NHS England Response to the Recommendations in the William Mead Root Cause Analysis May 2016

Ref:	Recommendation	NHS England response	Action agreed	Owner:
14.1	**National Recommendations**			
14.1 a	That NHS England SSW escalates to national bodies the issues relating to the pressure on primary care in relation to antibiotic prescribing, referrals to secondary care and workload.	NHS England has agreed to examine the assertion relating to pressure in Primary Care on the three areas of antibiotic prescribing, referrals to secondary care and workload. A number of workstreams are already in place as detailed under the action agreed column.	**Antibiotic prescribing:** NHS England is playing its part in supporting the cross-government strategy on Antimicrobial Resistance (AMR). Increasing AMR is a very significant risk to the future of healthcare provision worldwide and we must act to preserve the supply of effective antibiotics. As part of this, NHS England is supporting efforts to reduce inappropriate antibiotic prescribing. It is vital to reinforce that this is not about preventing appropriate antibiotic use, but reducing inappropriate use, supporting clinicians to promptly provide antibiotics where that is the right thing to do and not provide unnecessary antibiotics. The UK 5 Year Antimicrobial Resistance (AMR) Strategy (2103 – 2018) can be found here and sets out key activities in this area. NHS England's national team have reviewed the investigation report and in response have asked regional colleagues to consider the development, use, and evaluation of effectiveness of whole pathway infection management guidelines in response to William Mead's death. A number of resources have been made available which include the 'When Should I Worry?' educational resource for health care professionals to use with parents of ill children. It is available free to download from the Royal College of General Practitioners website, and contains safety netting information http://www.whenshouldiworry.com/ Work is also ongoing to understand more about the current position with respect to prescribing antibiotics to children. NHS England is working with the Health and Social Care Information Centre and NHS Business Services Authority on a prescribing	NHS England and Public Health England Clinical Commissioning Groups

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			comparator for antibiotic use in children to understand more about the patterns and variation in antibiotic prescribing for children. This work will continue through 2016/17. **Secondary care:** Many Clinical Commissioning Groups (CCGS) have already put in place facilities to help primary care more ably manage referrals to secondary care and this is very much an issue for local management. NHS England will ensure through its assurance process that CCGs are appropriately supporting Primary Care practitioners in the management of referrals into Secondary Care. In addition NHS England has launched the roll out of the Right Care Programme which will assist CCGs in identifying where there is significant variation in referral patterns from Primary Care to Secondary Care services. **Primary Care Workload:** NHS England recognises that general practices are under considerable pressure. Increased workload has been driven by an unprecedented rise in the number of patients, the growing complexity of their health needs, and changing societal expectations. In response to this, the GP Forward View has been published which sets out NHS England's intentions for a significant investment to stabilise and transform general practice.	NHS England NHS England

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			The plan is for a year on year increase in investment building up to an extra £2.4 billion a year by 2020/21 to modernise and improve GP services. NHS England has also commissioned a study by the Primary Care Foundation and NHS Alliance to quantify the sources of bureaucratic pressure in general practice and GP appointment demand, and make recommendations for action. The resulting report, *Making Time in General Practice*, identified a number of practical ways in which capacity can be released within general practice, to free up time for patient care, improve productivity and support GPs with their workload. NHS England is committed to taking action to address the issues identified in the report, and are working on a suite of national measures which will reduce workload. In partnership with the British Medical Association (BMA), NHS England hosted a series of roadshows in February and March 2016 to provide a practical introduction to the most promising changes that practices can make.	
14.1 b	That NHS England South escalates the issues regarding the sensitivity of NHS 111 Pathways.	NHS England accepts the need to review the sensitivity of the 111 pathway for Sepsis.	The existing question sets in NHS Pathways are being reviewed. NHS Pathways has undertaken its own review of recent adverse incidents involving sepsis in young children, informed by early discussions of the child sepsis working group. NHS Pathways Release 11 Changes (Deployed from 9th May). Deployment of this Pathways Release (11) has been delayed to allow the following changes:	National Programme for 111

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			• In the toddler, infant and neonate age group, a question asking if a child is "severely ill" and has cold extremities will be inserted into the relevant pathways. This question will be switched on at all 111 sites subject to satisfactory testing • In children under 1 year of age, where the child is reportedly cool, cold or clammy with no other symptoms on the "core temperature" question the caller will not be able to be given a disposition less urgent than to attend an Emergency Department in less than 1 hour. • In children between 1 and 5 years of age the supporting information on the confused question will be enhanced and made consistent with the "child" age category. Positive response to this will trigger as a minimum urgent primary care, within 2 hours. In addition there is an ongoing NHS Pathways cross-collaborative review: • Led by NHS Pathways Medical Director • Supported by representatives from RCPCH, Sepsis UK, NHS England, NHS 111 provider medical director • Review is expected to report June 2016 • Any changes to be implemented in Release 12 Autumn 2016 following successful 'beta test' in live service	
14.1 c	That NHS England South escalates the	NHS England accepts	NHS England recognises the need to rebalance non-clinical	National

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	issues regarding the need for more defined standards regarding how 111 services and local OOH services interact in regard to dispositions.	the need to review standards for 111 and out of hours services	and clinical input in 111 services. A range of action is being undertaken to achieve immediate improvements including: - Widening the net of calls referred to a clinical advisor for further assessment (Early Exit) as a 'complex call' to ensure that cases where there is a risk of sepsis are brought to the attention of a clinician more rapidly. - Targeted awareness raising and education for clinical advisors, and where suitable health advisors, using materials supplied by Royal College of Paediatrics and Child Health. - Ensuring that the caller agrees with, and accepts that, the disposition reached is 'reasonable' and the concerns of the caller have been understood. - Investigating the use of an initial question regarding recent contact with NHS services. - Developing a specification for clinical hubs to increase the proportion of NHS 111 callers receiving remote clinical assessment from a clinician rather than health advisor - A single commissioning framework *Commissioning Standards: Integrated Urgent Care* was announced in September 2015 which sets out expectations for bringing urgent care access, treatment and clinical advice into much closer alignment.	Programme for 111
14.1 d	That NHS England South escalates the importance of progressing the	NHS England recognises the need	The sharing of patient health records between NHS	NHS England Patients and

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	information / record-sharing agenda for all NHS bodies	to progress record sharing across NHS bodies	organisations is being progressed through NHS England's digital technology portfolio of programmes. NHS England is working with commissioners and providers to develop Local Digital Roadmaps that will be aligned to Sustainability and Transformation Funds (strategic plans for the next five years). The electronic sharing of health records between NHS bodies is a key priority for these plans. Progress against this goal will be measured as part of the NHS England assurance process.	Information Directorate
14.1 e	That NHS England Medical Director Office and the UK Sepsis Trust work actively together, with the input of experts and parents in the SW, on the development of national guidance to parents and GPs regarding childhood sepsis, using the SW as the initial pilot site.	NHS England accepts the need to work jointly across the NHS and with Sepsis UK	NHS England has been working with the UK Sepsis Trust, the Royal College of General Practitioners and other Royal Colleges and statutory organisations through the Cross-System Programme Board on Sepsis, convened in 2015, to consider those actions needed to improve the identification and treatment of sepsis. As part of this work, Health Education England is working with the Royal College of General Practitioners (RCGP) on an e-learning package on sepsis in primary care, to ensure that the primary care workforce is ably equipped to deal with this condition in the general population, including children. A total of 6 modules of e-learning content will be developed, with one module focussing specifically on Sepsis in primary care paediatrics. Health Education England is developing an awareness video targeted at primary care staff on recognising sepsis in children. The video will direct staff to a range of resources already available, to support the early recognition and	NHS England Medical Directorate Health Education England

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			appropriate management of sepsis in children. A summary of symptoms, a case study and patient experience will also be included. The work is being led by a range of eminent clinicians in the field. Work is currently being undertaken in the South West in collaboration with the UK Sepsis Trust in the development of a leaflet containing advice to parents. This is due to be published shortly. NHS England has developed a website – Re-ACT (Responding to Ailing Children Tool) – including a video featuring how to spot the signs of sepsis in children. As part of the level two all-age Patient Safety Alert in September 2014 resources were signposted to clinicians and organisations, including the Paediatric Sepsis Six (UK Sepsis Trust). A series of all age sepsis master classes across the country have been held and a series of webinars took place over 2014-15 as part of the ReACT tool.	NHS England South West NHS England
14.2	**SW England Recommendations**			
14.2 a	That NHS England identifies existing initiatives such as Care Connect in the SW that will enhance the sharing of patient records and information, and subsequently produces a programme of development for the SW.	NHS England South West is already progressing a number of initiatives to enhance the sharing of patient records	NHS England is committed to improving the way in which information about patients' care is shared among health professionals. There are a number of initiatives underway in the South Region that will deliver this, including the implementation of Summary Care Records (SCRs) which will provide authorised healthcare staff access to essential information. As a minimum SCRs contain details of	NHS England South West

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			medication, allergies and bad reactions. Patients can also choose to provide their explicit consent to their GP practice to have a 'richer' SCR created which includes significant medical history. NHS England is monitoring take-up and working closely with key partners to ensure implementation. The aim is for all GP practices to have enabled this functionality by the end of March 2016. As set out at 14.1.c the integration of health records is a key focus of the move to new commissioning expectations on integrated 111/OOH services. Implementation of this will be monitored locally. In the South West, clinical senates will check that Sustainability and Transformation Plan (STPs) include initiatives to enhance the sharing of patient records.	
14.2 b	That a SW initiative is developed urgently for the dissemination of information to parents and GPs on sepsis recognition as a pilot for the national work as per 14.1[e] above.	NHS England South West is progressing the work on dissemination of information to parents	Sepsis recognition and safety netting is now incorporated into GP training programmes in the South West. There has been a pilot of the pathway and tools that were recommended following an investigation into a previous case of child death. Plymouth University are in the final stages of evaluation and findings are expected imminently. Should the evaluation support the effectiveness of these tools then the next stage will be a roll out across the South West. Since this evaluation has started the National Institute of Health and Clinical Excellence guidelines for feverish	NHS England South West

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			children have been updated and are currently undergoing consultation. In addition, the document 'Improving outcomes for patients with sepsis – a cross-system action plan' has been published (23/12/2015). The National Sepsis Trust has also developed information and guidance for primary care to help identify sepsis in the community although this was not specific for paediatric sepsis. This information is ready to be disseminated to GP practices. We will consider how to further raise awareness and increase utilisation of all this information so that it becomes standard practice. Sue Morrish, mother of Sam Morrish, and Ron Daniels of the UK Sepsis Trust presented at a South West masterclass held in Taunton on the 2nd of February 2016. This recognised the work that needed to be done on listening to parents concerns and providing safety netting advice. NHS England is collaborating with this work – 'Are You Sepsis Savvy?' and has produced SAM's leaflet https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2014/10/sepsis-lflt-lowres.pdf . The leaflet is widely available in GP surgeries in Devon and has been adapted for, and is also available in, Cornwall GP surgeries. In addition, there is a piece of work being led by the West of England regional sepsis group supported by the West of	

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			England Academic Health Science Network (AHSN) which includes the support of the masterclasses in sepsis. Since February 2015 there have been three events of which the last two were opened up to primary care. Through a system wide programme in the West of England to implement National Early Warning Scores as a shared language, sepsis awareness is being promoted in the community and primary care.	
14.2 c	That a SW initiative is developed for best practice in primary care on safety-netting advice.	NHS England South West accepts the need to define more clearly what good safety netting advice might look like.	A project is underway with Health Education England to promote best practice in primary care on safety netting advice with junior doctors which includes a programme of masterclasses on sepsis. The National Institute of Health and Clinical Excellence guidelines, which have been updated and are currently out for consultation, include safety netting advice. There are examples of good practice in this area such as the app called the HANDi Taunton App. Developed by the paediatric team in Taunton, it aims to provide expert support in relation to looking after children with the most common childhood illnesses including high temperature and 'chestiness'. It provides advice to parents and carers, medical professionals in the community and gives details of local acute services, currently covering Taunton, Exeter, North Devon, Plymouth and Bristol Children's Hospital.	NHS England South West

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			Further evaluation of this tool will be undertaken alongside other areas of improvement around safety netting where this is possible.	
14.2 d	That the SW develops existing plans for referral to assess models of care between primary and secondary care.	NHS England South West will work with colleagues to examine potential improvements to models of care	Interface between primary and secondary care in the assessment of the unwell child is under consideration and development in different health communities. For example Royal Cornwall Hospital Trust has trialled a service whereby a GP can book an unwell child in to see a paediatrician later on the same day (e.g. 4 hours) if required. Somerset has a similar scheme. In addition Point of Care testing (POCT) may provide some discriminatory information and the Out of Hours (OOH) service in Cornwall is trialling the use of C-reactive protein (CRP) testing. The sepsis guidelines specifically mention White Cell Count (WCC) and lactate levels and this is an area of further exploration which will be undertaken.	NHS England South West
14.3 e	That SWASFT instigates a plan to train call advisors in probing questions, recognition of complex calls and referrals to clinicians.	SWASFT has accepted this recommendation	SWASFT has instigated an action plan to train call advisors in probing questions, recognition of complex calls and referrals to clinicians. The plan has been reviewed and largely operationalised.	SWASFT
14.3 f	That NHS England approaches the CDOP SW to discuss how many cases have been identified involving deaths and the possible reluctance of GPs to prescribe antibiotics.	NHS England South West will try to identify the number of cases through CDOP although it is likely to be extremely small in number	NHS England South West will review the annual report of the Child Death Overview Panel (CDOPs) in each Local Authority (LA) area to see if there is any general learning in relation to sepsis or antibiotics.	NHS England South West

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14.3	**Local Recommendations**			
14.3 a	That SWASFT produces an action plan for monitoring.	SWASFT have accepted the need to produce an action plan.	A full action plan has been produced and is being monitored.	SWASFT/CCGs
14.3 b	That the actions already been taken by the Practice are reviewed to provide assurance that all that should be done from the learning, has been done.	The actions taken will be reviewed by NHS England South	NHS England South has completed this action and is assured that all that should be done from the learning has been done. The practice has developed a template for doctors to use with feverish children that links to the sepsis guidelines and family SAM leaflet. The practice has embedded the learning from the incident through practice meetings and professional appraisal and other systems.	NHS England South
14.3 c	That the RCA process and how relatives are involved is reviewed and improved as a result of the positive learning from this case.	NHS England South West will ensure any lesson learned from this case will be shared and disseminated.	The RCA process has been reviewed and it clear from this tragic case that families need to be involved in every step of the process, to ensure their concerns have been heard and addressed in the learning. In addition the findings should be shared with the family in line with the NHS Duty of Candour. NHS England South West will remind all NHS bodies in the area of the need to follow the Serious Untoward Incident Framework 2015. NHS England South has established a Regional Investigations Assurance Group to ensure that RCAs are properly conducted in line with the NHS Serious Incident Framework 2015. This includes making sure that relatives are fully involved in the process.	NHS England South West