

Enquiries to Heidi Forster
Office Manager to the Chief Executive
Office Telephone 03033 303 918
Email Heidi.forster@nhs.net
Our reference PRR/hmf/18.146

Diana Princess of Wales Hospital
Scartho Road
GRIMSBY
North East Lincolnshire
DN33 2BA

17 October 2018

Switchboard 01472 874 111
Website www.nlg.nhs.uk

Sent by email:

MPs
OSCs
Healthwatch Chairs

Dear Colleague

I write to alert you to a recent issue which has been identified regarding a delay in the distribution of a number of discharge letters to GPs by the Trust and which is being investigated as a Serious Incident. The incident came to light on 25 September 2018, following receipt by the Trust of reports from some GP practices that they were not receiving discharge summaries. An initial investigation determined that letters were not automatically being transmitted due to a problem with the configuration of one of the two IT servers which manage the discharge letters. The interruption to the automated transmission caused a delay in receipt by 43 days. As this issue affected only 1 of 2 servers, GPs continued to receive some discharge letters during this period which in turn led to the incident not being identified immediately. Please be assured that the Trust has since reviewed its monitoring processes in order to avoid a repeat of this issue.

The problem with the system was rectified on 26 September 2018 and this triggered the system to send out electronically in bulk all the discharge letters which had not been sent at that point. This amounted to 4,584 letters in total, relating to patient discharges between 14 August and 26 September 2018. To put this in to context, the Trust sends out 1,800 per week.

Clinical review of all of the letters has identified that actions are required by GPs in 1,353 cases. The local CCGs are aware of and involved in the management of this issue. The Trust also wrote to each GP practice on 11 October 2018, apologising for the error and identifying all of their patients which have been impacted and which, of those, have letters requiring action.

The Trust is also writing to all affected patients on 17 October 2018, to apologise for the error and let them know their GP knows about the problem and is reviewing their ongoing care and treatment needs. The letter will include a helpline number for patients to ring if they have queries or concerns.

An investigation into the exact cause of the incident is underway. The Trust has also sought an external review of the processes and technology in place which support the issue of electronic discharge summaries. Any further required remedial actions will be taken once those processes are complete. Please be assured however that the Trust's discharge summary process is now working normally.

Further updates will be provided as the investigation progresses.

Yours sincerely

Dr Peter Reading
Chief Executive

