Department of Health & Social Care

From Helen Whately MP
Minister of State for Care

39 Victoria Street
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[redacted]

Our Ref: [redacted]

Ms Alison Mutch
HM Senior Coroner, Greater Manchester South
HM Coroner's Court
1 Mount Tabor Street
Stockport SK1 3AG

15 March 2021

Dear Ms Mutch,

Thank you for your letter of 17 December 2020 about the death of Philip Taylor. I am replying as Minister with policy responsibility for adult social care.

Firstly, I would like to say how saddened I was to read of the circumstances of Mr Taylor's death and the lengthy delay Mr Taylor experienced at the Emergency Department at the Stepping Hill Hospital, part of the Stockport NHS Foundation Trust. If you have the opportunity, please convey my condolences to Mr Taylor's family. Your report describes care that falls short of the high standards we expect from the NHS, and that the NHS strives to deliver, and it is important that we take the learnings from Mr Taylor's death to improve the quality and safety of care.

I am informed that the Stockport NHS Foundation Trust has provided you with information about its use of NEWS2, the National Early Warning Score for adults, and actions it has taken to strengthen oversight of patient acuity in the Emergency Department and processes for the escalation of care, among others. I understand the Trust has reduced its nursing vacancies and there is senior level oversight of nursing rosters.

I am aware that this is not the first Prevention of Future Deaths report you have issued concerning the pressures experienced by the emergency department at Stepping Hill Hospital, Stockport during the winter period of 2019/20. It is right that the Trust, and its health system partners, reflect carefully on the concerns you have raised and take the necessary action to improve the safety and quality of urgent and emergency services in Stockport.

As you will know from the Department's responses to previous PFD reports raising these concerns, regulatory action was taken by the Care Quality Commission (CQC) after it identified similar concerns during an inspection at Stepping Hill Hospital in early 2020.

The CQC found that people were not always kept safe and were at high risk of avoidable harm during periods of heavy demand on urgent and emergency care services. Emergency care was consistently unable to be provided in a timely way; and there were significant issues with the flow of patients through the emergency department and the Hospital. The report of the CQC's inspection is available on its website[1].

Following the CQC's inspection, health system partners in Stockport formed a system improvement board, that has representation from the CQC and NHS England and NHS Improvement (NHSEI), to oversee the implementation of an improvement plan.

I am assured that progress is being closely monitored by the Trust Board and the CQC. Furthermore, I am informed that the issues at Stockport NHS Foundation Trust have been escalated within NHSEI national governance structures, including to the Executive Quality Group (EQG), chaired by [redacted], National Medical Director, and [redacted], Chief Nursing Officer, and the Joint Strategic Oversight Group with senior representation from the CQC, where progress is regularly monitored. I have asked my officials to bring your report to the attention of NHSEI.

Turning to the specific matters of concern in your report, you ask the Department to address two issues, the first, in relation to the Pathfinder clinical assessment tool; and the second about the availability of national guidance on recognising and responding to the risk of dehydration.

In preparing this response, my officials have taken advice from health system leader, NHSEI; the independent regulator for care quality, the CQC; and the National Institute for Health and Care Excellence (NICE).

I am advised by the North West Ambulance Service (NWAS) that Pathfinder is a clinical presentation-based, triage tool based on the Manchester Triage System, which is used worldwide by emergency clinicians and by a number of ambulance services in the UK. It may be helpful to clarify that Pathfinder is not mandated for use nationally and it remains a decision for individual ambulance services as to which clinical triage tools they use.

I understand that Pathfinder was developed by the Manchester Triage Group, with involvement from NWAS, as a tool to support ambulance clinicians prior to them undergoing training on the full Manchester Triage System. The Pathfinder tool contains the main general discriminators of the Manchester Triage System, as well as some specific discriminators, however, whereas the full Manchester Triage System has 53 presentational charts, Pathfinder has just two; Medical and Trauma.

I am informed by NWAS that a review of the ambulance response to Mr Taylor identified the point on Pathfinder that the paramedic at the scene would have reached based on Mr Taylor's clinical presentation, specifically, a NEWS2 score of above five and a reduced level of consciousness. Both these clinical factors elicit the 'red priority response', '*Stabilise and immediate transportation to ED*'. NWAS advises that it was therefore clear from Pathfinder that an immediate transfer to hospital was required. I am further advised that NWAS investigation of the ambulance response to Mr Taylor identified other factors that impacted on the length of time taken to transfer Mr Taylor to hospital, including the need to stabilise and obtain the contextual history.

I am assured by the NWAS that having considered the concerns you have raised carefully, it believes that changes are not required as a result of this incident and that Pathfinder remains a safe and effective assessment triage tool.

You may wish to note that during the review of this incident, those responsible for the Pathfinder tool identified two improvements (not directly related to this incident) that will be put forward for action. These are an amendment to the Pathfinder chart to include guidance on timeframe for transfer to *all* red priority boxes; and to include 'possible sepsis' as a red priority outcome to ensure that where a patient's clinical presentation is triggering on a sepsis screening tool, that it is also captured in Pathfinder as a failsafe where patient observations fall outside the NEWS2 parameters.

In relation to the national guidance that is available to care home staff on recognising and responding to the risk of dehydration, I am advised that in its response to you, the CQC has provided a detailed explanation of the guidance and best practice materials that are available. I will not repeat the detail here. However, you may wish to note that Departmental officials have made enquiries with NICE, which has confirmed that appropriate guidance is available, issued by NICE itself and others.

For example, National Guideline 148: *Acute Kidney Injury* acknowledges that there can be practical difficulties in patients with dementia (recommendation 1.1.1[2]) which may make becoming dehydrated more likely. In addition, NICE guideline, *Older people with social care needs* (NG22[3]), identifies the need to maintain hydration for such patients and includes specific recommendations relating to hydration with regard to care in care homes (recommendation 1.5.13) and training for health and social care practitioners (recommendation 1.7.2). I understand guidance has also been issued by the Social Care Institute for Excellence (SCIE); British Nutrition Foundation and others.

The Care Certificate[4], that has 15 standards that define the knowledge, skills and behaviours expected of roles in the health and social care sectors, includes a standard (Standard 8) relating to fluid and nutrition.

Registered providers have a duty to deliver care safely and effectively. In particular, to ensure adequate nutrition and hydration for their service users; and that they employ suitably qualified, competent and experienced staff, that are supported with the right training, professional development and supervision necessary for them to carry out their role and responsibilities. Registered providers are expected to adhere to and implement national guidance and standards to ensure high standards of care. As well as signposting the guidance available, the CQC website provides information on issues around hydration that registered providers may need to consider when formulating and reviewing their local policies.

I am aware that the CQC has advised in its response to you that it identified no breach of the Regulations when it reviewed the death of Mr Taylor. Mr Taylor had a nutrition and hydration care plan in place; an assessment of Mr Taylor's nutrition needs had recently been made; and daily food and fluid records were being completed. Training records at the Home indicated that the majority of staff had completed the Care Certificate or had other relevant qualifications pertinent to their role. In line with its regulatory responsibilities, the CQC will continue to monitor the Home.

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

HELEN WHATELY