Ranworth Medical Group

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[redacted]

To HMC Assistant Coroner Ms Jeane Rosa Mellani

[redacted]

Dear Ms Mellani

This is the Clacton Community Practices' ("the Practice") response to your Rule 28 Prevention of Future Deaths report issued on 19 June 2023 in relation to Christine Margaret Cumbers – date of death 22 April 2022.

We have read your report made in accordance with paragraph 7 of Schedule 5 to the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroner's (Investigation). Rules 2013.

We have also read the Coroner's concerns regarding a lack of implementation of learnings, in particular, no detailed plans or timescales, for addressing the shortcomings identified in our Significant Event Analysis ("SEA")

The shortcomings you have identified in the Practice or the Practice's SEA are:

1. A lack of follow up following the failed home visit on 24 March 2022
2. The consultation on 28 March did not meet the required standards and the management plan was incorrect.

The Practice's answers to the identified shortcomings are as follows:

1. Failed Visits

It is customary for the CCP to contact patients with failed visits within 24 hours. This happened in the case of Mrs Cumbers, as a doctor contacted her on two separate occasions on 25 March 2022. We note that Mrs Cumbers did contact the surgery on 24 March, a few hours after the failed pre-arranged visit. We consider that, whilst it would have been the gold standard for a health care professional (HCP) to be able to speak to Mrs Cumbers directly when she rang to explain why the doctor had failed to gain entry, it was entirely reasonable for Mrs Cumbers to be advised by a non-clinical member of staff at that time, following a clinician's risk assessment. Such risk assessments are always HCP dependent and include factors such as:

· reason for visit
· living arrangements i.e. does the patient live alone
· past medical history
· carer support etc.

The SEA document intended to highlight the inability to guarantee a clinician will be available at every contact a patient makes with the CCP in such circumstances. Consequently, as a practice we believe it is safe for a person to receive signposting / safety netting from member of staff trained in care navigation (similar to all 111 hubs nationally) under the supervision of a clinician following their risk assessment. As this is what happened in Mrs Cumbers case, the CCP does not believe any further action is necessary.

2. Consultation Standard

A serious event analysis (SEA) on Mrs Cumbers identified a consultation which fell below expected standard. Had this not been the case, it could have led to her being admitted 24 hours earlier. This raised a concern, even if this did not contribute to her death. It is customary to address such concerns, which relate to an individual's sub-standard interaction with the relevant clinician in first instance by way of refresher training and reflection in order to minimise recurrence.

As there was no identified systemic failure, the Practice addressed the concern identified in the SEA as described above (with the individual clinician involved) as well as disseminating learning at a practice meeting on 9/8/22 in an anonymous manner, to promote reporting. This said, the Practice also strives to go beyond what is common practice and this is the reason why we decided to audit consultations retrospectively to essentially promote reflection and improve patient care.

We can confirm this was completed ahead of schedule on 31/7/23. As detailed in the SEA, it was agreed that every clinician would have at the very least one consultation audited against a known criteria (NHSE audit XL template) once a year and their result sent to them to be discussed with their appraiser. Appraisals are held yearly and are a means to help clinicians reflect on their practice to assure they continue to meet GMC standards. Hence this kind of sporadic monitoring (not mandated anywhere in the country) can never be a valid substitute nor give assurance on overall performance of a given clinician but is rather a quality improving exercise.

We hope this fully addresses the Coroner's concerns, but please do hesitate to contact us if you require any further information.

Yours sincerely

Clacton Community Practices.