being given to creating a Policy or Standard Operating Procedure around radiographers identifying unsuspected clinical findings, and bringing urgent x-rays to radiologist's attention. This is also being discussed at the Governance meeting within the Radiology department.

I hope the above response is testament to how serious the Trust has dealt with the events surrounding Mr Pryal's death. If you have any comments or suggestions in relation to the proposed actions above, I would be only too pleased to hear from you.

Yours sincerely

Andrew Foster
Chief Executive