Department of Health & Social Care

Steve Barclay MP
Minister of State for Health

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Mr Simon Nelson
HM Assistant Coroner, Manchester West
HM Coroner's Court
Paderborn House
Howell Croft North
Bolton BL1 1QY

Dear Mr Nelson

Thank you for your letter of 26 June to the Secretary of State for Health and Social Care about the death of Ms Angela Marion Turner. I am responding as Minister with portfolio responsibility for urgent and emergency care.

I was extremely saddened to read of the circumstances surrounding Ms Turner's death. If you have the opportunity, please convey my deepest sympathies to her family. I appreciate this must be a very difficult time for them, particularly given the serious concerns about the standard of care Ms Turner received.

Patients have a right to expect the very highest standard of care from the NHS. I would like to say how sorry I am that it appears that did not happen in this case.

Your report raises two areas of concern that I would like to address. The first around the NHS 111 service and the second about the treatment and care Ms Turner received at the Leigh Walk-in Centre.

My officials have made enquiries with the North West Ambulance Service NHS Trust (NWAS) which provides the NHS 111 service in the North West area. I understand that NWAS was not represented at the inquest. However, it is now conducting a full, comprehensive investigation into the incident and the concerns you have raised. The investigation is currently ongoing and you will appreciate that I am not in a position to comment any further.

However, I am aware that NWAS is experiencing challenges in performance and has developed a performance improvement plan that is being monitored closely by commissioners and NHS Improvement. Issues around the operation of the NHS 111 service are acknowledged, including the timeliness of response, and the Trust is taking steps to improve quality.

NWAS was inspected in June 2018 by the Care Quality Commission and publication of the report is awaited. With regard to the NHS 111 service generally, during last winter the NHS 111 service dealt with a record 1.5 million calls per month, 150,000 more per month than the winter before, and during 2017-18 as a whole answered over 15 million calls, the majority of which in less than a minute.

NHS England is looking to develop NHS 111 so that it becomes an integrated urgent care service – the "front door" to advice, assessment and treatment, with a range of clinical professionals such as paramedics, nurses with specialist experience, mental health professionals, pharmacists, dental professionals and senior doctors available to speak to callers who need it. By increasing clinical input into calls, NHS 111 aims to provide a 'consult and complete' model. It will still be appropriate in many cases to refer to other services including primary care, pharmacy and A&E but this will get people the right help they need.

NHS England plan that by March 2019 it will be possible to book all patients who call NHS 111 out of hours directly into further appointments, if required, with 30 per cent of patients able to book appointments in hours. It will also be possible for more people to be offered a prescription by the NHS 111 service.

Turning to the care and treatment provided to Ms Turner at the Leigh Walk-in Centre, I am advised that the Bridgewater Community Healthcare NHS Foundation Trust has conducted an investigation into the serious incident, overseen by the Wigan Clinical Commissioning Group (CCG).

Learning lessons where things have gone wrong is essential to ensuring the NHS provides safe, high quality care and I expect the NHS locally to ensure that recommendations are acted upon.

I understand there is work locally to review the resilience of the Walk-in Centre service within the urgent care system to ensure that the NHS can provide a high quality, timely service. These are matters for local determination.

One of the aims of NHS England's Urgent and Emergency Care review[1] is to make access to urgent and emergency services clearer for patients and to remove the confusing mix of walk-in centres, minor injuries units and urgent care centres, in addition to numerous GP health centres and surgeries offering varied levels of core and extended service.

To address this, new urgent treatment centres are being introduced which will standardise this range of options and simplify the system so patients know where to go and have clarity of which services are on offer. NHS England has set out a core set of standards for urgent treatment centres to establish as much commonality as possible. Patients and the public can expect to:

- be able to access urgent treatment centres that are open at least 12 hours a day, GP-led, staffed by GPs, nurses and other clinicians, with access to simple diagnostics, e.g. urinalysis, ECG and in some cases X-ray;
- have a consistent route to access urgent appointments offered within four hours and booked through NHS 111, ambulance services and general practice. A walk-in access option will also be retained;
- increasingly be able to access routine and same-day appointments, and out-of-hours general practice, for both urgent and routine appointments, at the same facility, where geographically appropriate; and
- know that the urgent treatment centre is part of locally integrated urgent and emergency care services working in conjunction with the ambulance service, NHS 111, local GPs, hospital A&E services and other local providers.

I hope this information is helpful. Thank you for bringing your concerns to our attention.

Yours sincerely

STEVE BARCLAY

[1] https://www.england.nhs.uk/urgent-emergency-care/