Department of Health & Social Care

From Minister Caulfield
Minister of State for Patient Safety

39 Victoria Street
London
SW1H 0EU

[redacted]

[redacted]

Mr G Irvine
Walthamstow Coroner's Court
124 Queens Road
London
E17 8QP

8 May 2024

Dear Mr Irvine,

Thank you for your Regulation 28 report to prevent future deaths of 20 October 2023 about the death of Thomas Doyle. I am replying as Minister with responsibility for Patient Safety.

Firstly, I would like to say how saddened I was to read of the circumstances of Thomas Doyle, and I offer my sincere condolences to their family and loved ones. The circumstances your report describes are concerning and I am grateful to you for bringing these matters to my attention. Please accept my sincere apologies for the delay in responding to this matter.

The report raises concerns over the poor standards of the Trust's clinical records which impeded the Trust's governance investigation and the inquest investigation in determining if any consideration was given to the fact that Mr Doyle was suffering from an infection and the Trust also failed to commence a diagnostic pathway to investigate sepsis when clearly indicated on Mr Doyle's admission, as required by both local policy and national guidance.

In preparing this response, Departmental officials have made enquiries with NHS England and the Care Quality Commission (CQC). The Trust has taken the issues identified very seriously and has taken positive action to address those issues. To improve standards, an internal alert and a screen saver has been shared with staff which details good record keeping standards that should be adhered to by all staff as well as a video which has been developed with the Medical Director explaining the importance of good record keeping.

PFD concerns and record keeping standards have been discussed at clinical group quality and safety meetings and the Medical Director has discussed PFD concerns with the Clinical Group Directors and requested they ensure attendance of named clinicians at the Trust Sepsis Group. All medical staff must complete a record keeping module on the Trust BEST learning management system that allows staff to undertake e learning module on their first day working at the Trust. Record keeping for nursing staff is included in the nursing preceptorship programme.

There is a mandatory field on the new electronic record asking the question 'is sepsis suspected' if yes this triggers the sepsis pathway and data is captured that way. Monthly audit of this takes place with the latest results showing 100% compliance of the records audited.

The Trust sepsis education programme is essential for all clinical staff and has recently been updated. This is supported by additional face to face training for doctors and nurses.

The Trust has adopted the UK Sepsis Trust`s adult screening tool and the use of this is audited by the Lead Nurse for Sepsis. Audits include patients who have scored over 5 on the National Early Warning Score to ensure that Sepsis was considered. In addition, all positive blood culture cases are audited to ensure compliance with the Sepsis 6. Most recent audits show that compliance with commencing the Sepsis 6 sat at 97% percent for adult inpatient areas with 100% compliance in ED and Acute Medicine.

Sepsis mortality reviews are scheduled on a rolling basis. The raw data is sent externally to a central review body in Birmingham. The data is analyzed with internationally accepted health modelling data to see if mortality rates are in keeping with that expected for the case mix in the hospital catchment area. These do not indicate failings in care but help each Trust to examine their processes.

Structured review of individual sepsis mortalities is completed internally in the Trust using defined criteria. A presentation of both external and internal reviews is made to the Sepsis Steering Committee every two months. Acute Medicine have regular weekly teaching sessions within which sepsis is the most regular topic on both sites. There are also monthly assurance walkabouts in clinical areas; the audit is completed on both sites by the band 7 nurses, who audits 10 sets of notes each month selected from patients who present with primary mental health presentation. The audit comprises of a variety of questions that monitor aspects of care including if safeguarding referrals have been made, risk assessments completed, nursing care risk assessments have been completed, incident report for rapid tranquilisation and compliance with enhanced observations. Matrons oversee the audits, results, and actions. Audit results are shared monthly at the speciality meeting and learning is shared between the two Emergency Departments. This is minuted in the meetings. Learning for the individual departments is shared with the staff through their daily safety brief which takes place at the twice daily huddle. Audit synopsis is shared with the team at the safety brief and printed and available in the staff room. The information is available for temporary workers who will attend the team brief and will also have access to the printout.

Specifically on the Trust's failure to commence a diagnostic pathway to investigate sepsis when clearly indicated on Mr. Doyle's admission, the Trust advises that there had been a number of significant improvements since the incident occurred. Sepsis screening in the Emergency Departments has significantly improved (evidenced by audit data). The Emergency Departments now use an electronic record, Careflow, which amongst several mandatory fields has a mandatory question with respect to consideration of sepsis. Monthly sepsis group oversight of sepsis management Record keeping standards included in nursing preceptorship programme and junior doctors' induction.

I am also informed, that the CQC published their report following an inspection carried out into the Trust, which operates from two sites: Queen's Hospital and King George Hospital, in December. CQC established that the emergency departments had improved at the Trust, however, the service at the Trust 'requires improvement overall'. The report identifies several actions the service must take that are necessary to comply with its legal obligations. It is encouraging to note that CQC will continue to monitor the trust's progress regarding the matters raised in the report and wider concerns identified by way of their inspection.

Finally, in February the Government and NHS England announced plans to implement Martha's Rule in at least 100 acute or specialist NHS sites in England by March 2025. Martha's Rule is an initiative that gives patients and their families who are concerned about deterioration in their physiological condition the right to initiate a rapid review of their case 24

hours a day from someone outside of their immediate care team. When requested, this rapid review will inform whether any new or additional action needs to be taken to help ensure patients receive the most appropriate care and treatment – which may include escalation.

I hope this response is helpful and assures you that the issues raised have been taken seriously and steps undertaken to address these. Thank you for bringing these concerns to my attention.

Yours sincerely,

MARIA CAULFIELD