NHS
Tameside and Glossop
Integrated Care
NHS Foundation Trust

Ms Alison Mutch O.B.E.,
HM Senior Coroner for Manchester South,
The Coroner's Court,
Mount Tabor Street,
Stockport SK1 3AG

Dear Ms Mutch,

Regulation 28: Report to Prevent Future Deaths, following the inquest touching upon the death of Matthew Robert Edwards

The purpose in writing is in respect of your letter, dated 17 July 2017, and enclosure in the form of the Regulation 28 Report, issued following the conclusion of the inquest touching upon the death of Matthew Roberts Edwards, which concluded on 7 June 2017.

I hope to be able to address the concerns raised in Section 5 of your report, and set out below my response, adopting the same numbering for ease of reference.

1. *Delay in completion of the discharge summary following Mr. Edwards' discharge from Tameside General Hospital in February 2016*

You will be aware of the Trust having previously responded to a Regulation 28 Report earlier this year, which was provided to you on 18 July 2017 following the inquest touching the death of Derrick Lawrence Brocklehurst. I have set out below for ease of reference my response to your concerns in this respect and which I hope is of assistance.

The Trust is aware of a historic issue with regard to the timely completion of discharge summaries in 2016, and I wish to reassure you that action has already been taken and progress made, in order to improve the situation in relation to both the Emergency Department and the in-patient wards, and bring the expected completion rates and timescales within those dictated by Trust policy.

In order to bring the position back to a baseline from which the Trust could confidently move forwards with new processes, extra resources were brought in to clear a backlog that had regrettably developed with discharge summaries. I wish to assure you that the Trust fully recognises the importance of discharge summaries as a handover of care between different organisations and services involved in the care of a patient. I was disappointed to learn that a backlog had developed due to other organizational pressures and asked my executive team to take immediate steps to identify the source of the problem and remedy it as swiftly as possible.

The Divisional Director of Operations for Adult Medicine has been tasked with leading on this issue, with support from Brendan Ryan, Medical Director. The responsibility to ensure that every patient has a discharge summary rests with the Consultant responsible for that episode of care, and this has been reiterated to all consultants. Compliance is being monitored by the Trust's Service Quality & Operational Governance Group (SQOGG), and the Clinical Directors and Directorate Managers are providing leadership on this issue to ensure that improvements are made and maintained.

I am advised that a new process is to be put in place for the discharge of patients from the Emergency Department. The Trust is implementing its plan to introduce new bespoke software to enable the production of an electronic casualty card, to replace the current handwritten casualty cards produced by the team in the Emergency Department. This will mean that the key data from the electronic casualty card will be used to create a discharge summary which will be electronically sent to the patient's GP practice in near real time. It is anticipated that this will ensure that a discharge summary is completed for every patient seen within the Emergency Department without increasing the burden on the clinical teams.

As you will no doubt appreciate, this is a significant piece of work which will revolutionise the way in which the Emergency Department operates. The bespoke software is currently being finalised and the Trust plans to begin the roll out of the new electronic casualty card from October 2017.

The new electronic casualty card system will include a dashboard clearly identifying each and every patient discharged from the Emergency Department who has not yet had a discharge summary completed, allowing the management team to monitor and take action to ensure compliance. The new process will also allow the Trust to monitor the arrangement of follow up investigations commissioned at the point of discharge from the Emergency Department.

The Trust has also introduced measures to improve the process of discharge summaries from in-patient wards. As mentioned above, additional resource was brought in to restore the position to an acceptable baseline. The Trust has also introduced increased managerial focus and monitoring of discharge summaries, with a routine 'safety net' email sent out to each Ward, identifying the number of discharge summaries outstanding for more than 48 hours, which is the timescale required under the Trust's Admission and Discharge Policy. The performance of each Ward is monitored by the Consultants responsible for the Ward, the Clinical Director and the Directorate Managers, to ensure that the right level of resource is available to prevent a backlog before it occurs.

I am advised that all completed discharge summaries originating from both the Emergency Department and the in-patient wards are sent to the patient's GP practice electronically using the Hub System and Synertec. The current process is that a discharge summary is created in the Trust's Electronic Patient Record (Lorenzo), which is completed by the doctor and finalised by the ward clerk before being sent electronically to the relevant GP practice overnight, and who in turn are required to acknowledge receipt of the discharge summary. A paper copy of the discharge summary will also be provided to the patient in certain circumstances, for example, if the patient is being transferred to another Trust, the Stamford Unit (a discharge to assess unit based on the grounds of Tameside General Hospital), a nursing, care or residential home facility, or if requested by the patient.

In addition to the completion of discharge summaries, the Trust also monitors the quality of discharge summaries. Regular audits of approximately 40 discharge summaries per month are carried out by the Trust's Chief Clinical Information Officer. The quality of the discharge summary is graded as excellent, good, poor or very poor, with 93% per month deemed as excellent or good between February and August 2017 inclusive.

2. *That a follow up appointment was not made at the point of the discharge being completed.*

This issue arose in the context of a particular and historical set of circumstances, in which a discharge summary was not completed for some five months following discharge. The junior member of medical staff completing the discharge summary made an assumption that the follow up actions would have taken place some months previously, and which has since been acknowledged as an incorrect assumption. This was an individual human error, which has been the subject of reflection and development on the part of the junior member of medical staff concerned.

As a consequence of the substantial improvements including the robust safety mechanisms incorporated into the discharge summary procedures as described in detail above, I am satisfied and can reassure that the particular scenario that allowed this individual human error to be made, should not reoccur.

3. *The delay of at least one week before a CT angiogram could be performed due to a shortage of available appointments.*

It would appear that this issue may have arisen in part out of misunderstanding and which I hope I can clarify, and having confirmed the position with the Ambulatory Care and Radiology Teams.

On 21 September 2016 Mr. Edwards' presentation and the results of investigations were suggestive of either chest infection or pulmonary embolism, and appropriate prophylactic treatment was commenced at this point. On return to the Ambulatory Care Clinic on 22 September 2016, a CT angiogram was booked for the following week. It is important to emphasise that Mr. Edwards was not considered acutely unwell at this point in time and was on appropriate prophylactic treatment until such point as the CT angiogram confirmed or excluded either chest infection or pulmonary embolism. The CT angiogram commissioned was for purely diagnostic purposes with appropriate treatment in place as at 22 September. The Ambulatory Care Clinic has two CT angiogram slots assigned per day. Patients such as Mr. Edwards who require a CT angiogram are assigned to the next available Ambulatory Care Clinic appointment and the CT angiogram performed during that appointment. I have included the current pathway in place for reference. The view taken by the clinicians at the time was that review and admission for a CT angiogram the following week was appropriate. The Ambulatory Care Clinic and Radiology Manager have confirmed that had Mr. Edwards been acutely unwell on 22 September the CT angiogram could have been expedited by a Consultant to Consultant discussion and no issue would have arisen with regard to availability of appointments. I hope this clarifies the position and is of reassurance with regard to the availability of and access to this important diagnostic resource.

I am very sorry that you had cause to issue this Regulation 28 Report and would like to take this opportunity to emphasise that I do take your concerns most seriously. I hope that I have responded to your concerns and reassured you of all the work that the Trust has already undertaken and is currently undertaking, particularly in relation to discharge arrangements and procedures.

Should you have any queries arising from the contents of this letter or require any further information or clarification, then please do not hesitate to contact me at any stage.

Yours Sincerely

Karen James
Chief Executive