NHS
Health Education England

Chair and Chief Executive's Office

2nd Floor, Stewart House
32 Russell Square
London
WC1B 5DN

Sent via email;
Dr Karen Henderson,
HM Assistant
Coroner for West Sussex
[redacted]

15 March 2023

[redacted]

Dear Dr Karen Henderson

RE: – Regulation 28 Report - Teegan Marie Barnard

I write in response to your report of 17 January 2023, made under paragraph 7, Schedule 5, of the Coroners and Justice Act 2009 and Regulations 28 and 29 of the Coroners (Investigations) Regulations 2013. I have been asked to respond on behalf of Health Education England. Please may I start by offering my sincere condolences to the family of Teegan Marie Bernard, following her tragic death. However, having carefully considered the report, together with the facts of the case, we believe that whilst there are valuable lessons to be learned; Unfortunately, these do not come within the scope of HEE's current role and statutory responsibilities.

Your report raises concerns regarding both the care Teegan Marie Bernard received, together with the handling of evidence shortly after her death and the Trust's obligations in relation to its statutory Duty of Candour. Your report also highlighted concerns around the Trust's procedures and process for investigating an unexpected death. We acknowledge that the Chief Executive of Health Education England (HEE) has been identified as having a duty to respond and the report has also been sent by the coroner to other national bodies including:

- [redacted], Chief Executive U. Hospitals Sussex NHS Foundation Trust
- [redacted], Medical Director, St Richards Hospital, Chichester
- The Chief Executive NHS England
- The Chief Executive of the Care Quality Commission.
- President, Royal College of Anaesthetists
- President, Association of Anaesthetists Great Britain, and Ireland

To respond to your concerns, I will first clarify HEE's current role in relation to the education and training of the medical, nursing and health workforce. HEE is currently a non-departmental public body accountable to the Secretary of State and Parliament. On the 1 April 2023, Health Education England will become part of a new organisation within NHS England. As part of the NHS, we work with partners to plan, recruit, educate and train the health workforce. HEE's primary functions will continue; this being to serve the people of England by educating, training, and developing healthcare professionals. However, HEE does not have responsibility for decisions on the local NHS workforce or resources and nor do we mandate training or clinical procedure for consultant medical staff, this is the responsibility of local NHS Trusts.

We recognise that both the Ockenden Report and the review and report into maternity and neonatal services in East Kent: *'Reading the signals,'* have placed a much-needed focus on what now must be done to raise standards of care in maternity services. We are working to implement the *Immediate Action Areas* in the Ockenden Report. This includes the recommendation that the Department of Health & Social Care (DHSC) must work with the Royal College of Obstetricians and Gynaecologists (RCOG) and HEE to consider how to deliver an adequate and sustainable level of obstetric training posts to enable trusts to deliver safe obstetric staffing over the years to come.

Regarding the independent investigation led by [redacted] into failures in East Kent; like our system partners we are working at pace to ensure the four areas for action are considered and implemented:

- identifying poorly performing units
- giving care with compassion and kindness
- teamworking with a common purpose
- responding to challenge with honesty

HEE, together with our system partners acknowledge there are areas where the NHS must do much better and this is now informing our approach, in delivery of the workforce of the next 15 years.

I would like to draw your attention to the work, which HEE has led on, around training in patient safety. This carefully designed training series is designed to be used by staff and clinical practitioners at all stages of their career and regardless of whether their roles are patient facing or not. This is because we believe that patient safety is everyone's business. Patient safety training materials have been developed by Health Education England, with NHS England and NHS Improvement, The Academy of Medical Royal Colleges and e-learning for healthcare. Completion of this training is helping to ensure health and care services will be made as safe as possible for patients and service users.

I hope this response provides assurance that steps are being taken to improve patient safety, together with ensuring the workforce has the appropriate knowledge and skills to deliver the very best patient outcomes. This is in line with the NHS Long Term Plan priority areas.

Finally, on behalf of HEE, I thank you for bringing these matters to our attention and the awareness of others.

Yours sincerely,

[redacted]

[redacted]
Chief Executive