Queen Victoria Hospital NHS
NHS Foundation Trust

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26 July 2017

Dr Karen Henderson
Assistant Coroner for West Sussex
West Sussex Record Office
Orchard Street
Chichester
West Sussex
PO19 1DD

Dear Dr Henderson

Thank you for your letter and the attached Prevention of Future Deaths report dated 6 June 2017, relating to Mr Dennis Teesdale.

I joined Queen Victoria Hospital in November 2017 and soon after joining was made aware of the circumstances surrounding the sad death of Mr Teesdale on 20 October 2017. I received regular updates in relation to the inquest and soon after it concluded Dr Edward Pickles, QVH medical director, briefed myself and the full Board on the inquest findings.

We have carefully considered the concerns highlighted in your report. My response is set out against each of the concerns raised.

1. Mr Teesdale's care was compromised by the isolated position and associated lack of facilities and other sub-specialty medical and surgical clinical personnel able to assist in the investigation and management of Mr Teesdale at Queen Victoria Hospital, East Grinstead.

Queen Victoria Hospital NHS Foundation Trust ("QVH") is a specialist surgical hospital. We work in close partnership with other provider trusts both providing services on other sites and benefitting from the expertise of clinicians from other provider trusts who work on the Queen Victoria Hospital site.

The death of Mr Teesdale was as a result of a complication of a percutaneous endoscopic gastrostomy ("PEG") tube, in a gentleman with head and neck cancer and significant comorbidities. The insertion of this PEG was in contravention of our own guideline, which states that previous upper abdominal surgery is a contraindication for PEG placement at QVH. Specialist opinion and imaging were available through service level agreements and memoranda of understanding with Brighton and Sussex University Hospitals NHS Trust ("BSUH"). Regrettably, in the case of Mr Teesdale this resource was not accessed with sufficient urgency. The Trust sincerely apologises for this and has learnt from this incident.

The Trust is committed to learning from serious incidents and has made changes to its systems to minimise the risk of a similar incident recurring in the future, including change of PEG policy, and the introduction of a PEG pathway checklist. The Trust does not, however, consider that the problems in Mr Teesdale's care were caused by a fundamental flaw with the QVH model of working, which is overseen and approved by regulators and commissioners alike. A copy of the Trust's updated action plan is included with this response and further information is given below about the model of working, QVH facilities and access to additional specialist clinical personnel.

Networked approach to patient care
QVH has formal contracts with a number of other providers as part of a networked approach to patient care.

We have a particularly close working relationship with BSUH, which includes provision of specialist input for paediatric services, acute medical and care of the elderly. A memorandum of understanding between BSUH and QVH has been approved by the QVH board, and is in the process of being reviewed and approved by the BSUH board. This sets out the nature of the future partnership between QVH and BSUH, working together across burns, plastics, trauma and maxillofacial surgery, mitigating co-dependency for both trusts.

Four days a week acute medical physicians are on site at QVH, with an SLA with BSUH. Outside of these times the service is provided by the on-call acute medical team at the Princess Royal Hospital, who provide telephone advice and take urgent referrals from QVH. The on-call cardiology team at the Royal Sussex County Hospital, Brighton, provide this service for cardiology.

Plain radiography is available on-site 24/7, with ultrasound available seven days per week on site. Consultant radiologists are available 12 hours per day, seven days per week. A mobile MRI managed service is hosted on site. In the relatively unusual circumstance where a patient needs an urgent CT scan, urgent CT scanning is provided by Princess Royal Hospital, Haywards Heath, with a 45 minute transit time. Patients requiring both CT scanning and general surgical opinion are transferred to Royal Sussex County Hospital, Brighton, with a one hour transfer time.

Admission policies and consultant pre-assessment minimise the risk of needing to transfer patients. We closely monitor our transfers out for investigation and referral. Our current rate is 0.2% across adults and paediatrics. This rate reflects the networked care we provide. Guidelines are in place to support patient transfers when needed. Staff are mindful of the need to seek appropriate referral when needed, and the learning from this case has reiterated the need for appropriate thresholds.

Oral and Maxillofacial Surgery service
The Oral and Maxillofacial Surgery ("OMFS") service provides trauma, dento-alveolar, orthognathic and head and neck oncology surgery. In April 2017 East Sussex Healthcare NHS Trust ("ESHT") brought together its inpatient and emergency service for Oral and Maxillofacial Surgery, with the service at QVH, with consultant surgeons from ESHT operating at QVH. From May 2017, BSUH has also requested that QVH support the trauma service for their patients in order to provide better safer care. A consultant maxillofacial surgeon working at BSUH until June 2017 has now been appointed to QVH, assisting in the understanding of the clinical pathways from both sites.

Head and neck oncology surgical service
The QVH head and neck oncology surgical service is commissioned by NHS England specialist commissioners and serves patients from across the south east of England. This service is provided in partnership with head and neck cancer multidisciplinary teams at Maidstone Hospital, BSUH and the Royal Surrey County Hospital in Guildford. The service is supported by clinical nurse specialists in head and neck oncology, speech and language therapists with specific experience of working with

head and neck cancer patients, physiotherapists and dietetics. Patient feedback on these specialist support services is excellent, with 100% stating that they would recommend these QVH services. The head and neck oncology surgical service participates in all relevant national and regional audits and we ensure that we identify and act on any learning. In 2016 we performed 119 major head and neck procedures, the majority requiring free flap reconstruction. The free flap success rate was 96%, with a 30 day patient survival of 99% (National benchmark form the 2014 DAHNO database, 30 day survival of 98.3%).

2. There are no facilities or clinicians (radiologist or gastroenterologists who normally undertake such procedures) available to place a PEG prior to surgery, thereby requiring oral maxillofacial surgeons of variable and unclear experience to undertake the procedure peri-operatively.

There are six consultant OMFS head and neck oncology surgeons at QVH, all of whom are dually qualified in medicine and dentistry. All six consultants have completed Basic Surgical Training, with associated endoscopic exposure, with award of Fellowship or Membership of the Royal College of Surgeons (RCS) in surgery in general, in addition to their specialist qualifications. Their training in the placement of PEGs has been gained whilst training in maxillofacial surgery at QVH. Since the incident, the Medical Director has discussed training, accreditation and best practice with a regional centre specialising in PEG placement, and the Clinical Lead for Head and Neck oncology surgery has attended a PEG placement list with experienced surgeons with a larger volume PEG practice at Maidstone in order to review techniques and ensure practice at QVH is up to date.

A PEG insertion requires two operators, and has always been led by a consultant. We have performed over 360 PEG insertions (30 – 50 PEGs per annum) in the last 10 years. Of these, 76 were performed by the lead surgeon in this case. The lead surgeon has been inserting PEGs for over 20 years and has completed the procedure without major complication in over 100 cases.

The pathway for difficult PEG placements is for the patients' referring hospital or the hospital of the referring multidisciplinary team to place the PEG using radiology or gastroenterology specialists so more complex PEG placements are not performed at QVH.

Notwithstanding the view that it is safe for QVH surgeons to continue to place PEGs, the continuation of PEG placement by OMFS surgeons at QVH is currently under review. Alternative pathways are being explored for the provision of PEG placement for enteral feeding for all our patients via gastroenterologists or radiologists at the patients' referring hospitals or the hospital of the referring multidisciplinary team.

In addition, we are working with other PEG services to see if it is possible to develop a competency based training and assessment and to provide assurance of the service. If appropriate training or accreditation cannot be achieved then we will cease the service. This would mean a change to patient pathways so that the PEG is placed at the patients' referring hospital or at the hospital of the referring multidisciplinary team. Assurance is currently being sought that this is available and will not adversely affect the length of the patient pathway to the detriment of the patients.

3. Written guidance by the surgeons for insertion of PEGs was not followed, with little reflection as to whether this was an acceptable procedure given Mr Teesdale's previous extensive surgery at or around the point where the PEG was inserted with concomitant poor gastroscopic trans-illumination.

The Trust and the individual surgeons involved recognise and deeply regret that QVH guidance was not followed in this case.

Considered reflection has been undertaken as part of the serious incident investigation and during and after the inquest, and all QVH surgeons recognise that adequate gastric distention and trans-illumination are important indicators in PEG practice.
A number of changes have been made to our process prior to the insertion of PEGs at QVH to minimise the risk of this incident ever being repeated. The requirement for enteral feeding and the decision as to the most appropriate route and any contraindications is now a documented decision at the multidisciplinary team meeting prior to surgery. A PEG safety checklist has been introduced, which includes stop points prior to the insertion, with a final check on contraindications and a stop point if poor gastric distention or poor trans-illumination is achieved. The Enteral Feeding Guideline, which includes the guidance on PEG insertion, has been re-written following this incident, widening and clarifying the absolute and relative contraindications to PEG placement. The checklist requires documentation of a risk assessment where the procedure is taking place in the face of a relative contraindication.

4. No risk assessment was undertaken as to whether a PEG insertion would have been appropriate, given that a non-invasive alternative of a feeding tube for enteral feeding was available.

The Trust and the individual surgeons involved recognise and deeply regret that QVH guidance was not followed in this case, with no documented risk assessment of why the guidance was not adhered to.

All medical staff are fully aware of the requirement for risk assessment documentation. Additional training and a process of audit have been arranged to support this. As set out above, the introduction of the PEG safety checklist requires documentation of a risk assessment where the procedure is taking place in the face of a relative contraindication.

On reflection the surgeon recognises that the widespread adhesions caused by Mr Teesdale's previous surgery would have resulted in high risk placement of PEG whether by gastroenterology or radiology and may have best been placed by general surgery via a mini-laparotomy. This in itself would have presented additional risks. A feeding tube (nasogastric or nasojejunal) would have been an unsatisfactory route for provision of nutritional support in the context of oropharyngeal cancer reconstruction.

5. No formal 'training' programme for the insertion of PEG or independent competency based assessment.

The experience of QVH clinicians in placing PEGs and the changes underway since Mr Teesdale's death is set out above in response to point 2.

6. The post-operative management of Mr Teesdale did not follow the written guidance for the management of abdominal pain after PEG insertion. This resulted in a delay in seeking appropriate advice, timely intervention and optimal treatment of this complication.

The Trust and the individual clinicians involved recognise and deeply regret that guidance was not followed in this case.

The guideline on care of patients following a PEG insertion has been re-written and all clinicians involved in PEG placement and the care of patients following PEG placement have received and noted the updated guideline. The guidance includes the requirement for warning stickers to be placed on the patient's notes and drug chart to alert staff.

The risks of PEGs will form part of induction training for new maxillofacial and anaesthetic doctors, and PEG scenarios will be included in regular multidisciplinary simulation training.

7. Mr Teesdale's transfer was delayed because of a reluctance to transfer in the immediate postoperative period complicated by the associated logistical difficulties of doing so given his major surgery.

Mr Teesdale needed transfer for a CT scan and there are clear patient pathways for this which were not activated in this case.

The reluctance to transfer a patient immediately post-surgery meant the recommended investigation for this clinical scenario was not undertaken. It is vitally important that we learn from the sad death of Mr Teesdale, and we are ensuring all relevant staff are aware of the risks and post-operative care of PEGs and the indications for transfer. In recognition of the potential reluctance to transfer, this will be included in 'human factors' training for staff at QVH. Transfers from QVH for investigation and referral are, and will continue to be, monitored, audited and shared through the clinical governance processes of the Trust. Any potential delay in transfers are reported through the Datix system and investigated appropriately.

8. As an isolated hospital, QVH has no 'on-site' clinical specialist experience when patients develop complications. As a consequence, there was no specialist available to assess Mr Teesdale's abdominal pain as detailed in guidance of post-operative pain following PEG insertion. No effort was made to seek such expert advice during 'daytime working hours'.

It is a matter of deep regret that guidance on timely referral and transfer was not followed in the case of Mr Teesdale.

In general, specialist opinion and imaging are available through regularly and appropriately used agreements with BSUH. We have reminded all relevant staff of the importance of timely referrals and transfers, through local and hospital-wide multidisciplinary governance meetings and written briefing, with learning from this case.

9. Mr Teesdale was cared for 'out of hours' by a trainee oral maxillofacial surgeon with unknown general surgical experience, who did not recognise or manage the severity of a surgical complication.

The Trust recognises that clinicians did not escalate Mr Teesdale's case appropriately during the night of 18/19 October 2016. The Director of Medical Education, educational supervisors, Training Programme Directors, Heads of School and the Dean of Health Education London and the South East are aware of the findings of the Coroner and consultant supervised case based discussions and portfolio reflection has been undertaken, with learning for the junior doctors involved.

Leadership of the critical care unit has been better defined with an improved system of handover, and the on-site consultant presence has been extended recently, with consultant led handover for junior night staff.

10. There was no recognition of how unwell Mr Teesdale was on the consultant surgical ward round at around 0900 on the 19th October 2016, despite considerable evidence present at the time that Mr Teesdale had developed multi-organ failure.

The Trust recognises that following the decision to refer Mr Teesdale to Brighton action was not taken with sufficient urgency. All relevant staff have been reminded of the protocols and indications for urgent transfer.

11. Poor communication between nursing staff, anaesthetic staff and surgical staff making it difficult to provide an overall consistent and systematic approach to the management of Mr Teesdale in a small High Dependency Unit with an inconsistent consultant presence during the day.

QVH has a five bedded critical care unit providing Level 2 and 3 care. The consultant in charge is available to review patients on critical care on an immediate basis. The consultant is supported in the critical care unit by an anaesthetic registrar. Consultant anaesthetists are resident in the hospital 12 hours per day on a weekday and 9 hours per day at weekends. As a direct result of this incident we have moved from a model where the surgeons and the critical care consultants shared responsibility for critical care patients, to one where the consultant in critical care is accountable and leads decision making.

We have recently employed a consultant with Faculty of Intensive Care Medicine accreditation, to lead the training and clinical governance of the critical care unit.

The Coroner drew attention to inconsistencies between the 'snap shot' medical reviews and the more frequent reviews of the nursing staff. Since Mr Teesdale's death, we have developed unified multidisciplinary documentation as part of the enhanced recovery programme, and are auditing its use. Multidisciplinary documentation will be further developed as we progress with electronic document management.

12. There are no haematology or biochemistry services at QVH. A courier service is required for emergency laboratory tests. This has the potential to either not request 'bloods' and/or a delay in obtaining results. Similarly, there is no 'out of hours' radiology service and there is no CT scanner on site to assist in a diagnosis (which was required as part of the management guidelines prepared by QVH).

Blood pathology services are provided by Princess Royal Hospital, Haywards Heath. There are seven routine transits of blood samples per day during the week, and four at weekends. If urgent blood results are required outside of these routine transits, an urgent courier service is available at any time, day or night, seven days per week. There is no evidence that this network arrangement impacts on the likelihood of requesting bloods. No concerns regarding this long standing arrangement have been raised by NHS England or the Care Quality Commission in their reviews. As part of the SLA with BSUH for blood pathology services, the Trust requires assurance that urgent specimens can be received and processed at the lab ready for testing within one hour of leaving QVH. This is an essential pass/fail requirement. There are regular SLA contract review meetings and neither BSUH nor QVH has reported that the urgent specimen sample time has been breached.

As explained in section 1 above, urgent CT scanning is provided by Princess Royal Hospital, Haywards Heath, with a 45 minute transit time. Patients requiring both CT scanning and general surgical opinion are transferred to Royal Sussex County Hospital, Brighton, with a one hour transfer time. The number of urgent CT scans requested by the QVH per year is between 30 and 40.

Urgent consideration is being given to options for CT provision at QVH. If it would be helpful we would be happy to update you on progress.

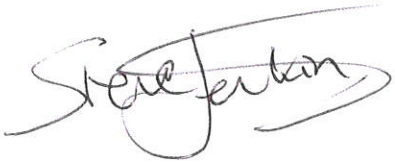
The Trust recognises that reluctance to transfer a patient immediately post-surgery meant the recommended investigation for Mr Teesdale was not immediately undertaken. As described above,

a number of actions have been taken to ensure that the most appropriate form of investigation is undertaken in future whether that is on or off site.

Actions taken
As Chief Executive I take full and personal responsibility to make sure that we are doing everything we possibly can to avoid such a tragedy being repeated.

QVH has taken actions to prevent future deaths as described above and as set out in the action plan arising from its revised root cause analysis. Since the inquest, the Trust has made further progress against the action plan and adopted additional actions. Please find enclosed a copy of the Trust's updated action plan. The Trust will maintain communication with the family, the court, our commissioners and the Care Quality Commission to confirm its progress against the updated action plan.

I hope this response provides reassurance that the care provided by the Trust provides a safe service to its patients. Please do not hesitate to let me know if any more information would be helpful.



Steve Jenkin
Chief Executive
Queen Victoria Hospital, NHS Foundation Trust

QVH action plan following inquest touching on the death of Mr Dennis Teesdale

This plan uses the initials of individuals who are leading on actions. For those external to QVH, the following key has been added to indicate the roles of those involved:

BSB	Mr Brian Bisase	Consultant Maxillofacial/Head & Neck Surgeon and Clinical Lead for Head & Neck Cancer
CP	Clare Pirie	Director of Communications
CS	Clare Stafford	Director of Finance
EP	Dr Edward Pickles	Medical Director
JCC	Mr Jeremy Collyer	Consultant Maxillofacial Surgeon TPD/STC Chair and Trainee Support Lead, HEKKS
JD	Mr Jagtar Dhanda	Locum Consultant Oral Maxillofacial Surgeon
JJ	Dr Jey Jeyanathan	Clinical Governance Lead, Critical Care
JMT	Jo Thomas	Director of Nursing
KCW	Karen Carter-Woods	Head of Risk
RL	Dr Rachael Liebmann	Deputy Medical Director
SJ	Steve Jenkin	Chief Executive
Exec	Exec Directors of QVH	CS, EP, JT, SJ, Sharon Jones – Director of Operations, Geraldine Opreshko – Director of HR and OD

Ref	Action	Respon sibility	By when	Update on progress / status	Comp leted (Y/N)	RAG
A	**Clinical – PEGs**					
A1	Explore training course for clinicians putting in PEGs (technical skills)	EP/BSB	31 Jul 2017	Training, accreditation and best practice being discussed with colleagues including those at Maidstone and Tunbridge Wells and University College London Hospital. (see A2)	N	
A2	Explore external oversight of PEG service (technical and organisational)	EP/BSB	Agree path by 31 Jul 2017	BSB attended PEG list with clinicians Maidstone and Tunbridge Wells 19 June 2017. EP discussion with Gastrointestinal Failure Unit, University College London Hospital 12 June 2017.	N	

A3	Explore alternative paths for PEG insertion pre- and post-op (West Kent & Medway multidisciplinary team – Maidstone/Medway/Darent Valley Hospital)	EP/BSB	31 Jul 2017	EP has discussed with gastroenterologists at Medway, Darent Valley Hospital and Maidstone. Now requires NHS Specialist Commissioning and NHSE discussion.	N	
A4	Guildford or Brighton multidisciplinary team alternative path for patients of lead surgeon involved in incident	BSB	31 Jul 2017	Surgeon not currently placing PEGs	N	
A5	Tighten Enteral Feeding Policy (section 10) regarding definition of Surgical Opinion and PEG checklist inclusion	BSB/EP	30 Jun 2017	Completed	Y	
A6	Pathway checklist for PEG patients incorporating risk assessment and requiring comply or document rationale if not adhering to guidance.	BSB/EP	31 Jul 2017	Completed and in use.	N	
A7	MDT documentation of enteral feeding requirements and contraindications	BSB	Immediate	Confirmation of implementation. Current audit of practice.	Y	
A8	Ensure more robust documentation for general surgical service provided by Brighton and Sussex University Hospitals Trust (BSUH)	EP + Exec	1 Sep 2017	Memorandum of Understanding in place. Plans to work with BSUH to develop into SLA as part of on-going partnership work	N	
A9	Decision on whether to continue to place PEGs at QVH	EP + Exec	31 July 2017 2017	Decision to continue pending external oversight and additional input.		

				Work underway with referring hospitals to review implications for patients of alternative pathways. QVH Board aware and in agreement.	Y	
A10	PEG training in trainee induction and in multidisciplinary simulation training.	BSB	31 Jul 2017	Clinical tutor and simulation lead to incorporate into induction and critical incident training.	Y	
A11	National Patient Safety Agency (NPSA) RRR/2010 and Enteral Feeding Policy to be circulated	EP	Immediate	Re-circulated to Max-Facs and anaesthetics 23 May 2017	Y	
A12	Ensure prospective PEG audit in place and capturing all necessary information	BSB/JD	31 Jul 2017	Audit will capture NPSA stickers, multidisciplinary team documentation, Consent, Checklist.	Y	
B	**Co-location and critical care**					
B1	Brighton and Sussex University Hospitals Trust (BSUH) Memorandum of Understanding progression with SLA review	Exec	Ongoing	Memorandum of Understanding approved by QVH Board 6 July 2017 Sign off due from BSUH Board. Discuss at next Brighton Partnership Board meeting.		
B2	Appointment of joint project manager	Exec	1 Oct 2017	Awaiting BSUH sign off of partnership Memorandum of Understanding	N	
B3	Colocation of critical care (intensive care, high dependency unit, step down) and development of critical care	Exec	30 Jun 2017	Business case approved HMT 19 June 2017. Amalgamation commenced 26 June 2017. Arrangement reviewed 26 July 2017.	Y	

B4	New trauma clinic progression and revised trauma policy and pathways.	Exec	1 Sep 2017	Building work underway		
B5	Review service level agreement with Brighton and Sussex University Hospitals Trust (BSUH) Intensive Care Medicine and network opportunities.	EP/KS/ JJ	Plan by 31 Jul 2017			
B6	Engage with Quality Surveillance Group	SJ/EP/ JMT	3 Aug 2017		N	
B7	Consideration of on-site CT scanning provision	Exec/CS	31 Aug 2017	Initial discussion at Executive Management Team. Rapid review to be led by Director of Finance	N	
C	**QVH clinical staff – general**					
C1	Presentation of Coroner's report to Joint Hospital Governance Meeting (JHGM)	EP	10 Jul 2017	Complete	Y	
C2	Documentation review, including Enhanced Recovery Pathway, audit and presentation	EP	JHCG meeting Nov 2017	Review of multidisciplinary documention in critical care – to be presented to July CC governance meeting. Next step to ensure this documentation integtrates with Enhanced Recovery pathway (EPR) documentation. EPR audit in progress.	N	
C3	QVH specific Human Factors Training	EP	31 Dec 2017	Localise HEE London and SouthEast training	N	

C4	Coroners / legal training	EP	Oct 2017	Training delivered by trust legal representative to JHCGM.	N	
C5	Multidisciplinary communication training, including ability to challenge decision maker	EP/JMT	Review 1 Oct 2017	Continuous programme of values, behaviours and communication.	N	
C6	Ensure multidisciplinary documentation, Enhanced Recovery Documentation and patient alerts maintained as move towards Electronic Document Management. Electronic document management and sequential notes / multidisciplinary input	EP/JCC	Intial plan by 31 Jul 2017	Documentation under review. Requirements need to feed into informatics clinical advisory group.	N	
D	**Serious incident route cause analysis (SI RCA)**					
D1	SI RCA for Mr DT to be rewritten with addendum	EP/KCW		Complete	Y	
D2	SI RCA for Mr DT to be re-submitted to CCG, after resubmission to clinical governance group (CGG) and Board Quality & Governance sub-committee (Q & G).	KCW/EP /JMT	**Clinical Governance Group:** 10 Jul 2017 **Quality & Governance Committee:** 17 Aug 2017	Reviewed at 10 July Clinical Governance Group. Sent to Quality & Governance Committee membership 13 July 2017.Resubmitted to CCG on August 24 agenda for presentation.	Y	
D3	Root cause analysis training to be made available to relevant staff.	JMT/KC W	Courses identified by 31 Jul 2017	Head of Risk reviewing the current training courses available and formulating proposal. Head of Risk and Risk Manager attended further	N	

				RCA training 25 / 26 July 2017. To develop multidisciplinary trust RCA training.		
D4	Review of process for declaring SI and RCA investigation, approval and changes to draft reflected in simple flow chart and add to risk management and incident reporting policy approval via CGG.	JMT	24 Jul 2017	New process outlined, documentation being developed.	Y	
D5	Duty of Candour process and responsibilities to be revised, including communication with patient/families that have been transferred or discharged to other providers.	JMT	Full implementation by 14 August 2017	Review undertaken. Protocol drafted and shared with executive team 3 July 2017. Now being consulted on and then will be presented throughout the trust	Y	
D6	'Responding to Deaths' policy (as per NHSI/CQC) to be written as per Quality & Governance Committee plans	EP/KCW	31 Jul 2017	Draft completed. For submission to Quality and Governance Committee 17/08/2017	N	
D7	Royal College of Physicians Structured Judgement Review training for key individuals (as per CQC Learning from Deaths publication). Guidance for bereaved families and carers required.	EP	1 Sept 2017	Reporting of SJR reviews to Board of Directors with commence September 2017 as part of Medical Directors Report. Awaiting national training programmes.	N	
D8	Review process for documentation submission to outside / legal / coroner	JMT	1 Sept 2017	Initial review of process undertaken. Head of patient experience drafting a protocol. First draft completed	N	

	scrutiny and due diligence.			will go to Executive Management Team 2017 August 2017.		
D9	Review of QVH accountability and process for scrutiny of RCAs	JMT	Quality & Governance Committee 17 Aug 2017	Requirements of clinical governance group and Quality and governance Board sub-committee to be reflected in TOR and discussed at next meeting.	N	
E	**Engaging partner organisations**					
E1	Care Quality Commission	JMT	23 May 2017	Completed, contacted Zoe Nixon Ensure update provided	Y	
E2	NHS England	JMT/ EP		Initial contact made 23 May 2017. Draft responses sent to Dr James Thallon, NHSE Medical Director, with follow up discussion 18/07/2017	Y	
E3	NHS Resolution	JMT		Completed, already aware as they provided the Trust solicitor. Report from NHS Resolution solicitor to them.	Y	
E4	Lead Clinical Commissioning Group	JMT	22 May 2017	Completed, contacted Julia Layzell Ensure update provided	Y	
E5	Brighton and Sussex University Hospitals Trust (BSUH) – CEO	SJ		SJ – MG conversation 24 May 2017	Y	
E6	BSUH – Med Dir	EP		EP – GF conversation 24 May 2017	Y	
E7	NHS Improvement	JMT	22 May 2017	Completed, contacted Mercia Spare. EP in communication with Med Dir Dr Ian Sturgess. Draft responses sent to Dr Sturgess 17/07/2017	Y	

E8	Strategic Transformation Partnership	EP		STP meeting 6 June 2017. Not formal agenda item.	Y	
E9	Local trusts – Maidstone and Tunbridge Wells, East Sussex Healthcare Trust	SJ	24 May 2017	Acknowledgements from ARP, GD	Y	
E10	Quality Surveillance Group	SJ, EP, JMT		3 Aug 2017, attendance confirmed.		
F	**Communication**					
F1	Engagement with family, including offer of involvement with investigations and actions; apology for areas below standard	EP	7 Jun 2017	Original duty of candour letter not sent until April 2017 – no response. Brief meeting following inquest (DoN, MD). Letter following inquest sent 7 June 2017	Y	
F2	Share with family QVH response to Coroner's private letter of concern and Prevention of Future Deaths notice	EP	2 Aug 2017		Y	
F3	Response to Coroner's private letter of concern	EP/SJ	2 Aug 2017	Sent	Y	
F4	Response to Coroner's prevention of future deaths notice	EP/SJ	2 Aug 2017	Sent.	Y	
F5	Share draft response and action plan with Clinical Commissioning Group, NHS Improvement, NHS England and Care Quality Commission (CQC)	EP/SJ/ JMT	w/c 24 Jul 2017	Complete. Final documents to be shared.	Y	
			6 July 2017			

F6	Information for NEDs	CP		Immediate initial communication. Board discussion 1 June 2017 and 6 July 2017.	Y	
F7	Information for governors	CP	31 July 2017	Immediate initial communication. Follow up at council of governors 31 July 2017		
F8	Communication to QVH staff	Exec	On-going	All directors briefed senior teams in May 2017. Reflective feedback session held with ITU staff. Hospital management team discussed. Discussed at JHCG meeting G 10 July 2017. Trust-wide staff briefings arranged for August.		
G	**Availability of documents**					
G1	Review availability of evidence following CQC 2015 report review and CQC action plan review.	JMT	31 Jul 2017	Head of Quality and Compliance undertaking this review with critical care lead. Specific focus on critical care and the well led domain.		
G2	Review the accessibility of the policies and how easy it is to find individual policies on intranet.	JMT/EP/ CP	1 Sept 2017	Head of risk to undertake review. Consider introduction of policy of the month presentation at local governance meetings. Governance leads to explore.		
H	**Support for individuals**					
H1	Non-clinical group debrief	EP	9 Jun 2017	Debrief held 8 June 2017 facilitated by senior psychologist.	Y	
H2	Sources of support to consultants	EP	31 May 2017	Emailed list and discussed.	Y	
H3	Sources of support for trainees	EP	31 May 2017	Support leads, college tutors and educational supervisors aware and engaged.	Y	

H4	Sources of support for non-clinical staff involved in inquest	JMT	31 May 2017	Complete	Y	
I	**Individual regulator issues**					
I1	Internal investigation medical staff to examine other concerns	EP	30 June 2017	Supplied by RL 5 June 2017	Y	
I2	Case discussed with GMC	EP	30 June 2017	Email to Employment Liaison Advisor – South 30 May 2017 PFD and letter of concern forwarded to GMC ELA 22 June 2017 Response 29 June 2017	Y	
I3	Care and individuals discussed with NCAS	EP	30 June 2017	Case discussed with NCAS. Local management advice. Summary received 23 June 2017	Y	
I4	Declaration of trainee involvement to HEKSS, Dean Head of School, Training Programme Director, ES, support leads.	EP	30 June 2017	Dean informed 24 May 2017. Appropriate action plan including declarations / CBD / reflections.	Y	
I5	Internal MHPS management process	EP	1 Sept 2017	Interviews arranged	N	
I6	Letters of concern	EP	1 Sept 2017		N	