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11 July 2024

Mr Ian Potter
HM Assistant Coroner
Inner North London

Dear Mr Potter,

re: Regulation 28: Prevention of Future Deaths report; Tracy Frances McCarthy (died 15 July 2023)

Thank-you for your communication of 21 May 2024 relating to the death and inquest into the death of Tracy McCarthy.

Your request for a response by us regarding action to be taken to prevent future deaths or risks is welcome and gives us an opportunity to review this sad case and identify ways of improving the safety and quality of our processes and patient care.

I was the lead GP for care with Tracy until my retirement from clinical practice in September 2022. At that time, I had a limited number of patients with complex problems on my caseload and I took action to handover to my colleagues. Tracy was certainly one of these patients, perhaps the most complex. I was very sad to hear of Tracy's death, but I was not aware of the findings of your inquest until your communication.

As a result, I have looked through her notes and met with two of my GP colleagues ([redacted] and [redacted]) who have had the most (but not only) contact with Tracy following my retirement. We have reviewed the notes and agree that there are a number of gaps and failings in the notes management that led to the amitriptyline prescription being issued that was, in Tracy's case, the wrong thing to do. I would say that I feel the most accountable in this case as the essential thing in this case was that the essential information be visible to all GPs managing Tracy's care (and not just the person taking the lead).

What was lacking to me as a retiring GP (and is still lacking) is a framework for creating a document for complex patients like Tracy so that any GP would be aware of the essentials of that patient's history without having to search through the notes.

It must be said that there is already in place a framework for certain patients (multi-morbidity, usually elderly). These patients have an annual review from which emerges a

Care Plan for the coming year (the patient is actively involved in the creation of this care plan). But this applies to a limited number of patients, and Tracy was not in this cohort.

How to fill this gap? My initial thought was to create a 'handover' template to be completed when one GP retires or leaves the practice. As I was drafting this letter to you and the template, it became clear that something else was required. Not a document created when the lead GP retires or leaves the practice, but a document that is created, for this category of patients, in real time, in the present, to serve as a resource now, not waiting for a GP to retire.

The proposed framework

By framework I mean a process involving a number of elements: a clear purpose; training; documentation; planned review; quality assurance (is the process being carried out reliably, as intended?); quality control (are improvements to the process needed?).

This framework has been created iteratively, and there will be further iterations (to improve it, to develop it).

Purpose

To provide a clear, readily accessible summary for complex patients to aid in safe and good quality planning and care for these patients. It is meant as an aid to assessment, a tool for review, and an aid to collaborative care by clinical staff.

Rationale

This framework has been designed in response to an avoidable patient death in a patient with complex health problems and behaviours. A major problem identified was lack of clear information to guide clinical staff who were not aware of the full picture. The information was in the notes, but not readily accessible, not readily visible.

This framework was initially conceived as a 'handover document' to be used if a GP who led in the care of a complex patient retired or left the practice. It then became evident that this document was needed from the start, not when a GP left the practice.

The Process

1. All GPs, practice nurses, nurse practitioners, and other clinical staff working at the practice be aware of the framework and its rationale. Locum GPs will also need to be aware of the framework. This will require a systematic training. (It should be possible for this to be done efficiently, without adding significantly to the staffs' considerable workload.)

2. **Identification of patients** to be entered into the framework.

What sort of cases should be considered? Complex patients with increased risks; patients who have a lead GP; patients in whom sharing information is important; patients in whom having a 'global' understanding is important.

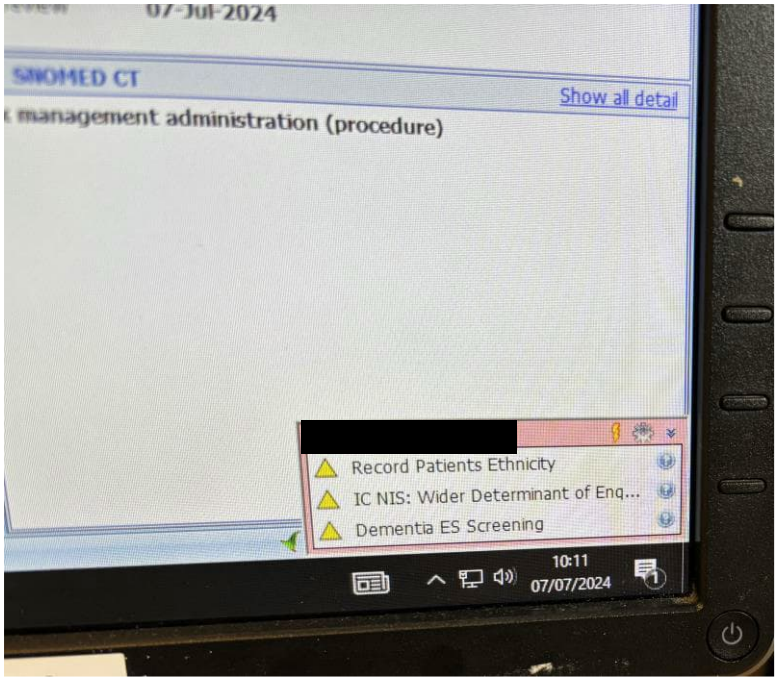
3. Each appropriate patient is added to the **Risk Management & Care Planning Register** (see separate document):

a. the lead GP will fill in the **Risk Management & Care Plan** (see separate document); the completed Care Plan will be filed in the patient's Documents page.

b. **In the EMIS patient record**: in the **Active Problem List** add the SNOWMED Code **Risk management administration** (as Active; Significant, Permanent)**;** in the free text space give name of lead GP, and the date of the **Risk Management & Care Plan** document. The purpose of this entry in the Problem List is to flag for any consulting GP (or other clinical member of staff) that this patient has complex needs and possible risks and signposts the **Risk Management & Care Plan** (which is designed to highlight and summarise the issues that a consulting clinician needs to keep in mind. This would also be of help to a GP doing repeat prescriptions). Of course, other clinicians, such as a pharmacist, would have access to this resource.

c. One thought would be that a copy of the most up-to-date Care Plan could be kept by the patient in case they are admitted to hospital. It might be helpful to include the Care Plan when referring the patient to hospital or community services.

d. The **Risk management administration** code will be added to the EMIS Alert flag list. (This alert is a pop-up in the bottom right of the patient's record).



4. **Reviews:** regular reviews will be needed in the process.

Proposed reviews (subject to change in light of experience):

a. *Overview* of the **Register** quarterly. This is to give a sense of the scale and which patients are on the Register. This may trigger GPs (or other staff) to suggest a patient to be added.
b. Each GP lead will review their patients on the list **6 monthly** (more frequently if need arises; **an hospital admission should trigger a review**)**.** This will entail a review of the **Risk Management & Care Plan** and documenting the review in the Care Plan[1]. The updated copy to be filed on the date of review, and that (new) document will be signposted in the Problem List (that is, it is the most recent version that is signposted).
   One important consideration: in some cases, it may be useful/necessary to review the patient's conditions and management with a colleague, or as a group of GPs (as in the GP Shared meeting). Having a 'fresh set of eyes' can often help.

c. A **review of the overall framework/process** to take place 6 monthly. The two questions to be asked: What is working well? What could be improved? Feedback will be given by the GP leads but also potentially by other clinicians who may have found the **Risk Management & Care Planning** framework helpful and may have suggestions for further development.
d. These reviews will need to be minuted, and these minutes circulated.

5. To ensure that this framework remains active and effective, **a GP lead for the framework/process** will be appointed. The role of this GP will be to ensure that the

[1] This review and update will take into account possible changes in the patient's circumstances, changes to the prescribed drugs, interventions, and so on. It will also be an opportunity to review the management.

reviews are taking place, making sure they are being scheduled, and making sure that the reviews are documented and that actions are actioned. This will not involve much work but will act as a reminder to ensure that this important work does not get forgotten, neglected.

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This draft has been reviewed by [redacted] and [redacted]. It will be presented at the next GP Shared meeting (17 July 2024). Additional suggestions are likely to arise, and the next iteration of the framework will be created, and steps taken to implement the framework.

I would suggest that I provide you with an update and report of the implementation towards the end of September 2024.

It has been suggested that we use this case in a presentation with GP colleagues, possibly on a PCN level, or among practices in Tower Hamlets.

You may well have additional suggestions to make in light of this initial proposal.

We are all saddened and chastened by this human tragedy. I hope we can learn important lessons from this review and the steps we will take so as to improve patient safety and quality of care going forward.

Yours sincerely,

[redacted]

[redacted]

GP Partner