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Assistant Coroner
South Yorkshire (West District)
Medico-Legal Centre
Watery St
Sheffield
S3 7ES

National Medical Director
Skipton House
80 London Road
London
SE1 6LH

4 June 2021

Dear Ms Combes,

Re: Regulation 28 Report to Prevent Future Deaths – Mr Thomas Rawnsley (4 February 2015)

Thank you for your Regulation 28 Report dated 9 December 2020, concerning the death of Mr Thomas Rawnsley on 4 February 2015. Firstly, I would like to express my deep condolences to Mr Rawnsley's family.

Secondly, I would like to apologise for the delay in response.

The regulation 28 report concludes Mr Rawnsley's death was "Natural Causes" and that Mr Rawnsley died as a result of

1a: Global hypoxic-ischaemic encephalopathy
1b: Cardio-respiratory arrest
1c: Chest infection
II: Down's Syndrome

Following the inquest, you raised concerns in your Regulation 28 Report to NHS England regarding

(1) Primary care are undertaking more and more virtual consultations with patients and the advice that is provided is inherently more risky over the phone with GPs not being in a strong position to assess the patients understanding of the advice that has been given in the same way as they can when the patient is sitting in front of them in the practice. This advice is not followed up in writing and therefore it may be misinterpreted or incorrectly passed from one care team to another in the event of someone, like Thomas, is having his care delivered by professional carers.

(2) There is a standard set of questions asked by the call handler on a 111 or 999 call which is not then replicated for clinicians who subsequently triage a patient. Without a standard set of initial questions asked it is entirely possible that clinicians will provide advice in isolation of other important matters. This could be

as simple as current medications that the patient routinely takes or current diagnosis the patient has which impact upon the advice to be provided. This may lead to incomplete or worse, inappropriate advice being given to patients during a clinical triage.

Point 3 of the Regulation 28 would be more appropriately answered by the Yorkshire Ambulance Service.

With regard to Point 1: NHS England and NHS Improvement (NHSE/I) understands the Coroner's concerns raised around consultations which are not undertaken in person, and we are assured that there are both new and established procedures in place to ensure that this is a safe practice. These are also supported by published guidance and training, which I aim to summarise below.

Telephone consultations have been in use in general practice for many decades to help patients access medical advice and care quickly and conveniently. Where studies have been conducted, telephone care has been shown to be safe. Telephone consulting is included as part of the general practice curriculum and training to support safe and effective practice.

It is clear the use of virtual consultations with patients and the delivery of NHS services remotely has progressed significantly and continues to evolve. The coronavirus (COVID-19) pandemic has brought about an unprecedented acceleration in the adoption of delivering NHS services remotely, and standard operating procedures have been produced to ensure general practice is able to operate safely in this context. These procedures make it clear that general practices and Primary Care Networks should triage patients remotely (determine the right person and timeframe for managing the problem) in advance wherever possible to help prioritise patient care based on needs; and that clinicians should determine the most appropriate consultation method with the patient - telephone, video, online, face to face. This should be determined by taking into consideration the patient's preferences, needs (including accessibility, privacy, capacity and communication requirements), clinical circumstances and currently, local risks of COVID-19.

In determining the most appropriate consultation method, considerations regarding patient safety, ability to make a satisfactory assessment, gain a sufficient understanding of the problem and whether information can be provided in a way the patient understands including assessing a patient's understanding of the advice provided should be factors in determining the most appropriate consultation method. Safety netting is a routine part of general practice consultations and explicitly sets out next steps to take for the patient in the event of a deterioration in their condition. The importance of these principles is emphasised in joint guidance between the Royal College of General Practitioners (RCG)P and NHS E/I (link is included later in my response).

If a particular concern did arise following a remote assessment or remote advice being given, then a decision could be made to move to an alternative approach, for example, face to face consultation or for remote advice to be followed up in writing or with the patient's permission with their carer.

Based on the clinical circumstance and considerations outlined above, many clinicians have used SMS and online messaging services that are now available in general practice to follow up a remote consultation with a patient with links to validated advice via NHS.UK, or attach information leaflets which patients can refer back to. Patients are also now able to request full access to their medical record which would enable them to refer back to previous consultations. The approach used would be expected to be tailored to the circumstance and individual patient needs taking into account the risk of information being "*misinterpreted or incorrectly passed from one care team to another in the event of someone, like Thomas, is having his care delivered by professional carers*".

Professional guidance published by the General Medical Council sets out high level principles of good practice expected of everyone when consulting and or prescribing remotely from the patient. https://www.gmc-uk.org/ethical-guidance/learning-materials/remote-prescribing-high-level-principles

Additionally, guidance has been developed jointly between NHS E/I and the Royal College of General Practitioners (RCGP) on Remote vs Face to Face: which to use and when?, Principles of safe video consulting in general practice during COVID 19 and RCGP - Top 10 tips for COVID-19 telephone consultations.

All these documents underline the importance of ensuring patient safety and that an individual's needs are paramount.

A further development since 2015 is the increased focus on improving how health services understand and respond to the needs of patients with learning disabilities and autism. The NHS E/I Long Term Plan highlights this as a priority and describes work being undertaken to implement national learning disability improvement standards for all services funded by the NHS. This includes, by 2023/24, a 'digital flag' in the patient record which will ensure staff know a patient has a learning disability or autism. The use of this 'digital flag' should further enable consideration of the needs of patient with regard to virtual or remote consultation.

In light of the above we consider it would be disproportionate to routinely require the provision of written follow up information following any and every remote consultation in primary care but that this should be based on clinical judgement.

In respect of Point 2: Turning to the recommendation on replicating the standard set of questions asked by 111 call handlers to clinicians subsequently involved, the current "standard set of questions" utilised in NHS 111 services is NHS Pathways. NHS Pathways is a series of questions, that assesses symptoms presented at the time of the call and identifies the appropriate next level of care.
NHS Pathways triage is built around a clinical hierarchy, meaning that life-threatening symptoms are assessed at the start of the call, triggering ambulance responses as necessary and progressing through to less urgent symptoms that require a less urgent clinical endpoint (or disposition).

Where a call is passed for further clinical assessment or consultation, all questions asked along with their response are shared with the receiving clinician to inform their subsequent assessment and decision-making.

If the case is subsequently passed to an NHS Pathways clinician, they would validate the information that has been shared and where necessary probe further if required to undertake a full assessment.

The process of validating the information from the initial call and probing further as necessary provides clinicians with the basis from which to seek information on other important matters which may impact on the advice to be provided.

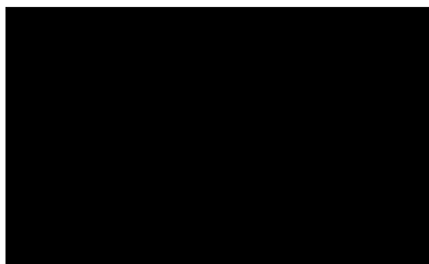
Some cases will be passed to a clinician within the Clinical Assessment Service (CAS), this will include those clinicians who formerly worked in organisations known as 'out of hours providers. These clinicians work within their professional competences and training and will use the usual medical model to assess patients. These clinicians will be subject to regular audit normally using the RCGP Urgent and emergency Care Toolkit.

There is also increasingly better sharing of patient records between clinicians working in different settings. Under a change in regulations (COPI - Control of Patient Information) for the coronavirus (COVID-19) pandemic to additional information in the summary care record and/or as part of a local shared care record GP OOH, NHS 111 and ambulance services are able to see, as a minimum, for direct care purposes, information such as details of long-term conditions, significant medical history, medications and allergies.

In light of this, we consider that replicating the standard set of questions asked by 111 call handlers to clinicians subsequently involved, would not improve the process which is in place, as described above.

Thank you for bringing these important patient safety issues to my attention and please do not hesitate to contact me should you need any further information.

Yours sincerely,



National Medical Director