NHS England

Professor Sir Bruce Keogh
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Mrs Louise Hunt
Senior Coroner for Birmingham and Solihull
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Birmingham
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5th September 2016

Your ref: 113279 – SYDNEY MAY NEIL (LH/RP)

Dear Mrs Hunt,

Re: Regulation 28 - Sydney Mya Neil

Thank you for sharing a copy of your Regulation 28 report regarding the sad death of Sydney Mya Neil.

This was a tragic case of a young girl, suffering from severe brittle asthma, who suffered a severe exacerbation of her asthma at school. At the inquest, you determined that there was ineffective ventilation due to the lack of available oxygen and obstruction of her airways by vomit.

You have raised the following concern:-

1. The absence of either suction equipment or oxygen at Wychall Lane Surgery which led to inadequate ventilator support being given for 8 minutes pending arrival of the ambulance service and the level of expertise in GP practices when resuscitation is required and whether GP surgeries are adequately equipped to deal with emergency situations.

Background

Asthma UK and other sources, suggest that up to 5.4 million people in the UK are currently receiving treatment for asthma and it accounts for high numbers of consultations in primary care, out-of-hours services and hospital emergency departments.

During 2011–2, there were over 65,000 hospital admissions for asthma in the UK and whilst the number of deaths from asthma is falling, the number of reported asthma deaths in the UK remains amongst the highest in Europe

A National Review of Asthma Deaths (NRAD) was commissioned by the Healthcare Quality Improvement Partnership (HQIP) on behalf of NHS England, NHS Wales, the Health and Social Care division of the Scottish government, the Department of Health, and the Northern Ireland Department of Health, Social

Services and Public Safety (DHSSPS).

Its report 'Why asthma still kills' was published in May 2014.

Key recommendations included the following.

- Better education is needed so that doctors, nurses and other healthcare professionals are aware of factors that increase the risk of asthma attack and death.
- Every NHS hospital and general practice should have a designated, named clinical lead for asthma services, responsible for formal training in the management of acute asthma.
- Asthma patients prescribed more than 12 reliever inhalers in a year should have an urgent review of their asthma control.
- Follow-up arrangements should be made after every attendance at an emergency department for an asthma attack. After discharge from hospital for asthma, patients should be followed up in hospital outpatients.
- People with asthma should have a structured review by a doctor or an asthma nurse with specialist training at least once a year.
- People with asthma should be provided with a personal asthma action plan (PAAP). This is a written record of the discussion that a patient has with their GP or asthma nurse about their asthma care to help them manage the condition.

Guidance

In England, a structured approach to the management of asthma is supported by the Quality Outcome Framework, which incentivises practices to offer all patients diagnosed with asthma an annual review.

The current guidelines for optimising asthma management are the 2014 guidelines published by the British Thoracic Society (BTS) and Scottish Intercollegiate Guidelines Network (SIGN)

The '*British guidelines on the management of asthma*'[1] highlights the challenges of managing 'brittle' or 'difficult' asthma similar to Sydney's condition. The guidance recommends that patients with difficult asthma should be jointly managed with shared care arrangements between primary and secondary care. Patients should be managed by a 'personal asthma action plan' and as highlighted in the NRAD report, in the case of such brittle disease this should advise a patient in the event of an emergency situation to access secondary care services directly.

The BTS/SIGN guidelines concur with your findings that supplementary oxygen should be available in all health care settings including GP surgeries and states that in addition, nebulisers for giving nebulised B2 agonists bronchodilators should preferably be driven by oxygen.

[1] SIGN 141 British Guideline on the management of Asthma. October 2014

The Care Quality Commission (CQC) as the regulator of general practice needs to be assured that practices are able to immediately respond to the needs of a person who becomes seriously ill. The CQC does not have explicit guidance around emergency equipment; however does state that if the practice does not have oxygen they are unlikely to be able to demonstrate they are equipped for dealing with emergencies.[2]

In determining what equipment and training a general practice should have, the CQC will consider the individual circumstances of the practice such as the practice's ability to access emergency services in a timely manner. On this basis, unless a practice is based in a particularly remote or inaccessible location, practices should be able to rely on rapid access to emergency services when planning what equipment and training is appropriate to meet the needs of patients in primary care.

In relation to the requirement for suction facilities to facilitate ventilator support, I have sought the views of NHS England's National Clinical Directors. Whilst a number of practices will have some access to suction facilities, it was not felt that this should become a national requirement of primary care. BTS guidance highlights the risks associated with ventilatory support and non-invasive ventilation, (NIV) in severe asthma. It is the view of my Clinical Directors therefore better to target training in primary care on recognising an emerging emergency situation rather than to attempt to train and maintain skills in using suction equipment in challenging emergency situations. As a result, I do not feel it appropriate to mandate all general practices to purchase and maintain suction facilities which would necessarily include ensuring all relevant staff are appropriately trained.

Action

I agree that the key action that must arise from this tragic case is the need to ensure that the health service doesn't become complacent in its management of asthma. The NRAD published in May 2014 has highlighted 6 key recommendations which would make a difference to the numbers of people who die each year because of their asthma. These recommendations have informed the General practice Quality Outcome Framework, supporting individualised personal asthma plans for asthmatic patients. It is recognised however that we need to go further to embed these improvements into routine clinical practice.

The 2016 update to the BTS/SIGN asthma guidelines is due to be published in the Autumn and I will use this as an opportunity to raise awareness of asthma management in primary care. I will do this by communicating to all GP practices through our GP Bulletin. I also intend to share this with the CCGs who commission secondary care and emergency services.

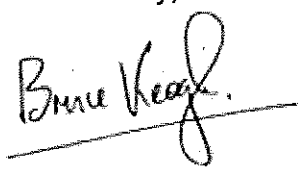
I have asked [redacted] Head of Primary Care Commissioning, NHS

[2] CQC has published agreed principles for defibrillators oxygen and oximeters and Cardiopulmonary Resuscitation in general practice.

England to write to Steve Field, CQC Chief Inspector for primary care, to ensure the CQC through its inspection regime, ensures that primary care services carry the necessary equipment and skills to address respiratory emergencies.

I hope the above has provided some reassurances that NHS England has taken your concern on board.

Yours sincerely,



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