DRC/CS

3 July 2015

Ms Jacqueline Devonish,
Coroner's Officer,
127 Poplar High Street,
London E14 OAE

Dear Ms. Devonish,

re: Mrs Viola Burke dob 30-Apr-1934 [redacted]

You sent our practice a Regulation 28: report to prevent future deaths. You feel that there were a number of actions the practice could have taken to prevent the death of this lady, mostly concerning the absence of a care plan for this lady.

I thought it might be helpful if I started by providing some additional background to care plans. The Care Plan scheme started in City and Hackney in June 2014 and therefore, in line with the scheme's introduction, Mrs. Burke's invitation to participate in the scheme and have a care plan provided was the first round of invites the practice had sent. The terms of the contract were that the practice should invite 2% of our vulnerable patients over 75 who we considered would benefit from a care plan. The invite letter explained what the care plan was and that we would contact them to arrange an appointment to complete the care plan with them if they wished to go ahead.

Under the terms of the contract, we were obliged to see them by the end of September 2014. Patients could of course decline and might do so actively, by informing the practice that they did not wish to participate, or passively, by refusing to respond to the practice's approach and invitations.

This initial window was intended only for the first group of patients invited and the rules of the contract are now that the care plan has to be completed within one month of inviting the patient. We sent Mrs. Burke an invitation on 26th June 2014 to

have a care plan developed and our receptionists then rang her 3 times to arrange an appointment for her but were unable make contact with her. In light of this, we added the code 'Admission avoidance care ended' to her notes as we had not been able to arrange to undertake the plan within the allotted time span for the initial invites.
This code on the notes was only intended to make clear that we had not been able to undertake the plan in that year for her. We are limited by what codes are available on the national computer systems. Adding this code did not mean we would not offer her a care plan again. The scheme was in its infancy and nobody had decided how to address the issue where a patient didn't respond within the window so we used this code as a pragmatic solution, simply to signal to ourselves the situation. It was intended to serve as an audit trail so that we may know those patients previously approached, so this could be demonstrated to the CCG.

Care plans have on them the patient's past medical history, present medications, and contact numbers for the next of kin. It may then record information about what care the patient would wish to receive in the event of becoming unwell, such as whether they would wish to go to hospital. The plans are supposed to include information as to whether a 'do not resuscitate' discussion has been undertaken, especially as we are often talking about a group of very vulnerable and unwell patients.

Care plans cannot be accessed electronically by the out-of-hours service, the Accident and Emergency department or the Ambulance service. City and Hackney CCG have been actively discussing how we can try and enable this to happen and, as I understand it, are presently working on the information technology to make this possible. This is not something that my practice could control. Care plans can only be accessed if the hard copy plan is taken by the patient and given to out-of-hours doctors or the ambulance service and indeed I am aware some patients do this.

To respond to the 4 points listed as being 'Matters of concern' as required I would comment as follows:

1. You were concerned that no questions had been asked about the reason for the use of the asthma pump (salbutamol inhaler). Looking back at this lady's notes, [redacted] (GP) saw the patient on 15th July 2015 for a review. The cardiology specialists had questioned the reasons for the patients' breathlessness in a letter to the surgery after seeing the patient in the cardiology clinic. Having taken the patient's symptoms and findings on examination in to account, [redacted] did not feel any further action was needed at that time. Again from what I can see from the notes, it seems she decided not to add the diagnosis of asthma to the notes. We are aware of how important a diagnosis of asthma is. We do have a small number of patients who say they find that Salbutamol inhalers are helpful but who don't fulfill the clinical criteria for making a diagnosis of asthma and so would not want to add such a code to their notes. I can see that [redacted] considered whether or not the patient would benefit from spirometry (a test to demonstrate whether a patient may have chronic obstructive airways disease or asthma) but did not arrange it at that time. She states that she did not think referral to the respiratory physicians was necessary at that time. We do make every effort we can to ensure that patient records are kept accurate and up to

date. For instance, and of relevance in this case, we employ a permanent notes summarizer to ensure information is transferred from other doctors accurately. In acknowledgement of the concern expressed we will continue to do this. [redacted] no longer works at this practice so I have not been able to speak to her about her thoughts at the time.

2. I have explained above why Mrs. Burke did not have a care plan at the time of her death. Due to the initiation of the new scheme we could not ensure all patients in the practice had a care plan at once as it takes considerable time to undertake these. Therefore the approach employed was to target one group at a time for the invitations and care plans. Mrs. Burke would have come back on to the list of patients being offered a care plan at a later date. To address this concern and ensure that patients are approached if they have not initially responded to invitations in previous rounds, we have now put a system in place whereby all patients identified by means of the NELLIE search tool (a risk stratification tool developed by the CCG) who are considered high risk of admission are identified by adding 13Zu 'At risk of Emergency Hospital Admission', to their notes so that our administrators can re-run the search in the future. We will be developing a protocol in EMIS where this code will now cause a 'pop-up' box to appear on the patient's medical records to prompt the doctor to discuss the issue of care plans with the patient. We expect to have this completed and operational by the end of July 2015.

3. You query the use of the code 'Admission avoidance care ended' on this lady's notes. I have explained the reason for using this code was purely pragmatic, an acknowledgement that the patient had been invited to participate but that no care plan had resulted from this invitation (in this case due to an inability to contact her on the telephone although we rang three times to arrange an appointment for her) and so the patient should not be on the register. We had to complete the care plan before 26th September 2014 so that by the time she attended with her son and subsequently, it was outside the care plan window and 'too late' for us to complete. The Lawson Practice raised the issue about the problem of how to manage non-attenders at the Clinical Commissioning Forum (a regular meeting between the CCG and its member GPs) and at an education session run by the CCG when care plans were first being discussed. Although attempts to re-invite patients are not required by the contract, we have learnt from a clinical care perspective that this would be helpful and thus we will develop the protocol as described above.

4. You mention that the intention with care plans was to ensure that the London Ambulance Service and OOH Service would have full access to the patient records of the most vulnerable patients. Regrettably this is not the intention and neither is it what occurs. The Care Plan is intended primarily to be used to help patients avoid unnecessary hospital admissions, to give clinicians an understanding of the patient's present medical condition(s) and to record (where appropriate) the patient's expressed wishes at the time it is written. It is about having an agreed plan for people who are vulnerable and may not wish to go into hospital or may wish for other actions to be followed when they become ill and

have decided where they want to die. It is not designed to give full access to the patient's medical records. You mention questions being raised about how the care plan would be kept up to date. This is very relevant and was raised with our CCG some months ago and they are considering how best to do this, as are CCGs across the country as this is a national problem. This is not a practice related issue and is outside our control and rests with the CCG and NHS England. However we are willing to cooperate fully with the CCG in working to make any changes in practice that are beneficial and will address these issues. You mention doctors attending out-of-hours operating in a medical vacuum. Sadly that is the case across the country. It is not something my practice can address. It is not an issue that is practice related but might be something that our CCG or the national policy makers will be able to address. I cannot respond to these points therefore.

We are continuing to work hard on trying to ensure all our vulnerable patients have care plans. We consider them very valuable and useful documents as the process of writing them together gives the patient an opportunity to think about their future care and what they want for themselves. It gives them the opportunity to ask questions and to plan. We are working with our CCG to try and resolve some of the observed IT problems with the care plans. Our CCG is working to try and ensure limited access to the medical history and drug sections of the GP record for the out-of-hours service and the local hospital and hopefully this will be possible very soon.

I trust this response meets with your satisfaction and wish to thank you for bringing these issues to my attention so that I might reflect on them further with the practice and our CCG.

Yours sincerely,

[redacted].