Concerns and Complaints
After the Ombudsman’s Sepsis report - errors and problems

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Society for Acute Medicine

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The Parliamentary & Health Service Ombudsman

- Final stage of the process for complaints about public services
- Process “lay lead” - supported by clinical advisors
- Powers set out in law
- Accountable to Parliament through Select Committees
- Independent of Government and the NHS
PHSO Strategy

• “...Work with others to use what we learn from complaints to help them make public services better”
TIME TO ACT
Severe sepsis: rapid diagnosis and treatment saves lives
“Time to act”
- who we worked with

- UK Sepsis Trust
- Royal College of Physicians
- Royal College of Surgeons
- Royal College of Obstetrics & Gynaecology
- College of Emergency Medicine
- NHS England
- NICE
“Time to act” - Findings

- Clinical Findings:
  - inadequate assessment
  - Delayed inadequate investigation
  - delayed treatment
  - inadequate monitoring

- Organisational Failings:
  - timely senior input
  - Timely critical care
  - Effective handover
Recommendations

- Headings -
- Improving recognition
- Improving treatment
- Continuous improvement
- Research
What can the Ombudsman add?

- Impact of powerful patient stories
- In-depth independent investigation
- Personal authority
- Relationship to Parliament
- Networking
“Time to act”
- What’s happened since?

- **UK Sepsis Trust:**
  - Tool kits
  - All party parliamentary group formed

- **Health Education England:** Supports the Tool kits

- **NICE**
  - Guideline in preparation (2016) - quality standard will follow

- **NHS England**
  - Alert on recognising sepsis

- **Public Health England**
  - Public education program initiated

- **Public Administration Select Committee**
  - Hearing (Health Select Committee will follow)
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- **Health Education England:** Supports the Tool kits

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- **NHS England**
  - Stage 2 Alert on recognising sepsis

- **Public Health England**
  - Public education program initiated

- **Public Administration Select Committee**
  - Hearing (HSC will follow)
Patient Safety Alert

Stage Two: Resources

Resources to support the prompt recognition of sepsis and the rapid initiation of treatment
2 September 2014

Alert reference number: NHSPM9/2014/015
Alert stage: Two - Resources

This patient safety alert applies to all patient age groups

Sepsis is a life-critical medical emergency, which can occur as part of the body's response to infection. The resulting inflammatory response adversely affects tissues and organs. Unless treated quickly, sepsis can progress to severe sepsis, multi-organ failure, septic shock and ultimately death. Septic shock has a 50% mortality rate.[1]

Sepsis is almost unique among acute conditions in that it affects all age groups and can present in any clinical area and health sector. Over 70% of cases arise in the community[2]. However, sepsis can be easily treated through timely intervention and basic, cost-effective therapies.

Recent epidemiological studies[3][4] and data from the Intensive Care National Audit and Research Centre (ICNARC)[5], estimate that 35,000 people die from sepsis in England each year. We are lacking in recent data, especially in the UK, but the mortality rate for sepsis in children is estimated to be 10 – 15%. Key to reducing these figures are:

- Timely recognition and diagnosis of sepsis
- Fast administration of intravenous antibiotics
- Quick involvement of experts including intensive care specialists

It is estimated that the reliable delivery of basic elements of sepsis care could save 11,000 lives a year and £150 million annually.[6] This equates to 100 lives and £1.25 million in bed days for an average district general hospital each year. Furthermore, in 2010 the Centre for Maternal & Child Enquiries (CMACE) published the UK Confidential Enquiry into Maternal Deaths for the period 2006 – 2008 that found sepsis to be the commonest cause of direct maternal death[7].

This stage 2 alert has been issued to continue to raise awareness of sepsis and to signpost clinicians in the ambulance service, primary and community services and secondary care to a set of resources developed by the UK Sepsis Trust, and others, to support the prompt recognition and initiation of treatments for all patients suspected of having sepsis. These resources include the Sepsis 6, a care bundle whose use is associated with significant numbers of lives saved and reduced length of hospital stay[8].

The resources are available from here: UK Sepsis Trust's clinical toolkits

Actions

Who: Chief Executives of NHS Trusts, Foundation Trusts, Ambulance Trusts & General Practitioners

When: To commence immediately and by no later than 31 October 2014 have a robust action plan developed to achieve compliance

Ensure staff have access to both adult, paediatric and infant sepsis screening and action tools that can be used for patients presenting on first attendance, or developing suspected infection as an inpatient. Examples of such tools can be found at the resource links given in this alert.

By either circulating this alert or through local alternatives (such as newsletters, local awareness campaigns, etc.) ensure that all relevant staff are aware of the key messages and the linked resources (or local equivalents) so they can be introduced into clinical practice. In particular the administration of antibiotics within one hour of suspicion of sepsis and early escalation to senior medical management.

Share local good practice or further locally developed resources relating to sepsis via the deterioration page of the Patient Safety First website.
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“Time to act”
- What’s happening now?

- Ombudsman’s casework
- College of Emergency Medicine audit
- Attitudes to complaints
College of Emergency Medicine: Sepsis audits (2011/12 and 2013/14)

Some important measures improved
- eg, vital signs ... fluid challenge

Some measures not improved
- eg, urine output ... Oxygen

Some measures still low
- eg, urine output

Wide variation in performance
“Time to act”
- What’s happening now?

- Ombudsman’s casework

- College of Emergency Medicine audit

- Attitudes to complaints
Mrs C, aged 68  

Presentation: fall & fractured ankle

Medical problems:

- SLE - on prednisolone and azathioprine (200 mgs)
- Stroke aged 45
- Recurrent DVT on warfarin
- Type 2 diabetes mellitus - on insulin
- Recurrent urinary infections
- Hypertension
- Epilepsy
1st case study (2)

- Increasingly unwell
- Albumin 32 → 24
- Urine WC 186 → 1729 (culture mixed growth)
- Abdominal pain persistent
- CT abdomen (day 18)
  - Severe sepsis (day 24)
  - Died (day 37)
1st case study (3)

- Increasingly unwell
- Albumin 32 → 24
- Urine WC 186 → 1729 (culture mixed growth)
- Abdominal pain persistent
- CT abdomen (day 18)
- Severe sepsis (day 34)
- Died (day 37)
Trust response:

Denied that:

- assessment was inadequate
- antibiotics were indicated for emphysematous cystitis (their antibiotic policy for urinary infection)
- physician support was needed for so complex a case

and they maintained that position on challenge
Health and Social Care Act 2008
Regulations 2014

- Statutory duty of candour for NHS bodies
- Patient or relevant person must be informed of harm
- NRLS, moderate, severe or harm related death
- From 1 October 2014
...to be open and honest with patients...

...where a patient has suffered harm... put matters right ....offer an apology and explain fully and promptly...
Second Case Study (1)

59 year old female

Cellulitis associated with large leg ulcer
R.A. - on prednisolone and methotrexate
BMI 45
T 36.4, HR 127, BP 115/50
N 1.1, CRP 444, Creatinine 377
+ 12hrs: BP 81/65: anuric
Second Case Study (2)

Severe sepsis not diagnosed
Delay iv antibiotics 7 hours
No action on acute kidney injury
No action in fall in BP

+ 14hrs: died
Second Case Study (3)

Trust response

“Treatment was entirely appropriate”
2013 Major report related to patient safety

- Francis Report (Mid Staffs)
- Bewick Report (Patient safety)
- Clwyd-Hart Report (complaint handling)

‘DENY, DEFEND, DELAY‘
Why aren’t guidelines implemented and standards met?

• Are there barriers?
• Information overload?
• Knowledge and skills?
• Priority overload?
• Clinical difficulty?
• Emergency working environment?
• Workforce resources?
• Leadership?
• Organisational culture?
Take Home Message

“Time to Act ...”

Recommendation 2.3

“...foster attitudes and behaviours among front-line staff which values critical clinical thinking, the timely availability of senior decision makers, focused priorities and the prompt implementation of clinical plans.”