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CARING YOU

# United Lincolnshire Hospitals NHS

NHS Trust

*Office of the Medical Director*

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12th May 2017

Mr Paul S. Cooper
Acting Senior Coroner for South Lincolnshire

Via email: lincscoroner@lincolnshire.gov.uk

Dear Mr Cooper

I refer to the Regulation 28 Report issue by yourself following the inquest into the death of Mrs Olive Daynes.

The matter of concern you have raised relate to:

1. Her attendance at the Accident & Emergency Department at Pilgrim Hospital with leg ulcers resulting in a change to her medication and referral back to her general practitioner.

2. She was seen by a doctor at her GP surgery the following day who was unaware of the advice provided by the hospital regarding her change in medication and the increased INR levels (relating to her anticoagulation with Warfarin).

3. The hospital did write to the surgery but this letter arrived 5 weeks after she was first seen in the Accident & Emergency Department.

4. In the intervening period her anticoagulation deteriorated resulting in an INR in excess of 9 and her passing away on 05/01/2016.

5. In order to prevent similar deaths in the future, the discharge letter is sent by electronic means to the appropriate GP email address of the appropriate GP surgery.

6. Electronic communication to GPs following the discharge of inpatients is already place and has been so for some time. The expectation is that electronic discharge letters are sent to the patients GP within 24 hours of discharge on 95% of occasions. Our compliance with this has improved from 74% (April 2016) to 83% (March 2017). This is under constant review by a Task and Finish Group which is Chaired by myself. We have also developed a template for the electronic communication of deaths in hospital. The aim of this is in order to facilitate time and communication for the benefit of the relatives, carers and GPs. I anticipate this to be up and running in the next 6 months.

7. In 2016 the Trust and the Lincolnshire Local Medical Committee issued a document setting the standards and principles by which test results should be communicated by secondary and primary care. I enclose a copy of this document which was sent to all clinicians within ULHT. This has been circulated again to remind colleagues of their responsibilities.

8. With reference to the prescription of antibiotics which led to the abnormal anticoagulation for Mrs Daynes a Patient Safety Bulletin highlighting this interaction and the need for effective and timely communication has been circulated across the organization. I attach a copy of this. I have written to the Lead Clinicians of our 3 Accident and Emergency Departments highlighting the concerns you have raised as well as the need to ensure appropriate and timely communication.

9. At present electronic communication between the A & E Department and Primary Care is not available to the Trust. However, we are aware of an impending requirement to move to this. We are therefore in the process of developing electronic documentation in the A & E Department which will also enable direct electronic communication of clinical information to the patients GP. Our ability to progress this is influenced by a range of other actions currently being rolled out including:

10. Electronic Observation and Charting Trust Wide (approx. 60 Wards), a new electronic maternity system as well as upgrading our IT software. We are also aiming to introduce electronic patient records as well as an electronic prescribing; both of which will improve patient safety. For the immediate future we will remain restricted to conventional correspondence.

11. A more detailed root cause analysis of the events surrounding Mrs Daynes is being undertaken and I would be pleased to share this with you as soon as it is available.

I hope the above provides you with the reassurance you are seeking following the issue of a Regulation 28 report into the death of Mrs Daynes.

With best wishes

Yours sincerely

**Dr Neill Hepburn MBA MD FRCP**
Interim Medical Director (GMC 2255408)

*Encs*

*cc:* *Jan Sobieraj – Chief Executive*
*Michelle Rhodes – Director of Nursing*
*Dr Koshy Jacob – Clinical Director, Integrated Medicine (Pilgrim)*
*Dr Ravindranath Sant – Consultant in A&E (Pilgrim)*
*Dr Megan Kelly – Consultant in A&E (Lincoln)*
*Dr Furat Murrani – Consultant in A&E (Grantham)*

Lincolnshire LMC
Local Medical Committee Ltd
Supporting and Representing General Practice

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Dear Colleague,

In March 2016 NHS England, the Academy of Royal Colleges, and the BMA produced "Standards for the communication of patient diagnostic test results on discharge from hospital"[1,2,3,4]. This document sets out the standards and principles by which test results should be communicated between secondary and primary care. This document, and previous discussions between GPs and hospital clinicians, has prompted United Lincolnshire Hospitals Trust (ULHT) and the Lincolnshire Local Medical Committee (LMC) to develop local policies and principles for the delegation of workload from secondary to primary care.

ULHT and the LMC have agreed-

1) The underlying principle for this policy is that either the clinician requesting an investigation or the consultant whose care the patient is under, should be responsible ultimately for ensuring that the test is acted upon when needed. It is not the role or responsibility of primary care practitioners to follow up the results of outstanding investigations. As a corollary it would be equally inappropriate to expect hospital clinicians to review test results requested by GPs.

2) Every test result received by a Clinician for a patient should be reviewed and where necessary acted on by a responsible clinician even if this clinician did not order the test. As to not do so could lead to patient harm.

3) Primary care teams should have a system to ensure that any discharge information they receive is seen and acted on in a timely manner by a clinician able to understand the importance of the information and able to take responsibility for taking appropriate action.

4) If a patient needs on-going investigation(s), and will remain under follow up by a hospital clinician:

    a. The hospital clinician should arrange for the appropriate investigation(s) and follow up the results and the patient should be informed that this is the case.
    b. If a blood test is required, phlebotomy may be performed at the general practice, and the request form should be generated by the hospital clinician.
    c. If other investigations are required such as radiology, ECG, echocardiogram etc, the request should be made and sent by the hospital clinician.

5) If it is felt further investigation(s) are warranted but the patient will not remain under follow up by the hospital clinician:

    a. the hospital clinician should depending on the clinical condition:

        i. request that the general practice reviews the patient to identify what further action is required or
        ii. make a suggestion to primary care as to the course of action the hospital clinicians feels is appropriate. In this circumstance the hospital clinician should explain in writing their rationale for this.

    b. Ultimately, it is the responsibility of the general practice clinician to decide with the patient what further tests are required, to arrange these, and to follow up the results.

6) When a patient has a serious condition which requires urgent referral for investigations, treatment and management, a consultant to consultant referral should be made without delay.

7) When a patient has a condition which the specialist is not qualified to treat within their own specialty, for instance, an orthopaedic specialist does not perform shoulder surgery which the patient requires, a consultant to consultant referral should be made directly.

8) When a secondary care clinician sees a patient who has a non-urgent condition, which is beyond the expertise of their own specialty and requires further assessment, the hospital clinician should refer the patient back to the patient's own general practitioner for review. For instance, an orthopaedic consultant, seeing a patient with psoriasis, may suggest that the GP refer the patient to a dermatologist. However, the general practitioner is able to treat psoriasis without the need for a dermatology review. Thus, it would be appropriate for the consultant to ask the general practitioner to discuss the problem with the patient, so that the appropriate treatment or referral can be made.

We hope the above will provide some clarity over responsibilities by primary and secondary care clinicians for the safe transfer of information about diagnostic results and tests. The above agreed between by ULHT and the LMC should be adopted by primary and secondary care clinicians of all grades. We envisage continual whole-system learning and improvement and welcome constructive suggestions to this effect, to improve safer patient care

We thank you for your co-operation

Yours sincerely

***Dr S Kapadia***
***Medical Director ULHT***

***Dr K Sharrock***
***Medical Director Lincolnshire LMC***

[1] NHS England Patient Safety Domain, 10 March 2016: Standards for the communication of patient diagnostic test results on discharge from hospital

[2] https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2016/03/discharge-standards-march-16.pdf

[3] http://www.bma.org.uk/support-at-work/gp-practices/service-provision/duty-of-care-to-patients-regarding-test-results

[4] www.bma.org.uk/-/.../gpc-letter-to-ccgs-test-results-march-2016.pdf