Urgent Question on NHS England’s report into the death of William Mead and the failures of the 111 helpline (House of Commons – 26/01/2016)

Heidi Alexander (Lewisham East) (Lab) (Urgent Question): To ask the Secretary of State for Health if he will make a statement about NHS England’s report on the death of William Mead and the failures of the 111 helpline.

The Secretary of State for Health (Mr Jeremy Hunt): This tragic case concerns the death of a one-year-old boy, William Mead, on 14 December 2014 in Cornwall. While any health organisation will inevitably suffer some tragedies, the issues raised in this case have significant implications for the rest of the NHS, from which I am determined that we should learn.

First, however, I want to offer my sincere condolences to the family of William Mead. I have met William’s mother, Melissa, who spoke incredibly movingly about the loss of her son. Quite simply, we let her, her family and William down in the worst possible way through serious failings in the NHS care that was offered, and I want to apologise to them, on behalf of the Government and the NHS, for what happened. I also want to thank them for their support for, and co-operation with, the investigation that has now been completed. Today NHS England published the results of that investigation—a root cause analysis of what had happened. The recommendations are far-reaching, with national implications.

The report concludes that there were four areas of missed opportunity on the part of the local health services, where a different course of action should have been taken. They include primary care and general practice appointments made by William's family, out-of-hours telephone conversations with their GP, and the NHS 111 service. Although the report concluded that they did not constitute direct serious failings on the part of the individuals involved, if different action been taken at those points, William would probably have survived.

Across those different parts of the NHS, a major failing was that in the last six to eight weeks of William’s life, the underlying pathology, including pneumonia and chest infection, was not properly recognised and treated. The report cites potential factors such as a lack of understanding of sepsis, particularly in children; pressure on GPs to reduce antibiotic prescribing and acute hospital referrals; and, although this was not raised by the GPs involved, the report also refers to the potential pressure of workload.

There were specific recommendations in relation to NHS 111 which should be treated as a national, not a local, issue. Call advisers are trained not to deviate from their script, but the report says that they need to be trained to appreciate when there is a need to probe further, how to recognise a complex call and when to call in clinical advice earlier. It also cites limited sensitivity in the algorithms used by call-handlers to red-flag signs relating to sepsis.

The Government and NHS England accept these recommendations, which will be implemented as soon as possible. New commissioning standards issued in October 2015 require commissioners to create more functionally integrated 111 and GP out-of-hours services, and Sir Bruce Keogh’s ongoing urgent and emergency care review will simplify the way in which the public interacts with the NHS for urgent care needs.

Most of all, we must recognise that our understanding of sepsis across the NHS is totally inadequate. This condition claims around 35,000 lives every year, including those of around 1,000 children. I would like to acknowledge and thank my hon. Friend the Member for Truro
and Falmouth (Sarah Newton), who—as well as being the constituency MP of the Mead family—has worked tirelessly to raise awareness of sepsis and worked closely with UK Sepsis Trust to reduce the number of avoidable deaths from sepsis. In January last year I announced a package of measures to help to improve the diagnosis of sepsis in hospitals and GP surgeries, and significant efforts are being made to improve awareness of the condition among doctors and the public, but the tragic death of William Mead reminds us there is much more to be done.

Heidi Alexander: No one who watched the courageous interviews that Melissa Mead gave this morning could fail to be moved by this tragic case. I pay tribute to Melissa and her husband Paul, who have fought to know the truth about their son’s death and who are now campaigning to raise awareness and improve the care of sepsis. It is right that we should express our sorrow at what has happened, and the Health Secretary was right to apologise on behalf of the NHS. They key now is to ensure that the right lessons are learned and that action is taken. As the Secretary of State noted, the report found a catalogue of failures that contributed to William’s death, including four missed opportunities when a different course of action should have been taken. I want to press the Health Secretary on those areas.

First, the report states that William saw GPs six times in the months leading up to his death, but that none spotted the seriousness of the chest infection that cost him his life. Ministers were warned about poor sepsis care back in September 2013, when an ombudsman’s report highlighted “shortcomings in initial assessment and delay in emergency treatment which led to missed opportunities to save lives.”

Will the Secretary of State tell us what action was taken following that report? Why was it only in December 2015, more than two years later, that NHS England finally published an action plan to support NHS staff in recognising and treating sepsis?

Secondly, the report found that the NHS 111 helpline failed to respond adequately to Melissa’s call. It concluded that if a doctor or nurse had taken her call, they would probably have seen the need for urgent action. The replacement of NHS Direct, which was predominantly a nurse-led service, with NHS 111 means the service relies on call-handlers who receive as little as six weeks’ training. So when will the Health Secretary review the training call-handlers receive, and will he consider increasing the number of clinically trained staff available to respond to calls?

The report says the computer programme that call-handlers are using did not cover some of the symptoms of sepsis, including a drop in body temperature from very high to low. Does the Health Secretary have confidence that the 111 service is fit to diagnose patients with complex, life-threatening problems who may not always fit the computer algorithm call-handlers have to rely on?

Finally, may I ask the Secretary of State what he is doing to raise awareness of the symptoms of sepsis so that treatment can begin as quickly as possible? I know this is an issue that Melissa and Paul feel particularly strongly about and we owe it to them to implement the recommendations of the NHS England report and do all we can to ensure the failures in this tragic case are never, ever repeated.

Mr Hunt: I hope I can reassure the shadow Health Secretary on all the points she raised. First, there has been a sustained effort across the NHS since September 2013 to improve the standard of safety in the care we offer in our hospitals. An entirely new inspection system was set up that year. It has now nearly completed inspections of every hospital, and it has caused a sea change in the attitudes towards patient safety. Sepsis is one of the areas that is looked at. In particular it is incredibly important that when signs of sepsis are identified in
A&E departments the right antibiotic treatment is started within 60 minutes. That is not happening everywhere, but we need to raise awareness urgently to make that happen, and that inspection regime is helping to focus minds on that.

On top of that—I will come to the issues around 111, and I agree that there are some important things that need to be addressed—a year ago I announced an important package to raise awareness of sepsis. It covers the different parts of the NHS. For example, in hospitals a big package on spotting it quickly has been followed from December 2015, with NHS England publishing the cross-system sepsis programme board report, which is looking at how to improve identification of sepsis across the care pathway.

The hon. Lady is right to raise the issue of faster identification by GPs. That is why, in January 2015, I announced that we will be developing an audit tool for GPs, because it is difficult to identify sepsis even for trained clinicians, and we need to give GPs the help and support to do that. We are also talking to Public Health England about a public awareness campaign, because it is not just clinicians in the NHS, but it is also members of the public and particularly parents of young children, who need to be aware of some of those tell-tale signs.

So a lot is happening, but the root cause of the issue is understanding by clinicians on the frontline of this horrible disease, and it does take some time to develop that greater understanding that everyone accepts we need. I can reassure the hon. Lady, however, that there is a total focus in the NHS now on reducing the number of avoidable deaths from sepsis and other causes, and that is something the NHS and everyone who works in it are totally committed to.

With respect to 111, there are some things that we can, and must, do quickly in response to this report, but there is a more fundamental change that we need in 111 as well. One thing we can do quickly is look at the algorithms used by the call-handlers to make sure they are sensitive to the red-flag signs of sepsis. That is a very important thing that needs to happen. NHS 111 has in some ways been a victim of its own success: it is taking three times more calls than were being taken by NHS Direct just three years ago—12 million calls a year as opposed to 4 million—and nearly nine of out 10 of those calls are being answered within 60 seconds.

When it comes to the identification of diseases such sepsis, we need to do better and to look urgently at the algorithm followed by the call-handlers. Fundamentally, when we look at the totality of what the Mead family suffered, we will see that there is a confusion in the public’s mind about what exactly we do when we have an urgent care need, and the NHS needs to address that. For example, if we have a child with a high temperature, we might not know whether they need Calpol or serious clinical attention.

The issue is that there are too many choices, and that we cannot always get through quickly to the help that we need. We must improve the simplicity of the system, so that when a person gets through to 111, they are not asked a barrage of questions, some of which seem quite meaningless, and they get to the point more quickly and are referred to clinical care more quickly. We must simplify the options so that people know what to do, and that is happening as part of the urgent emergency care review. It is a big priority, and this tragic case will make us accelerate that process even faster.