



Public Administration Select Committee

Oral evidence: Follow-up: [Parliamentary and Health Service Ombudsman's Report on Severe Sepsis](#) , HC 616

Wednesday 10 September 2014

Ordered by the House of Commons to be published on 10 September 2014.

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Members present: [Mr Bernard Jenkin](#) (Chair), [Paul Flynn](#), [Rt Hon Cheryl Gillan](#), [Kelvin Hopkins](#), [Greg Mulholland](#), [Mr Andrew Turner](#)

Dame Julie Mellor DBE, Parliamentary and Health Service Ombudsman, was in attendance.

Questions 1-99

Witnesses: **Dr Daniel Poulter MP**, Parliamentary Under-Secretary of State, Department of Health, **Professor David Haslam**, Chair, National Institute for Health and Care Excellence (NICE), **Dr Ron Daniels**, Chair, UK Sepsis Trust, and Chief Executive, Global Sepsis Alliance, and **Dr Mike Durkin**, Director of Patient Safety, NHS England, gave evidence.

Q1 Chair: Can I welcome you to this session of the Public Administration Select Committee? Apart from the issue of Equitable Life, this is the first time that we have decided to scrutinise a report of the Parliamentary and Health Service Ombudsman, and to scrutinise the Government's response to it. This is because of the seriousness of the issues raised in that report. The title of the report was *Time to Act. Severe sepsis: rapid diagnosis and treatment saves lives*. Sepsis, I should say, is the correct modern term for what we used to call septicaemia or blood poisoning. Its incidence has been increasing dramatically. The mortality rate is around 36%, with 102,000 cases annually. It means we are suffering a death rate of nearly 37,000 a year. The cost of this is in the order of about £2.5 billion. If these recommendations had been implemented by now, we would be perhaps saving about 12,500 lives a year. So it is astonishing to me that perhaps not more urgency has been given to this matter, and this is what we want to address. The PHSO made a number of recommendations, which are set out in the report. These are about improving recognition of symptoms of septicaemia, improving treatment, implementing procedures for continuous improvement

around these things and improving the research around sepsis. I wonder if each of our witnesses could identify themselves for the record.

Dr Poulter: I am Dr Dan Poulter. I am the Parliamentary Under-Secretary of State for Health.

Dr Daniels: My name is Dr Ron Daniels. I am a full-time NHS consultant and Chief Executive of the UK Sepsis Trust.

Professor Haslam: I am Professor David Haslam. I am the Chair of NICE, the National Institute for Health and Care Excellence.

Dr Durkin: I am Dr Mike Durkin. I am the Director of Patient Safety for NHS England and previously a consultant in intensive care.

Q2 Chair: Welcome to you all and thank you for being with us. We are relatively short of time, so it would help if we ask short questions and your answers could be as brief as possible. In these sessions, we are going to have the Parliamentary and Health Service Ombudsman present at the horseshoe. This is partly so that she can inform us of things she thinks we are missing and, if she catches my eye, to ask you questions which she feels need to be added to our cross-examination. Her report highlighted shortcomings in initial assessment, delays in emergency treatment, missed opportunities to save lives, and failings in the care and treatment of people with severe sepsis. This was both at home and in hospital wards and emergency departments. The case studies are all painful to read, and the grief of those who lost their loved ones, perhaps unnecessarily in many cases, is something that we need to acknowledge. Can I ask first of all, Mr Daniels, what progress do you feel has been made to the improvement in care and treatment of sepsis?

Dr Daniels: I think if you asked a cohort of families affected by sepsis you would see little progress. We are seeing pockets of excellence in the country. We are seeing excellent responses from some ambulance services, some acute trusts. We have developed a blueprint with NHS England for what good sepsis care looks like. What we do not have is the reliable implementation of that blueprint in order that sepsis care is anything more than a lottery according to where the patient suffers geographically.

Q3 Chair: This report was produced now a year ago. How satisfied are you that it is being treated with the urgency it deserves?

Dr Daniels: I will not be satisfied until all patients with sepsis are treated well. That has not yet happened; therefore I am dissatisfied. It is a very complex issue and the pace can never be as rapid as one might hope, looking in as a scrutiniser. However, I think we can do a lot more, and I think we can do a lot more, more quickly.

Q4 Chair: That was quite a diplomatic answer. How satisfied are you with the urgency with which this is being approached by people in the health service and the Government and so on?

Dr Daniels: In terms of urgency, I am relatively dissatisfied.

Q5 Chair: Relatively dissatisfied. What in particular are you dissatisfied with?

Dr Daniels: The prime thing is that we have, as I have described, set out blueprints. We understand what good sepsis care will look like, but there has been nothing in the way of resource allocation to this for hospitals or ambulance services to make a difference. It currently relies upon clinical champions to effect that difference. What we need is the ability for organisations, firstly, to access resources and training and, secondly, to have an incentive to deliver improvement programmes, other than public expectation. I think commissioning for excellence would be a very good start. Some form of mandate towards the inclusion of education on sepsis in healthcare curricula would be another good start.

Q6 Chair: Mr Durkin, why is NHS England slow in applying these recommendations?

Dr Durkin: I do not think we have been slow in applying the recommendations, Chair. I think we have worked very hard since our inception to work with the other stakeholders in this debate. We have worked to identify how we influence, in a systematic and systemic way, the behaviour of clinicians when they first see patients and they first recognise that a patient is deteriorating in front of them. For me that is the challenge. It is to identify how we create the conditions within which every clinician will treat every patient effectively in as quick a time as possible in the right place.

One of the elements of sepsis that is quite challenging is the recognition that a patient is on a journey to becoming septic. Therein lies one of the difficulties, or conundrums, that we face here. In terms of what we have done, I think we have a number of different elements that we are working with. We are influencing the curriculum changes that need to be taking place, both with regard to postgraduate trainees and also undergraduate trainees. This is through the College of Physicians, through the Intensive Care Society and through working with Ron. We have also been working hard to introduce a systematic approach to safety improvement across the whole system that will impact on every sector and every setting. This is particularly looking at primary care and community settings. It is a relatively safe environment in a hospital, but I think there is much more to do in terms of general practice and care home settings with regard to sepsis and recognition of sepsis.

Q7 Chair: Your use of the word “relatively” is interesting. If some of these hospitals were airliners, they would be grounded by the Civil Aviation Authority. What have you done to identify the best practice in the best hospitals, and what have you done to make sure that practice is spread to all hospitals?

Dr Durkin: We have worked on two particular work streams to aid clinicians in identifying deterioration in adults and in children. That is particularly related to sepsis. We have some champion organisations; Nottingham in particular would be one that I would like to name here. We have worked hard with them to identify how, across the whole system, we can start to spread that best practice through webinars and through a patient safety alert mechanism, which is one that we introduced recently. Over the last year, we have introduced a new alerting system. The second phase of the alerting system is one we use for sepsis, where we spread good practice to every sector and every setting. That has gone to every hospital. It is going through local government to directors of public health, and it will go to general practice as well. We are spreading the resource package to help support the early detection.

Q8 Chair: We will come to some of those initiatives later. Minister, when did you first read this report?

Dr Poulter: I was made aware of this report, I believe, in a conversation that Dame Julie and I had earlier in the year. We were discussing at a routine meeting the general powers of the Ombudsman and some of the work that had been done by the Ombudsman over the last few years.

Q9 Chair: Earlier this year is when you became familiar with the contents of the report. I know that Ministers are under great pressure and you depend upon your officials to provide you with your papers. Given that this is a report that has identified 37,000 deaths a year and estimates that 12,000 of these deaths are avoidable, do you think your Department has attached a high enough priority to this? This report was published months before your attention was drawn to it.

Dr Poulter: You are right to say that as the Minister who has the responsibility for working with the Ombudsman, I would expect to be informed in a timely manner about reports.

Q10 Chair: How satisfied are you that you were informed of this report in a timely manner?

Dr Poulter: I am not fully satisfied that things always get to me as quickly as they should do. However, from a broader perspective, there is an issue in terms of how seriously the Government has gripped this agenda and addressed this agenda. We have, as you know now, sent mandates to NHS England and Health Education England to set priorities for the NHS. These are priorities for commissioning and priorities for staff education and training. In both of those mandates, there is a priority about enhancing and supporting good patient care. The Health Education England mandate makes sure that there is greater understanding amongst all staff of the early signs of sepsis, and that staff are properly trained. From 2012, foundation doctors, which are doctors in the first two years after they have finished their medical school training, now have much more rigorous training in how to recognise and understand the signs of sepsis as a part of their curriculum. There has been a lot of work going on to improve and enhance the skills and understanding in the workforce as a whole. It is the job of every doctor and every healthcare professional to recognise, when a patient is sick, when they may have sepsis or other life threatening conditions. That is something we have taken very seriously as a Department.

Q11 Chair: That was a very extended answer, but thank you for it. I must ask you to give shorter answers. Can you just use this opportunity to say something to the relatives of the case studies in this report, to acknowledge that you really did not read this report sooner and that your Department has failed to attach to this report the urgency that it deserved? Their particular cases are very painful to read and it does not look as though the Ombudsman's report has had the importance attached to it that it should have done.

Dr Poulter: As you know, I still practise as a doctor, so I see on a weekly basis, very often, some of the tragic cases when things do go wrong in healthcare. There is a very real issue here in understanding how we can better identify and look after patients who have

sepsis. That is something that we know the NHS has to continue to improve at and do better at.

Q12 Chair: What will you do, Minister, to ensure that reports like this are drawn to your attention much more readily?

Dr Poulter: I am sure that this has been a reminder to all the team at the Department of Health that, when there are important reports coming forward from the Ombudsman, they need to be disseminated quickly—particularly where there are issues of patient care and patient safety involved. That is something that I will expect.

Chair: Because this is the first of these kinds of hearings that we have taken, we may be a bit more forgiving on this occasion than we will be in future. We are going to scrutinise, in future, how the Department of Health responds to reports from the Parliamentary and Health Service Ombudsman in order to make sure that these delays in the implementation of recommendations do not recur.

Q13 Greg Mulholland: It is important just to look at the summary of findings again of the Ombudsman's report. That was really fundamental things: failure to recognise the signs of sepsis, failure to treat sepsis, failure to escalate a case to senior staff. This was a shocking case—a case that brought to the attention of the Department of Health, the medical profession and this place that there was something fundamentally wrong with regards to the whole treatment of sepsis. The excellent report that the Ombudsman produced has done the job of the Ombudsman in terms of holding our public services to account. What concerns us today, as the Chair has said, is that we do not feel that is being given the priority and, indeed, the speed of response that is necessary. The first thing is to say to you, Minister, now that we have had the changes of the Health and Social Care Bill, exactly where does responsibility and accountability for clinical leadership on sepsis lie? That seems to be something that is not clear.

Dr Poulter: Leadership lies every single day with the clinicians and healthcare staff who are looking after patients. It is not the role of Whitehall to micromanage clinicians. It is the role of Government to set, in a publicly funded health service, the right framework and the right mandate to the NHS to make sure that care is delivered in the right way. When there are concerns that are raised like this and very tragic events happen, our role is to respond them to in as timely a manner as possible. I accept some of the concerns that the Chair of the Committee raised. I think it is important that Ministers are sighted as quickly as possible on issues to do with patient care and patient safety. That is something I know the Secretary of State would echo. What we have done is through the mandate, for example, to Health Education England, which is about how each and every member of staff in the NHS is trained, we set a clear priority for staff to have greater awareness and understanding of sepsis.

Chair: Minister, I am sorry to interrupt you. We are having difficulty hearing. Please could you raise your voice?

Dr Poulter: Apologies, Sir, I am sometimes a little softly spoken. I apologise.

Through Health Education England's mandate, with their budget, there is a priority to make sure that all staff have a greater awareness and understanding of sepsis. That is something that has already taken place in terms of the training of foundation doctors,

which are those doctors who have immediately left medical school. There is a greater part of their core training syllabus that they now do in sepsis. Indeed, for NHS England, in terms of where the money is spent in the NHS and how the commissioning of services is prioritised, you have, as I am sure Mike will be able to tell you about in a moment, a priority in there. This is in the outcomes framework against which the Government judges how the NHS is delivering on its priorities. There is a clear priority for potential years of life lost from causes considered amenable to healthcare. That is where we could have intervened and done better because of medical practice that has not been successful. Where there have been deaths, for example, in some of these tragic cases, and things could have been done better, there is a clear priority for NHS England to commission for safe care and commission for improving care as part of their commissioning arrangements.

Chair: Minister, I am going to insist on shorter, sharper answers. I am very sorry.

Q14 Greg Mulholland: Do you not understand, Minister, that part of the problem is what you said in the first part of your answer? You were saying, “We are not there to micromanage and it is up to individual doctors.” This was something of such national significance—I am sure you will agree it was a national disgrace—and yet because of that change in the structures of the NHS through the changes of the Health and Social Care Act there does not seem to be the taking of responsibility by people, including Ministers. Do we have political accountability on this? Do we have political leadership?

Dr Poulter: You still always have political accountability through Parliament, and we have political accountability here in this Committee today. It has never been the case before the current Act or previously that frontline professionals have been micromanaged by Whitehall.

Q15 Greg Mulholland: This is not micromanaging. You have heard the figures. You have heard the waste of public money. That is a scandal. That is an economic scandal, apart from the fact that lives are being lost unnecessarily. That is something that the Department of Health and ministers in the Department of Health must take responsibility for.

Dr Poulter: It is, and we do take responsibility for that. That is why we set very clearly, as I outlined in my previous answer to you—and I will not rehearse those answers again—clear priorities for the training of medical professionals and healthcare professionals. Indeed, in the commissioning arrangements and the commissioning priorities for the NHS, those are patient safety and avoiding deaths that should not happen in the NHS. One of the key priorities of the Secretary of State, as you will be aware of, following the Staffordshire scandal, has been to make sure that we improve patient safety throughout the whole of the NHS. That has been a clear driver and a clear message coming from Whitehall. I am sure NHS England will explain what they are doing in the commissioning arrangements to make sure that commissioning is effective in delivering those clear priorities.

Q16 Greg Mulholland: My final question to you, Minister—and I will come on to NHS England—is do you really feel that you can say to this Committee and to the families of victims that this is as high a priority as it should be within the Department? Is this being taken as seriously as it possibly can be? Is this being dealt with so we will not be looking at

those kinds of figures, in terms of lives lost and in terms of the money that is having to be spent dealing with sepsis, in a year's time, two years' time, three years' time?

Dr Poulter: I can give you an absolute reassurance this is a clear priority for the Government. It is a clear priority for the Secretary of State. He has had recent meetings with the College of Emergency Medicine, for example, on how we can collect better data to understand where things could be improved on the front line when patients first present at accident and emergency with sepsis. It is a clear priority in the mandates and the directions that we set for the NHS commissioning board, NHS England and Health Education England. That is something we take very seriously. When bad things have happened, as they have done to families in this case, we have to learn from those bad things and do our very best to make sure those things do not happen again. That is something that I am committed to and I can assure you the rest of the ministerial team are, too.

Q17 Greg Mulholland: Dr Daniels, to what extent does the UK Sepsis Trust think there is clear clinical leadership on sepsis, and to what extent do you think there is clear political leadership on sepsis?

Dr Daniels: It is quite right of course that individual professionals are accountable for their actions. As we improve training and awareness, then those professionals will know what to do. Where leadership has worked well within the NHS has been where a condition has belonged to an individual professional body, a royal college or society. Sepsis does not belong to emergency medicine. It does not belong to intensive care. It does not belong to the Royal College of Physicians. It is a cross-speciality condition, and therefore I think there are some rather unique aspects to sepsis. We do need political leadership in putting in place the resources and the systems to ensure a system-wide reliable response. Also within other stakeholders, like NHS England, Public Health England and Health Education England, we need a broad-brush leadership, and that is not currently in place.

Q18 Greg Mulholland: Do you think political leadership is currently there?

Dr Daniels: The political leadership is being championed currently by the Ombudsman and by our All-Party Parliamentary Group. That is not the same as having a top-down drive that is visible to me, as a patient-focused organisation.

Q19 Chair: Minister, would you like to answer that point? Why are you not in the political leadership of this?

Dr Poulter: There is clear political leadership because sepsis is a priority. Thanks to before the reviewing period of the 2012 Act, we had work done by Andrew Lansley, the Right Honourable Member for South Cambridgeshire, when he was Secretary of State. He directly intervened to make sure that foundation doctors had their training improved. That was a clear drive from the current Government and the Secretary of State to improve care. We have also seen this as a priority in the mandate, which has only just been produced and refreshed in the last 12 months, for Health Education England. This is directly focused on sepsis and is about raising awareness. I personally wrote that, so I would take exception to the fact that that has not been something that was included in that mandate as a priority: all training for all staff. Indeed, it is something that is measured very clearly in how we

measure how well the NHS is doing in terms of, “Can we avoid deaths in the NHS?” Where deaths can be avoided, we must reduce avoidable deaths. That is a priority for NHS England. There are clear priorities that have been set by the ministerial team for the NHS.

Q20 Greg Mulholland: Professor Haslam, from a NICE point of view, is it really going to take until 2016 to get the guideline in place that is clearly needed here?

Professor Haslam: As people have said, it is a remarkable and extremely heart-breaking and moving report. NICE was involved prior to publication and throughout the time of publication, working with the Ombudsman, NHS England and the College of Emergency Medicine, because we absolutely do see this as a priority. We are responsible for producing guidance across the whole of healthcare, public health and social care, but because of the power of the message of this report, we have given this absolute priority. We normally have a two-year waiting list to begin to develop work; we have sidetracked that completely. This has got our complete priority. The work has already started, but we must ensure that we produce a world-class piece of work. The NICE methodology, which involves bringing together experts, patients, going out for full consultation, does take time. I know it is frustrating, but I frequently seek guidance and advice. It is very similar to drugs: if you get it wrong, if you do not use it properly, you run into side effects—you run into unintended consequences. This is too important to get wrong, so we have to stick to our world-class methodology.

Q21 Greg Mulholland: You are absolutely right about the level of importance, because does that not suggest that to support the guidance NICE should actually develop a quality standard on sepsis?

Professor Haslam: Absolutely, and that is what we will do. Quality standards are really brief metrics that are extracted from the guidance when it has been produced. That will then give us a means of comparing and assessing different organisations and how they have responded to this. You cannot develop the quality standard until you have got the guidance. It is almost like an executive summary of a key part of the guidance that is measurable, comparable, usable, but you cannot start with the conclusion.

Q22 Greg Mulholland: But it is going to happen.

Professor Haslam: Absolutely.

Q23 Chair: Can I just come in here? This report was produced in 2013 and my brief tells me you are not due to publish your guidance until 2016. Why does it take three years?

Professor Haslam: It takes a lot of time because of the huge amount of work that goes into this.

Q24 Chair: What I am hearing is that the best is being the enemy of the good. Any GP would be able to give you a list of symptoms that clinicians should look out for. Why does NICE not just produce this list of symptoms and instruct all hospitals that they have to make all their frontline staff aware of these symptoms and to do exercises on patients at

spotting these symptoms? This is overcomplicating and over-bureaucratising some very simple things.

Professor Haslam: I completely understand the point you are making, Chair, but it is not as if NICE has ignored this topic in the past. For instance, we have produced guidance around feverish illness in children, the early use of antibiotics in neonatal infection, infection control, neutropenic sepsis, bacterial meningitis. I have got a list here of the number of different pieces of NICE guidance that already address this. The key part here is bringing it all together into a single extremely accessible, valuable whole that will also generate the quality standard.

Q25 Chair: So it is going to take another two years?

Professor Haslam: To do it properly, yes.

Q26 Chair: How many people are involved in this in your employ?

Professor Haslam: We have a guideline development group. They are not in our employ.

Q27 Chair: I am asking, how many people are involved in this in your employ?

Professor Haslam: The majority of our work is not done by people in our—

Q28 Chair: I am asking a question: how many people in your organisation are on this task?

Professor Haslam: I cannot answer that. We are very happy to respond.

Q29 Chair: It might have something to do with why it is taking so long.

Professor Haslam: The point is that most of the work of NICE is not done by NICE. It is done by advisory committees.

Q30 Chair: Yes, but if you have got more people jolly along more of your advisers you will get more out of them more quickly. It seems quite obvious.

Professor Haslam: Well, for instance the Chair of the group is a professor of paediatric immunology. We have got clinical directors. All the people involved, apart from the patient and carer representatives, are people who are working full-time in medicine. They give their time to NICE voluntarily. We have a huge number of other projects ongoing at the same time. I understand the frustration.

Q31 Chair: I am sure if we had taken that long to invent radar, we would have lost the Second World War. I imagine inventing radar was just as complicated.

Professor Haslam: I completely understand the point that you are making, but I do believe that NICE has produced a great deal of guidance to date on this topic.

Q32 Chair: I think my Committee is likely to conclude from this that there is a complete lack of urgency in NICE.

Professor Haslam: NICE made this its absolute priority. We took it off any waiting list that we had. We gave it priority. We worked with the Ombudsman prior to the publication. I do understand your point about the excellent being the enemy of the good, but this is too important to get wrong.

Q33 Greg Mulholland: Finally, to Dr Durkin and NHS England, the Ombudsman's report was very clear that there needs to be clear clinical leadership from NHS England, but it was equally clear that has not happened. The Ombudsman has very clearly said that, until sepsis is made a national priority, with clear clinical leadership, progress is not going to happen. Yet, we have NHS England revising its business plan and its national performance measurement measures—all important things. However, that seems to have prevented NHS England identifying anyone to lead on sepsis, and to identify any national commissioning levers. So what sort of message do you think that is sending to people who are concerned about this issue?

Dr Durkin: It is a message that I do not understand, because that is not how I perceive how sepsis is being led by NHS England. I know that Sir Bruce Keogh, the Medical Director of NHS England, has spoken to the Ombudsman team about this. Sepsis is a priority for NHS England. We have clearly identified it as a priority for us in terms of our whole-system approach to patient safety improvement. It is a priority, both within Domain 5 of the outcomes framework as an indicator for infections and, as the Minister has said, Domain 1, which looks at preventable deaths, particularly looking sepsis and acute kidney injury, which are often co-related in terms of identifying indicators to improve against, in terms of years of life lost. In terms of individuals within NHS England, we have an individual who is a subject matter expert and works on deterioration, and has worked very closely with the Sepsis Trust and the Ombudsman in terms of supporting change and looking to implement recommendations.

Q34 Greg Mulholland: Who is that person?

Dr Durkin: He is one of my team.

Q35 Greg Mulholland: Can we not have a name? Is there not someone in NHS England who is there to lead on this?

Dr Durkin: Yes. I, as Director of Patient Safety, take on the responsibility and accountability for leading on all safety issues for NHS England.

Q36 Greg Mulholland: But not for sepsis specifically?

Dr Durkin: We have a number of priorities, of which sepsis is one of the highest, in terms of specific conditions. We also have priorities, as I am sure you would imagine, in terms of leadership for safety and measurement for safety. I had been the National Clinical Director for venous thromboembolism, and one of the clear lessons I learned from that was that you have to garner the whole system, and use every stakeholder in the system to effect change in a systematic way. One of the elements that we have not done yet, using the Ombudsman's report, is we have not tied in the issue of regulation against standards. I have spoken with Professor Sir Mike Richards on how they are determining, when they do their inspections and through their intelligent monitoring tool, whether or not local

systems are safe. That is his first question when the regulator inspects a hospital: “Is it safe?” He then goes on to, “Is it well led?” etc. but first, “Is it safe?” Some of the key questions he asks are, “How do they manage sepsis? Have they got a local training programme? Are they auditing against sepsis? Are they using sepsis 6?”, which is a guideline to use to enable rapid change and advancement in improving the management of sepsis. I believe that we are working very hard. I know that we have sepsis as a high priority. This year we launched a whole-system approach to patient safety improvement through 15 networks across the country to look at how local systems and local hospitals can come together with primary and secondary care, and community care. Sepsis is a priority for each of those 15 learning networks.

Q37 Greg Mulholland: Could sepsis be included in the NHS outcomes framework?

Dr Durkin: Yes, we have identified sepsis as an element there. What I would like to see us do is to see what commissioning levers we can introduce to enhance and incentivise the system to concentrate on sepsis. It worked very well for VT risk assessment, and now we are seeing a fall in deaths from VT, which is another major cause of avoidable deaths. I would like to see us work towards that. That is part of our business planning this year.

Q38 Chair: It does seem to me we are trapped in this sort of oxymoron that, as the systems are so cautious before they do anything, in fact we are losing lives. This caution, presumably designed to mitigate risk, leaves risk in the system. Do you accept that?

Dr Durkin: We have a risky system, yes. The system is full of risk. Health is a very risk-related area. Ill health becomes riskier. That is why, for me, as I said when I first started answering, the key issue is how we create the conditions in which the clinician acts in the right way, at the right pace, at the right time with their patient: that they listen to the patient; that they see from their examination of the patient that there is a deterioration in place, particularly with regard to sepsis; and that they act quickly. As a systematic response, we have helped them by creating the conditions around them that supports their active change.

Q39 Chair: By acting more quickly, couldn't you reduce the risk of people dying from sepsis?

Dr Durkin: I think we have been acting quickly. The onus now is on us to demonstrate how that action is now starting to improve local responses.

Q40 Chair: Who, in NHS England, is actually responsible for sepsis?

Dr Durkin: I would take on that responsibility.

Q41 Chair: You are personally accountable for that.

Dr Durkin: I believe I am accountable for all of the safety elements that NHS England has taken on.

Chair: Thank you for accepting that accountability. Ombudsman?

Dame Julie Mellor: Can I just build on that question, Chair? We have heard about your leadership within NHS England's responsibilities: for example, coming up with commissioning levers, when NHS England determines what those are going to be. Where

does the co-ordination take place with all the other activity around Public Health England, Health Education England, NICE, the royal colleges, CQC, so that we have a sense of someone saying, “I know that the scale and pace of action is going to add up to a whole that will save lives.”? Where does that lie?

Dr Durkin: We have a particular group—we are an executive safer care working group—which ties in all the ALBs as well as the Department of Health. Other elements of it include NICE, Health Education England, the regulators, Monitor, as well as the CQC.

Q42 Chair: When did that last meet?

Dr Durkin: We meet monthly.

Q43 Chair: You meet monthly? And when did it last meet?

Dr Durkin: We are in September. I do not think it met in August, so July.

Q44 Chair: Were you present?

Dr Durkin: At the last meeting? I cannot remember, Sir.

Q45 Chair: Are you part of that body?

Dr Durkin: Yes. If I am not able to be present, then I have deputy present.

Q46 Chair: So the last meeting was two months ago, and you may not have been at that meeting?

Dr Durkin: I cannot specifically remember whether I was at that meeting, no.

Q47 Chair: You can see how this reinforces an impression that it is not actually being given the priority it deserves.

Dr Durkin: I would like to redress that comment, because I think it is a high priority. We work very hard to deliver this improvement. That committee works very hard to help bring together all the bodies across England that are interested in patient safety.

Q48 Chair: Ombudsman, is your concern that that body is not functioning as it should, or is not effective?

Dame Julie Mellor: No, I was seeking to clarify where the locus of responsibility is to do that whole-system approach you were talking about, and whether you, as patient safety lead for NHS England, take responsibility for that co-ordination, or whether it is somewhere else.

Q49 Mrs Gillan: I declare a personal interest, because back in 2006, because of the swift action of my dermatologist, Professor Bunker, and a team at Chelsea and Westminster, I am lucky enough to be sitting here and questioning you today. I have to say, reading the case histories in the Ombudsman’s excellent report brings a tear to my eye. I do not think that anybody reading those case histories cannot be affected by them. It is not just about the

education of the medical professions. I was lucky enough to hit those medical professionals who knew what to do, and were at a level to act immediately. It is about public awareness. I would like to ask the Under-Secretary whether he, first of all, accepts the Ombudsman's recommendation for a public awareness campaign on sepsis?

Dr Poulter: First of all, it is the primary responsibility—

Chair: It is a yes or a no.

Dr Poulter: I think it is important to, as much as we can, raise public awareness of how people can recognise when they are unwell. Of course that is a good thing to do. The primary focus if we want to get this right and we want to tackle this is going to be about making sure that we have all healthcare staff, as I outlined earlier—particularly doctors but all the various healthcare staff who come into contact with patients—understanding the importance of prompt action and recognising the signs and symptoms of sepsis and what to do when a patient becomes unwell, as much as possible to take any doubt or uncertainty out of diagnosis, and then to get people to engage quickly. That is why in the training of foundation doctors, for example, there were, I believe, six protocols put into place about how to act if there are concerns about patients having sepsis.

Q50 Mrs Gillan: Minister, can I interrupt you and can I repeat the question again to you? Do you accept the recommendation for a public awareness campaign? I am talking about the reverse side of the coin.

Dr Poulter: Yes, I absolutely said that there is a role for raising public awareness.

Q51 Mrs Gillan: What have you done about it?

Dr Poulter: The public health function now, as you will be aware, is primarily directed by Public Health England. Public Health England, I believe, are going to be doing something on public awareness during September, as part of their antimicrobial resistance strategy.

Q52 Mrs Gillan: So, nothing really has been done about this in the year since the report came out.

Dr Poulter: Well, it would be interesting to know how you would want to raise public awareness, because the main awareness raising needs to be amongst healthcare staff. If we actually want to make a difference to patients, that is where the main focus needs to be.

Q53 Mrs Gillan: So you do not accept the recommendation. You are saying that it is only important for the medical professions to have that awareness, not members of the public.

Dr Poulter: No, I did not say that. It is important that the public have as much awareness as possible about when they may be unwell, be it diabetes, heart disease, and how to recognise their own signs and symptoms. There are awareness campaigns for other illnesses and diseases where people may become septic. For example, in the past there have been awareness campaigns about meningitis. There have been awareness campaigns in the past for various conditions that would put together a picture that may lead to a person becoming septic. In the past there have been a number of awareness campaigns for

specific conditions. That has already happened. However, the big, main focus of this, undoubtedly, has to be on improving the quality of medical education and training for all healthcare staff.

Q54 Mrs Gillan: Mr Daniels, can I turn to you? As far as I understand it, it is your organisation that has been raising awareness amongst the public. Like you and like your organisation, I think this is a very important part of the equation. Could you just tell me to what extent you think raising awareness amongst the public would reduce the number of deaths?

Dr Daniels: We see themes throughout Dame Julie's report, where people have had a delayed presentation to healthcare and a delayed presentation from the community aspects of healthcare through to hospital. There has to be a public awareness aspect to that. Members of the public, to my mind, need to know what some of the symptoms that might differentiate sepsis from the flu or a viral illness might be, not only so they can present rapidly to healthcare but also so that they can challenge healthcare. If we take our mother to hospital and we think our mother is having a stroke or a heart attack, we will know that if the hospital does not act rapidly something is badly wrong. The public do not yet know that for sepsis, and they need to be empowered to challenge healthcare, so that healthcare has an additional driver to get things right.

Q55 Mrs Gillan: As far as you are aware, what sort of financial resource is going into public awareness campaigns across the whole of our health system at the moment in England?

Dr Daniels: I am not aware of resources allocated specifically to public awareness. We are a small charity and we do what we can.

Q56 Mrs Gillan: I presume you would think that—I am putting words into your mouth—if some resources were put into this, good and rapid progress could be made?

Dr Daniels: I do agree with the Minister that it has to be done robustly. We would be heavily criticised if we flood emergency departments, or flood primary care, with the worried well. We do know some of the symptoms patients who later turn out to have severe sepsis describe in the early stages. That would be a very robust starting point for a public awareness campaign.

Q57 Chair: Can I just ask the Minister to chip in?

Dr Poulter: Yes, I think this is the important point, because sepsis is the concept that we are talking about, but there are many conditions that can lead to someone becoming septic. Where know public awareness campaigns work—for example, with meningitis, recognising the rash that is symptomatic, there is a specific there that it is possible to communicate to the public is a matter of concern. That is where it is important, if we are developing a campaign, as Dr Daniels just said, it has to be robust and there have to be tangibles to tie it down to. What we do not want is a situation where we are adding pressure to A&Es unnecessarily with the worried well.

Q58 Mrs Gillan: What sort of funds are the Department willing to commit to a public awareness campaign of this nature, as it is now obviously so important, and you have reaffirmed its importance?

Dr Poulter: At the moment, Public Health England are working on an awareness campaign, I believe, as part of their antimicrobial resistance strategy generally.

Q59 Chair: What conversations have you had with Public Health England about sepsis public awareness?

Dr Poulter: I have not had any conversations directly. That would be the sponsor Minister for Public Health England, the Parliamentary Under-Secretary of State for Public Health, Jane Ellison. She engages with that element.

Q60 Chair: I presume you are Minister for sepsis, otherwise you would not be sitting here.

Dr Poulter: We have a Minister for Health Services, which is my role.

Q61 Chair: Are you the Minister responsible for sepsis? Presumably you are, otherwise the Government would not have put you here.

Dr Poulter: In respect of the fact that I am the Minister responsible for health services and health service delivery, so how health services are delivered, perhaps in hospitals and elsewhere, and involved in writing the mandate for Health Education England and NHS England.

Q62 Chair: Was it your responsibility to receive this report as a Minister?

Dr Poulter: It was my responsibility to receive the report.

Q63 Chair: When you read the report and you realised that a public awareness recommendation was included in the report, what action did you take to ensure that Public Health England was going to pursue this?

Dr Poulter: Public Health England is pursuing this.

Q64 Chair: But what action did you take?

Dr Poulter: I was reassured; I was told that they are taking action. I was told by my officials that they are taking action to respond to the report, as I have outlined.

Q65 Chair: Are you satisfied they are doing enough?

Dr Poulter: I believe that there is further engagement that would be useful, probably, with the gentleman sitting to my left and the Sepsis Trust.

Q66 Chair: How have you reached that conclusion?

Dr Poulter: It is about working out, as we have just discussed here, how we tie down a public awareness campaign into specifics that people can easily identify with and recognise.

Q67 Chair: Yes, but how have you decided that you need to do more if you have not even discussed it with Public Health England?

Dr Poulter: There is always more that we can do in everything to improve patient care and improve awareness. In terms of Public Health England, they have been given a budget of over £400 million. I have not got the exact figure to hand, but they have a substantial budget to do public awareness campaigns and to raise public health issues with the public. It is clearly something that they have taken on board and taking seriously, but there may well be more that we could do.

Q68 Mrs Gillan: Can you answer a simple question? Who is going to take responsibility, politically, in the Department of Health for driving forward a public awareness campaign on sepsis? Is it you?

Dr Poulter: The sponsor Minister would be the Public Health Minister.

Q69 Mrs Gillan: So, it is Miss Ellison who is going to be responsible.

Dr Poulter: That is correct

Q70 Mrs Gillan: We can hold her directly accountable for the development of a public awareness campaign on sepsis.

Dr Daniel Poulter: Well, the responsibility for the awareness campaign will be with Public Health England, as the national body that is responsible for protecting public health.

Q71 Mrs Gillan: But she is responsible for Public Health England; the buck has to stop somewhere.

Dr Poulter: She is the sponsor Minister for Public Health England, as I am for Health Education England, and I am sure that, in the report that I am sure you will publish as a result of this, if you wish to make that case very clearly, that is for the Committee to do. Also, I will take this issue up and pass on the conversations that we have had today.

Q72 Mrs Gillan: Can I ask you to do that urgently? I have been sitting here and I have been listening to everybody talking the talk, and I am not entirely sure they are walking the walk rapidly enough. It is a year since this report came out and the progress is, positively, like a snail crawling over the ground. I would like you to take from this meeting that we would love you to have that immediate conversation with your fellow Minister, and perhaps write to this Committee to let us know exactly who is doing what and how they are going to drive forward a public awareness campaign on sepsis and what budget is going to be committed. It is only by being very definite on this that you can bring comfort to those families who have lost people, and also ensure that our Ombudsman's excellent report is being taken seriously at the highest possible levels.

Dr Durkin: Earlier this year, the Secretary of State also announced a Sign up to Safety campaign, which is a campaign for the whole system to look at how we improve on many different fronts. I have spoken to the campaign director, who has assured me that we will be making sure that sepsis is actually part of that campaign as well. That has a committed budget from the Department of Health, and has the commitment of all the major stakeholders for health in England.

Q73 Mrs Gillan: It would be good to have a note of that all pulled together, so that we can see what is being committed in terms of resources.

Dr Durkin: I will provide that for you.

Q74 Mrs Gillan: On the professional side, I think we have heard about that earlier on, but whilst on it, Dr Durkin, do you think that we are doing enough to increase the awareness of sepsis amongst our health-care professionals?

Dr Durkin: No, I do not. The evidence for that is in a recent audit from the College of Emergency Medicine, which clearly outlines that still, against standards set, those standards are not being met, in emergency departments in particular.

Q75 Mrs Gillan: We are failing people, at this stage, on that front.

Dr Durkin: As far as the local systems are concerned, it does appear that, from the audit material, there are delays in giving antibiotics, there are delays in putting patients on 100% oxygen, and there is a delay in measuring urine output and some other markers that are important. Those delays are in place. The difficult role, then, is to determine how that impacts on outcome. It is the end outcome that is difficult. At the moment, it is safe to say that there are avoidable delays that should not be happening.

Q76 Mrs Gillan: Can I just ask a simple question about the antibiotic element? I take prophylactic antibiotics and have done since 2006, and I am very aware of this campaign that giving antibiotics is bad. Isn't that absolutely the reverse message that should be given for those patients who present with sepsis? On reading the information that I have been given, it is the speed with which antibiotics are administered that is, perhaps, one of the contributory factors to having a good outcome. Do you think we have got conflicting messages, and do you think we have gone too far the other way when dealing with sepsis?

Dr Durkin: I think you are absolutely correct in that antibiotics must be given as soon as possible. As soon as there is an identification that the patient is deteriorating and that the likely cause is septic, antibiotics should be given quickly and without concern about antimicrobial resistance and stewardship for antibiotics. Early antibiotics is essential.

Q77 Mrs Gillan: Let me get this clear. What you are saying is that one campaign that is being driven by Government is actually counter-indicative to what is absolutely necessary in another area of medicine, where we are losing, possibly, 30% of the patients who present with it.

Dr Durkin: No, I think the antimicrobial resistance campaign led by the Chief Medical Officer is absolutely appropriate, and I happen to have an opportunity to sit on that group. It does not conflict with the management of the deteriorating patient with sepsis.

Q78 Chair: Dr Daniels, I will come to you in just a second. Ombudsman, how satisfied are you with the degree of co-ordination in NHS England in bringing the awareness of sepsis to health professionals?

Dame Julie Mellor: I think that is for the Committee to determine. I was trying to clarify that earlier by asking Dr Durkin questions around the responsibilities of NHS England, as distinct from the responsibilities for the mandates of the Department, so that you, as a Committee, can get a sense of whether all the relevant people are signed up and accountable for increasing the scale and pace of action.

Chair: Dr Daniels.

Dr Daniels: I just wanted to build on Dr Durkin's comments on the perceived conflict in public messages between AMR and rapid treatment of sepsis. I also chair a coalition of relevant professional bodies: the Infection Prevention Society, British Infection Association and BSAC, the British Society for Antimicrobial Chemotherapy, who have been one of the main drivers behind the AMR message. Over a year ago now, we issued a public statement to say that the messages are entirely compatible: infection management is about the rapid treatment of sepsis; it is about appropriate antimicrobial stewardship; and it is about preventing avoidable infection. Dame Sally and Margaret Chan from the World Health Organization are well aware of that statement. We have absolute compatibility.

Chair: Thank you. Minister.

Dr Poulter: Chairman, just very quickly on the issue of raising awareness—and it links to this particular point on antimicrobial resistance and appropriate use of antibiotics—given the fact that various different presentations of conditions can present as sepsis, say meningitis, one of the big areas where I would have particular concerns, and I know NHS England will want to take forward, is neutropenic sepsis, where someone has chemotherapy, or effectively has their immune system suppressed. That is something that can become life-threatening very quickly. In terms of public awareness, some of the public awareness campaign is actually about raising awareness amongst individual groups of patients, more so perhaps than having a general, wholesale public-awareness campaign. That information is best disseminated by the medical and healthcare professionals who look after them. That is quite an important point for the Committee to take away in terms of how we actually raise awareness amongst important groups of patients where there might be a risk of sepsis.

Q79 Chair: Ombudsman, that was not one of your recommendations, but do you agree with that? The public awareness campaign needs to be targeted at certain groups of patients, rather than the public in general.

Dame Julie Mellor: We have said that. It is particularly valuable for those who have compromised immune systems to know about sepsis.

Q80 Kelvin Hopkins: I want to ask you questions about information and data collection. There are some remarkable statistics here. It is estimated that there are over 100,000 cases of sepsis annually, including about 37,000 deaths. Yet, the ONS records only just over 2,000 deaths from septicaemia, the former term. There is a glaring gap there, and if the figure, I may say, of 12,500 avoidable deaths is true, that means that my constituency is having 20 avoidable deaths every year, if you average it across the country. There is clearly a serious problem with the statistics. To the Minister, where does responsibility and accountability lie for data collection and the coding of conditions such as sepsis?

Dr Poulter: You have put across quite an important issue here, which is that we have many different data sources for what is defined as sepsis. Part of that coding may well be about the responsibility for signing a death certificate. For example, giving primary and secondary causes for death will be the responsibility of the doctors and physicians who sign the death certificate, and the more qualified doctor who has been registered for a longer period is the secondary signature on the death certificate. That is a judgment that is made by the doctor. In many cases, it can be very obvious; in other cases, it is not. Some of the data we have here is from the Sepsis Trust, which says there are an estimated 37,000 people who die of sepsis each year, of which 12,500 may be preventable. You have other data from NHS England, which suggests that there are around 12,000 avoidable hospital deaths a year, and that some of those will be due to sepsis. One of the challenges of this is working out what is the right data to use. However, whatever data you do use, we have all got to recognise that there are very tragic things happening to people—and their families—who should not be dying from sepsis and we have got to do more to make sure that we improve the way that the NHS treats and looks after people with sepsis, and that we avoid people dying.

Q81 Kelvin Hopkins: The coding is clearly important, because on a death certificate it might say “pneumonia” when it actually was sepsis. It is often associated with another health condition. Is there a sense in which doctors and hospitals may prefer to have the other condition listed as the cause of death, rather than sepsis, because it might imply that they missed the diagnosis when they first came in and did not treat them quickly enough?

Dr Poulter: No, that would be illegal, and I think the coroner would have quite a lot to say about that, and I would imagine that those doctors would be very quickly struck off. That is not the case, and that is against good medical practice.

Q82 Kelvin Hopkins: But clearly there is a problem with this great gap between the estimate of sepsis deaths, which is very large, and this very small number of septicaemia deaths recorded by the ONS. Something is obviously wrong. One way this might be observed is if comparisons were made between hospitals. If some hospitals seem to have a very high proportion of patients dying of—shall we say?—pneumonia, and another one has a much higher proportion dying from sepsis, clearly, there is some mis-recording going on. Is that not a fact?

Dr Poulter: It is a very good point that we want and need to see greater transparency between different hospitals and how they treat patients across a whole range of conditions, and there is already some data out there about hospitals and standardised mortality ratios. Of course, there are multiple factors that play into that, but specifically if we want to recognise—as was said at the beginning, I think, by Dr Durkin—that there are areas of

excellence in the NHS, but there are some parts of the NHS that do not deal with sepsis as effectively, then it is through that transparency that we are going to help to raise the game in areas that need to raise their game.

One of the parts about this is getting a more consistent approach to data collection, so we really understand that. As I said earlier, it is not just about emergency medicine; a lot of patients' first point of contact with a hospital will often be through accident and emergency. The work that is going on with Public Health England, the College of Emergency Medicine, and the Department to collect and identify the right data to collect to look at sepsis is an important part of beginning to standardise and understand more effectively how to identify patients at risk, and also how we can get a better understanding in hospitals, rather than have different sets of data presented by different organisations.

Q83 Kelvin Hopkins: Perhaps I could ask Dr Daniels to say what he thinks are the current limitations in data and monitoring, and what is needed to address these.

Dr Daniels: Certainly. There is a differential between the way in which patients who die are coded, which might be through death certification and therefore on the Registry of Births, Marriages and Deaths—and which are data that will ultimately go to the ONS—and patients who survive, who are coded by clinical coders, not by doctors. The clinical coders have very little in the way of clinical training, and they rely upon what is recorded in a note, so there are several aspects to this. One is that we need to educate our healthcare professionals in what to write in the notes. The second is that the coders need some form of standard operating procedure, so they can understand how to transcribe what is written in the notes into clinical codes, and, thirdly, we have—particularly for survivors—an over-reliance on the primary diagnostic code, and if that primary diagnostic code is the underlying infection, like a pneumonia, then even if severe sepsis is included as secondary diagnostic code, a lot of audit organisations will not pick that secondary diagnosis up. We need certainly to address the way we are coding patients.

Q84 Chair: May I just intervene for a moment? Your advice seems to concur with our understanding that significant numbers of deaths from sepsis are miscoded, are mis-recorded, and with the Ombudsman's report. The Minister seems to be denying that. Have I misunderstood? You said a doctor would be struck off if they put down the wrong cause of death.

Dr Poulter: No, I was talking about misleading the coroner, and the death certificate.

Q85 Chair: Yes, but the point is perhaps a different one. I do not want to get at cross purposes and accuse you of being wrong, but it does seem to me, and our advice is, that the Office for National Statistics—and I think the Ombudsman would concur with this—significantly under-records the primary cause of death as sepsis, because the preliminary condition that might have led to the sepsis tends to be the coding that goes on the data.

Dr Poulter: I think the points just made are about the differences in coding, and potentially variability in clinical coders from one hospital to another. I do not think that is a widespread problem, but it is one that could exist.

Q86 Chair: Not just “could exist”; it does exist.

Dr Poulter: I think it is a challenge.

Q87 Chair: There are wide statistical variations from hospital to hospital.

Dr Poulter: Absolutely, and that is why there is now a group set up specifically across the College of Emergency Medicine and Public Health England, with the Department involved as well, to look at these issues and actually get the data right when patients first present into accident and emergency, and that, I think, will be a big step in the right direction to get greater consistency and help hospital staff to understand how this looks. There is other data that does exist on how we compare hospitals with each other; but, notwithstanding that, we need to have one agreed measure by which this is assessed.

Q88 Chair: Most of the Department of Health's statisticians went to NHS England, so is this one of your responsibilities, Dr Durkin?

Dr Durkin: I am not sure where the statisticians went to, Chair, but certainly I take it as one of our responsibilities to understand how we can measure avoidable deaths. In England, our context is that 250,000 deaths are recorded in hospitals per year. We have between 20 million and 25 million episodes of care that take place in hospitals per year; we have 320 million episodes of care that take place in primary care and community settings, so that is the context. Just to cut to the chase, there are two research projects that looked at retrospective case-note reviews, so they looked in-depth at case notes of patients who died to look for avoidable causes, and the first cohort was 1,000 case-note reviews; the second cohort, which is just coming to completion, was 2,400 across, first of all, 10 hospitals and now 22 hospitals. We are about to launch this as a national approach for retrospective case-note reviews in every hospital in England from 2016.

The data that is coming out from that would suggest that of the order of 5.2%—this is the PRISM 1 study that was published in 2012—of deaths were considered avoidable. That would equate to 12,500 or so deaths per year. The real question for me is where you set that threshold for avoidability. There is a real question about the threshold for avoidability, and this approach for retrospective case-note reviews, looking at in-depth the case-note file for each patient, really starts to marry up with Ron's and the Minister's view that clinical coding is a variable we want to reduce, in terms of the consistency of that threshold that is applied.

Q89 Kelvin Hopkins: This under-recording seems to be very mysterious, because looking at the Ombudsman's report, there are signs of sepsis—these six conditions—that even to an amateur, non-medical person like myself, look like sepsis. Doctors and medical staff should be able to recognise these things fairly quickly. We should get a fairly accurate estimate of how many sepsis patients there are.

Dr Durkin: I think you are right, and as we build up this approach of retrospective case note reviews, we will have that data and we will be able to identify within each year how many deaths were appropriately coded towards sepsis.

Q90 Kelvin Hopkins: One more question, to Dr Daniels: to what extent would establishing a national clinical champion for sepsis help drive better monitoring?

Dr Daniels: I think someone with overarching responsibility would have to interface reliably and well with the various stakeholders, including NHS England, Public Health England and HSCIC, for example; somebody who did that would be well placed to co-ordinate activity. It would appear from Dr Durkin's earlier comments that there is such a committee already in place, but I wonder whether that committee is sufficiently wide-reaching to access all stakeholders and whether there is the opportunity to develop a sub-committee from that committee with specific focus on sepsis. I do think a national clinical champion would be a good driver across the various stakeholders.

Q91 Kelvin Hopkins: One more question: is the Government now going to look very seriously at where there are major differences between apparent levels of sepsis infections across hospitals, areas, and even constituencies, to make sure that we are going to get a better grip on how much sepsis there is, how many people are contracting it, and how many people are dying, so that in future we make sure these avoidable deaths reduce?

Dr Poulter: Absolutely, and I think that is what Dr Durkin just talked about: how we get the data more consistent across different providers of healthcare to make sure that we recognise where the coding is not as good as it should be. Once we have data that we can be absolutely certain is more reliable, that enables NHS England to take action—as Sir Bruce Keogh did in the past—potentially to look at trusts where things are not happening in an appropriate way, and where patients may be being treated in a way that is not as good as it should be.

Q92 Chair: Are these figures on sepsis national statistics? Are they designated by the UK Statistics Authority as national statistics?

Dr Poulter: You have got some. NHS England has statistics, which you have just heard about, on the avoidable deaths. The Sepsis Trust has statistics, and there is the ONS data.

Q93 Chair: Do you understand my question? There are a certain series of statistics that are designated as national statistics, because that is the quality standard. Do these statistics have that quality standard? Dr Daniels, you are shaking your head.

Dr Daniels: Our statistics, in terms of 37,000 deaths, 102,000 cases a year, are drawn from both national within the UK and international literature.

Q94 Chair: I do not think we know: what discussions have there been between NHS England or the Department of Health and the UK Statistics Authority or the National Statistician as a result of these recommendations from the Ombudsman about statistics? Maybe, Ombudsman, you can shed some light on my question?

Dame Julie Mellor: I do not think I can. What I can say is that the data that Ron Daniels is talking about would suggest that the ONS are under-identifying reported cases of sepsis, and that that was the case in 2013, but that is different from talking about standards.

Q95 Chair: Yes, that is what we understood, but I do not think we know the answer to the question I am asking. What discussions have there been with UKSA to get them to help you improve the quality of these statistics? Has there been any discussion? No, it does

not seem so. That may be something we recommend that you do, and maybe you might do that in anticipation of a recommendation that we might make. I think we have reached the end of our questioning. Minister?

Dr Poulter: Just absolutely for the record—because I have had a note passed by officials, and I do not want to have misled the Committee at all—I mentioned that I had a meeting with Dame Julie much earlier in the year to discuss the report. It was actually, I think, in mid-December 2013, so it was a month or two previous to that. I would like to say that, just so that I have not misled the Committee.

Q96 Chair: Well, I am very pleased you have been able to put that on the record. Mr Flynn?

Paul Flynn: I have no questions.

Q97 Chair: I am very pleased you managed to put that on the record. That is very important and significant, but I do not think it alters an impression that we have gained that this report has been treated rather more as business as usual than as an exceptional report that deserved urgency and a more expedited approach. I think I speak for the Committee in saying that your innate caution might be slowing your response in a way that is actually costing lives, and I do not know how we would quantify that, but that is the impression we get. Professor Haslam?

Professor Haslam: I simply wanted to say that, whilst I understand the frustration about slowness, NICE did give this absolute top priority.

Q98 Chair: Well, God help us if it was not a priority. How long would it take then? I think that makes the point.

Professor Haslam: No, I would challenge that, on the grounds that we have the whole of health and social care to deal with, and this was identified by NICE as our number one priority, and moved to the front of the list given its priority. But we have to get it right.

Q99 Chair: I am pleased you have emphasised the point, because you obviously feel it very strongly.

Professor Haslam: I do.

Chair: And I take the point from Dr Durkin that health is a risky business, and you are managing many risks across the Health Service that are life and death risks. However, I would just like to emphasise one other point: even the statistics question is in the end—is it not?—a people question. It is a leadership question; it is a trust and openness question; and it is not just about process, procedures and protocols, but about heightening people's sense of responsibility for what is happening in front of them in the hospital, in the GP's surgery, and in people's homes. When they see a patient, are they taking responsibility, and are they aware?

I am minded to just remind us of one of the Ombudsman's recommendations: "Provider organisations should foster attitudes and behaviours amongst their front-line staff which values critical clinical thinking, timely availability of senior decision-makers, focused priorities, and prompt implementation of clinical plans." I do not know if you want to add anything before we close this session, Ombudsman, because I think the NHS Leadership

Academy has a very important role in promoting that kind of openness and trust that will allow people to exercise their judgment in front of patients and in front of their fellow professionals. I hope the panel would agree with that.

Thank you very much for being with us today. I think this has been a very important session that will certainly be important to a great many people who have lost their loved ones