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

8th February 2020

Dear Ms Hassell,

Re: Prevention of Future Deaths report – Shanté Andreé Marie Turay-Thomas

Thank you for your Regulation 28 Report to prevent future deaths, detailing your concerns arising from the inquest into the death of Miss Shanté Turay-Thomas.

I would like to assure you that all matters related to patient safety are taken extremely seriously by Advanced. We employ a highly skilled Clinical Team who ensure that we fully comply with the NHS requirements on clinical safety in the manufacture of software (DCB 0129).

Correction (section 18)

I would like to make a correction to section 18. The algorithms embedded into the Adastra application are the NHS Pathways 111 algorithms, and Advanced have no editorial control over the content of these algorithms. Thus your comments around the second administration of adrenaline need to be directed to the NHS Pathways team.

Errors made in collecting the address (section 14)

The Adastra application allows the collection of two address fields, a home address and a current location address. The home address is checked against the Personal Demographic Service (PDS), the national record of every patient's demographic information. This includes the patient's NHS number and registered General Practitioner's details.

The error made by the call handler was not in failing to untick the boxes, as they should have remained ticked to record the correct home address, but in realising this address was not the same as the current location of the patient. If the patient is not at the registered home address the current location address can be recorded, and this is where the ambulance will be sent if one is required. The Adastra application allows the address fields to be changed, but the system has to depend on the user ensuring the recorded address details are correct with the caller. It is important that the patient's registered home address is recorded as this allows access to the Summary Care Record (SCR) which will often provide information on allergies and drugs taken – which would have been very useful in this case. It also allows the post event message to be sent to the GP, who can then provide onward care where needed.

Access to the PDS was developed into Adastra in 2008 and there has been no changes to how this functionality works since. During that time, we estimate that over 100 million calls have been taken through Adastra, resulting in an estimated 12 million requests for ambulance despatch. The Adastra application sent the ambulance request to the correct address as displayed. There are already alerts in the application so that when performing a 111 assessment using the NHS Pathways algorithms, if a point is reached where an ambulance despatch is needed, the address is displayed in a pop up screen. The user must confirm with the caller that this is correct, before ticking to confirm the address is correct, to enable the electronic despatch request message to be sent. If the application cannot determine the correct ambulance service to send the case to, or if the address details are not sufficient or clear, a second pop up message is displayed. This pop up occupies almost the whole screen, and cannot be cleared from the screen, until the user has confirmed what actions they have taken to resolve the issue. These have been in the application from 2013 and were introduced to try and avoid this situation arising (ie ambulances being sent to the wrong address) when the functionality was designed.

This is the first time Advanced has been made aware of the scenario outlined in this case. This involved a second user being asked verbally by the call handler to contact the ambulance service and details from a different screen (that was not the screen in live use) were used. Within two-working days of being made aware of the scenario outlined in this case, Advanced issued a reminder to all call handlers not to manually circumvent the software process and this was followed by a software update being released to prevent this manual override re-occurring ie a message is displayed if a second user opens the same user case, warning them that the address details may be out of date. This was deployed to all customers.

Subsequently, and as a direct result of this case, we are currently making two changes to the Adastra application which are in development. These changes will ensure that the user will have to actively select, and tick, the address field that is required when there are differences between the locally recorded home address and the PDS registered home address. Also if any changes are made to the address during the course of the consultation they will be saved to the database immediately and will then be available contemporaneously to any other user, on any other screen. We anticipate these changes will be available to all Adastra customers by the end of April 2020.

I hope that these measures we are undertaking provide you with the appropriate level of assurance in relation to our commitment to clinical safety.

There are two further areas we would like you to consider:

Review of the NHS 111 Ambulance Request message

As part of his verbal statement to the inquest, Dr Alex Yeates spoke of the message structure used by Adastra and all ambulance system suppliers which was developed by the Health and Social Care Information Centre in 2013. This message structure works well and has been used by Adastra to request many millions of ambulances, but it could be improved. One of the issues raised at the inquest was that when LCW contacted the London Ambulance Service, they could not find the case on the ambulance system as they did not know the CAD reference number for it. It would also have been useful if there had been electronic updating of LCW to inform them that the initial Category II ambulance had been recalled. Advanced has spoken to several ambulance system suppliers and we are all happy to work with NHS Digital to develop this standard further, but it requires NHS Digital to lead.

Independent review of clinical triage systems

One of the points raised at the inquest was the inconsistency in categorisations between AMPDS used by the London Ambulance Service for their 999 calls, and the NHS Pathways clinical decision support triage system used by the 111 service. There are alternative clinical decision support triage systems in use within other urgent care settings. The recent Care Quality Commission recommendations published in their 'Getting to the right care in the right way – digital triage in health services' report, states that there should be a 'fair test of clinical performance of digital triage solutions'. We would like to see you recommend that this is carried out and conducted by an independent body and not NHS Digital, the providers of the NHS 111 Pathways system, as this could be seen as a conflict of interest.

Yours sincerely

Gordon Wilson
Chief Executive Officer > Advanced