[redacted]

Telephone enquiries, please contact:
Name: [redacted]
Tel:

NHS
Leeds West
Clinical Commissioning Group

[redacted]

Mr. D. Hinchliff,
Senior Coroner, West Yorkshire (Eastern)
Coroner's Office,
71 Northgate,
Wakefield,
WF1 3BS

22nd August 2014

Dear Mr. Hinchliff,

Inquest touching the death of Joan Dorothy Richardson (deceased)
Response to Regulation 28: Report to prevent deaths

Your report issued following the inquest into the death of Ms Richardson was passed to me, as the responsible Medical Director, by [redacted], the Chief Officer of Leeds West Clinical Commissioning Group. The family have my, and the organisation's, sincere condolences. I hope I am able to reassure you and them that the actions outlined in this response that have been taken, and are being taken, will prevent the likelihood of future deaths in similar circumstances.

Please accept my apologies for the delay in this response but, as you will be aware, I believed it was necessary to address fully the concerns raised in your report for me to coordinate a response, not just on behalf of NHS Leeds West Clinical Commissioning Group (the CCG), but also from NHS England (West Yorkshire Area Team). The latter organisation is responsible for the contractual obligations and performance of general practitioners and also for dealing with formal complaints when addressed to several parts of the NHS as is this case. The CCG is responsible, among other things, for supporting quality improvement in general practice which includes the commissioning of staff training as well as the necessary medical cover provided to maintain safe access to care for patients during training sessions. Your key matter of concern is the provision of safe medical cover during training sessions in general practice for the reasons raised in your report

As you rightly state, it is correct and appropriate for GP Practices to have time, and continue to have time, for staff training. For many years in Leeds a regular cycle of half-day training afternoons have been held called TARGET (Time for Audit, Reflection, Guidelines, Education & Training). In Leeds West ten such afternoons are held each year with five being in-house sessions where practices arrange their own event and five are organised centrally with GPs, practice nurses and other practice staff being required to attend an organised training event off-site. These sessions are organised on dates set over a year in advance. The Leeds CCGs commission the provision of GP out-of-hours care (the services which operates during the times practices are closed at night and weekends) to provide additional cover during this protected learning time commencing at mid-day on the training day.

NHS Leeds West Clinical Commissioning Group
Unit 2-4, WIRA House, West Park Ring Road, Leeds, LS16 6EB
Tel. 0113 843 5470 Fax. 0113 843 5471

This service consists of identical cover to that during out-of hours periods, that is a clinically based telephone triage (accessed via the NHS 111 urgent care number operated by the Yorkshire Ambulance Service NHS Trust) with the option for further telephone assessment and advice, face-to-face consultation at a number of primary care facilities in the city, or the provision of a home visit by a GP depending on the patient's clinical condition (operated under contract to the NHS by Local Care Direct). The three Leeds CCGs run their TARGET events in very similar fashion but they are held on different days to allow the providers of the medical cover to more easily provide the necessary capacity.

As you state in your report, practices should provide patients and the public with advance and adequate notice of practice closures for training and with clear instructions on how to seek urgent medical attention. The usual processes for doing this include:

- a telephone recorded message informing callers to the practice of the NHS 111 service if urgent medical attention is required;
- clearly visible signs at the entrances to a practice stating how to access urgent medical attention (ie via calling NHS 111);
- similar notices can be displayed in waiting rooms, in practice leaflets and newsletters, and on practice websites.

The first two methods are expected as a minimum and the other methods are recommended as good practice.

I refer you to the attached letter from [redacted] (acting Medical Director, NHS England West Yorkshire Area Team) which sets out the obligations of practices to provide medical cover during contracted hours. This includes during agreed closure periods such as TARGET. You will note that she and her team are taking responsibility to ensure that:

1. Fountain Medical Centre is meeting the required standards
2. all practices in West Yorkshire are reminded of their obligations and
3. your concerns are communicated to NHS medical director colleagues across the country.

I have discussed the recommendations of your report with my colleagues, the Medical Directors of Leeds South & East CCG and Leeds North CCG, and we have agreed the following:

1. A letter will be sent to all practice managers and senior partners in Leeds jointly from the local CCG medical director and NHS England (West Yorkshire) acting Medical Director reminding practices of their obligations as set out above and recommending:

    a. They review the prominence and clarity of their advertising of how to seek medical attention when the practice is closed for training
    b. They ensure recorded telephone messages are similarly clear
    c. They all provide advanced notice of training closure days and how to access urgent medical attention on their websites, on practice noticeboards and practice newsletters / leaflets

d. They undertake appropriate training with reception staff to ensure that consistent, clear and safe messages are given to any patient who attends in person at the practice reception if clinical staff are away from the practice at a training event.

e. Particular attention will need to be paid by practices who operate from buildings where other services are also located and which may remain open during the training sessions to ensure that the advertising and the training of other staff within the building are able to safely advise any patients who arrive at the building of how to seek urgent medical attention.

2. At the earliest possible opportunity, a statement will be made at a centrally organised TARGET event in each of the three CCGs reiterating the obligations and recommendations set out in the letter.

NHS England will then continue to monitor and ensure that practices are meeting their contractual obligations.

I hope these actions assure you that we are taking appropriate steps to address your concerns.

One further matter of concern which has become apparent during the preparation of this report is that during initial investigations into a complaint raised by the deceased's partner, carried out by NHS England (West Yorkshire), it appears the deceased attended another NHS contracted service (the St George's Minor Injuries Unit provided by Local Care Direct) on the morning of 21st November 2013 although this was not referred to in your report. An investigation led by NHS England is continuing into the care received at this unit and I have been assured that the Medical Director of Leeds North CCG (which holds lead contractor responsibility for urgent care services on behalf of the three Leeds CCGs) and I will be informed of the progress and findings of this investigation.

If I can be of any further assistance please do not hesitate to contact me.

Yours sincerely

[redacted]

[redacted]

Medical Director,
NHS Leeds West Clinical Commissioning Group

Encl Letter from [redacted] acting Medical Director, NHS England (West Yorkshire)

Cc [redacted]
[redacted] Medical Director, Leeds North CCG
Medical Director, Leeds S&E CCG