North West Ambulance Service NHS
NHS Trust

OUR REF: [redacted]
YOUR REF:

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11th October 2016

Mr N L Rheinberg L.L.B L.L.M M.A. Dip Crim (Cantab)
Senior Coroner for Cheshire
West Annexe
Town Hall
Sankey Street
Warrington
WA1 1UH

Dear Mr Rheinberg

Prevention of future death report following inquest into the death of Joyce Mary Ravenhill

I write further to your letter dated 24th August in connection with the inquest into the death of Joyce Mary Ravenhill.

The incident in question occurred during the Christmas and New Year period 2015/2016. During that period the NHS 111 service received two calls from the daughter of Mrs Ravenhill, who was visiting her family in Macclesfield, Cheshire, having travelled from her home in Doncaster.

As a result of the first call, the assessment of the NHS 111 service was that Mrs Ravenhill should have a face to face consultation with a clinician from the local GP Out of Hours (OOH) service within 2 hours.

The OOH service in Macclesfield is operated by East Cheshire NHS Trust (ECT).

Where the NHS 111 patient assessment arrives at a primary care referral outcome, there are essentially two types of referral. These are 'speak to' and 'contact'. Each of these types will then have an associated time frame applied. 'Speak to' outcomes require the patient to have a contact call from the relevant primary care provider, to assess ongoing need. 'Contact' outcomes are required to receive a face to face clinical assessment.

In practice, across the North West, local GP OOH services have various commissioning arrangements in place, and may choose to manage the NHS 111 referrals differently. Many choose to reassess all patients by telephone, regardless of the initial NHS 111 recommendation. NWAS manages up to 2 million NHS 111 calls each year and we are cognisant of the variation of commissioned practice across the region.

The NWAS NHS 111 service and ECT, have an arrangement whereby the NHS 111 service assessment is accepted to have been sufficiently detailed to be considered a 'definitive clinical assessment'. ECT accept that the time frame for the next stage of care suggested by the NHS 111 assessment is correct, and have allowed the NHS 111 service access to their appointment booking system. The NHS 111 service therefore completes the patient assessment and if a 'contact' outcome is reached, offers the next available appointment time to the patient. If a 'speak to' outcome is reached, the patient is advised accordingly, and told to expect a call back from ECT.

In both cases, the full electronic record of the assessment is transferred from the NHS 111 service to the ECT OOH service, in order to inform the next stage of care.

This appointment booking arrangement is unique in the North West; all other OOH services have so far chosen not to offer NHS 111 booked appointments, though this position is expected to change with learning from experience in Eastern Cheshire.

Where a 'contact' appointment has not been available for booking, the agreed process is that the patient record should be sent electronically, and that the receiving staff at ECT should recognise from the call outcome summary that this is a 'contact' request and make arrangements to call the patient back and provide an appointment time. ECT has an ability to hold back a small number of appointments for this eventuality.

In this situation, the ECT referral system would receive the transferred information, and present the 'contact' referral alongside 'speak to' referrals for their action.

This arrangement has been in place for some time, and operated without incident, however the root cause analysis into Mrs Ravenhill's death identified that the actions of the ECT staff may have been affected as a result of not realising that this was a 'contact' request. The ECT clinician instead carried out a reassessment of the patient, and determined that a face to face assessment was not indicated.

In the inquest the you remarked that this inability to clearly see that the call was a 'contact' call rather than a 'speak to' call led the ECT clinician to perform this reassessment rather than simply offering a face to face appointment. Whilst NWAS would contend that the information was in fact available, we accept that further steps needed be taken to make the information clearer.

Actions taken

Following the initial request for information in support of the Inquest, NWAS carried out an assessment of our involvement in Mrs Ravenhill's care. In addition to the matter noted above, some further issues in the call were identified on the part of one of our clinicians in the NHS 111 service. NWAS reported the incident under its StEIS reporting procedure and carried out a full investigation.

A further full joint root cause analysis exercise was undertaken between NWAS and ECT.

Where the findings of both incidents related to individual staff failings in the NHS 111 service, these have been addressed through reflection and retraining, with staff removed from duty until the retraining and review were satisfactorily completed.

A clinical issue relating to the management of abdominal pain and vomiting blood was subsequently identified through the investigation into a different, unrelated incident. That issue was found to be common to this investigation and as a result has been reported to the national NHS Pathways authoring team. The NHS Pathways team has recognised the issues that we identified, and have agreed to review this assessment pathway, specifically the question and answer algorithms, in order to remove any potential for confusion and incorrect use.

Guidance has been issued to NWAS NHS 111 staff in the management of abdominal pain and vomiting, as an interim measure pending any national NHS Pathways redesign.

In terms of the specific issue raised relating to the visibility of calls where appointments could not be booked, actions have been taken by both NWAS and ECT in order to ensure that 'contact' outcomes requiring an appointment can be easily identified.

At NWAS a procedure has been applied for all staff to manually note where an appointment booking has been attempted, but found not to be possible.

Additionally, staff guidance has been issued at ECT to help them to navigate the NHS 111 electronic data that has been transferred between systems, again to ensure that there is no risk of misinterpretation of the information exchanged.

At ECT, technical changes have been designed on their IT infrastructure to highlight transferred records relating to failed appointment bookings. That change has been applied to their system, and fully tested. From now on, 'contact' outcomes with no available appointment will be clear to ECT staff, prompting them to take the appropriate action, and removing the risk identified at Inquest.

I hope that the content of this letter offers assurance that the matters associated with this tragic incident have been investigated, with lessons learned and actions taken to help to prevent a recurrence of not only this specific sequence of events, but from a wider perspective the way that all abdominal pain and vomiting is managed by the NHS 111 service and NHS Pathways.

If you have any further concerns or questions related to this incident, please do not hesitate to contact me

Yours sincerely

[redacted]

Regional Manager – North West NHS 111 Service Operations