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NHS
Tameside and Glossop
Integrated Care
NHS Foundation Trust

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Telephone: 0161 331 6000

Ms Alison Mutch
HM Senior Coroner for Manchester South
The Coroner's Court
1 Mount Tabor
Stockport
SK1 3AG

18 July 2017

Dear Ms Mutch

Regulation 28: Report to Prevent Future Deaths following the inquest touching upon the death of Derrick Lawrence BROCKLEHURST

I write further to your letter dated 5 June 2017 enclosing a Regulation 28 Report issued at the conclusion of the inquest touching upon the death of Derrick Lawrence BROCKLEHURST, which took place on 17 May 2017.

I hope to be able to address your concerns, as set out in Section 5 of the Regulation 28 Report, and adopt the same numbering for ease of reference.

2. *No discharge summary was provided by Tameside General Hospital to the GP after the deceased was seen in A and E.*

The Trust is aware of a historic issue with regard to the timely completion of discharge summaries in 2016 and I wish to assure 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. I am sorry if the action which the Trust has taken to date was not clearly available to you during the course of the inquest and you could not be reassured that the Trust had fully identified the issues and put a robust plan in place to improve the situation.

In order to bring the position back to a baseline from which the Trust could confidently move forwards with new processes, extra resource was brought in to clear a backlog that had 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.

[redacted] Divisional Director of Operations for Adult Medicine has been tasked with leading on this issue, with support from [redacted], 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.

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 planning to introduce new bespoke software to enable the production of an electronic casualty card, to replace the current handwritten casualty cards produced by the doctors and nurses in the Emergency Department. 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. It is anticipated that this will ensure that a discharge summary is completed for every patient seen within the Emergency Department without unduly increasing the burden on the doctors.

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 written 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 that has been discharged from the Emergency Department but has not yet had a discharge summary completed, allowing the management team to effectively scrutinise 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 which will further improve patient safety.

Although not directly relevant in the context of this Regulation 28 Report, I would like to advise you that the Trust has also introduced measures to improve the situation in terms of discharge summaries from in-patient wards. As mentioned above, additional resource was brought in to bring the position back to an acceptable baseline. The Trust has also introduced increased managerial focus and monitoring of discharge summaries, with a '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 by the Trust's Admission and Discharge Policy. The performance of each ward is monitored by the consultants responsible for the ward, the Clinical Directors 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), this is completed by the doctor and finalised by the ward clerk before being sent electronically to the relevant GP practice overnight who are required to acknowledge and receive 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 January and June 2017 inclusive. The Trust has received 9 incidents related to discharge summary quality from approximately 37,000 discharge summaries; an incidence rate of less than 0.03%.

Whilst I understand that the following area of concern was directed at Tameside Metropolitan Borough Council, this issue is relevant to the Trust as a provider of community services and I wanted to take the opportunity to address you on the Trust's work in this area.

1. *There was no documentation available of the carer visits. The care provided and any issues with the provision of care could not be established. They were not recovered by Social Services when care stopped. There was no system for recovery of care notes when care ceased.*

In addition, the Trust is aware that you have previously issued a Regulation 28 Report to Stockport NHS Foundation Trust in relation to the retention of a central contemporaneous set of notes by the District Nursing Service and retrieval of those notes following the death of a patient. The Trust is very keen to adopt a proactive approach and demonstrate learning from issues which arise not only in relation to the care of its patients, but also learning from the wider health economy, and other organisations.

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The Trust's District Nursing Service, which covers the Tameside and Glossop locality, has recently amended the process in relation to note keeping and strengthened the process for retrieval of notes.

I am advised that the old process was very similar to that adopted by Stockport NHS Foundation Trust in that carbonated evaluation sheets were used to record findings during a home visit.

However, the Trust identified that this represented a concern in that the central set of notes may not be fully up to date and important information about a previous visit may not be available to the district nurses at base. It was considered essential to have a central contemporaneous set of notes, particularly for complex cases where a patient's care needs may be constantly evolving, in view of the fact that the district nurses work as a team and are not allocated specific patients due to shift patterns and fluctuating visit requirements. A comprehensive handover of care between staff is imperative to ensure a consistent and holistic approach to the care of each individual patient in this setting.

The new process requires a separate carbonated evaluation sheet to be completed for each and every visit (excluding those for routine insulin or low molecular weight injections) and brought back to base immediately thereafter so that it can be filed in the central notes. A standard operating procedure has been produced and disseminated to all staff within the District Nursing Service setting out the new process and compliance will be monitored by the Team Leaders.

I am advised that the District Nursing Service also use "Team Time" for the handover of important information between staff. Team Time takes place each day and is used as a mechanism for staff to highlight any problems or issues that they encountered during the morning. It is also an opportunity for the Team Leader, who is responsible for leading Team Time, to understand the workload of the team and to reorganise the workload if necessary.

A record of the handover provided during "Team Time" is documented, signed by the Team Leader and retained centrally at base but not placed in an individual patient's notes as this could contain confidential information in relation to another patient. If follow-up tasks are allocated during Team Time, such as increasing the frequency of visits or making a referral to another service, these remain the responsibility of the district nurse that attended on the patient on the last occasion, unless specifically re-allocated to another member of staff.

I am very sorry that you had cause to issue this Regulation 28 Report and I would like to take this opportunity to emphasise that I do take your concerns very 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 in relation to discharge arrangements. I understand that a meeting has been arranged for 30 August 2017 with the Trust's Medical Director, [redacted] and Director of Quality & Governance, John Fletcher at which these issues can be further discussed, if required.

Should you have any further questions arising from the contents of this letter, please do not hesitate to contact me.

Yours sincerely

Karen James
Chief Executive