NHS
South Tyneside and Sunderland
NHS Foundation Trust

Sunderland Royal Hospital
Kayll Road
Sunderland
Tyne & Wear
SR4 7TP

Tel: 0191 565 6256 ext 42907
Direct tel: 0191 569 9157
paul.mcandrew@chsft.nhs.uk
www.stsft.nhs.uk

28 May 2020

Mr Peter Bower
Chair
Healthwatch South Tyneside
Hebburn Central
Glen Street
HEBBURN
Tyne & Wear
NE31 1AB

Dear Mr Bower

Do Not Attempt Cardiopulmonary Resuscitation (DNACPR)

Thank you for your letter regarding the use of Do Not Attempt Cardiopulmonary Resuscitation (DNACPR) orders, and policy and practice relating to such, within South Tyneside and Sunderland NHS Foundation Trust. I can assure you that as an organisation we are committed to protecting the rights of our patients and ensuring that they are at all times involved in decisions that relate to their care.

To answer your specific points, in order:

1. ***Is your organisation acting in accordance with guidance provided in the letter; especially the paragraph in bold type at the end of page 1.***

Yes. We are cognisant of the letter, and the referenced material within the letter. As part of the response to the SARS CoV 2 (COVID-19) pandemic, the Trust established a rapid Clinical Advisory Group COVID-19 (RCAG COVID-19), of which I am chair. The aim was to provide a rapid access governance process for clinical guidance relating to COVID-19. As part of that arrangement we have considered DNACPR, and the guidance relating to COVID-19. We have also integrated it into our existing arrangements for DNACPR.

However, we have made no alteration to our DNACPR policies (see point 2 below) as COVID-19 does not remove the obligation staff have under these policies, ie "*The key principle is that each person is an individual whose needs and preferences must be taken account of individually", a*s detailed in the letter from Professor Powis et al.

What we have done is to include the clinical frailty score (CFS) within all our front of house patient documentation, so that this is now recorded and used as part of forming a full clinical picture of the patient. In addition, we have started a wider discussion on treatment escalation plans and how we can incorporate these into the usual practice of the wider organisation.

2. ***Does your organisation have a policy and procedure in place for the application of DNACPRs? If they are in the public domain could we be sent a copy and, if not, could the contents be shared with our manager Sheila Scott.***

As you know the Trust was formed on 1 April 2019, with the merger of the legacy Trusts, South Tyneside NHS Foundation Trust (STFT) and City Hospitals Sunderland NHS Foundation Trust (CHSFT). Since merger, we have been working to amalgamate many legacy policies, including DNACPR Policy (CHSFT) and Resuscitation Decision Policy (STFT). In addition we have worked to ensure that we use the same documentation across all our settings. We have a new draft policy however the consultation on this policy was delayed with the advent of the COVID-19 pandemic planning and actions. This draft new policy also includes changes in the legal framework around DNACPR that have been introduced since the previous legacy policies were produced.

Whilst we are happy to share our extant policies with you, we feel it would be helpful if you would be agreeable to wait until the new policy is ratified. Now that we are seeing smaller numbers of COVID-19 confirmed and suspected cases and are planning for the recovery phase, I consider the DNACPR policy high priority, and anticipate consultation and ratification within 3 months from the date of this letter.

Nevertheless, we are confident that other systems are in place to mitigate any risk whilst we work to merging the policies.

The Trust also uses its electronic medical record system (EMR), Meditech, as the medium to record DNACPR decisions in a manner which exactly matches the current DNACPR forms in use within the region:

Physician Care Manager - HIM Dept: CHM (DAGSUN/DAGSUN.LIVEF/DAGSUN.LIVEF) - McAndrew,Paul [GSDT]

Pha,Test4	DNACPR in place (Senior)	D00009520344	X051400000
23 F 01/01/1997	1.4m 78kg BSA:1.65m² BMI:39.8kg/m²	No NHS Number	S01249821
ADM IN DG06 DG06-3	Allergy/Adv: PENICILLINS, ACE INHIBITORS		

At **Appendix 1** is the flowchart which is available on the Trust internal intranet, which explains the process for DNACPR in the electronic world.

In addition, the Trust has a single Consent for Examination and Treatment Policy which is current for all consent-based decisions.

2. Do all the practitioners who could administer a DNACPR receive training in the policy and procedure which apply in your organisation.

All medical staff receive a dedicated session on DNACPR as part of their Trust induction; this is provided by a consultant anaesthetist with an interest in resuscitation. In addition there is signposting to additional resources (including DNACPR within Meditech) on the *Resuscitation* page of the intranet.

The Trust is also preparing a new initiative to train Advanced Care Practitioners (ACPS) in the Emergency Department to institute DNACPR decisions, within a framework developed by another Trust and adapted by the organisation. This is due to be presented to our Clinical Governance Steering Group at the end of June 2020.

3. Is there a lead person in your organisation who oversees the governance of DNACPR?

Yes. As Deputy Medical Director, and Consultant in Anaesthetics and Intensive Care Medicine, I am the lead for DNACPR and responsibilities are outlined within the Trust policies. The Trust's Deteriorating Recognition and Resuscitation Group oversees DNACPR audit, which is overseen by the Chair of that group.

4. In the letter referred to above, there is reference to a statement issued by the British Medical Association, Care Provider Alliance, Care Quality Commission and the Royal College of General Practitioners, on the role of general practitioners in this regard. Are you aware of the statement and that it is thought to provide an excellent basis for the approach required.

Yes, we are aware of the statement and do not disagree with any of the content.

https://www.rcgp.org.uk/about-us/news/2020/april/joint-statement-on-advance-care-planning.aspx

5. Are DNACPRs able to be transmitted electronically to NEAS paramedics and would they use them to help their decision-making process when they decide which call(s) to prioritise or on arrival at the scene.

No, DNACPRs are not transmitted electronically to NEAS.

I refer you to the content of **Appendix 1**, which highlights our processes for charts that come into, or leave the organisation.

We are unable to comment on how NEAS act on the information that they have at their disposal to inform clinical decision making and would refer you to the NEAS Medical Director for a response to this element of your question.

6. Are DNACPRs time limited or reviewed or do they remain in place permanently unless a suitably qualified person decides to remove the DNACPR.

DNACPR documentation is *live* documentation, and as such must be reviewed regularly. Such review might result in the rescinding of a DNACPR order, or a continuation. We require any such review to adhere to the same professional standards around decision making and discussion as when the decision was initiated.

I hope the responses provided to your individual questions are helpful however should you require any clarification please let me know.

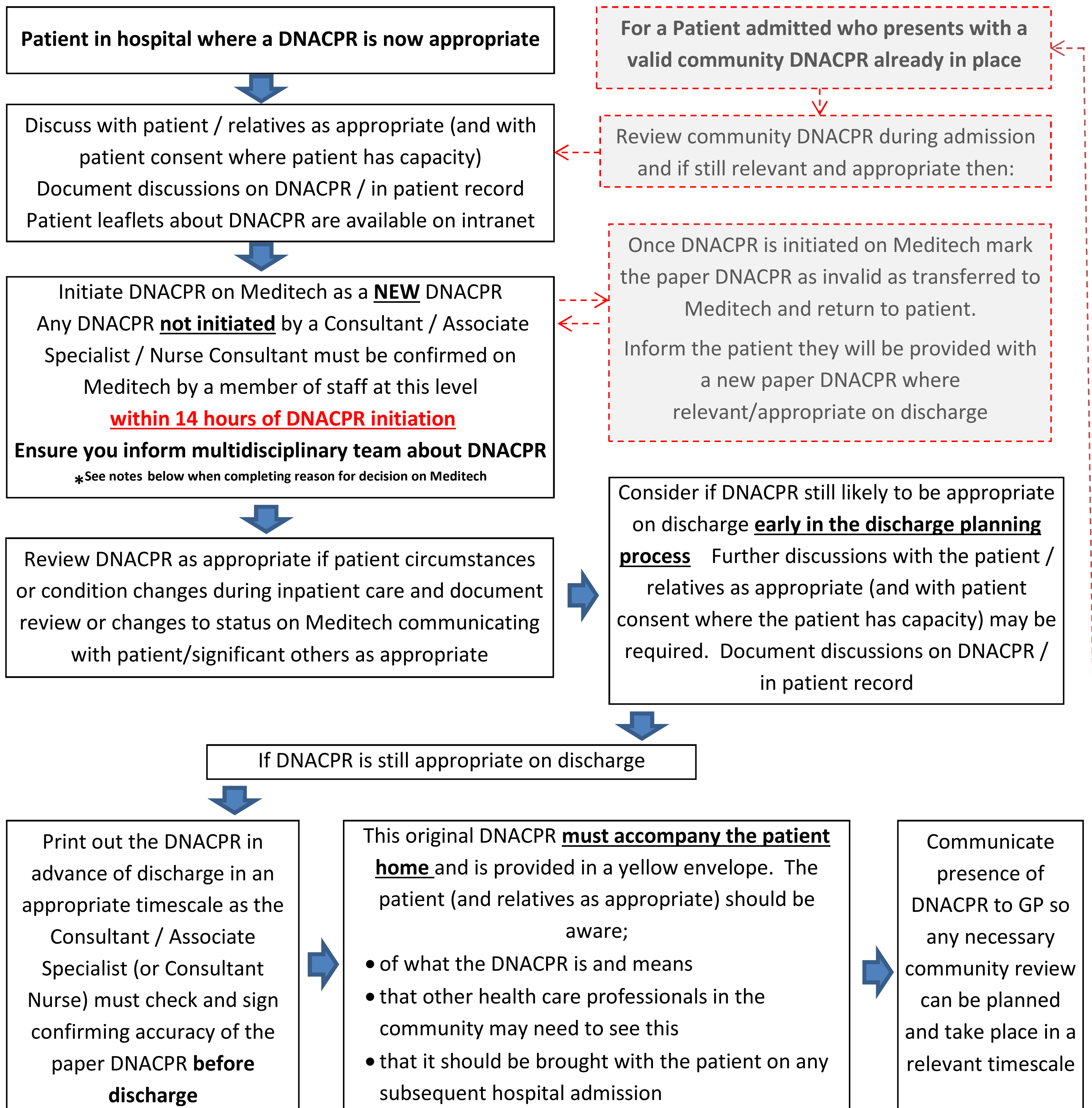
Kind regards.

Yours sincerely

Paul McAndrew
Deputy Medical Director

FLOW CHART FOR DO NOT ATTEMPT CARDIOPULMONARY RESUSCITATION (DNACPR) IN HOSPITAL USING MEDITECH

South Tyneside and Sunderland NHS Foundation Trust



DNACPR Status on Discharge

Any DNACPR initiated on Meditech is flagged on the system but any current DNACPR flag is removed on patient discharge (although historical orders can still be viewed). On any subsequent admission a **NEW DNACPR** would be required if a patient presented with an existing paper DNACPR.

*Notes on Recording DNACPR Status on Meditech

- At least one reason for DNACPR must be selected
- Where **reason one** is selected, (*'no realistic chance…'*), the following terms have been identified by the Deterioration Recognition and Resuscitation Group (DRRG) as not being clinically appropriate:
  - *Previous DNACPR, Learning Disability, Down Syndrome, Autism, Immobility, Low BMI, Prolonged recent antibiotics, Fully dependent/dependent, Age/Elderly†,* Poor chance of successful outcome, Functional Deficit, Cognitive impairment / deficit

(†More suitable clinical reasons could be used in such circumstances e.g. frailty of old age)

- When a paper DNACPR is provided at discharge, and **reason one** is selected, your text may be the only information that staff (including Trust employees) delivering community healthcare to the patient may have access to which informs them of the rationale for the decision
- The following are additional examples seen on forms, these require further clinical information to be included:
  - *As documented in V6/Meditech, As per previous decision, Transcribed from previous decision, See medical notes for details, Multiple Co-morbidities, Existing community decision , CPR would not succeed*
- Reason two can be selected in isolation where a competent patient refuses consent for CPR. Meditech notes may expand on this.