NHS
Royal Devon
University Healthcare
NHS Foundation Trust

Philip Spinney
H M Coroner
County Hall
Topsham Road
Exeter
EX2 4QD

Royal Devon and Exeter
Hospital (Wonford)
Barrack Road
Exeter
EX2 5DW

CHIEF EXECUTIVE'S OFFICE
[redacted]

26 November 2023

Dear Mr Spinney

Regulation 28 response .

I am writing as Interim Chief Executive of Royal Devon University Healthcare NHS Foundation Trust in response to your recently issued Regulation 28 Report following the Inquest touching the death of Mr Geoffrey Brooks. You asked me to consider reviewing the process of discharging patients to ensure that all discharge documentation includes an accurate summary of the ongoing care needs of the patient.

Please find my response below and I hope that will satisfy you that we have taken steps to prevent future deaths of patients. However, if you need any further information then please do not hesitate to contact me.

Current situation

The Royal Devon University Healthcare NHS Foundation Trust (RDUH) is an organisation focused on providing patients with safe, high quality medical care. One of the key aspects of a patient's hospital journey is their discharge summary and timely transfer of information to primary care and other healthcare providers.

The case leading to this paper was complex and involved a rare medical condition requiring specific and closely monitored fluid balance management. Although there are clear areas for improvement and learning, it is also recognised to be a rare set of circumstances that led to this incident.

The RDUH switched to an electronic patient record (Epic) across its Eastern services in October 2020, which was after the date of this incident. This has led to significant improvements in documentation across inpatient and outpatient encounters. Epic has several features that help improve documentation specifically around discharge:

1. Hospital course function
   Epic has a section in the sidebar referred to as the Hospital Course. Doctors are encouraged to summarise a patient's admission in "real-time" and add to this document during their inpatient stay. This means at the point of discharge there is a summary written by doctors who have been involved with the patient (rather than the traditional process of reading the notes and compiling a summary). Historically discharge letters have sometimes been written by doctors who have not met the patient which carries risk around factual accuracy and follow-up instructions. The Hospital Course function mitigates this to a degree.

The hospital course is automatically pulled into discharge letters when they are generated on Epic. There remains a separate section on the discharge letter for ongoing primary care instructions ("Suggested Primary Care Actions").

2. Bespoke templated discharge summaries
   Some areas (e.g. Stroke, Acute Care of the Elderly) have specific templates for completing discharge letters which ensures pertinent information and ongoing instructions are as clear as possible. This is important for more complex patient groups who need to have specific assessments and follow-up.

3. After Visit Summary
   Epic has introduced the ability to generate a patient focused document for inpatient and outpatient attendances - the After Visit Summary (AVS) which can be given to patients at the point of hospital discharge. To date, the AVS has not been widely rolled out, particularly after inpatient stays.

   A working group has been established and will shortly begin meeting to review the use of the AVS across inpatient and outpatient areas across the Trust. Once completed, the group will produce new guidance and Standard Operating Procedures (SOPs) for ward teams, meaning the AVS would be given to the patient and the discharge summary sent electronically to the GP as a matter of routine. It clearly lays out medication changes, follow-up arrangements and can be used to provide patient's with specific instructions. In this case, clear documentation of fluid intake requirements could have been flagged in this document.

4. Education around discharge
   Junior doctors receive induction and complete training in Epic which includes the discharge process and completion of discharge letters. Departmental induction also encompasses local information on discharge letter formulation.

5. Enhanced ward staffing consistency
   Within Medicine, our staffing model was changed recently so that junior doctors in training have switched to a 4-day working week. Previously, compensatory rest meant that juniors were often moved from their base wards to cover rota gaps; this led to a loss of consistency in medical staffing which is a risk to discharge letter writing as discussed above. The new rota pattern means the need for cross cover is greatly reduced.

Other considerations
The Trust has considered whether every discharge letter should be reviewed by a consultant. On balance, this would not seem feasible due to:

- Volume and time requirement (to go through a long admission takes a significant amount of time resource)
- Difficult to define who should review (multiple consultants may have looked after a patient during a long inpatient stay)
- Potential additional time delay in sending out discharge summary information to primary care (or alternatively sending out addendums which would mean different discharge letters in circulation for the same admission which carries risk)
- Risk of mistakes due to a false sense of reassurance

Certain areas have bespoke arrangements in place. For example, all generated discharge letters from the stroke unit (Clyst ward) are flagged to a stroke consultant for review to ensure all relevant follow-up is actioned. This is noted to be a very time-consuming process.

Epic allows a clinician to keep a list of patients for follow-up so offers individuals an option to keep track of patients which is useful in complicated cases where a consultant may want to ensure a discharge letter contains specific information or instructions.

Future developments

We are currently reviewing the staffing model of our community hospitals which we hope will lead to a more robust, consistent medical team with specialty doctor and Advanced Clinical Practitioner oversight. This will provide an additional safety-net around discharge and again letters will be more likely to be written and checked by individuals who have reliably been involved in a patient's care.

The Trust wide discharge summary working group will be shortly relaunched with a plan to have primary care representation to try and further refine discharge processes and communication with primary care. There is potential to develop more discharge summary templates for specific specialties or conditions. We are continually working on improving the completion rates of discharge summaries and ensuring they are sent in accordance with the NHS Standard Contract agreement of within 24 hours following inpatient, day case or ED attendance.

The Trust is currently transitioning to the Patient Safety Incident Response Framework which will guide future investigations into patient safety incidents. This process involved detailed retrospective analysis of 117,000 events which were thematically reviewed to identify key areas for future investigations. One of the three main themes was discharge from hospital; this will be a focus for future investigations due to the significant potential for systemic learning and improvement. Future learning will help guide further refinement of our discharge processes. Learning will be disseminated through relevant forums, teaching sessions and training packages.

At a system level, there is a wider piece of work looking at the expected standards of communication between primary and secondary care (One Devon Primary and Secondary Care Interface document – in draft currently). When launched, there is a plan for engagement and regular dialogue between services to ensure adherence and to target areas for improvement.

I hope that the above information is helpful and do let me know if I can assist you with anything further.

Yours sincerely

[redacted]

[redacted]

CHIEF EXECUTIVE OFFICER (Interim)