NHS

MAYLANDS HEALTHCARE

300 UPPER RAINHAM ROAD, HORNCHURCH, ESSEX, RM12 4EQ

[redacted] [redacted]

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Maylands Healthcare

Response to Regulation 28: Report to Prevent Future Deaths - dated 16 May 2023

For the attention of HM Senior Coroner - Mr Graham Irvine

13 June 2023

Dear Mr Irvine

I am writing in reply to the Regulation 28: Report to Prevent Future deaths, dated 16 May 2023. Within section 5 you have stated the following,

Coroner's Concerns
During the course of the inquest the evidence revealed matters giving rise to concern. In my opinion there is a risk that future deaths could occur unless action is taken. In the circumstances it is my statutory duty to report to you.

The MATTERS OF CONCERN are as follows -

1. Delay in the provision of emergency response by the 111-service due to a chronic insufficiency of resource.

2. The absence of a facility in the 111 computer system to allow advisers from different organisations to review notes made by predecessors.

3. The inadequate pathway of communication between the 111 service and the patient's GP

a. [redacted] clinical advisor did not have a functioning smart card that would allow both; review of the GP's records and the ability to book specifically reserved GP appointment slots.

b. The only route for communication between 111 and the GP were letters sent electronically.

c. The letters were not streamed for urgency by the GP surgery - meaning that the GP could not discriminate those letters that provided a specific instruction for action and those that did not require action. In this case there was a seven-day delay between the letter arising at the surgery and it being considered by a GP.

We were saddened to have learnt of the death of Mrs Houghton and would like to take this opportunity to once again express our sincere condolences to the family and friends of Mrs Houghton on their loss. We have taken this matter extremely seriously and had commenced actions before the Regulation 28 Report was issued.

For the assistance of the Coroner, we attach the following documents,

- Statement of [redacted] dated 20 September 2022;
- Significant Event Analysis Form dated 4 May 2022 and updated 29 June 2022;
- Statement of [redacted] dated 27 July 2023;
- Maylands business continuity plan;
- Audits of NHS 111 letters coming into Maylands;
- Response from Maylands to the Coroner following the conclusion of the Inquest dated 5 May 2023.

As the Coroner will no doubt appreciate the concerns relating to the resourcing, delays and the absence of a facility in the NHS 111 service to allow advisers from different organisations to review notes made by predecessors as set out in points 1 and 2 are not a matter on which Maylands Healthcare can take action. A GP Practice such as Maylands has no administrative rights to the controls or settings of the IT systems used by the Surgery to communicate with NHS 111. We infer from the other organisations mentioned in the Regulation 28 Report that these concerns are addressed to them.

We therefore have confined ourselves to responding specifically to point 3 and the concerns over the inadequate pathway of communication between NHS 111 and the patient's GP.

It may be of assistance at this stage to once again explain the communication pathway between NHS 111 and a GP Surgery, as Maylands Healthcare understand it to be, both at the time prior to Ms Houghton's death and after.

During normal surgery hours, (which are Monday to Friday between 8am and 6.30pm), there are a number of ways in which the Practice can be contacted by an external organisation such as NHS 111. NHS 111 can contact the surgery by phone. In addition to the normal surgery telephone number, there is also a bypass number.

The bypass number is separate to the patient line and the telephone is situated on the senior receptionist desk. The bypass line is designed to avoid telephone queues and is available to NHS 111. Had NHS 111 contacted the surgery by phone, Maylands would have been able to facilitate an urgent review as they have the necessary mechanisms in place. This number is frequently utilised by London Ambulance Service when they are visiting patients at home and require further service. It is also used by the Laboratory at the Acute Trust when they have urgent blood test results or x-rays reports which they wish to communicate with us.

Unique to NHS 111 is the ability to directly book into the doctor's appointment system. NHS 111 can directly book appointments into the GP Surgeries on the designated NHS 111 slot for GP appointments. Maylands offer 5 appointments per day (this is based on an NHS requirement to offer one appointment per 3000 list size) dedicated to NHS 111. No other provider has this ability to book appointments directly into our system.

Outside of opening hours, there are two pathways of communication between NHS 111 and Maylands surgery. There is the online booking system as described above. This is the safest method as the appointment is booked direct and there is no delay in attending the patient via appointment. There is also the option of sending an NHS 111 letter which is received via email. Maylands have since this incident taken active steps to ensure that all NHS 111 letters are reviewed by a clinician within 24 working hours. (Full details to be provided below)

There are various other options and pathways available out of hours to NHS 111 to manage patients for whom there is an immediate concern such as,

1. Extended Hubs;
2. Urgent Care Centre;
3. Accident & Emergency.

I am afraid Maylands Healthcare cannot explain or account for why the NHS 111 clinical advisor did not have a functioning smart card so that they could review the GP records and book specifically reserved GP appointment slots.

Nevertheless, Maylands Healthcare acknowledge that there was a regrettable delay in the NHS 111 letters being sent to the Surgery and being reviewed by a GP.

Maylands undertook a full audit of the NHS 111 letters created and sent to the Surgery in respect of Mrs Houghton, as part of the Significant Event Analysis ("SEA"). The Coroner is referred to the statement of [redacted] in which he confirms that he spoke to [redacted], EMIS Computer Record System Trainer, employed by Havering Health. [redacted] undertook a full audit trail on the NHS 111 reports dated 12 and 13 April 2022. Within [redacted] statement he explained as follows,

> The first NHS 111 document, created on 12/04/2022 at 17:55, came as an inbound document into the GP practice document system. As per the audit trail, this document was opened and filed on 14/04/2022 at 13:47 by the surgery Senior Receptionist.

[redacted]

The second NHS 111 document arrived on 12/04/2022 at 18:59 into the system, was opened by the senior receptionist on 14/04/2022 at 13:49, and was sent to [redacted] document system. [redacted], another GP at the surgery, reviewed the document on 20/04/2022 at 09:21.

The third NHS 111 document arrived on 13/04/2022 at 11:04, was opened by our Senior Receptionist on 19/04/2022 at 16:43, and was sent to my documents on 19/04/2022. 1 opened the document on 19/04/2022 at 16:53 and noted that the summary of the last 10 consultations were sent to the Coroner on the same day, following the death of Mrs Houghton on 14/04/2022.

Prior to this incident, the procedure for ensuring a GP review of NHS 111 letters was as follows. NHS 111 letters coming into the surgery were to be opened daily by the Senior Receptionist. The Senior Receptionist would review the letters and if no action is required the document would be filed. If action was required, the letter would be sent to the Duty Doctor at the surgery to ensure a full clinical review and any required actions were completed as soon as possible.

As [redacted] explained, during the first two weeks of April 2022, two of the receptionist staff, including the Senior Receptionist were on sick leave with COVID-19. The Senior Receptionist who manages the documents every day was on sick leave from 4 April 2022 to 12 April 2022. Consequently, there was a regrettable delay in opening the documents. The NHS 111 letters sent on 12 April 2022 were not opened until 14 April 2022. Due to the Easter Bank Holiday period (15 April 2022 - 18 April 2022), the document sent on 13 April 2022 was not opened until 19 April 2022.

In respect of the first NHS 111 letter opened by the Senior Receptionist this was filed as there was no action required. In respect of the second NHS 111 letter the Senior Receptionist had sent this letter to a GP for review on 14 April 2022. This was reviewed by [redacted] on 20 April 2022. [redacted] was on call on 14 April 2022 and reviewed the letter on his first day returning from the Easter Bank Holiday period. Whilst it is right to say there was a seven-calendar day delay, in fact the Surgery was closed for the Easter Bank Holiday for four days over that period. There was in reality only a three-working day delay between the opening of the letter, and it being reviewed by a GP. This is despite the absence of the Senior Receptionist and the exceptionally busy time of year.

The first day back after a Bank Holiday weekend is one of the busiest days in the Surgery. The Easter Bank Holiday weekend is in fact the busiest time of year as the Surgery was closed for four consecutive days.

The letter reviewed by [redacted] stated, “to contact primary care service within 24 hours was considered appropriate” and “will arrange GP review”.

As there was evidence of triage already undertaken by NHS 111 which had been actioned, the document is likely to have been filed, had it been seen on the day it had arrived at the surgery. Notwithstanding this Maylands fully acknowledge that the letters were not reviewed in a timely fashion and have taken action to ensure that it does not happen again.

The NHS 111 letter sent on 13 April 2022 was opened by the Senior Receptionist on 19 April 2022 and sent to GP for review. [redacted] reviewed the letter on the same day. [redacted] noted the details of the last consultations with Mrs Houghton and could see that all required information had already been sent to the Coroner that day, following the death of Mrs Houghton on 14 April 2022.

These are the actions and details of plans to take forward.

A SEA was carried out by the Practice on 4 May 2022. Whilst the process for opening and arranging a clinical review of NHS 111 letters ordinarily worked well, it was identified that there was room for improvement. Changes were therefore implemented to ensure a tightening and improvement of the process.

It was recognised that all NHS 111 documents needed to be opened daily, triaged and given to clinicians to carry out any necessary action. The Senior Receptionist is required to open all NHS 111 documents on the day they are received. All NHS 111 reports that come into the Practice are now forwarded to the on-call GP for review on the day they are received. The on-call GP has dedicated time during the day to review all communications that come into the surgery including NHS 111 letters.

Maylands has produced a business continuity plan which deals with staff cover at reception during unprecedented times of absence. In the event of significant numbers of staff unable to come into work due to illness, testing positive for Covid-19, weather, etc, members of staff from other areas of Practice administration teams would be asked to step-in and provide cover for the essential areas of work within the Reception Area, in no particular order as follows:

- Doctors' Assistants
- Other Admin Staff
- Managers

A key requirement should the Senior Receptionist be absent is that NHS 111 letters continue to be opened daily by other Members of staff as outlined above and forwarded to the on-call GP for review.

Maylands have been doing weekly audits since the end of September 2022, to see if any NHS 111 reports have not been dealt with since the new system began. The audits confirm that all reports have been dealt with in a timely manner (within 24 working hours) and that the unacceptable delay in reviewing NHS 111 letters as happened in the case of Mrs Houghton has not been repeated.

[redacted]

Maylands also met with NHS 111 on 26 May 2023 to discuss potential improvements in the line of communication between NHS 111 and a GP Surgery. Maylands has suggested that the pro format nature of the NHS 111 letters could be improved by making it clear what if any action is required from the GP. The letters as drafted now contain a large amount of pro format information which is not always relevant to the necessary actions required from the GP. Maylands will continue to work with NHS 111 to develop potential improvements in the communication pathways.

Maylands wish to apologise again for the delay in reviewing the NHS 111 correspondence in the case of Mrs Houghton. Maylands is fully committed to openness and promoting a learning and improving culture. Maylands always accepts that there are improvements to be made and they will actively engage with these. Going forward it is the intention of Maylands to continue to conduct audits of NHS 111 correspondence to ensure they are all reviewed within 24 working hours. The surgery will also undertake to share the learning from this incident with the wider Primary Care Network (PCN) in South Hornchurch.

At an appropriate time in the future, we will contact the family of Mrs Houghton and apologise for the delay in reviewing the NHS 111 correspondence that was sent to the Surgery and to offer assurances about the steps taken to prevent a future occurrence.

Yours Sincerely

[redacted]

[redacted]

[redacted]

[redacted]

(GP Partner until January 2023)