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Clinical Commissioning Group

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Private and Confidential
Mrs Jacqueline Lake
Senior Coroner for Norfolk
Norfolk Coroner Service
Carrow House
301 King Street
Norwich
NR1 2TN

11 November 2019

By post and
By email to: [redacted]

Dear Mrs Lake

Re: The late Tyla Katherine Joan Cook

Regulation 28 Report to Prevent Future Deaths dated 17 September 2019: West Norfolk CCG's response

I refer to the Report to Prevent Future Deaths (PFD) dated 17 September 2019 issued following the Inquest into the death of the late Tyla Katherine Joan Cook.

The PFD Report was sent to West Norfolk Clinical Commissioning Group (CCG) together with the Chief Executives of Norfolk and Suffolk NHS Foundation Trust (NSFT), The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust (QEH) and Norfolk County Council (NCC). It was also copied to East of England Ambulance Service NHS Trust (EEAST) as an Interested Person for the Inquest.

Point 3 of section 5: Coroner's matters of concern in the PFD Report relates to a multi-disciplinary learning event involving participants from NSFT, QEH, NCC and EEAST. This matter of concern is jointly addressed to West Norfolk CCG, NSFT, QEH and NCC ('joint addressees') who are under a duty to respond by 12 November 2019.

This letter comprises West Norfolk CCG's response to the Point 3 of section 5 of the PFD Report. Copies of this letter will be sent to the Chief Executives of the joint addressees and also, for information, to the Chief Executive of EEAST.

Point 3 of Section 5: Coroner's concerns

For ease of reference, Point 3 of Section 5 is set out below (using the above abbreviations for the stakeholders):

> "3. *The Review carried out by the West Norfolk CCG in May 2019 recommended a multi-disciplinary learning event involving participants from NSFT, QEH, NCC and EEAST be developed and implemented to train staff on how to apply good non-technical skills (teamwork, leadership, task prioritisation and communication) when responding to an emergency.*
>
> *At the inquest it became clear no steps have been taken to organise this event and there is confusion as to who is responsible for arranging this learning event. The Care providers indicated it was for West Norfolk CCG. The West Norfolk CCG do not appear to accept responsibility for organisation of the event.*
>
> *Tyla Cook died on 15 November 2017. The West Norfolk CCG Review was published 8 May 2019. No steps have been taken with regard to this learning event, save EEAST who has been in contact with the West Norfolk CCG. There is concern that a multi-disciplinary learning event will not be organised and will not take place."*

West Norfolk CCG response

Background and context

The Review referred to at point 3 of Section 5 comprises Recommendation 2 of the Action Plan to the independent Investigation Report dated 08 May 2019 (the 'Action Plan' and 'Investigation Report') compiled by an independent reviewer commissioned by West Norfolk CCG.

The key points of Recommendation 2 are summarised as follows:

1. A multi-disciplinary learning event ('the learning event') involving participants from NSFT, NCC, EEAST and QEH must be developed and implemented to train staff on how to apply good non-technical skills when responding to an emergency.
2. QEH to set up a pan-Trust and West Norfolk CCG task and finish group ('the task and finish group') to develop the learning event designed for NSFT, QEH, NCC, West Norfolk CCG and EEAST.
3. The task and finish group to be led by QEH's named Deputy Director of Patient Safety with the group's members from each organisation to include NSFT, EEAST and NCC with their representatives also named.
4. The task and finish group led by QEH's Deputy Director of Patient Safety to deliver the learning event.
5. The target dates for implementation of the task and finish group and delivery of the learning event were 30 June 2019 and 31 October 2019 respectively.
6. West Norfolk CCG has associated monitoring responsibilities for Recommendation 2 (via our Serious Incident Review Panel) to include that the learning event has taken place.

The Investigation Report was issued in the week before the initial date for the Inquest to commence in May 2019 and provided to the Coroner at that time. The proximity of the dates of the issue of the Investigation Report and Inquest aside, the plan was that the learning event would take place after conclusion of the Inquest. This was in order for any learning or other issues from the Inquest to be captured in one event.

In the event, as the Inquest was deferred from the initial date of May 2019 to September 2019, the date of delivery of the learning event was in turn deferred. However this did not preclude initiating and undertaking the action required to set up the task and finish group and preliminary arrangements for the learning event.

Issues

The issues in point 3 of section 5 comprise:

- **Issue 1**: Clarification and confirmation of the lead organisation with responsibility for organising the learning event
- **Issue 2**: The organisation and delivery of the learning event to ensure and assure that it takes place

Issue 1: Lead organisation for the learning event

Recommendation 2 clearly states that firstly, the task and finish group is responsible for the implementation of the recommendation (i.e. is the 'action owner'). Secondly, that QEH and its Deputy Director of Patient Safety are the organisational and individual leads respectively for this recommendation.

The CCG was not aware that there was any issue about the lead for Recommendation 2 until we received QEH's submissions dated 15 September 2019 made to the Coroner in respect of prevention of future deaths via our solicitors on 16 September 2019. This was despite requesting each of the 3 NHS trusts to provide an update to us on the relevant actions for their organisation by Friday 30 August 2019. This was both to monitor progress but also in anticipation that the Coroner may require and request this information.

Neither NSFT nor QEH responded to us specifically as regards Recommendation 2. On 30 August 2019, EEAST advised us that it was taking part in 'a workshop with all involved' and was awaiting dates to be shared and further information.

Paragraph 25 of the QEH submissions states that a meeting took place on 24 June 2019 between QEH's Medical Director [redacted] and Deputy Director of Patient Safety and the CCG's Director of Nursing and Quality Assurance (QA) and Deputy Director of Nursing and QA to discuss the taking forward of a 'joint training event'.

Further information regarding this meeting was provided in the statement of QEH's Deputy Director of Patient Safety dated 16 September 2019 which we received after the conclusion of the Inquest and receipt of the PFD Report. In the statement, the Deputy Director of Patient Safety refers to Recommendation 2 Action 1 of the Action Plan and that he had been given an action to set up a task and finish group and arrange a learning event. He references a meeting on 24 June 2019 which QEH's Medical Director [redacted] and he attended with the CCG's Director of Nursing and QA and Deputy Director of Nursing and QA. He states that this action was discussed and the CCG agreed to facilitate and lead on it.

Having reviewed this statement, the CCG's Director of Nursing and QA has confirmed that the meeting on 24 June 2019 was set up in response to her letter of 10 May 2019 sent to QEH's then Medical Directo[redacted] Chief Nurse Advisor and Acting Chief Nurse. The letter referenced the Investigation Report and assurance on the learning and associated actions and requested a meeting with all QEH addressees to discuss the care and service issues identified for QEH in the Investigation Report.

The CCG's Director of Nursing and QA has confirmed that:

- Whilst she attended the meeting on 24 June 2019 with QEH's Medical Director [redacted] and Deputy Director of Patient Safety, the CCG's Deputy Director of Nursing and QA was not present in relation to the discussion regarding the Investigation Report – also confirmed by the Deputy Director of Nursing and QA.
- Her recollection of the meeting is that the CCG and QEH agreed that QEH would commence or complete their actions on the Action Plan. Also that the CCG would defer its action on Recommendation 7 – after-action review (i.e. until after Inquest). There was no discussion regarding a 'joint training event' and/or Recommendation 2.
- Given the nature of the meeting, there was no requirement (or request) for formal minutes to be taken, approved and circulated. She did not receive any written follow up from QEH as to the outcome and actions from the meeting.

Accordingly there was no agreement by the CCG at that time or subsequently that the CCG would take the lead on any training event or Recommendation 2.

In summary on this point relating to Recommendation 2:

- West Norfolk CCG has always understood and proceeded on the basis that QEH and its Deputy Director of Patient Safety were the leads for Recommendation 2 and, prior to the contact from the Coroner's officer during the Inquest, was not aware that there was any issue relating to this.
- At no point did the CCG agree to take over from QEH as the lead on Recommendation 2 and/or any training event referred to in the Action Plan.

  Given the specific and frontline nature of the action under Recommendation 2 which relates to providers, the CCG would not have been an appropriate lead on this action and, for this reason, would not have agreed to this. Our participation and involvement in the action and task and finish group relates to advising the providers on the commissioning of any services necessary to complete the action.
- Had QEH provided a written update of the outcome and actions to the CCG following the meeting on 24 June 2019, any issues about the lead for Recommendation 2 could have been identified and resolved at that point.

  Similarly, this would have been identified and resolved if QEH had responded within the deadline to the CCG's request in mid-August 2019 for an update on its actions under the recommendations in the Action Plan and specifically Recommendation 2. In the event, the Deputy Director of Patient Safety responded on 16 September 2019 solely in relation Recommendation 9 – Duty of Candour.
- Neither NSFT nor EEAST have indicated to the CCG at any point their understanding is that the lead for Recommendation 2 was transferred from QEH to the CCG.
- In relation to the reference (in point 3 of Section 5) to EEAST's contact with the CCG, EEAST has confirmed that the only contact it has received centrally throughout the process is from the CCG and the independent reviewer commissioned by the CCG. This is in relation to the investigation or progress on the Action Plan.

On reflection, West Norfolk acknowledges that:

- The CCG having initiated the meeting with QEH on 24 June 2019, arrangements should have been put in place for the outcome and actions from the meeting to be documented and circulated within a reasonable timeframe for agreement by the attendees; and

- As QEH's response for an update on its actions on the Action Plan was not received by the deadline of 30 August 2019, the CCG should have sent a further request soon after this date and then escalated within QEH.

Actions

In relation to the lessons learned on this aspect and with the aim of preventing similar events occurring:

1. The CCG will contact QEH as regards the implementation of agreed governance arrangements for the management of less formal meetings.

   Specifically that the outcome and actions from meetings will be documented and circulated by a named person within a reasonable timeframe for agreement by the attendees (also within a reasonable timeframe).

   Action date: The CCG has identified a proposed CCG lead and a potential QEH lead for this action. The CCG will contact QEH by Monday 25 November 2019 (i.e. after QEH has received a copy of this letter).

2. The CCG will implement more robust governance arrangements for tracking QEH's responses to prescribed deadlines and action where these have not been met.

   Action date: This action was commenced by the CCG on 06 November 2019 – a proposed CCG lead and options for taking this forward have been identified.

Issue 2: Delivery of the learning event

In order to progress Recommendation 2 to completion, the action taken and proposed by West Norfolk CCG comprises the following.

The CCG has:

- Arranged for the task and finish group (with attending representatives from NSFT, EEAST, QEH, NCC and West Norfolk CCG) to meet on 04 November 2019 to discuss the development of the learning event. **Action completed 04 November 2019**.

- Requested QEH (Risk and Safety team) to draw together the learning from the Investigation Report for consideration by the task and finish group (in line with Action 1 of Recommendation 2). **Action completed 01 November 2019.**

The task and finish group meeting on 04 November 2019 was attended by representatives (the 'group members') from NSFT, EEAST, QEH, NCC and the CCG and chaired by the CCG.

The actions (with provisional timescales to be confirmed by the group members) agreed at the task and finish group meeting are ongoing and include:

- Tyla's parents are to be updated by the CCG as to the action that has been taken and is proposed in relation to Recommendation 2.

- The learning event is to be arranged to take place for mid-February 2020 (this broadly equates to the same period for implementation of the learning event in the Action Plan in relation to the Inquest date).

- An External facilitator for the learning event has been identified by West Norfolk CCG and is available for the proposed date of the learning event.

- The materials to be developed for the learning event are to include a pen portrait of Tyla (his parents are to be invited to share their wishes on this), changes made by NSFT and QEH in light of the incident and key messages from the staff involved in the incident. Information regarding the relevant Lessons Learnt will also be included e.g. Lesson Learnt 12 - Monitoring of acute physical health deterioration.

- As part of the sharing and dissemination of the outcomes of this incident and the Investigation report, the invitees to the learning event are to include senior operational staff from the Emergency Department at Norfolk and Norwich University Hospitals NHS Foundation Trust (NNUH) and James Paget University Hospitals NHS Foundation Trust.

I hope that this response addresses the issues raised in the PFD Report as these relate to West Norfolk CCG and is of assistance to you.

Should you require any further information or wish to discuss with me, please may I request that you contact [redacted], my PA, in the first instance, who will make the necessary arrangements. [redacted] can be contacted on [redacted] or by email: [redacted]

In the meantime, I propose to update you about the outcome of the learning event when it has taken place early next year.

Yours sincerely

Cath Byford
Chief Nurse
The NHS Clinical Commissioning Groups for Norfolk and Waveney

CC:

Professor Jonathan Warren, Chief Executive, NSFT

Andrew Proctor, Executive Leader, NCC

Caroline Shaw, Chief Executive, QEH

Dorothy Hosein, Interim Chief Executive, EEAST

Melanie Craig, Chief Officer, NHS Clinical Commissioning Groups for Norfolk and Waveney

[redacted], Associate Director of Nursing and Quality, NHS Clinical Commissioning Groups for Norfolk and Waveney