Department of Health

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Our reference: PFD-1086888

Ms Karen Henderson
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Dear Ms Henderson

18th September 2017

Thank you for your letter of 7 June 2017 to the Secretary of State about the death of Mr Dennis Teesdale. I am responding as these matters fall within my portfolio and I am grateful to you for allowing extra time for the Department to determine our response.

I was very saddened to read of the circumstances surrounding Mr Teesdale's death. Please pass my condolences to his family and loved ones.

Your Report detailed several, serious areas of concern in the care and treatment provided to Mr Teesdale at the Queen Victoria Hospital, East Grinstead. I can appreciate how distressing these circumstances must be for Mr Teesdale's family, and I am truly sorry that the NHS failed to provide adequate care and treatment to Mr Teesdale.

You issued your Report to the Queen Victoria Hospital NHS Foundation Trust, NHS England and the Care Quality Commission (CQC). As the matters you raise concern specific service quality and patient safety issues, you were right to do so. In addition, my officials have made enquiries with NHS Improvement, which has lead responsibility for patient safety in the NHS in England, as well as oversight of NHS providers.

In light of this incident and the concerns raised, I understand the Surrey and Sussex Quality Surveillance Group (QSG) agreed to establish a single item QSG to review the safety and quality issues raised and the action taken to respond to this incident.

NHS England and NHS Improvement co-chaired the single item QSG, held on 3 August, which brought together the Trust, commissioners and regulators to review the mitigation plans, gain assurance around the delivery of safe and sustainable surgical services at the Trust and to identify any system support required.

I am advised that Professor Sir Bruce Keogh, Medical Director NHS England, has responded to you with details of the action being taken following the meeting of the QSG. You will therefore be aware that this includes enhanced governance arrangements to monitor the implementation of the Trust's action plan; temporary cessation of PEG insertion at the Queen Victoria Hospital; and strengthening partnership working between the Queen Victoria Hospital NHS Foundation Trust and the Brighton and Sussex University Hospitals University Hospitals NHS Trust, among other actions.

I am further advised that NHS England is satisfied that clinical outcomes at Queen Victoria Hospital are, in general, within recognised limits and that current clinical activity, subject to the restrictions and improvements identified, may continue while the Trust addresses the issues raised in your Report.

I am informed that the Care Quality Commission will visit the Queen Victoria Hospital to assess the existence and utilisation of relevant protocols particularly surrounding the recognition and management of the deteriorating patient, and will monitor implementation of the Trust's action plan.

I understand that the Trust has responded to you on your concerns and I hope that reply is helpful. I am aware the Trust has apologised for the failings identified in the care and treatment provided to Mr Teesdale, and has detailed the steps it has taken to learn from his deeply regrettable death.

I hope those responses provide some assurance to you and Mr Teesdale's family that the concerns you have raised have been considered carefully.

I would like to assure you that improving patient safety across the NHS is a key priority for the government. We want to continue improving how the NHS investigates and learns from mistakes when things go wrong, as we work towards making the NHS one of the safest healthcare systems in the world.

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The need for an unremitting focus on continual learning in the NHS, to prevent the same mistakes from happening again, was reinforced in the Care Quality Commission's report of December 2016, *Learning, candour and accountability: A review of the way NHS trusts review and investigate deaths of patients in England* (www.cqc.org.uk/content/learning-candour-and-accountability). The review found that learning from deaths is not being given sufficient priority and that Trusts need to do more to engage bereaved families.

We are taking forward a national programme with system partners to support Trusts to improve the way they learn from the deaths of people who were in their care. This responds to the recommendations in the Care Quality Commission's report, all of which were accepted by the Secretary of State. In March, the National Quality Board responded to one of the highest priority recommendations by publishing *National Guidance on Learning from Deaths* (www.improvement.nhs.uk/resources/learning-deaths-nhs-national-guidance/). The guidance provides a national framework for Trusts on identifying, reviewing, investigating and learning from deaths. It also places an important emphasis upon the need for Trusts to be open with bereaved families and involve them appropriately in any investigation.

We are also requiring individual Trusts to publish on a quarterly basis from 2017-18 estimates of how many deaths they could have avoided had care been better.

Finally, I am satisfied that the regulators are alert to the risks you have highlighted, and it is for NHS Improvement, NHS England and the Care Quality Commission, working with the Trust and its commissioners, to ensure sufficient and appropriate action is taken to address the concerns raised. My officials have asked to be kept informed of developments.

I hope this reply is helpful. Thank you for bringing the circumstances of Mr Teesdale's death to our attention.

Yours sincerely

Ph. Dunne

PHILIP DUNNE