NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Tarncroft
Lanchester Road Hospital
Lanchester Road
Durham
DH1 5RD
[redacted]

13 September 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.

On the 3 July 2023 I wrote to [redacted] proactively to articulate the actions we are taking to ensure we review care in accordance with the standards required in the NHS framework. I confirmed at this time that I have written personally to each of the families where a review was overdue and apologised sincerely for the further distress we may have caused. I speak on behalf of the TEWV Board in saying we fully recognise that this is not acceptable, and we will make improvement.

In responding to this PFD, I will reiterate the steps we have taken, the additional steps since 3 July 2023 and a summary of the progress we are making.

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 I last wrote to you, we have allocated a further 16 serious incident reviews, we have completed a further 10, there are 8 reviews in the final stages of quality assurance and / or proof reading prior to submission and there has been a further 5 deaths of people who we understand will have a hearing within your jurisdiction. This means that apart from which review which requires an external review due to the nature of the incident all serious incident reviews are underway, this is a significant improvement.

I have taken the opportunity to share an updated version of the list of the serious incident reviews that I have previously shared with you to be open and transparent and to demonstrate progress. You will see from this list that of the reviews that are not yet complete the majority

are working to a clear timeline for internal quality assurance which is also 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, whilst the purpose of this letter is to articulate how we are meeting your direction, I wish to re state that the driver for me and my colleagues is the recognition that these delays potentially have an impact on people who have lost someone dear to them. It is not acceptable, and we are committed to working with the people who come into contact with our services in a proactive and compassionate way.

Yours sincerely,

[redacted]

Chief Nurse

Encs.