NHS
East Cheshire
NHS Trust

Ref: [redacted]
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Office of the Medical Director
Trust Headquarters, Top Floor
New Alderley Building
Macclesfield District General Hospital
Victoria Road
Macclesfield
Cheshire
SK10 3BL

Tel: [redacted]

Email: [redacted]
www.eastcheshire.nhs.uk
Follow us @eastcheshirenhs

PRIVATE AND CONFIDENTIAL
Ms Alison Mutch
Senior Coroner
Manchester South Coroner's Court
1 Mount Tabor Street
Stockport
SK1 3AG

Dear Ms Mutch

Re: Inquest into the death of Mr David Almond

I write regarding the inquest into the death of Mr Almond which concluded on 8th July 2024 in which you issued a Regulation 28 Report to Prevent Future Deaths.

May I take this opportunity to express our sincere condolences to the family of Mr Almond.

I understand that the Regulation 28 Report was issued to East Cheshire NHS Trust on the basis that the Trust is not able to access GP records for patients who are outside the footprint of the Trust. We, the Trust understand that your concern is that limited information sharing causes difficulties in providing effective and timely care to patients and that this poses a risk that future deaths may occur.

In collaboration with the medical teams in the Acute Medicine Department and the Digital Services Team, the Trust has carefully considered your conclusion. We have outlined below our response and the actions which the Trust will undertake to reduce the risk of further harm. For clarity these are presented below in three subsections:

1. The inability to access GP records for the wider footprint of East Cheshire NHS Trust.
2. The inability to access information in GP records due to differing IT systems across the NHS.
3. The inquest heard evidence that in September 2023 when he went to his GP practice, he did not see a doctor. It was not recognised by the practitioner who saw him that there may need to be a follow-up appointment or a recommendation that he return to see a doctor should the x-ray be negative given his history and presentation.

We, the Trust, have addressed matter one in full. We have addressed matter two briefly, as we are aware this is being addressed in full by NHS England in their response. We have liaised with *gtd healthcare* to provide further information for matter three as this does not concern care provided by East Cheshire NHS Trust.

1. **The inability to access GP records for patients in the wider footprint of East Cheshire NHS Trust.**

The local, regional, and national infrastructure for sharing patient records is complex. A variety of digital systems are available, but it is a complex landscape arising from locality-focused legacy investments and collaborations. Although Integrated Care System (ICS)-based record sharing arrangements are progressing, significant challenges around how they are resourced remain, and a clear national architecture for sustainably linking together ICS-based shared records, and / or developing national infrastructure in this domain, remains in development. This complexity is heightened for a provider like East Cheshire NHS Trust with a catchment area spanning several ICS boundaries and a requirement to view patient records from across the catchment. That said, the following possibilities have been identified.

The Summary Care Record

On the 14th of August 2024, the Trust's Chief Information Officer met with the Integrated Care Board (ICB) Lead for Shared Records and the ICB Assistant Manager for Derbyshire. The purpose of the meeting was to discuss potential information-sharing solutions. As a result, the Summary Care Record (SCR) was identified as the most appropriate system for accessing external patient records.

The SCR is a national database containing essential patient information, such as current medications, allergies, and any adverse reactions to medications. This information is derived from GP medical records and is accessible by authorised staff across various healthcare settings, including Accident & Emergency and acute assessment units. The SCR offers clinicians the advantage of accessing previous diagnoses and medication records, which is crucial for providing comprehensive patient care.

By enabling access to the SCR, clinicians at East Cheshire NHS Trust would be able to view key details of GP records for patients registered outside the East Cheshire boundary, significantly improving the continuity of care.

Implementation Plan

To successfully implement SCR access, the following steps will be taken:

1. Identification of Relevant Staff
   The Trust will identify groups of staff who would benefit from access to the SCR. These groups have been provisionally identified as, Clinical staff in the Emergency Department, Medical Assessment Unit and the Discharge Team. Further assessments will ensure all necessary personnel are included.

2. Smart Card Distribution and Access
   Each staff member will require a smart card to access the SCR. A smart card is a plastic card containing an electronic chip and is used alongside a pin to provide staff with the appropriate level of access to the healthcare information. The Trust will ensure that all relevant staff have smart cards. Those who do not will be booked into a fast access smart card clinic where they can obtain one.

3. Training and IT Induction
   Staff will receive training on how to access and use the SCR. This training will be provided in a face to face format in the Trust lecture theatre or via Microsoft Teams, allowing staff to practice accessing the system during the session. Additionally, the Trust will design an IT induction program for new starters, focusing on SCR usage.

4. Super Users and Troubleshooting
   The Trust will establish departmental super users who will assist staff with queries, ensuring swift resolution of issues. A clear troubleshooting pathway will also be implemented, addressing common issues such as expired smart cards and incorrect permissions.

5. Implementation Timeline
   The Trust aims to roll out SCR access by the end of December 2024.

Post-Implementation Review

Following the implementation period, the Trust will conduct an audit to assess SCR usage and gather staff feedback for potential improvements. This review will include:

1. Incident Reporting System (Datix)
   A review of Datix will be conducted to identify any issues related to access to patient records.

2. Staff Usage Audit and Feedback
   An audit of staff usage of the SCR, supplemented by questionnaires to gather feedback.

3. NHS Midlands and Lancashire Commissioning Support Unit Data Review
   An analysis of data from the CSU on logged calls related to smart cards, identifying common issues, affected staff, and potential mitigation strategies.

Further Mitigating Factors

In response to this incident, the Trust has also taken proactive measures to enhance patient care and reduce the risk of recurrence by making changes to the Deep Vein Thrombosis (DVT) telephone follow-up clinics.

Changes to DVT Telephone Follow-Up Clinics

1. Clinic Scheduling Adjustments
   - Reduced Frequency and Increased Capacity: The frequency of DVT follow-up clinics has been reduced, while the number of patients seen in each clinic has increased. This adjustment allows clinicians more time to prepare for each patient and consider specific questions tailored to individual needs.

   - Dedicated Post-Clinic Time: Additional time has been allocated after each clinic session to thoroughly complete any necessary follow-up actions, such as ordering further investigations, making referrals, and/or drafting complex communication letters. This ensures that all patient needs are addressed comprehensively.

2. Enhanced Patient Interaction and Assessment
    - Tailored Questioning: Clinicians now dedicate time before clinics to prepare personalised questions for each patient, enhancing the detail and relevance of assessments. For instance, younger patients are routinely asked about family history and past DVT incidents, which has already led to the early detection of a potential inherited thrombophilia in a young man.

    - Collaboration with GPs: In cases where patients are unable to provide detailed information, clinicians are encouraged to communicate directly with the patient's GP. This ensures that all relevant medical history is obtained, supporting a more accurate and comprehensive assessment.

3. Improved Patient Communication and Safety Netting
    - Verbal and Written Advice: During the clinic, patients receive tailored safety netting advice, which is also included in the follow-up letter sent to both the patient and their GP. This advice is personalised to consider the patient's lifestyle, travel habits, and sports activities, ensuring that it is relevant and actionable.

    - Holistic Approach Dissemination: The additional time allocated before and after clinics allows clinicians to adopt a more holistic approach to patient care. This approach is being actively shared with junior doctors, promoting a consistent standard of care across the team.

These changes aim to improve the quality of patient care by providing clinicians with the time and resources necessary to thoroughly evaluate each case, consider individual patient needs, and ensure that all follow-up actions are completed effectively.

The doctor involved in this incident delivered an anonymised presentation of the facts and outcome of Mr Almond's unfortunate death at the Medical Department meeting on 16 August 2024. This has enabled a wider dissemination of the lessons from Mr Almond's death and increased awareness of the changes that have been implemented.

<u>Individual Learning and Reflection</u>

The doctor involved in this incident has also undertaken extensive reflection on their role in Mr Almond's care. During the inquest, the doctor acknowledged that the decision to discontinue anticoagulants was incorrect, given the information available at the time.

Key Reflections and Changes in Practice

- Acknowledgment of Error: The doctor openly accepted that had they been fully aware of all pertinent information during the clinic, they would have continued anticoagulation therapy. This recognition underscores the importance of comprehensive information gathering in clinical decision-making.

- Commitment to Professional Curiosity: Moving forward, the doctor has committed to demonstrating greater professional curiosity. This includes proactively asking the GP to review older records when we do not have access to the relevant information, ensuring that decisions are based on the most complete information available.

- Personal Practice Changes: The doctor has made significant adjustments to their approach, particularly in gathering patient information. They now prioritise obtaining a more thorough understanding of each patient's history and context before making clinical decisions.

- Contribution to Collective Learning: The doctor is using the insights gained from Mr Almond's case to educate others. By sharing their reflections and the lessons learned, they aim to increase awareness and promote better practices among colleagues, thereby improving overall patient care.

2. **The inability to access information in GP records due to differing IT systems across the NHS.**

   As detailed in relation to matter one, the Trust is implementing the use of the Summary Care Record as a way for clinicians to gain further information. This would not only be beneficial for patients in the bordering areas of the Trust but will also be of benefit at a national level .

   The national Connecting Care Records program is currently reviewing its technical target architecture options, timescales, and associated resources. Details are expected to be made available as part of the emerging national One Digital strategy. It is anticipated that these future developments will aim to improve and simplify record sharing arrangements across the whole of the NHS. As well as technical enablers, it is anticipated that information governance arrangements will be streamlined, retaining vital controls and assurances but simplifying the administration of data sharing across boundaries for direct care purposes.

   The Trust understands that NHS England will be addressing this matter in detail within their response to the PFD and therefore proposes not to address this further.

3. **The inquest heard evidence that in September 2023 when he went to his GP practice, he did not see a doctor. It was not recognised by the practitioner who saw him that there may need to be a follow-up appointment or a recommendation that he return to see a doctor should the x-ray be negative given his history and presentation.**

   As this concern relates to Mr Almond's clinical contact with his GP practice and not to care delivered by East Cheshire NHS Trust, we have sought the input of the *gtd healthcare* for the GP practice to provide the response that follows:

   It is established practice in primary care that care is delivered by a multi-disciplinary team. The team may include for example, GPs, advanced clinical practitioners (ACPs), pharmacists, practice nurses or healthcare assistants.

   ACPs have completed additional qualifications to Masters level that enables them to independently assess and manage a range of clinical presentations. As such, patients who are seen by an ACP do not have to be routinely seen by a GP either before or after their consultation with the ACP. However, as autonomous practitioners, if an ACP believes that the patient's presenting complaint is outside their defined scope of practice to safely assess and manage, they can escalate to the onsite GP if an immediate review is required or re-book the patient into a GP appointment for a later date.

The types of caseloads that will be booked in to see ACPs will often be patients with acute or new undifferentiated presentations. Further information about what is expected of ACPs can be found in the following guidance:

https://www.skillsforhealth.org.uk/services/item/724-advanced-clinical-practice-core-capabilities-for-nurses-working-within-general-practice-settings-in-england

The care provided by the ACP has been reviewed and the Coroner's concerns noted. We agree that Mr Almond's family history and diagnosis of thrombophilia should have been documented by the ACP and explored fully with Mr Almond.

The reasoning behind the decision to refer Mr Almond for a chest x-ray should have been documented by the ACP, as should have the reasoning for excluding a possible pulmonary embolism.

The ACP's plan (as documented in the records) was that the x-ray results should be reviewed on receipt. What is not recorded, and should have been, is the advice Mr Almond should have received that if his symptoms did not resolve, worsened or returned when previously resolved, he should seek medical advice. It should also have been recorded that if his chest x-ray results were normal, further investigation might nevertheless be warranted.

At the inquest the Coroner heard evidence that the following steps have been taken in response to this incident:

- *Additional learning regarding the identification and management of venous thromboembolism including the use of anticoagulation has been shared with all clinical staff.*
- *Consultation with East Cheshire NHS Trust has taken place to enhance both parties' understanding of the DVT pathway and the information that is provided to patients about management of their risk of pulmonary embolism.*

Since the inquest, the following actions have also been identified:

- *Record keeping guidelines will be updated to give greater guidance on the need to document in the notes all relevant past medical history i.e. those elements relating to the presenting symptoms, and to also include a differential diagnosis or the rationale for excluding a potential diagnosis so that it is clear what has been taken into consideration when determining a management plan.*
- *Opportunities for learning from the case will be shared as part of the organisation's clinical hot topics bulletin and as part of its Non-Medical Prescribers/ACP forums.*

The Trust is always keen to review, learn and wherever possible, strengthen our clinical processes and so we are grateful for your bringing these concerns to our attention. We hope the above offers you assurance of the Trust's ongoing commitment to managing patient safety risks and continually improve the services we provide.

Yours sincerely

[redacted]

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Medical Director