London Central & West
Unscheduled Care Collaborative

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25th April 2016

Coroner ME Hassell
Senior Coroner
Inner North London
St Pancras Coroner's Court
Camley Street
London N1C 4PP

Response to HM coroner in respect of regulation 28 (PFD report)

Dear Ms Hassell

Regulation 28: Prevention of Future Deaths report
Lisa Margaret DAY (died 12.09.15)

This response, on behalf of London Central and West Unscheduled Care Collaborative ('LCW UCC') in respect of the above, will address the following concerns put to the organisation in the PFD, namely:

1 a) When Ms Day's friend rang the 111 service on her behalf, the possibility of conveying her to hospital by means other than an ambulance was discussed with her and she declined.

However, it was not discussed with her friend who made the call. He would have been much better placed to organise this and, if he had, it would probably have resulted in life saving hospital treatment.

b) The potentially very grave consequences of a vomiting illness in a person with diabetes were not explained to him.

2. I heard at inquest that the 111 and 999 services have begun a process to promote more effective communication of 111 concerns to the London Ambulance Service ('LAS') in situations like this. It seems that this would be of great benefit to patients.

Local response

LCW UCC as a single provider of 111 services under licence have addressed these concerns in conjunction with the Pan London Integrated Urgent Care Group as any recommendation arising requires consideration for its impact across 111 providers as a system wide change to current practice.

Pan London Integrated Urgent care Group response

Role of group and context of response

LCW UCC is a licensed provider of 111 services and as such is required to comply with the NHS Pathways end user license. Any system-wide changes to 111 practice or systems including changes to standard practice, policy or training are therefore not within individual providers remit to change without the approval of the appropriate authority.

In response to this regulation 28 report issued to LCW UCC, one of the NHS 111 London providers, the response and recommendations arising have been considered and endorsed by the Pan London Urgent Care Group and therefore represents a consensus view of its membership comprising of providers, commissioners and representatives from Healthy London Partnership and the National 111 team at NHS England.

The Pan- London Integrated urgent care group met on the 15th March and the findings of the inquest touching the death of Ms Day were discussed. The issues discussed were specifically a review of the contact with London Ambulance service and 111 and the concerns put in this regulation 28 report further to the inquest.

Discussion and conclusion of the Pan London group

1. a) Alternate means of conveyance to hospital

Since September 2014, if an ambulance disposition is returned on the 111 system, other than a red one or two category requiring an 8 minute emergency response, NHS England has required that all 111 service providers undertake an enhanced clinical assessment by a NHS pathways trained clinician. This is usually either an experienced Paramedic or registered nurse who determines whether an ambulance is required or whether there is a safe alternative that can be recommended.

Staff undertaking this role need to identify clinical situations where an alternative means of conveyance may not be safe- either due to the severity of the patient's symptoms or where their circumstances do not allow an alternative to be a viable option.

On reviewing the assessment carried out on the severity of Ms Day's symptoms, the decision to dispatch a 30 minute ambulance was deemed appropriate and accorded with the NHS Pathways assessment processes.

At the time of the call, LAS reported a particularly high level of demand so the clinician who undertook the assessment and dispatched the ambulance contacted the ambulance service directly and did pass on her specific concerns re Ms Day's need for an ambulance transfer for emergency treatment.

Whilst the clinician had asked Ms Day about alternative means of getting to hospital which she declined, instead responding that she required an ambulance, this was not further discussed with Ms Day's friend who was making the call on her behalf.

It is acknowledged that this alternative means of conveyance if undertaken in Ms Day's case may have resulted in life saving hospital treatment and as a result the group representing all London 111 providers have agreed the following amendment to the memorandum of understanding in place between the providers and the London Ambulance Service:

All London 111 providers will at times of likely significant delay defined by London Ambulance Service as "Surge Purple" status or above will expect their clinicians carrying out assessments resulting in an ambulance emergency treatment and transfer disposition (requesting a 30 minutes response), to clearly notify the patient and the person calling on their behalf (if any) that there is likely to be a significant delay and to consider whether they would prefer to convey the patient to hospital themselves if they have the means to do so.

The risks of self transfer should be explained to the patient and the caller (if different). The decision to use alternative means of transport is that of the patient. Clinicians are to inform patients and callers to contact LAS for updates on the estimated time of arrival of the ambulance should they need to.

The clinicians in these circumstances are to reiterate the worsening instructions given to the patient and person calling on the patient's behalf.

b) Vomiting in a person with diabetes

The 111 clinician did not offer specific information to Ms Day's friend who was involved in the call process in relation to the significance of her symptoms of vomiting in type 1 diabetes. The clinician did give the recommended "worsening instructions", which must accompany any 111 call for the process to be deemed compliant.

Worsening instructions within NHS pathways are standardised and in normal operating conditions present on screen for the operator as "scripts" to select those that apply and read back to the caller.

Additional scripting of condition specific additional information specifically in relation to type 1 diabetes has been raised as a result of this concern with the National NHS Pathways team for their consideration and response as a result.

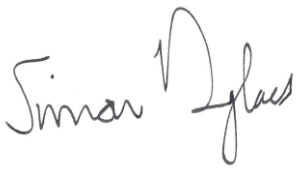
2. System wide changes implemented since inquest

The process whereby a direct call to the ambulance service to pass on specific concerns by the clinician dispatching the 30 minute ambulance in this case, did not lead to any additional prioritisation within the ambulance service system of queuing.

As a result of changes to internal processes in LAS, it is now the case that all clinical information of this nature passed over by phone following dispatch of a green category ambulance by 111 clinicians, will result in a priority being applied within the queue of LAS dispatch requests.

This process went live for all London 111 providers and LAS on Monday 14th March 2016. Please see the detailed response from LAS.

Yours sincerely



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Interim Medical Director