NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

Tarncroft
Lanchester Road Hospital
Lanchester Road
Durham
DH1 5RD

11 September 2023

Private & Confidential
Mr Chipperfield
HM Senior Coroner for County Durham and Darlington

Dear Mr Chipperfield

Re: Report to Prevent Further Deaths issued on 15 August 2023 in relation to Mr Ian Darwin

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 15 August 2023 regarding the death of Mr Ian Darwin 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 last month, 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 CEO and our Board share this concern and therefore I am keeping our Quality Assurance Committee and our Board fully briefed.

Whilst we are continuing to improve, we are paying particular attention to ensuring that families have good information to help them understand what a serious incident review is and how they can be involved.

We have good evidence that the recovery plan is meeting the improvement trajectory which we also report to our regulators and NHS England.

I hope the following summary is a helpful reminder of the action we have taken:

1) We have contracted in additional expert capacity in incident reviews to actively address the reviews that are delayed, this is a group of incidents that happened before February 2023. Some of these reviews are now being concluded and are going through the internal quality assurance checks before we share them with the families, submit to the ICS and to your office. The attached document gives the detail of this.
2) We have increased our internal capacity to review incidents by engaging our leaders in completing incident reviews in order that we can review incoming incidents and avoid further delays developing. We intend to continue to use some of this capacity and expertise in the future which is part of our plan to avoid delays in the future.
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.

4) We commissioned an external company who specialise in incident management to review our incident data and establish if incidents are being properly categorised and therefore responded to. We recognised that with a delay there was a risk we were missing issues and we wanted to be proactive.
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 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 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.
9) We have modified our documentation, reviewed our report templates and are utilising standard operating procedures to support efficient working and flow.
10) To ensure timely presentation and review of reports we are introducing more flexibility to our Serious Incident Review Panels and as we have allocated a lot of reviews over a short period we are planning ahead the 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 will continue to expand our range of subject matter expert categories to lead specific types of reviews and we are currently contracting with an external provider who are a professional incident review company. Again, this is an opportunity to avoid delays in the future.

I have taken the opportunity to share a list of the serious incident reviews that we believe will be required by you and I have indicated the dates that we expect the internal quality assurance process to be taking place. You can reasonably expect to receive most finalised serious incident reports within 2 weeks of the internal review however some will take longer than two weeks depending on, and this is difficult to predict, when the final report is available for review.

From November 2023 we anticipate being able to allocate an SI review within the month the incident occurs. This is significant improvement.

I hope this information meets your direction.

Yours sincerely,

Chief Nurse

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