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Mr Kevin McLoughlin
Senior Coroner for West Yorkshire (East)
HM Coroner's Court
71 Northgate
Wakefield
WF1 3BS

[redacted]

4 February 2022

Dear Mr McLoughlin

I am writing to you in response to your Regulation 28 report dated 3 December 2021, following the inquest into the death of Alexander Theodossiadis, which you conducted over the course of two days on 17 and 30 November 2021.

First, and on behalf of all the staff at One Medical Group, I would like to express my deepest condolences to Alex's family. It was clear from all that was said at the inquest that Alex was a kind, creative individual with a bright future in the music industry ahead of him, and that he was well-loved by many friends and family. We were all deeply saddened by his tragic death.

Your report raises two matters that cause you concern and I shall take each in turn.

(1) The Inquest heard evidence that when Mr Theodossiadis sought an appointment with a GP he was only able to get one in three weeks' time. He did not venture any details of his symptoms. Nor, however, did the GP's receptionist probe to obtain any information which would help to assess the urgency of the situation or the priority to be given to his request. Within six days of this telephone call, Mr Theodossiadis was irretrievably overwhelmed with a meningitis infection.

One Medical Group appreciates that it can be difficult for individuals to navigate health services to secure appropriate assistance, particularly in the case of a usually young and fit man who hasn't had previous contact with health services, and who is new to a geographical area. One Medical Group notes that you heard evidence that Alex had not previously had cause to interact with health services as an adult, and that when he registered with the GP practice on 16 January 2020 he had likely not been registered with a GP for some years before then.

You were provided with a transcript of the telephone call with the GP receptionist on Monday 20 January 2020 and heard evidence that Alex was advised that urgent appointments were made available at 08:00 each morning if required. Alex was therefore provided with appropriate advice in order to secure an urgent appointment should he have felt this was necessary. You found that there was no reliable evidence that Alex made any further efforts to secure an appointment with a GP after this time until he attended the Walk in Centre at 8am on Friday 24 January 2020.

You heard evidence from [redacted], Head of Patient Safety and Quality, that she had listened to the recording of the call between Alex and the GP receptionist and that it was a "*very*

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friendly" conversation in which Alex did not convey any urgency about the need for an appointment. This is consistent with your finding that, at the point Alex spoke to the GP receptionist, all involved (including Alex) felt he was suffering from flu like symptoms and did not consider it necessary to press the GP for an urgent appointment or to take him elsewhere to be cared for. On the balance of probabilities, therefore had the receptionist probed to obtain further information she would likely have concluded that Alex did not require an urgent appointment.

You heard evidence from various medical practitioners that meningitis can appear very swiftly; "*within hours*" and you accepted that, on the balance of probabilities, Alex was not displaying any relevant meningitis symptoms other than a headache when he was reviewed by ANP [redacted] at 8am on Friday 24 January 2021. It is therefore unlikely that Alex was suffering any red flag symptoms four days earlier, on 20 January 2021, when he spoke to the GP receptionist. It is likely therefore that further probing by the GP receptionist would not have resulted in Alex reporting symptoms that would have necessitated an urgent appointment.

When One Medical Group heard of Alex's death, it investigated Alex's contacts with the service and immediately recognised that its GP receptionist should have asked for more information regarding the need for the appointment in accordance with One Medical Group's protocol. One Medical Group apologised to Alex's family that this did not happen.

The receptionist was no longer employed by One Medical Group and so we were unable to ascertain why she failed to probe on this occasion. She was trained to do so (please see below) and the expectation of the organisation was that she would question every patient regarding their need for an appointment. We are regretfully unable to say why this did not happen on this occasion.

One Medical Group takes its learning obligations extremely seriously and you heard evidence from [redacted] that, since Alex's death, refresher red flag training has been undertaken with all GP receptionists and non-clinical staff. In addition, an audit of telephone calls to the GP Practice was undertaken from September – November 2021. This audit found that all calls were handled in a friendly and professional manner, and reception staff asked appropriate questions to ascertain the urgency of the appointment i.e. appropriate probing occurred. You also heard evidence from [redacted] that in mid-2020 more receptionists were employed by the GP practice in order to cope with pandemic-related additional demand and the intention is for these employees to remain in their role post-pandemic.

(2) GP receptionists must strike a difficult balance between respecting medical confidence and obtaining sufficient information to enable a judgement to be made in relation to access to medical help. In the case of fast-moving medical conditions such as meningitis afflicting otherwise healthy young people the Inquest heard concerns that refresher training was regularly required but may not be provided with sufficient frequency to maintain vigilance at this important interface between patients and clinicians.

OneMedical Group has no recollection of any concerns being raised at the Inquest regarding the frequency with which refresher training (either specifically for sepsis and meningitis, or training in general) was provided to non-clinical staff. Had this issue been raised, [redacted] would have been able to provide additional evidence. In any event, we are able to respond as follows:

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No regulator or advisory body provides guidance on the content or frequency of mandatory training for GP receptionists or non-clinical staff (or indeed for any member of a GP Practice administrative team). As noted by the CQC: "*ultimately, the practice is responsible for determining what mandatory and additional training staff need and how this is delivered*".[1]

One Medical Group is acutely aware of the importance of appropriate training and has implemented a rigorous training programme. As explained in the letter dated 13 August 2020 from [redacted], Director of Professions at One Medical Group (pages A.95 – A.98 of the inquest bundle), NHS England identified in the 2016 'GP Forward View' Guidance[2] that training for reception and non-clinical staff was a "high impact" action. As a result of this 2016 Guidance, One Medical Group developed and implemented bespoke training for its reception and non-clinical staff.

Staff training is a key line of enquiry considered by the CQC during any inspection and it is of note that during their most recent inspection of the GP Practice (15 February 2019) the CQC found[3]:

1. "*All staff received up-to-date safeguarding and safety training appropriate to their role. They knew how to identify and report concerns.*"

2. "*There was an effective induction system for temporary staff tailored to their role. This included a mandatory three-day corporate induction prior to starting with the organisation. The corporate induction covered all mandatory training including basic life support.*"

3. "*Staff were suitably trained in emergency procedures.*"

4. "*The practice understood the learning needs of staff and provided protected time and training to meet them. Up-to-date records of skills, qualifications and training were maintained. Staff were encouraged and given opportunities to develop. At the time of our inspection a number of staff were being supported by the practice to complete additional training.*"

5. "*The practice provided staff with ongoing support. There was an induction programme for new staff. This included a mandatory three-day corporate induction prior to starting with the organisation. The corporate induction covered all mandatory training including basic life support.*"

6. "*The practice had plans in place and had trained staff for major incidents.*"

[1] https://www.cqc.org.uk/guidance-providers/gps/gp-mythbuster-70-mandatory-training-considerations-general-practice
[2] https://www.england.nhs.uk/wp-content/uploads/2016/04/gpfv.pdf
[3] https://api.cqc.org.uk/public/v1/reports/5b8d65d6-1ab9-495a-a0ae-42378bc9be86?20210116092739

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The CQC report also contained a quote from a patient commenting that "*The reception staff are great and welcoming and very approachable*".

You heard evidence from [redacted] that GP receptionists and non-clinical staff have "red flag" training whereby they must demonstrate knowledge of various "red flag" symptoms necessitating further follow up. [redacted] provided the example that if a patient mentioned chest pain then a receptionist is trained to get immediate advice from a clinician and then advise the patient to call 999 or to attend the GP practice urgently (depending on the clinician's preliminary view). You also heard evidence that GP receptionists and non-clinical staff are trained to identify vulnerable patients who may struggle to convey their symptoms and [redacted] provided the example of a patient with dementia requiring additional assistance.

[redacted] told you that the training provided is interactive and contains lots of scenarios. In the letter dated 13 August 2020 from [redacted], it was explained that the training includes group discussions, case-based reviews, PowerPoint presentations and short educational video clips. Staff understanding is reviewed through an assessment following the training session. If a staff member failed to show sufficient understanding, they would be required to re-attend the training. You were provided with a copy of the training presentation and assessment sheets for both red flags and sepsis recognition for non-clinical staff. The final slide of the training presentation (at page A.111 of the bundle) is as follows:

> "- *What should you do if you suspect a patient has sepsis?*
>
> *YOU MUST BOOK THE PATIENT TO BE SEEN BY A CLINICAN AS SOON AS POSSIBLE (TODAY!!) AND INFORM THE CLINICAL TEAM IMMEDIATELY*
>
> *HOWEVER, IF THE PATIENT REPORTS ANY OF THE FOLLOWING – YOU MUST CALL AN AMBULANCE…*
>
> *- CHEST PAIN / IRREGULAR HEART BEAT*
>
> *- DIFFICULTY BREATHING*
>
> *- SOMEONE TELLS YOU THE PATIENT IS CONFUSED (AND ISN'T USUALLY) OR IS DIFFICULT TO WAKE*
>
> *Always speak to a clinician if you are unsure……!*"

It is therefore apparent that, during the training, significant emphasis is placed on the relevant red flag symptoms for meningitis and other conditions and that non-clinical staff are required to err on the side of caution if they have any concerns. One Medical Group considers the training is comprehensive and thorough and notes that no concerns have been raised about the content of the training provided.

You heard evidence that the training for non-clinical staff is refreshed on an annual basis and One Medical Group strongly disagrees with your suggestion in the PFD Report that refresher training was not provided with sufficient frequency to maintain vigilance. As stated above, there is no CQC or any

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other guidance on the frequency of training for GP receptionists and non-clinical staff, however it is of note that Practice Index, the UK's leading provider of support and services to GP Practice Managers, recommends that sepsis training is undertaken annually for all staff[4]. Indeed, of the 18 different training areas identified by this organisation for all GP members of staff, no one area is recommended to be repeated more frequently than annually. One Medical Group therefore has no doubt that the frequency of training of non-clinical staff is appropriate and in line with GP practices across the country.

The receptionist who took Alex's call had received sepsis training six months before taking Alex's call. She had demonstrated a high level of understanding of the training and increased frequency of training is unlikely to have resulted in the receptionist having had any more recent training prior to the relevant date. One Medical Group believes that the receptionist's failure to probe on this occasion was likely an isolated circumstance and, as set out above, audits have shown that this is not a recurring issue. The annual training provided to reception staff emphasises the need to elicit information from all patients in order to establish the urgency of their need for an appointment.

I would like to take the opportunity to assure you, and Alex's family, that One Medical Group seeks to learn from all untoward incidents and absolutely recognises that Alex's death was the most serious type of such incidents. As outlined in the evidence of [redacted] during the inquest, One Medical Group has already taken learning from Alex's extremely sad death and will continue to do so. Again, I send my deepest condolences to Alex's family.

Yours sincerely

[redacted]
CEO, OneMedical Group

[4] https://practiceindex.co.uk/gp/blog/mandatory-training-requirements-what-when-and-who/