Tees, Esk and Wear Valleys
NHS Foundation Trust

Office of the Chief Executive
West Park Hospital
Edward Pease Way
Darlington
Co Durham
DL2 2TS

20 October 2023

Private & Confidential

Ms J Richards
HM Assistant Coroner
for County Durham and Darlington
H M Coroners Office
PO Box 282
Bishop Auckland
Co Durham
DL14 4FY

Dear Ms Richards,

Re: Report to Prevent Further Deaths issued on 19 July 2023 in relation to Mr Kenneth Rippon

I am writing to you in response to your direction in the prevention of future deaths notice served to Tees, Esk and Wear Valleys NHS FT on 19 July 2023 regarding the death of Mr Kenneth Rippon to provide in writing further information on what the Trust is doing to ensure Serious Incident reviews are completed within a timely manner as well as an update on the estimated time of arrival for each outstanding review.

I am responding in the same format and with similar information to that in the response letter sent September 2023, I hope this consistency will be helpful in enabling you and your team to see the clear evidence of the progress we are making towards providing timely serious incident reviews. I have continued to have direct oversight of how we are performing as I am concerned that we improve our position as soon as possible. Our Board share this concern and therefore I have asked the Chief Nurse to keep our Quality Assurance Committee and our Board fully briefed.

The following action has been taken:

1) We have contracted in additional expert capacity in incident reviews to actively address the reviews that are delayed. Since, my previous update we have contracted / employed further reviewers and to date we have allocated 41 of these reviews which is an increase of 16 since my previous letter to you.
2) We have continued to increase our internal capacity to review incidents, our clinical and leaders are engaged across services in completing incident reviews in order that we can review incoming incidents and avoid further delays developing.
3) We have reviewed all incidents to ensure we have met Duty of Candour, that families have received notification of a review and have a named contact person and that we have a clear term of reference for each review. We report weekly to the Executive Directors on our compliance with Duty of Candour to ensure there are no delays.

4) An external company specialising in incident management has reviewed our historical incident data so that we can address the potential risks of missing issues and learning due to a delay with some reviews.
5) We have adapted processes to facilitate much earlier identification of the type of review required (concise or full) – this now takes place at the daily patient safety huddle, and we follow the national, soon to be Patient Safety Incident Response Framework (PSIRF), guidance for this. It is anticipated that we will increase the number of concise reviews, where appropriate, in line with this national guidance.
6) We have also adapted our processes to ensure they identify immediate / early learning for each incident and that we take immediate improvement action where appropriate. We never wait for a full investigation before implementing any immediate action necessary to reduce the risk to other patients and service users. While a full investigation will often have a broad scope and capture learning which is not directly relevant to a death, immediate learning is designed to eliminate or reduce any identified patient safety issues. We have examples of Trust wide patient safety briefings we have developed following immediate learning.
7) We have in place weekly sitrep / report out meetings to ensure we are sighted on the progress of each review and can provide any additional support to reviewers that may be needed. We will be monitoring our performance against the trajectory we have developed, and this is being reported to executive directors on a weekly and monthly basis.
8) We are reporting to our regulators and regional leaders via the mandated Quality Board our progress and have demonstrated progress.
9) We have modified our documentation, reviewed our report templates and are utilising standard operating procedures to support efficient working and flow.
10) We have increased our internal Serious Incident Review Panel capacity to ensure we can be efficient in our internal quality assurance in order that this does not delay the release of reviews to families once completed.
11) We have increased our Family Liaison Capacity so that we can better support families and ensure that they are enabled to ask questions about their loved one's care as a part of the review process.
12) We will continue to expand our range of subject matter expert categories to lead specific types of reviews.
13) The Associate Director of Patient Safety commenced in post as planned from 19 July 23 and is being supported by the Deputy Chief Nurse who commenced at TEWV 3 July 2023. Together they are ensuring that reviews are of the right standard and that reviewers have the right support and supervision to complete high quality reviews.

Since we last wrote to you we have made steady and consistent progress with allocating and completing incident reviews and at the beginning of this week we reported only 13 reviews outstanding for allocation across the whole of TEWV services, we also reported this to our Quality Board which is chaired by our regional Chief Nurse. This is a significant improvement.

I hope that the progress list and the actions outlined above will provide some assurance that we share your concern about the delays in serious incident reviews and that we are focussed on eradicating the delays.

Finally, I wish to restate that I would welcome an opportunity to meet and discuss these issues as would our Executive Medical Director and Chief Nurse.

Yours Sincerely

[redacted]

[redacted]

[redacted]

Chief Executive