NHS England

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06 September 2017

Dear Dr Henderson

Inquest into the death of Dennis Alan TEESDALE

I am responding to your letter of 6 June 2017 addressed to Simon Stevens, Chief Executive, NHS England, with regard to the inquest into the death of Dennis Alan Teesdale completed on 18 May 2017, noting that you have kindly allowed an extension for the required response date to 6 September 2017.

NHS England is responsible for the commissioning of services at the Queen Victoria Hospital (QVH), East Grinstead, both through its responsibilities for the commissioning of specialised services, as in the case of Mr Teesdale's surgery, as well as our responsibilities as the commissioning regulator for Clinical Commissioning Groups (CCGs) which commission a wide range of other services from QVH, the overall supervision of which is led by Horsham and Mid Sussex Clinical Commissioning Group as lead commissioner for QVH.

NHS England, working closely with NHS Improvement, made a number of enquiries on receipt of your Regulation 28 report culminating in a "Single Item Quality Surveillance Group" (QSG) meeting on 3 August 2017 of all relevant parties including QVH trust senior executives, NHS England, NHS Improvement, the lead CCG, NHS England Specialised Commissioning, and the Care Quality Commission, to consider issues regarding patient safety at QVH raised by this case.

NHS England is also in receipt of Mr Steve Jenkin's (Chief Executive of QVH) letter to you of 26 July 2017 setting out in detail the Trust response to the Regulation 28 letter together with their associated action plan. My letter to you is written in the light of these documents which were examined at the single item QSG of 3 August 2017. The QSG felt that the Trust had given open and reasonable responses to the failings identified in the care of Mr Teesdale as he deteriorated under their care. However we have made a number of significant further observations which are set out below.

Firstly, as set out in your 'matters of concern' numbered 1, 2, 6, 7, 8 and 12, QVH is an 'isolated' institution in geographical terms and provides a relatively narrow range of mainly specialised services within a discrete range of clinical specialities. In recent years the NHS has developed guidance and implemented programmes governing the provision of specialised surgical services to non-specialised centres, whilst concentrating surgical expertise in 'centres of excellence'. Vascular surgical and neuroscience centres operate for example on a networked basis with smaller district general hospitals offering specialised surgical advice and referral pathways to clear protocols agreed between clinicians and in this way extend the benefits of concentrated surgical expertise to satellite centres. QVH operates in a 'less usual' though nonetheless analogous way in that, as a provider of a narrow range of specialised and complex surgical services, it requires and has in place similar networking arrangements for the provision of general surgical advice for 'non-specialised' surgical complications, such as a perforated viscus, with Brighton and Sussex University Hospitals. It is clear from your 'matters of concern' numbered 6, 7, 8, 9, 10 and 11, that any such designated pathways did not operate effectively in Mr Teesdale's case, which is a matter of real regret and of ongoing concern.

In his reply Mr Jenkin details that comprehensive protocols were and are in place specifying action to be taken in the event of a patient deteriorating at QVH – there are active arrangements for the transfer of general surgical patients to Brighton and Sussex University Hospitals (BSUH) and urgent CT scanning is available on a similar transfer protocol with the Princess Royal Hospital in Haywards Heath. We accept that the hospital has taken effective action following the evident failure to operate these protocols to ensure that both junior and senior staff are aware of the existence and detail of these pathways and are trained to implement them in a timely and effective manner in future. However, we remain concerned that the physical difficulties of such transfers may potentially act as barriers to their future implementation and thus may continue to delay their timely access by junior clinicians assessing the severity of deterioration of patients in the post-operative phase. These concerns have been discussed in detail with the Trust and are mitigated by the existence and promotion of a Memorandum of Understanding between BSUH and QVH setting out the nature of the future partnership between the two hospitals working across burns, plastics, trauma, and maxillo-facial surgery, deepening the networking of their clinical relationship and mitigating the geographical co-dependency for both trusts, as set out in Mr Jenkins' letter to you. Furthermore, the Medical Director at QVH, Mr Ed Pickles, will continue on an ongoing basis to monitor the quality of patient transfers between QVH and BSUH together with the 30-day re-admission rate to the Trust. These arrangements will be monitored through the enhanced governance arrangements which will operate between NHS England, NHS Improvement, the CQC and the Trust, and which are set out below.

In your 'matters of concern' numbered 2, 3, 4, 5, and 6, you note significant deficiencies with the practise of PEG insertion, associated training, and post-PEG management within QVH. These deficiencies have been acknowledged by the Trust, noting that the unfortunate circumstances surrounding Mr Teesdale's procedure were the first very serious incident the Trust had experienced in the more than 360 PEG insertions that had been undertaken in the past. At the

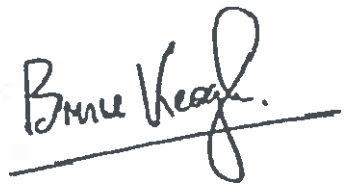
single item QSG of 3 August, and following significant discussions with NHS England and NHS Improvement, the Trust announced that it is planning to cease PEG insertion at the QVH site, initially on a 6-month trial basis, in order to consider the impact on patients. Those patients requiring a PEG as part of their planned surgery will receive this procedure at a JAG (Joint Association of Gastroenterologists) accredited neighbouring Trust, which possesses all the relevant facilities, training and resources for effective PEG insertion to best practise standards. Both NHS England and NHS Improvement endorse and fully support this move and have asked the Trust closely to look at the impact of this initiative on their ability to continue to operate in a timely manner on patients with time-sensitive conditions. NHS England will be seeking JAG accreditation for any future service should the Trust elect to recommence PEG insertion at the QVH site at any future point. This would require significant changes to clinical operations in order to occur. We believe that this decision on behalf of the Trust is proportionate to the risks highlighted in Mr Teesdale's case given the facilities and expertise available on the QVH site at the current time.

At the single item QSG of 3 August NHS England and NHS Improvement noted the contents of the action plan submitted to you along with Mr Jenkins' letter. A number of improvements have been required following the meeting surrounding governance arrangements and standards following concerns expressed at the quality of the original root cause analysis presented to the original inquest and the implications for the quality of clinical governance within the Trust - although the improvements apparent in the Trust's reworking of that document were also noted. Nonetheless we have requested a 'look back' exercise on all Root Cause Analyses (RCA) together with evidence of training in RCA conduct in the future. This will be monitored through the enhanced governance arrangements set out above Similarly a 'look back' through Serious Incidents reported by the Trust has not identified any similar or related incidents and in particular no adverse outcomes related to failure to identify a deteriorating patient. Further work was also requested with regard to the Trust's ability to evidence the embedding of learning from this incident both in substantive senior staff and in the induction that the Trust will give to future trainee doctors who may hold clinical responsibility for the care of a deteriorating patient.

In view of the significance of the events surrounding Mr Teesdale's case an enhanced set of governance arrangements have been set in place with regard to QVH in order to monitor the delivery of the action plan. NHS England Specialised Commissioners will engage with the Trust with regard to promoting and deepening the networking relationship with BSUH and assessing the suitability of the QVH site for longer-term provision of highly specialised services. In the meantime, NHS England is satisfied that clinical outcomes are, in general, well within recognised limits and that current clinical activity, subject to the restrictions and improvements set out above, may continue while the issues in the Regulation 28 letter are addressed. The Care Quality Commission will visit QVH in order to assess the existence and utilisation of relevant protocols particularly surrounding the recognition and management of the 'deteriorating patient' and a monthly CCG-regulated quality forum will operate to oversee the attached and amended action plan to ensure that all elements are visibly and comprehensively implemented by the Trust.

We believe that the Trust has responded in an open and proactive way to the failings identified within their organisation and NHS England will seek to ensure, in the exercise of our commissioning responsibilities as well as through the enhanced governance mechanisms set out above, and in partnership with the Trust, that this engagement is maintained until we can be confident that the risks to users of our commissioned services are mitigated to the highest possible degree.

Yours sincerely,



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