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Mr A R Barkley
HM Senior Coroner for South Wales Central Area
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4 October 2017

Your Ref: ARB/SLR/9971

Dear Mr Barkley,

Re: Touching upon the death of the late Percy JACKS

I am writing to inform you of the actions we have taken to date in relation to the sad death of Mr Jacks and the subsequent steps we are proposing.

Prior to your Regulation 28 Report dated 27 July 2017, we had no knowledge of Mr Jacks' death. As the regulator for health and social care in England we would expect services registered with CQC to notify us of a death happening during the course or as a result of care and treatment activities coming within the scope of our regulations being carried out. However, as Mr Jacks was resident in a care home in Wales at the time of his death, any notification of death would be required to go to CSSIW as the regulator for care homes in Wales.

On receiving your Regulation 28 report we contacted the two providers involved in the delivery of Mr Jacks' care in treatment which are registered with the Care Quality Commission, namely Pencombe Hall care home and Cantilupe Surgery in Herefordshire.

Pencombe Hall is a residential care home in Herefordshire, registered to provide accommodation for persons who require nursing or personal care for up to 32 people. There are conditions placed on the provider's registration with CQC that the home must have a registered manager and must not provide nursing care. The home is compliant with these conditions. The last comprehensive inspection was completed on 23 May 2016 at which time the home was fully compliant and rated as 'Good' in all the key questions we inspected against. We do not have

any current concerns about the quality or safety of care at this location. The next scheduled inspection for this service is June 2018.

Cantilupe Surgery in Herefordshire is a GP partnership providing primary medical services to approximately 11,100 patients in an area to the east of the city of Hereford. There is a condition placed on the provider's registration with CQC that the practice must have a registered manager. The practice is compliant with this condition. The last comprehensive inspection was completed on 15 October 2014 at which time the practice was fully compliant and rated as 'Good' in all the key questions we inspected against. We do not have any current concerns about the quality or safety of care and treatment at this location. The next scheduled inspection for this service is February 2018.

We have investigated the actions taken by both services whilst they were responsible for providing care to Mr Jacks. The information provided to us by both the care home and the GP practice has assured us that they acted appropriately and in accordance with current regulations and national guidance in providing care and treatment for Mr Jacks. Accordingly we do not consider that persons using either of these services regulated by CQC are at current risk.

HM Senior Coroner's Concerns

We note the specific concerns held by HM Senior Coroner arising from the inquest touching on the sad death of Mr Jacks and raised in the Regulation 28 report. We propose to respond to each of them in turn for ease of reference.

1. ***The investigation revealed that the system for the Bronglais Hospital contacting the GP was poor. The result of the DVT scan which took place on 06 February was sent to the incorrect GP surgery and despite an investigation as to why that happened no satisfactory explanation could be found.***

Mr Jacks lived at Pencombe Hall from 18 January 2017 to 2 February 2017, where he was receiving respite care. He was seen at Cantilupe Surgery on 1 February 2017 and was due to move to a care home in Wales the following day. As a result of this GP consultation, Mr Jacks was diagnosed with suspected deep vein thrombosis, prescribed a course of rivaroxaban, and given a letter to pass on to his next GP outlining the diagnosis and prescription and requesting that the next GP arrange an ultrasound scan locally. We view this as an appropriate course of action by the practice in the circumstances, as it did not know which GP practice Mr Jacks was going to register with next.

Mr Jacks' family gave the rivaroxaban tablets to Pencombe Hall, and signed Medication Administration records confirm that he took the tablets for the evening dose on 1 February 2017 and the morning dose of 2 February 2017, prior to him moving out of the home. The records confirm that he was discharged with all his medicines.

A scan of the discharge summary submitted to us by Cantilupe Surgery demonstrates that an ultrasound scan took place on 6 February 2017 at Bronglais General Hospital in Aberystwyth. This hospital is not regulated by CQC. This discharge summary, which shows a positive identification of DVT in Mr Jacks' left leg was sent in error to Cantilupe Surgery and should have instead been sent to the GP practice in Wales that arranged for the scan to take place.

When patients move between GP practices in England, practices are able to forward their notes electronically, provided they have signed up to this service. When the new practice is not signed up to this system, as in the case when patients move from England to Wales, this facility is not available and in such cases the only remaining option is to send hard copies of patients' notes via a secure courier system. In England, this role has been contracted out to the company Capita, who will collect the patient's notes from the outgoing practice and, once the incoming practice has been identified, will deliver the notes to their correct destination. This is dependent on the patient registering with a new practice, at which point the new practice will apply to Capita to have the patients' notes delivered.

Cantilupe Surgery has informed CQC that hard copies of Mr Jacks' notes, along with the scan results which were sent in error to the surgery by Bronglais General Hospital were collected by Capita on 10 February 2017. While Cantilupe Surgery did not contact the Bronglais Hospital to inform them of the error, they considered that the action of including the scan results along with Mr Jacks' patient records were sufficient to ensure the information would reach the new practice promptly. The practice have informed us that in the event of a repetition of this kind of error they would inform the hospital in the light of Mr Jacks' case. We do not consider that there is cause for additional input from CQC here.

Through this process of transferring hard copies of patients' notes, the outgoing GP does not know who the incoming GP is unless the new GP practice contacts the previous practice directly. Although there is no regulatory requirement for practices to do this, we would consider this to be good practice. Cantilupe Surgery has informed us that it was not contacted by Mr Jacks' new practice at any time.

Information provided by HM Senior Coroner's office indicates that Mr Jacks was registered with two further GP practices following his departure from Cantilupe Surgery, namely Rhayader Group Practice and Arwystli Medical Practice. Neither of these practices is regulated by CQC.

CQC does not provide specific guidance in relation to the passing of information between hospitals, GP practices and care homes, although in order to comply with the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014, service providers registered with CQC must ensure that the medicines that are necessary to meet people's needs are available when they are transferred between services.

We consider that Cantilupe Surgery took appropriate action to ensure that Mr Jacks continued to receive safe and effective care and treatment once he left the practice's patient register.

During CQC inspections of GP practices, where we consider the effectiveness of the provider, we do examine how information is shared when patients move between services, One of our Key Lines of Enquiry which we follow during inspections is ' *Do staff have all the information they need to deliver effective care and treatment to people who use services?*' This question is supported by a specific prompt for inspectors: '*When people move between teams and services, including at referral and transition, is all the information needed for their ongoing care shared appropriately, in a timely way and in line with relevant protocols? How well do the systems that manage information about people who use services support staff to deliver effective care and treatment? (This includes coordination between different electronic and paper-based systems and appropriate access for staff to records.)*' This area was covered through our key Lines of Enquiry when we inspected Cantilupe Surgery in 2014 and we found that the practice had systems in place to provide staff with the information they needed.

We have revised and improved the wording of our Key Lines of Enquiry and from November 2017 inspectors will be considering the following two specific questions when they are reviewing the safety of a practice, instead of one being a prompt supporting the other: '*When people move between teams, services and organisations (which may include at referral, discharge, transfer and transition), is all the information needed for their ongoing care shared appropriately, in a timely way and in line with relevant protocols?*' and '*How well do the systems that manage information about people who use services support staff, carers and partner agencies to deliver safe care and treatment? (This includes coordination between different electronic and paper-based systems and appropriate access for staff to records.)*'

This will make it clearer for providers how they can meet this Line of Enquiry and will also allow CQC to monitor more effectively the systems that providers are using to transfer information.

2. The system within the GP surgery for prescribing rivaroxaban was poor and relied solely on receiving the notification of the results of the scan from the hospital. There was no facility to review the medication to ensure that the correct dosage for the correct period of time continued to be prescribed.

We expect GP practices registered with CQC to have arrangements in place to keep patients on high risk medicines under review to ensure they continue to receive the correct amount of medicine for the correct time period.

Following our review of the information made available to us by Pencombe Hall and Cantilupe Surgery, we are satisfied that any failure to prescribe a continuing supply of rivaroxaban for Mr Jacks did not occur at either of these two services. At the point of leaving Cantilupe surgery, Mr Jacks had been prescribed a sufficient amount of this medicine to last for 28 days, and so we conclude that the breakdown in the prescribing system occurred within the GP practices and care homes that Mr Jacks went to after he had been seen at Cantilupe and had left Pencombe Hall. As outlined in the Regulation 28 Report, Mr Jacks' last recorded dose of rivaroxaban took place on 12 March. This is some 12 days after his initial prescription from Cantilupe would have run out had it been administered consistently, and 38 days after he had left Pencombe Hall.

3. The evidence revealed a view from one of the hospital doctors to the effect that DVT management should be undertaken within the hospital setting rather than by the GPs to ensure that a comprehensive and failsafe system operated rather than the somewhat haphazard one revealed by the evidence.

The management of DVT within a primary care setting is accepted practice. For this to take place safely we would expect to see a D-Dimer blood test carried out, followed by an ultrasound scan. Once DVT has been confirmed we would expect the practice to liaise with the local secondary care provider to agree that ongoing management within a primary care setting would be appropriate.

We are satisfied that the part played by Cantilupe Surgery in carrying out a consultation, arranging a D-Dimer test, prescribing rivaroxaban, providing information for the next GP practice and requesting an ultrasound scan be carried out by the successor GP was appropriate.

4. The evidence further revealed a practice of sending details of the medication and clinical plan back with the driver of the patient who had taken the patient back from hospital to the care home.

In cases of a patient travelling from a care home to a hospital and back we would usually expect to see a member of staff with knowledge of the patient accompanying them, or possibly a family member, along with an information sheet detailing the medicines that the patient was taking at the time and any other relevant information for the hospital staff. We would also take into account the mental capacity of the patient and the particular wishes of that person to be accompanied or otherwise. In the event of a member of staff or family member not being available to accompany the patient, we would expect to see that this

risk had been assessed and mitigated. We would also expect to see an audit trail of communication between the hospital and care home.

5. Overall the evidence revealed a very fragile system of communication between GP hospital and care home in circumstances in which the deceased had moved between three care homes in a short period of time.

As a result of the concerns being brought to our attention we have taken the opportunity to review how CQC checks that information about patients being transferred between services happens in a timely manner and whether there is any more we as a regulator can do to prevent an incident such as this from happening in future.

This has involved input from our Head of Primary Care and Community Services Policy, from our Medicines Optimisation team as well as specialised clinical input from our senior national GP advisor. We consider that our current inspection methodology covers the elements of care relevant to Mr Jacks' case. We feel that this is a very sad but also highly unusual event, but as a result of our analysis we are satisfied that no additional policy change from CQC is required at this point.

Yours sincerely,

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[redacted]
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