NHS England

Professor Sir Bruce Keogh
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Mrs Louise Hunt
HM Senior Coroner
Birmingham & Solihull Districts
50 Newton Street
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28 June 2017

Dear Mrs Hunt

Re: Johan Stone Pambou (deceased)

Thank you for agreeing to an extension of time for us to respond to your Regulation 28 Report into the tragic death of Johan Pambou. I would like to express my deep sympathy to Mr Pambou's family.

In this letter I outline the actions that have been taken and proposals for next steps.

In your report you identified two main matters of concern.

1. **Systems and record keeping in the GP practice.** Four letters were received asking for this child to receive pneumovax23 vaccination from February 2016 to November 2016. None of these letters were actioned by the GP. You raised concern that there was no adequate system in place to monitor and act on letters received from hospitals which means other essential treatment may be missed for other patients.
2. **Availability of pneumovax vaccine 23**. You heard evidence from the GP in this case that attempts were made to obtain the vaccine in June 2016 but it was unavailable. You were advised that the vaccine continues to be unavailable, raising concern that GPs will not be aware where to access the vaccine.

To inform our response, we have engaged with Public Health England and Merck Sharp & Dohme (MSD) the manufacturers of the Pneumococcal Polysaccharide vaccine (Pneumovax) over the issue of availability of the pneumovax vaccine 23. In addition, a serious incident group has been established which has met on 22 May 2017 and 9 June to discuss the local issues relating to the care provided to Johan Pambou at his general practice.
The serious incident group representatives include;

- Dr Dhamija and the practice manager from the GP practice – Lea Village Surgery
- Screening & Immunisation lead and manager (Public Health England, West Midlands)
- NHS England Quality lead (West Midland)

- Birmingham Cross-City Clinical Commissioning Group (CCG)
- The Clinical Governance lead for the Midland Medical Partnership
- Consultant paediatric haematologist – Birmingham Children's Hospital (BCH)

The outcome of the serious incident process is to establish a root cause analysis (RCA) and to identify learning that can inform actions which can be taken locally to improve safety as well as to inform wider learning which can be shared across NHS England.

Systems and record keeping in the GP practice.
Your Regulation 28 Report identified deficiencies in how communication from Birmingham Children's Hospital had been actioned by the GP practice.
Once a patient with sickle cell disease reaches the age of 2 years of age they should receive a single dose of Polysaccharide Pneumococcal Vaccine (PPV). BCH routinely request this for affected patients from their GP Practice. Sickle cell patients would then need subsequent PPV immunisation every 5 years.

NHS England commissions a national PPV enhanced service which requires participating practices to identify and offer PPV to eligible patients through a 'proactive call and recall basis.' The enhanced service requires practices to have a system for identifying and calling / recalling at risk individuals which should occur independent of any letter from specialist services.

Lea Village Surgery had signed up to deliver the PPV enhanced service, however the significant incident review identified that there was poor record keeping in the practice with no documentation that the requested action in the February and March letters were undertaken on receipt of the letters. This falls short of the expectations of a practice providing this service and the commissioning team will consider what contractual action should be taken in the circumstances.

In June 2016, prompted by a conversation with Johan's parents, the practice state that they had sought advice from the community specialist nurse about the appropriate vaccine.

The serious incident review has identified confusion over terminology regarding the name of the appropriate vaccine. Communication between the practice nurse and the community specialist nurse failed to establish that 'Polysaccharide Pneumococcal Vaccine' (which the practice had in stock) was the same vaccine as 'Pneumovax23' which was the recommendation from BCH.

The Incident group has found that the systems and processes governing patient related communication at the Lea Village surgery was poor, however, since the inquest, the practice has merged to become a member of the Midland Medical Partnership (MMP). At the time of the merge, MMP were not aware of the findings at inquest.

The Incident group have received assurances that MMP have undertaken a thorough review of Lea Village Surgery's systems and processes. The review has established that PPV *was* likely to have been available at the practice in June 2016 and further stocks were received in October 2016.

An action plan has been developed and implemented by MMP which has included the setting up of regular dedicated immunisation clinics and a recent audit has demonstrated robust electronic recording of actions from hospital letters.

Availability of pneumovax vaccine 23
Although you heard at inquest that attempts were made to obtain the vaccine in June 2016 but it was unavailable, findings from the serious incident meeting have subsequently shown this to have been mistaken.

This has been supported by our inquiry of MSD who have confirmed that whilst there had been some intermittent interruptions in the availability of PPV vaccine between September 16 until the end of the year, there had been **no** interruptions in vaccine availability between January and September.

Many vaccines have supply issues from time to time as they are a biological products that can take a long time to manufacture and can fail quality testing and are influenced by worldwide demand/supply issues

GP practices are kept up to date with vaccine supply issues through a publication 'Vaccine Update' which is the monthly PHE publication for anyone involved in delivering immunisations https://www.gov.uk/government/collections/vaccine-update. Public Health England (PHE) informs commissioners via the National Immunisation Network (scheduled every 2 weeks) of vaccine supply problems with instruction to cascade to local providers what action to take and which cohorts of patients should be prioritised. PHE also alerts providers via notification on the ImmForm ordering and data collection system of supply problems.

Further clinical advice is available from the screening and immunisation team (SIT) via england.wmid-imms@nhs.net – the team can signpost to any national guidance on prioritisation of patients during a period of vaccine shortage.

Despite these systems, the system broke down in relation to the care offered to Johan Pambou. It is evident that this was not due to a vaccine supply shortage but in part caused by confusion over vaccine nomenclature. NHS England will write to Public Health England to inform them of this incident so that they can include the learning in their planning for further communication with front line staff. We are aware that PHE is considering further means by which communication with practices can be enhanced by developing a regional or national cascade.

Next steps
Whilst the serious incident review process is not yet complete, it has identified a number of issues which need to be addressed locally and which need to be disseminated more widely so that lessons can be learnt.
These are:

1. The need for adequate coding of significant disease to allow robust follow up and recall
2. The need for a robust system in general practice to ensure actions requested by outside parties are managed

3. Ensuring practices are aware of the escalation process if there are issues with availability of vaccinations.

In addition, there is a need to establish how a provider like a Trust (in this case Birmingham Children's Hospital) escalates a concern if they become aware that a required action is not being addressed by a patient's GP.

A letter to GPs has been developed and shared with Local Medical Committee (LMC) for comment prior to dissemination to all local GPs by the regional Medical Director, Dr Kiran Patel. The LMC has also contacted all practices on 15 June to reinforce the responsibilities and actions required at practice level in compliance with the enhanced service.

The letter will be shared with all regional medical directors in NHS England for onward circulation to ensure there is national sharing of these learning points. The incident group is next meeting on June 29 and will continue to oversee the process to establish effective systems and processes at the Lea Village Surgery site so that NHS England can be confident that the practice is providing safe and effective care.

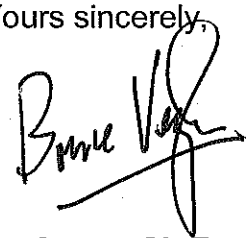
Contractual or regulatory issues will be addressed by the relevant teams within NHS England and the commissioning CCG.

I can confirm that NHS England has convened a Performance Advisory Group to consider the issues and the regulatory process is underway to address capability and conduct issues of the GP.

Summary
This is a tragic case of what could have been a preventable death of a young child. We are taking action to ensure individuals and the wider system, learn the lessons of how such deaths could in the future be prevented.

Thank you for raising these issues through the formal processes, I hope I have been able to reassure you that whilst your concerns were well founded. NHS England is taking action to address the risks of such an event occurring again in the future.

Yours sincerely,



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