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 Derek Winter
HM Senior Coroner, City of Sunderland
HM Coroner's Office
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20 July 2021

Dear Mr Winter

Thank you for your letter of 25 March 2021 to Matt Hancock about the death of Sheldon Farnell. I am replying as Minister with responsibility for hospital care quality and patient safety and I am grateful for the additional time in which to do so.

Firstly, I would like to say how deeply sorry I was to read the circumstances of Sheldon's death and I offer my most heartfelt sympathies to his family and all those affected by his death. I appreciate how devastating it must be to lose a child and that the pain must be particularly hard to bear when there are concerns about the care provided.

We must do all we can to learn from such tragic incidents to ensure the safety of health services and prevent future deaths.

In preparing this response, my officials have consulted widely with health system organisations including NHS England and NHS Improvement (NHSEI), the National Institute for Health and Care Excellence (NICE), the Care Quality Commission (CQC), the Academy of Medical Royal Colleges (AOMRC), the Royal College of Paediatrics and Child Health (RCPCH), and Health Education England (HEE).

Sepsis can be a devastating condition and patients rightly expect the NHS to be able to recognise and diagnose it early and provide the highest quality treatment and care.

Over recent years, the NHS has become much better at spotting and treating sepsis quickly. This means that more people are being identified as at risk of sepsis and mortality rates are falling. However, we know that some patients who deteriorate with sepsis are still not being diagnosed quickly enough. NHSEI is working to ensure that clinical staff caring for patients with infections in all settings are trained to spot and manage sepsis.

Good progress has been made in improving guidance and educational tools for the detection of sepsis since 2018. In April 2018, a National Early Warning Score patient safety alert was issued to support providers to adopt the revised National Early Warning Score (NEWS2) to detect deterioration in adult patients, including those with suspected sepsis[1]. NHSEI has, in recent years, with support from the Department of Health and Social Care, used NICE guidelines to disseminate guidance to clinicians on sepsis, ensuring they can diagnose early and implement the correct treatment.

The Government continues to work closely with NHS Trusts to design policies and best practice for improving the diagnosis and management of sepsis. Public Health England and NHSEI have recently developed a prototype for real time patient level data. We are committed to developing data linkage of infection, treatment and resistance histories to optimise life-saving treatments for serious infections, including sepsis.
We understand what a fast moving and complex area of diagnosis sepsis can be. Sepsis is not a single disease but a syndrome, has no specific diagnostic test or standard case definition and presentation can vary. As a result, we recognise it can be difficult to recognise and diagnose.

Guidance which takes account of differences in the population, including age groups, is therefore vitally important. With respect to detection of sepsis in children, we are continuing to improve. NHSEI is working with clinical specialists to develop a single, nationally validated observation (i.e. vital sign) based system to improve the recognition of, and aid to, children who are deteriorating. The use of a national early warning score in adults, NEWS2, has standardised the approach to acute deterioration in this population group and is now in widespread use across the NHS.

The Paediatrics Early Warning System (PEWS) programme board was established to address difficulties with standardised early warning systems in children. It brings together a wide-ranging group of child health experts, including input from the Royal Colleges, to look at how the system identifies and responds to deteriorating children in all settings and presentations.

The system to detect early deterioration in children is due to be implemented in the coming months and will be named the System-wide Paediatric Observations Tracking (SPOT) to recognise that deterioration may occur from primary and community care, through ambulance services, emergency departments and into hospitals.

In relation to sepsis training, we agree that proper training for clinicians to recognise sepsis is critical so that early signs of deterioration are diagnosed in patients. Improved awareness and clinical recognition of acute deterioration has led to an increase in the number of people identified and diagnosed as at risk of sepsis in recent years.

Multiple training resources have been made available by HEE[2]. These include:

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[1] Patient_Safety_Alert_-_adoption_of_NEWS2.pdf (england.nhs.uk)

[2] Sepsis awareness | Health Education England (hee.nhs.uk)

- A ‘Think Sepsis’ learning package designed to help clinicians spot the early sign of sepsis in children and infants;

- Training for GP reception staff to spot deteriorating patients and serious conditions including sepsis;

- Work to support sepsis identification in both adults and children across both primary and acute care that can be accessed on e-learning for healthcare https://www.e-lfh.org.uk/programmes/sepsis/;

- *The sepsis educational digital game*, an accessible introduction to sepsis for all clinical and non-clinical staff;

- *Deterioration, NEWS and Sepsis in Care Homes* is a training session designed for care home staff to ensure care home residents receive appropriate, timely medical care;

- The *Leadership in Primary Care* module, designed for non-clinical and clinical leaders working in primary care, looks at the challenges in leadership roles in identifying and managing acute deterioration and sepsis; and,

- Development of an animation to promote resources available through HEE on sepsis, how to access them and opportunities for their use. This video is anticipated to be launched shortly and hosted on the HEE YouTube Channel.

A metric in the Clinical Commissioning Group (CCG) Improvement Assessment Framework helps embed the use of these educational resources by prompting CCGs to ensure that sepsis education takes place for staff in all the services that they commission.

The Department’s 2019/20 Mandate to HEE includes objectives to:

- Explore training needs for pharmacists working in primary care networks and community settings to review the dose, duration and appropriateness of antimicrobial prescriptions;

- Increase awareness of sepsis among health and care workers including pharmacists working in primary and community settings, health visitors, community nurses, and domiciliary and care home workers; and,

- Commission projects to fulfil specific education and training gaps in antimicrobial resistance and sepsis.

Regarding whether sepsis training should be mandatory, this is currently an employer decision, and I note the action taken by the South Tyneside and Sunderland NHS Foundation Trust to introduce multidisciplinary training for medical and nursing staff involved in the acute paediatric care and mandatory three-yearly sepsis training updates.

In relation to the third matter of concern and messaging related to prescribing to ensure prescribers are not overly cautious, we recognise the critical balance needed for optimal

prescribing of antibiotics. Optimal prescribing can be a very complex practice and something that medical and non-medical prescribers should be supported to do in the best way possible, with availability of testing, point-of-care diagnostics and support for clinical decision making.

There is a clear need for more supportive guidance to drive forward best practice of optimal use of antimicrobials and many organisations are working together to provide best practice guidance for infection management. For example, the British Infection Association recently created a quick reference guide on sepsis in adults, and the Royal College of General Practitioners has completed a spotlight project on sepsis leading to creation of a sepsis toolkit aimed at providing knowledge, tools and guidance for GPs[3].

At the end of 2019, the AOMRC agreed a proposal from the Faculty of Intensive Care Medicine (FICM) for cross-college work on sepsis management following concerns over the current management of sepsis and alignment of guidance. A multi-organisational group with experts in the field are advising on the development of guidance to reduce unnecessary antibiotics and create national uniformity when diagnosing sepsis.

I am advised that the guidance will be based on the clinical analysis sequence, and consists of three questions:

1. *Is the patient sick?*
2. *Does the patient have an infection?*
3. *What is the degree of urgency in specific components of treatment? (including time to antimicrobials).*

The group has chosen to develop a clinical pathway with NEWS as the entry point, taking into account clear guidance, clinical judgement and flexibility on antimicrobial prescribing. The pathway is currently being piloted amongst trainee colleagues of the group and the guidance is expected to be launched in the Summer.

It is of course essential that hospitals and emergency departments have effective procedures in place for taking, recording and confirming the contact details of their patients or their families and carers, to avoid such unfortunate circumstances as in this case.

I am aware that the South Tyneside and Sunderland NHS Foundation Trust has taken action to improve its processes in this regard to include mandated checks at the point of patient discharge from hospital, as well as the establishment of a formal escalation plan for staff to follow if or when they are unable to contact a patient or family following discharge.

My officials have brought this concern to the attention of the NHS National Director of Patient Safety, Dr [redacted] at NHSEI, to explore whether insight from Sheldon's death and the actions taken by the Trust can be acted upon more widely through existing national patient safety processes.

[3] Sepsis Toolkit (rcgp.org.uk)

I expect the South Tyneside and Sunderland NHS Foundation Trust to ensure that it has taken all the learnings from the circumstances of Sheldon's death and the findings of your investigation to prevent future tragedies.

I am informed that the Trust has taken a range of action to improve the identification and management of sepsis, particularly in children, including improvements to processes and policies, and as noted above, introduced multidisciplinary training for medical and nursing staff involved in the acute paediatric care, as well as mandatory three-yearly sepsis training updates.

You may be aware that the CQC identified issues around the timely administration of antibiotics to patients diagnosed with sepsis in an inspection of the Trust conducted in early 2020. The CQC also highlighted that the Trust must ensure that paediatric nursing staff have sepsis awareness training and access to recognised sepsis tools. The CQC noted in its report of the inspection that the Trust was aware of these issues and was taking action to improve.

Following inspection, the CQC received regular progress updates from the Trust in relation to management of sepsis, including paediatric nursing staff receiving sepsis awareness training. The CQC has requested that the Trust provide a report of any investigation completed in relation to Sheldon's death, lessons learned and improvements secured. The CQC will continue to monitor the Trust in accordance with its regulatory activities.

I hope this response is helpful. Thank you for bringing these concerns to my attention.

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