The Leeds Teaching Hospitals
NHS Trust

Trust Headquarters
St James's University Hospital
Beckett Street
LEEDS
LS9 7TF

Date: **29th September 2023**

[redacted]

Ms Catherine Cundy
Area Coroner for North Yorkshire and York

[redacted]

By e-mail only to:
[redacted]

Dear Ms Cundy

I write in response to the Report to Prevent Future Deaths dated 19th July 2023 sent by you to Leeds Teaching Hospitals NHS Trust following your investigation into the death of Carole McQuinn and the inquest that concluded on 11th July 2023.

The Regulation 28 Report has been shared with relevant staff in the Trust and this response provides details of action taken by the organisation in relation to the concerns set out in it.

In your report the matters of concern are set out as follows:

1. The deceased was discharged from hospital on the evening of 20th April 2022 with no discharge note, medications or follow-up appointment. There was evidence that evening discharges are a cause for concern for the Trust and that while consideration is being given to ensuring follow-up appointments are set on discharge, this is not yet in place. Trust staff were falsely reassured in this case that the deceased had this safety net in place when she did not.

2. Trust staff interacting with the deceased and her daughter regarding infection concerns arising in the post-discharge period between 21/4/22 and 3/5/22 made no records of the same. Nursing staff were shown photographs of the deceased's drain site, and issued stoma bags and a swab to her daughter for suspected infection, but did not flag this development to the treating team or make arrangements for the results of the swab to be reviewed. No clinical observations of the deceased were recorded when she attended the hospital on 3/5/22. The swab result did not come to anyone's attention or get reviewed until the deceased's daughter flagged the issue to staff on 3/5/22. These omissions led to missed opportunities for earlier assessment and treatment of the deceased.

3. The deceased had an emergency admission to York Hospital on 4/5/22 with suspected intra-abdominal sepsis. A York doctor was verbally tasked with communicating with the surgical team at Leeds to report back on a comparison of CT scans from both hospitals. No record of this contact - which was verbally reported in positive terms - was made by either hospital and no evidence could be provided as to who had spoken to whom and in what terms. Further, despite the lengthy and complex treatment the deceased had undergone in Leeds, and her

attendance there the day prior to admission to York, no contact was made by the treating team at York with the treating team at Leeds, to allow for additional specialist input into the deceased's management and consideration of possible transfer of care.

Having considered your concerns carefully our response is set out below.

1. The Trust regrets the deceased's discharge from hospital on 20th April 2022 in the evening and without a copy of her discharge note, the medication that had been prescribed for her and a date for her outpatient follow-up.

The process for discharging patients from in-patient wards is complex. Planning for discharge starts before the in-patient admission and usually involves a number of different teams, including pharmacy who will only dispense medication on the day of discharge to ensure that accurate and up to date information about the patient's requirements is available. There may also be a need to liaise with community services such as the local district nursing team in addition to the GP, to confirm that support is in place for the patient at home. Even though that was not part of the discharge process in this case, the workload for the discharge coordinator on any given day may be considerable and it can impact on the timing of patients being ready to leave the ward.

In this case, as was clear from the written evidence provided by the Trust, a nurse had discussed the discharge plan with the deceased before she left hospital. In accordance with her usual practice the nurse would have explained steps the deceased should take if she became unwell or had concerns about her progress, and what to do if her drain site or surgical wound leaked fluid. The nurse would also have explained that the deceased's medication would be available for collection from the ward the following day.

Following the death and in the course of preparations for the inquest the circumstances of the deceased's discharge and usual discharging practice within the Abdominal Medicine and Surgery Clinical Service Unit (AMS CSU) were reviewed. As explained at the hearing the review highlighted the need for improvements. The pancreatic team acknowledged that all patients should have booked outpatient appointments on leaving the ward and that those in the deceased's position should receive specific written guidance on wound care, including management of drain sites where abdominal drains have been removed recently. In addition, the team accepted that patients should be provided with more specific information about support available to them after discharge, including explanation of the role of the Clinical Nurse Specialists. They should also be given contact details for those members of staff.

Since this review all staff involved in the discharge process have been informed of the team's requirements, including providing patients with (a) a paper copy of their discharge note on leaving the ward even if medication has yet to be dispensed, (b) the date and time of outpatient follow-up appointments, (c) wound care plans, (d) supplies of medication, dressings etc. They have been reminded of their responsibility for making appropriate arrangements for community resources such as district nursing and the need for clear instructions about repeat prescriptions in the discharge summary. The document template for the electronic discharge note (EDAN) has also been amended to ensure that all relevant information and advice is included and can be reviewed by patients, their relatives and their GPs.

I can confirm that all patients discharged from inpatient treatment in the AMS CSU now go home with an EDAN and details of booked outpatient appointments. There will be regular audit of records by the CSU's quality team to ensure that this is being done consistently. Patients with drains and those whose drains have been removed recently now receive written guidance on management of any appliances, associated drain sites and their surgical wounds. A document summarising the process to be followed by staff is attached for your reference (attachment 1). Use of this drain pathway will be audited quarterly to ensure compliance.

Following the hearing and in response to your report the CSU has reviewed the steps taken to improve discharging practice and it has drafted Good Practice Guidance for the completion of discharge advice notes by registered nurses (please see attachment 2). Dissemination of this guidance, with training for staff, will be complete by the end of October 2023. Support to embed good practice will also be provided by the CSU quality practitioners and the clinical education team by the end of November 2023. The guidance has already been discussed with the nursing staff at the CSU Perfect Ward meeting (where all matrons and ward sisters meet each month to review all quality indicators and incidents within the CSU) and ward sisters are now sharing it with their staff in each ward area.

The Trust recognises the difficulties that can arise when patients leave hospital late on the day of discharge and it is committed to improving discharging practice throughout the organisation. A Quality Improvement collaborative led by a specialist quality improvement practitioner is in place to support wards to achieve the majority of discharges before 3pm. By using data and metrics the Trust can track all wards' progress towards this target each month and it can also check that EDANs have been sent with patients at the point of discharge. AMS CSU is part of this collaborative and it will continue to work to improve its practice.

2. Deficiencies in the recording of contacts with the deceased and her daughter after her discharge are acknowledged. The Trust also accepts that action taken in response to concerns raised by the deceased's daughter was inadequate and that this led to missed opportunities for earlier assessment and treatment.

   The problems that arose in this case have been discussed at ward meetings. Staff have been instructed that all contact with recently discharged patients and their relatives must be recorded on the Trust's electronic case record system PPM+ for the first 7 days after discharge at least. Notes made must include details of advice given, any investigations undertaken or arranged and the clinicians involved. Staff have also been informed that requests for advice or review should be forwarded to the outpatient team to facilitate early face to face assessment, coordination of any additional investigations, formal review of results and appropriate communication with the patient and family members afterwards. It has been made clear that swabs should not be given to relatives for patients to use at home and that there should be a low threshold for requesting face to face review of patients reporting problems.

3. As explained in the evidence for the inquest the Trust has no record of contact made by clinicians from York Hospital about the deceased's admission there on Wednesday 4/5/22 or on Thursday 5/5/22 and no member of the surgical team recalls a discussion about the deceased with anyone in York on either day.

It is accepted that communication between York Hospital and the Trust should have taken place. Clinical staff within the AMS CSU should have been informed of the admission and details of the deceased's condition should have been given to the pancreatic team, preferably by way of discussion between consultants. Recent imaging should also have been transferred to the Trust. If contact was made with a junior member of the surgical team, there should have been senior review of the information provided and comparison of the recent imaging with that obtained previously in Leeds. Details should have been noted in the deceased's electronic patient record.

Since this death the AMS CSU has started to use new IT software (Patient Pass) to improve coordination and recording of requests for information and advice. Patient Pass is a two-way messaging tool that is used to facilitate referrals and improve communication between hospitals and specialist departments. It is relied on by a number of specialist teams in LTHT to speed up referrals and support clinical process reliability. It improves record keeping as details of referrals and responses are automatically saved onto patients' PPM+ records and it also provides the organisation with a full audit trail for information governance purposes.

As the Trust provides a regional referral, advice and guidance service for patients with pancreatic problems, requests for information and advice from neighbouring trusts are common. Awareness of referral pathways is generally good, including the option of telephone access to the consultant on duty during working hours and more recently the CSU's use of the online referral tool Patient Pass, described above. All members of the pancreatic team are used to receiving telephone calls and/or written referrals to the Multi-Disciplinary Team and they understand the need to ensure that the pancreas-specific Advanced Care Practitioners and/or the consultant on duty on any given day are notified promptly.

As explained by the witnesses at the hearing, if contact had been made with any member of the Trust's pancreatic surgery team about the deceased, senior review would have been expected, leading to specialist input into her management thereafter and consideration of the need for her transfer to Leeds.

Since the death, and in response to your report, senior members of the team have made contact with colleagues in the surgical team in York to explain the arrangements in place and to discuss the issues raised by this case so that both trusts can work together to avoid similar problems arising in the future.

Thank you for bringing these issues to my attention. I hope that this response provides confidence that the Trust has considered and addressed them appropriately.

If I can be of any further assistance, please do not hesitate to contact me.

Yours sincerely

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Chief Medical Officer

Encs:
AMS - Best Practice Guidance - Think Drains
Good Practice Guidance for the completion of discharge advice notes by registered nurses