Department of Health & Social Care

From Nadine Dorries MP
Minister of State for Patient Safety,
Suicide Prevention and Mental Health

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Mr David Ridley
HM Senior Coroner, Wiltshire and Swindon
HM Coroner's Court
26 Endless Street
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12 April 2021

Dear Mr Ridley,

Thank you for your correspondence of 19 January 2021 to Matt Hancock about the death of Vhari Ingall. I am responding as the Minister responsible for patient safety and I am grateful for the additional time in which to do so

Firstly, I would like to take this opportunity to offer my sincere condolences to the families of Vhari Ingall and also Mary Johnson, who you also refer to in the Report.

I have noted carefully your concerns about the interpretation of the use of Treatment Escalation Plan/Do Not Attempt Cardiopulmonary Resuscitation (TEP/DNACPR) forms and the difficult position paramedics may face in intervening appropriately in providing emergency care.

In preparing this response, my officials have made enquiries with NHS England and NHS Improvement (NHSE/I) and the Care Quality Commission (CQC). Responses from CQC and the Association of Ambulance Chief Executives (AACE), to an earlier Regulation 28 notice relating to Vhari Ingall's death, have also been brought to the department's attention.

Advance person-centred care planning enables individuals to make informed decisions about their future care treatment and support. As part of this planning, DNACPR decisions can allow focus on the wishes of the individual in cases where cardiopulmonary resuscitation (CPR) may be needed. However, unless it meets the strict criteria for an advance decision to refuse treatment, a DNACPR decision itself is not legally binding. The form should be regarded as an advance clinical assessment and decision, recorded to guide immediate clinical decision-making in the event of a patient's cardiorespiratory arrest or death. The final decision regarding whether or not attempting CPR is clinically appropriate, rests with the healthcare professionals responsible for the patient's immediate care at that time.

A DNACPR decision does not override clinical judgement in the unlikely event of a reversible cause of the person's respiratory or cardiac arrest that does not match the circumstances envisaged when that decision was made and recorded.

In most hospitals the average survival to discharge rate for CPR has been given as 15-20% of patients. Where CPR is attempted out of hospital, the average survival rate is given as between 5-10%. However, the probability of success depends on many factors.

There is a range of national guidance on the application of DNACPR forms to assist healthcare professionals.

The Department has commended to NHS Trusts the expert advice provided in *Decisions relating to cardiopulmonary resuscitation*[1] (2016). This is joint guidance on decisions relating to CPR from the British Medical Association, Resuscitation Council UK and Royal College of Nursing. The guidance has provided a sound framework to support these decisions and for communication with the patient or those close to the patient.

The guidance provides general principles that allow local CPR policies to be tailored to local circumstances. Healthcare professionals also have access to other guidance, including:

- Ethical guidance on care and treatment towards the end of life from the General Medical Council[2]; and
- The ResPECT process[3]

The joint guidance is clear that a DNACPR decision applies only to CPR and that "all other appropriate treatment and care for that person should continue".

On your point of having a central database for DNACPR forms, a DNACPR decision is to provide immediate guidance to attending professionals. Recorded decisions about CPR should be up-to-date and accompany a patient when they move from one setting to another. Record sharing capability relating to DNACPR forms varies across the country and remains a key priority for the NHS. Examples of where this is working well include those that have adopted the Recommended Summary Plan for Emergency Care and Treatment[4] (ResPECT) process and areas using frameworks such as Coordinate My Care.

Guidance also exists on the review of CPR forms. The ethical guidance on care and treatment towards the end of life from the General Medical Council states clear arrangements should be in place to review DNACPR decisions with patients where a condition may have improved. Practitioners are advised to seek a second opinion or advice from an experienced colleague, where necessary.

At the time a DNACPR decision is made, patients should be informed when the decision will be reviewed, and the review date recorded on the DNACPR form. It is recommended that a DNACPR form is reviewed each time a patient's situation changes. The frequency of review should be determined by the healthcare professional responsible for their care and influenced by the clinical circumstances of the patient. The GMC guidance further states

[1] Decisions relating to CPR (cardiopulmonary resuscitation) (bma.org.uk)
[2] Cardiopulmonary resuscitation CPR - GMC (gmc-uk.org)
[3] ReSPECT | Resuscitation Council UK
[4] https://www.resus.org.uk/respect/respect-healthcare-professionals

that “revision of decisions about CPR should be as responsive to changes in a patient’s clinical condition and physiological observations as review and revision of any other aspect of their treatment”.

In light of concerns around DNACPR notices used during the pandemic, the Department commissioned the Care Quality Commission to review the use of DNACPRs and provide a series of recommendations to ensure inappropriate notices are not placed on patient’s records. The final report was published on 18 March 2021. We are committed to driving forward implementation of the recommendations within the report.

I hope this information is helpful and explains the actions being taken to address the matters of concern. Thank you for bringing these matters to my attention.

NADINE DORRIES MP
MINISTER OF STATE FOR PATIENT SAFETY, SUICIDE PREVENTION AND MENTAL HEALTH