Department of Health & Social Care

From Maria Caulfield MP
Parliamentary Under-Secretary of State for
Mental Health and Women's Health Strategy
Department of Health and Social Care

39 Victoria Street
London
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[redacted]

[redacted]

Louise Hunt
HM Senior Coroner for Birmingham and Solihull,
The Birmingham and Solihull Coroner's Court,
Steelhouse Lane,
Birmingham,
B4 6BJ

[redacted]

13 May 2024

Dear Mrs Louise Hunt,

Thank you for your Regulation 28 report to prevent future deaths dated 05/04/2024 on the death of Tracey Ann Farndon. I am replying as Parliamentary Under Secretary of State (Minister for Mental Health and Women's Health Strategy).

I was saddened to read of the circumstances of Tracey's death, and I offer my sincere condolences to her family and loved ones. The circumstances your report describes are very concerning and I am grateful to you for bringing these matters to my attention.

Your report raises concerns over a failure to identify and treat sepsis within the emergency department at Queen Elizabeth Hospital in Birmingham, and highlights the following matters of concern:

1. The Emergency Department (ED) was, and continues to be, overwhelmed with patients with insufficient staff to care for, monitor and manage those patients. There is also continued regular use of agency staff.

2. Staff failed to consider a diagnosis of sepsis throughout Ms Farndon's admission. This raises the concern that staff do not fully understand the variable signs and symptoms of sepsis.

3. Ms Farndon's blood pressure (BP) was not recordable when she first presented at the emergency department. It was likely to be very low. This was not considered by the staff and no further attempts were made to assess Ms Farndon's BP. This raises concern that staff do not understand the implication of a low BP, the importance of continued observations when a key parameter cannot be recorded and that this may indicate the patient is seriously unwell.

In preparing this response, DHSC officials have made enquiries with NHS England. NHS England also consulted with University Hospitals Birmingham NHS Trust on local actions taken. The following response addresses each of your matters of concern in turn.

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. We must do all we can to learn from tragic incidents such as Ms Farndon's death to ensure the safety of health services and prevent future deaths.

Your report raised concerns about the demand and capacity in Queen Elizabeth Hospital's Emergency Department. I recognise the significant pressure the urgent and emergency care system is facing. That is why we published our 'Delivery plan for recovering urgent and emergency care services', which aims to deliver sustained improvements in waiting times. Our ambitions include improving the Accident and Emergency (A&E) Department waiting times and reduce overcrowding, so that, by March 2025, 78% of patients are admitted, transferred, or discharged from A&E within four hours. A&E waiting times have improved this year following the delivery plan's publication, with national A&E 4-hour performance improving from 71.5% in March 2023 to 74.2% in March 2024.

A key part of the plan has been to increase hospital capacity to reduce overcrowding in A&E. We have delivered 5,000 more staffed, permanent beds this year compared to 2022-23. A whole-system approach is needed to ensure people get the emergency care they need. This is why £1.6 billion of funding has been made available over two years to support the NHS and local authorities to ensure timely and effective discharge from hospital, helping to free up beds and reduce long waits for admission from A&E.

The commitment to improving patient safety is highlighted in the first NHS Patient Safety Strategy. This spring, NHS England will launch a deterioration toolkit called 'PIER' which stands for Prevention, Identification, Escalation and Response. This suite of resources will be accompanied by improvement support delivered by Patient Safety Collaboratives and targeted at Integrated Care Systems to improve deterioration pathways. This programme of work will also incorporate the implementation of 'Martha's Rule', which will be rolled out to at least 100 acute NHS trusts in 2024-25. 'Martha's Rule' will allow inpatients and families to request a rapid review 24 hours a day when a patient's physiological condition is thought to be deteriorating.

We aim for all acute trusts in England to use PIER to create and implement deterioration improvement plans, alongside Matha's Rule. This will help staff to ensure an individual's vital sign baseline (including blood pressure) is understood and that a range of risk assessment tools and methods are used to identify, monitor and mitigate their risk of deterioration.

We must ensure clinicians, and other NHS staff, can recognise unwell and deteriorating patients. The National Early Warning Score (NEWS2) is a system for scoring the physiological measurements that are routinely recorded at the patient's bedside to support clinicians in identifying acutely unwell patients, including those with suspected sepsis. Since 2018, NEWS2 has been implemented across 98.4% of acute trusts and 100% of ambulance trusts in England.

Despite the widespread use of NEWS2, some patients who deteriorate with sepsis are still not diagnosed quickly enough. To address that, '*Recording of NEWS2 score, escalation and response time for unplanned critical care admissions*' was identified as a clinical priority area for the NHS over 2023/2024. It was included in the Commissioning for Quality and Innovation (CQUIN) scheme in 2023/2024, which aimed to incentivise the use of NEWS2 to improve care by ensuring appropriate steps are taken to record and respond to deterioration.

Sepsis requires early recognition and prompt treatment with antibiotics. In May 2022, the Academy of Medical Royal Colleges published a position statement on the initial antimicrobial treatment of sepsis. Subsequently, in March 2024, the National Institute for Health and Care Excellence (NICE) updated Guideline 51 on suspected sepsis. It is critical

that updates to national sepsis guidance are disseminated and well recognised amongst a wide range of healthcare professionals who may encounter sepsis and acute deterioration. NHS England has developed several sepsis training and education resources, including e-learning, sector specific toolkits, and the 'sepsis educational digital game,' an accessible introduction to sepsis for clinical and non-clinical staff. We will continue to work with NHS England to understand what resources are needed ensure that healthcare professionals recognise and respond appropriately when patients deteriorate.

Furthermore, there is a commitment to drive evidence generation in this area. In 2022, the National Institute for Health and Care Research (NIHR) awarded £3.2m of funding to the Sepsis Trials In Critical Care study (SepTIC), which will look to answer critical questions on sepsis diagnostics and treatment. NIHR continues to fund many ongoing studies into sepsis and welcomes applications for further research in this area.

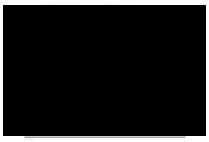
Your report also raised concerns regarding the assessment of Ms Farndon's low blood pressure. I note you have shared your report and concerns with University Hospitals Birmingham NHS Foundation Trust, to respond directly to your matters of concern. I have included below some of the local actions that the Trust has committed to in response to the concerns in your report.

Firstly, the trust has acknowledged the need for further clinical skills training for nursing staff, which includes being competent and confident in taking manual blood pressure readings. Queen Elizabeth Hospital's A&E department has also recognised that an alternative method of assessing perfusion, such as checking the radial pulse, is needed in addition to manual blood pressure. The Trust have agreed to include this in its induction programme along with an educational update to increase awareness and compliance. The A&E standard operating procedure will be updated to reflect that any observations that are incompletely documented must be handed over to the patient's nurse, with the need to repeat the observations being clearly documented.

In addition, feedback has been given to all staff involved in Ms Farndon's care. The Trust has recognised that further education is required by clinical staff to be able to identify patients with possible sepsis having back pain, gastrointestinal symptoms and/or being afebrile. This learning will be shared at Morbidity and Mortality meetings, through local training and via the ED Safety Newsletter. The Trust has also acknowledged the need for a review of both the "Role & Responsibility Action Cards" for staff leads on shift, and the escalation procedures within ED.

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

Best Wishes,



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