Inq 236/16

University Hospitals of Leicester NHS

[redacted]

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15 December 2016

Mrs C E Mason
HM Coroner
Leicester City and South Leicestershire
Town Hall
Town Hall Square
Leicester LE1 9BG

Dear Mrs Mason

Re Margaret Mary Dempsie

I write further to the Regulation 28 Report sent by your Assistant Coroner on the 24th October 2016.

In that Report concerns were raised about the accuracy of the information sent to GP's by junior doctors. Understandably your Assistant Coroner was concerned that primary carers are reliant upon the information provided to them in discharge letters and that if that information is incorrect then patients could come to harm.

As a result of this Regulation 28 Report, the medical records of Mrs Dempsie have been reviewed by [redacted], Associate Medical Director & Consultant Physician, who has concluded that the discharge letter should not have referred to the patient as having had bronchopneumonia. However in this case, whilst the patient was clearly unwell and required end-of-life care following discharge; no harm befell Mrs Dempsie as a result of this inaccurate information being provided to her GP.

The process for compiling a discharge letter at the Trust should be a joint enterprise between the junior doctor and the most senior clinician on the ward at the time that the discharge letter is signed off. Information contained in the discharge letter should reflect that contained in the patient's medical records and best practice occurs when the discharge letter is prepared in real time at the point the decision to discharge the patient is made in order to ensure that senior members of the clinical team involved in the care of the patient are involved in the process. Consultants ultimately have responsibility in providing clinical leadership to their junior teams to ensure that this process is supported. Our Medical Director has noted that the consultant in this case appears to have raised concerns with your Assistant Coroner that discharge letters for patients under their care regularly contained inaccuracies and so will be meeting

with the consultant involved to understand what actions they have taken to address this and as to whether he has raised this as a concern with the Trust.

Whilst we strive to ensure that all discharge letters contain all relevant and accurate information, we recognise that we do not get this right on every occasion. To minimise the risk of inaccurate information being provided to GP's, the Trust has developed a standardised template for discharge letters which detail the reason for admission and main diagnosis at discharge. Additionally the Trust provides an e-learning package for junior doctors to reinforce the importance of providing accurate information to GP's.

Approximately 500 GP concerns per year come through the Patient Safety team and these are themed and discussed at the Clinical Quality Review Group. The Senior Patient Safety Manager and the Head of Services for GPs now meet monthly to triangulate GP concern themes to monitor these and inform required actions at Trust wide level.

In addition, the Trust has for some time requested individualised feedback from GP's regarding any poor or inaccurate information received from the Trust and undertakes regular audits to provide assurance on the quality of the information provided in Discharge Letters. These audits show an improvement in the quality of the information that we provide to GP's.

As a result of this case the Trust has taken and will be taking the following actions:-

1. The frequency of internal audits for discharge letters will be increased for each CMG every month with immediate effect and our Head of Outcomes and Effectiveness will lead on this.

2. Our Chief Medical Information Officer and Head of Services for GP's will encourage GP's to provide individualised and patient specific feedback concerning poor discharge letters throughout December 2016 to assess the level of inaccuracies and perception of poor Discharge letters. Our Chief Medical Information Officer will then review any feedback and discuss necessary actions with the doctors involved and the GP dependent upon the findings. He will report on this matter to the Executive Quality Board in March 2017. Our Head of Services for GP's will promote the opportunities to feedback errors on discharge letters directly to her in the December GP Newsletter. This extended audit will then be repeated at regular intervals, depending on the findings.

3. Our Head of Effectiveness and Outcomes has raised the issue requesting GPs to provide feedback concerning incorrect discharge letters at the Clinical Quality Review Group Meeting on 17 November 2016. This review Group includes GP leads for the Clinical Commissioning Groups

4. Our Medical Director will ensure that this case is discussed with the Consultant involved before the end of December 2016 to encourage reflective learning. [redacted] has met with the junior doctor who wrote the discharge

letter in this matter. She has reflected upon this case and clearly understands the importance of accurately completing discharge letters in future.

5. Our Head of Outcomes and Effectiveness will strengthen our "Letters Policy" to ensure that there is clarity concerning the process for discharge letters and the importance of senior medical oversight. This should go to the Policy and Guideline Committee Meeting in January 2017.

I trust that this response assures you that we are take these matters seriously and if you wish for any further information please do not hesitate to contact me.

Yours sincerely

John Adler
Chief Executive