Regulation 28 Report to prevent future deaths – Robert Gordon John Hogg

NHS Pathways Response

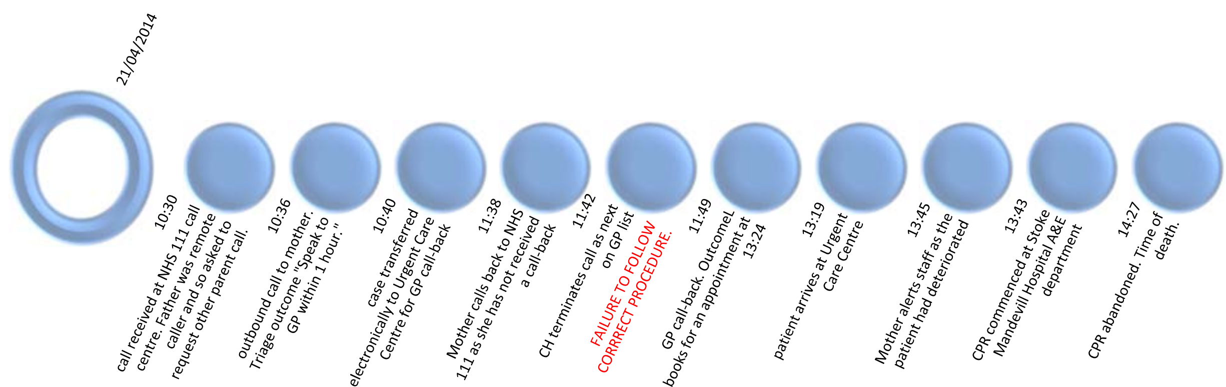
NHS Pathways Overview

NHS Pathways is the provider of the Clinical Decision Support System (CDSS) for six of the ten ambulance providers in England. In addition to this it is used in all NHS 111 sites. Use of this system is wrapped around by a comprehensive package of training and continuous quality assessments.

NHS Pathways clinical content, which comprises the hierarchical algorithmic questions presented to call takers, is continuously subject to review. Where there are grounds to amend the content NHS Pathways undertakes to make such amendments in good time and without increasing risk to patient assessment. It encourages sites to submit issues where they consider improvement could be made to the system. The NHS Pathways Clinical Author Team investigates these issues and makes any necessary changes. The changes within any particular timeframe are included in a single release. There are usually two releases per annum. This is because of the safety issues related to making patch updates without adequate testing or training.

Sequence of events

This case relates to calls handled by SCAS - the sequence of events is as follows:



The Incident Report and its Claims

The incident report referred to in the Coroner's ruling (IR 4865) states:

"The Call Handler did a thorough assessment using the NHS Pathways and came to an appropriate disposition for what symptoms were being described."

It is **difficult to understand**, therefore, **any basis for the** later **statement**:

"NHS Pathways toddler/child Pathways are not necessarily highlighting/picking up very sick children."

Furthermore, the statement:

"*This is not the first event relating to incidents involving toddlers/children and this has been highlighted through our own Pathways Lead to NHS Pathways for investigation."*

is in fact **incorrect** as no similar cases in this age category, toddler/child[1] have been highlighted to NHS Pathways for investigation by SCAS.

NHS Pathways Safety Record

NHS Pathways takes patient safety extremely seriously. The system supports the safe triage of approximately 1 million calls per month in the NHS 111 environment. There are a handful of cases, across all ages, where there have been adverse incidents. Indeed an internal NHS England document, *Learning from NHS 111 Related Serious Incidents – Childhood Sepsis,* states:

"The rate of reporting of clinical Serious Incidents is approximately 1 in 250,000 calls answered."

A search on the records by NHS 111 relating to childhood sepsis identified a total of twelve incidents in the 13 month period between March 2013 and May 2014, in a total of over 12 million calls assessed. The majority of these were related to operational matters outside of NHS Pathways clinical assessment of the child.

However as a learning system, and as a consequence of this document, NHS Pathways did amend the system, and is continuing to review the clinical content and architecture in regards to safe identification of cases of paediatric sepsis.

[1] Toddler encompasses ages 1 to 5 years, Child refers to patients aged 5 to 16 years.

Specifically, NHS Pathways added advice to regularly check on un-well children overnight and enhanced the training materials.

Assessment and Sorting in this Case

From the timeline above, and as is detailed in Suzanne Solera's report (IR 4865) the case was **appropriately assessed** at the time of the initial triage.

There was a **failure to follow correct procedure** in the later call logged at 11:42. This error is referred to in the report. Had the call been triaged, a different (higher) outcome may well have been reached if the patient had clinically deteriorated.

Speak to GP within 1 hour is an urgent primary care disposition in the NHS Pathways system. The reason for a "Speak to" rather than a "Contact" disposition is that the system determines that a high level of clinical expertise is required to determine the correct skill-set and timeframe required to respond to the patient's needs at the time of the call.

Allegations

1. **NHS Pathways toddler/child pathways are not necessarily highlighting/picking up very sick children.**

   There are no grounds for this claim either within the Incident Report submitted to the court, or by the weight of evidence of 12 cases, mainly associated with issues outside of the decision support system, in approximately 12 million calls handled in 2013-14.

2. **This is not the first event relating to incidents involving toddlers/children and this has been highlighted through our own Pathways Lead to NHS Pathways for investigation.**

   No similar related cases have been notified to NHS Pathways by SCAS.

Further Actions

1. **Matters to be struck from the record**

   It should be considered that **the allegations made be struck from the record** as they are misleading and not an accurate representation of the facts as found by the investigation at site.

2. **Seeking adjournment**

NHS Pathways would seek that in similar cases, where NHS Pathways CDSS is alleged to be attributable, that they have adequate opportunity to be held accountable and answer directly to the Court. In this case we consider it a grave error if the patient's family have been led to believe that the NHS Pathways system is in any way attributable for this, or any other similar death. Since the NHS Pathways system is publically owned, it is incumbent upon us to hold its leaders to account when required, but also to uphold its reputation where necessary.

3. **Working with SCAS**

NHS Pathways are liaising directly with SCAS to better understand why these allegations may have been made. From initial enquiries, it seems that the views expressed in court are not consistent with those of the senior clinical leadership of SCAS.