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|---|---|
| **REPORT TO:** | **BOARD OF DIRECTORS** |
| **DATE:** | **8 SEPTEMBER 2017** |
| **SUBJECT:** | **MEDICAL DIRECTOR'S REPORT** |
| **BOARD SPONSOR:** | **MEDICAL DIRECTOR** |
| **PAPER AUTHOR:** | **MEDICAL DIRECTOR** |
| **PURPOSE:** | **DISCUSSION** |
| **APPENDICES:** | **ANNEX A: TRUST RESPONSE TO CARE QUALITY COMMITTEE (CQC) LETTER OF CONCERN**<br>**ANNEX B: CQC LETTER INDICATING NO ENFORCEMENT ACTION** |

**BACKGROUND AND EXECUTIVE SUMMARY**

This report encompasses the following areas:

1. Infection Prevention and Control (IPC)
   The written report following the NHS Improvement NHSI led quality review of infection prevention and control on the 8 and 9 August has yet to be received. C. difficile figures are below Department of Health (DH) trajectory for this year to date. There have been no infection control incidents for this period.
2. Hip Fracture Mortality Update
   Preliminary analysis following a review of 60 hip fracture related deaths is presented in the report. Mortality appears chiefly related to post-operative care. All cases have been reviewed using the structured judgement review methodology. Overall care was rated either poor or very poor in 23 of the 60 cases and there will be clear actions and recommendations to be undertaken once the review has been completed and a report has been formulated.
3. Medicines Safety
   With the better establishment of pharmacists the Director of Pharmacy has been able to reintroduce medicines safety spot audits which indicate an emerging risk for patient safety through omission of doses of critical medicines. This is discussed in greater detail in the report.
4. Never Events and CQC
   Following a number of non-fatal never events the CQC had issued a letter of concern which the Trust has responded to, subsequently receiving a response from the CQC indicating that they were assured that necessary action had been taken.
5. VTE update
   The picture continues to slowly improve, overall Trust performance is at 92% (required performance is 95%+), Specialist Division achieve the highest performance and now average 95.4% for the last 12 months.

| | |
|---|---|
| **IDENTIFIED RISKS AND MANAGEMENT ACTIONS:** | Risks:<br>Risks to patient safety from poor safety culture evidenced by sub-standard post-operative care, omission of medicines, never events and sub-standard compliance with VTE assessment recording.<br>Actions:<br>Recommended actions resulting from the hip fracture |

| | |
|---|---|
| | mortality review are awaited; actions to address medicines omissions are underway; specific human factors training has been identified to address required actions from root cause analysis of never events; and action to improve VTE assessment recording compliance continue. |
| **LINKS TO STRATEGIC OBJECTIVES:** | **Patients:** Help all patients take control of their own health.<br>**People:** Identify, recruit, educate and develop talented staff.<br>**Provision:** Provide the services people need and do it well.<br>**Partnership:** Work with other people and other organisations to give patients the best care. |
| **LINKS TO STRATEGIC OR CORPORATE RISK REGISTER** | SRR 2 - Failure to maintain the quality and standards of patient care<br>CRR 18 - Failure to comply with the recommendations in the Mazar's report which include case note review of each and every patient death<br>CRR 22 - Failure to record/carry out timely Venous Thromboprophylaxis (VTE) risk assessments<br>CRR 47 - Inability to prevent deterioration in the number of healthcare associated infection metrics |
| **RESOURCE IMPLICATIONS:** | N/A |
| **COMMITTEES WHO HAVE CONSIDERED THIS REPORT** | N/A |

| | |
|---|---|
| **PRIVACY IMPACT ASSESSMENT:**<br>*NO* | **EQUALITY IMPACT ASSESSMENT:**<br>*NO* |

**RECOMMENDATIONS AND ACTION REQUIRED:**

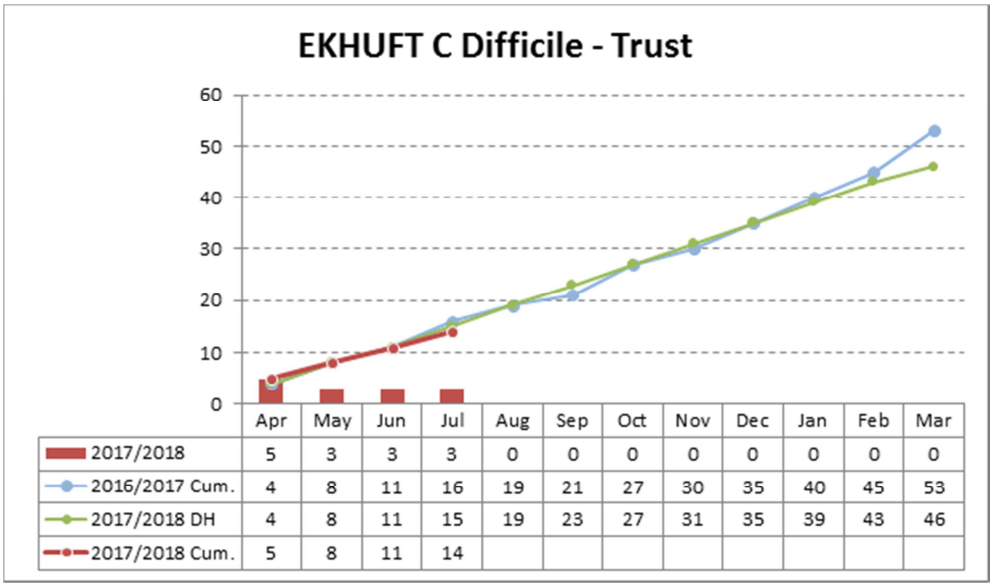
The Board is asked to note, review and discuss the risks and required actions as necessary.

1. Infection Prevention and Control

NHSI conducted a quality review of IP&C on the 8 and 9 August but the formal report following the visit has not yet been received. Verbal feedback was presented to last month's Board.

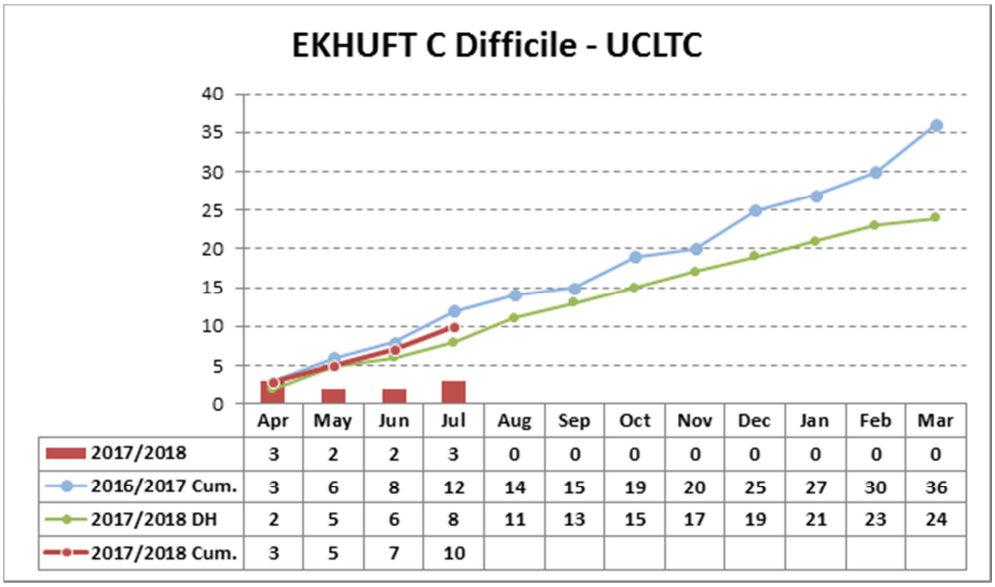
1.1 C.difficile and MRSA

The IP&C team continue to remain particularly concerned about both C.difficile and MRSA within the Trust. The graph below indicates that as a Trust we continue below the DH trajectory for this year.




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/2018 | 5 | 3 | 3 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 2016/2017 Cum. | 4 | 8 | 11 | 16 | 19 | 21 | 27 | 30 | 35 | 40 | 45 | 53 |
| 2017/2018 DH | 4 | 8 | 11 | 15 | 19 | 23 | 27 | 31 | 35 | 39 | 43 | 46 |
| 2017/2018 Cum. | 5 | 8 | 11 | 14 | | | | | | | | |

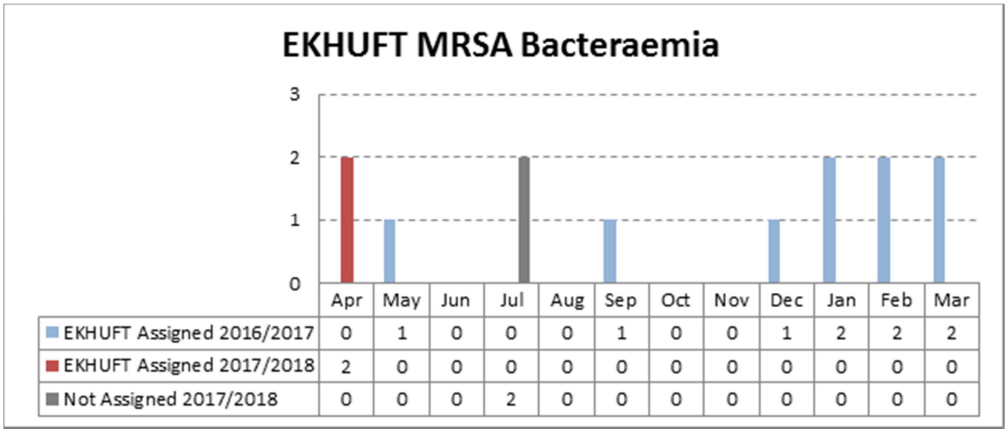
However, within the most vulnerable division figures are above trajectory, although thankfully better than the previous year.




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 2017/2018 | 3 | 2 | 2 | 3 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| 2016/2017 Cum. | 3 | 6 | 8 | 12 | 14 | 15 | 19 | 20 | 25 | 27 | 30 | 36 |
| 2017/2018 DH | 2 | 5 | 6 | 8 | 11 | 13 | 15 | 17 | 19 | 21 | 23 | 24 |
| 2017/2018 Cum. | 3 | 5 | 7 | 10 | | | | | | | | |

Our Trust count at the end of August was 15 against a DH trajectory of 19, to put that in perspective the total number of Trust assigned cases in the South of England is currently 424 and only 9 of the 36 Trusts contributing data are in a better position than us.

The picture with MRSA currently is that there were 2 unassigned cases of MRSA bacteraemia confirmed in July (as shown in the graph below), it is likely that one of these will be assigned to the Trust (this was a contaminant, ie a result of poor blood culture technique and not a true bacteraemia).




| | Apr | May | Jun | Jul | Aug | Sep | Oct | Nov | Dec | Jan | Feb | Mar |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| EKHUFT Assigned 2016/2017 | 0 | 1 | 0 | 0 | 0 | 1 | 0 | 0 | 1 | 2 | 2 | 2 |
| EKHUFT Assigned 2017/2018 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Not Assigned 2017/2018 | 0 | 0 | 0 | 2 | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |

1.2 Influenza

The 'Stay Well This Winter' campaign begins with the 'Flu vaccination campaign in October. In terms of influenza infection we generally tend to follow experience in Australia and New Zealand and the news from down under is not good. There has been almost two and a half times the number of laboratory confirmed notifications of influenza reported to the National Notifiable Diseases Surveillance System in Australia this year when compared with the same period last year. Influenza A(H3N2) was the predominant circulating influenza A virus reported.

2. Hip Fracture Mortality Update

In last month's report I advised that there was a difference in mortality following hip fracture between the 2 acute sites, 30 day mortality in Ashford being 9.9% and in Margate 6.1% against a national figure of 6.5% from the National Hip Fracture Database (latest figures March 2017). Helen Goodwin and Michelle Webb have since reviewed the case records of 60 deaths following hip fracture at the William Harvey Hospital from between January 2016 and May 2017. In reviewing these deaths they have also used the new structured judgement review methodology. Reported below are some key facts extracted from the raw data.

The average age was 88.4 years (range 68-99), 32 patients were female, 28 male. Only 10 patients were fully independent prior to admission, 53 of 60 were admitted with their hip fracture and the average number of long term conditions on admission was 2.8 (range 1-5). Average length of stay (LoS) was 17.9 days (range 1-59), overall LoS for WHH hip fracture patients is 22.5 days, versus an overall LoS of 15.9 days at Queen Elizabeth the Queen Mother Hospital (QEQMH) and an overall national LoS of 21.3 days.

Six patients were too unwell for operation and surgery was undertaken in less than 36 hours in 41 of the remaining 54 (no different from national data). 48 of the 54 patients operated on had an American Society of Anaesthesiology (ASA) score of 3 or more and 17 had an ASA score of 4 or more. An ASA score of 3 indicates severe

systemic disease and a score of 4 indicates severe systemic disease that is a constant threat to life.

Overall care was rated either poor or very poor in 23 of the 60 cases using the structured judgement review methodology. In one case death was thought to be definitely avoidable, in 2 there was strong evidence of avoidability (both these cases were referred to the coroner), in 5 death was probably avoidable (more than 50:50) and in 11 death was assessed as possibly avoidable but not very likely (less than 50:50). In the remaining cases death was either definitely not avoidable (29 cases) or there was slight evidence of avoidability (12 cases). The next immediate actions are to ensure that where indicated the duty of candour was followed and to extract, disseminate and embed the learning from these cases.

3. Medicines Safety

As the Director of Pharmacy has rebuilt the clinical pharmacy service he has been able to reintroduce the medication safety thermometer. To date a snapshot audit has been carried out on 9 wards in the Trust and some headline data is shown in the table below together with national comparison.

| | Medicines reconciliation | Omitted dose | Omission of critical medicine | Allergies documented |
|---|---|---|---|---|
| Bishopstone | 47.40% | 36.80% | 42.10% | 100% |
| Cambridge L | 52.20% | 8.70% | 4.30% | 100% |
| Cambridge K | 17.60% | 35.30% | 5.90% | 94% |
| Sandwich Bay | 37.50% | 18.80% | 0.00% | 100% |
| Minster | 24.40% | 13.30% | 8.90% | 100% |
| Kingston | 24.00% | 20% | 4.00% | 100% |
| Mount Mcmaster | 28.10% | 18.80% | 9.40% | 96.90% |
| Kennington | 27.30% | 27.30% | 27.30% | 100% |
| Birchington | 8.30% | 16.70% | 25.00% | 100% |
| Trust | 32.10% | 24.30% | 14.70% | 99.10% |
| All Organisations | 70.80% | 11.90% | 7.10% | 96.30% |

This is a snapshot taken on a single day but it presents an emerging and potentially serious safety risk. There is good evidence that omissions of medicines pose a threat to patient safety, particularly in respect of missed doses of critical medicines. This also aligns with incident reports on Datix where omitted doses are one of the most frequently reported medication incidents. There are many reasons for omission of medicines including poor prescribing, distraction, staff shortages, inappropriate or incomplete actions, failing to identify a medication actually present and missing stock. As part of the medication safety plan for the Trust the Medication Safety Officer (MSO), supported by the clinical pharmacy service, is working with the ward teams to address the issues identified above.

Immediate actions will include:

- Gathering further data: The medication safety thermometer monthly audit will be undertaken on 16 wards each month in a rolling program to cover all wards across the Trust in a cycle.

- Supporting improvement: All wards will receive a follow up report, support and advice to make improvements; those areas with particular issues will receive more intensive support. This is in place now as part of the roll out.
- Sharing the learning: This will include the results of the safety thermometer and feedback of the learning and themes arising from medication incidents review by the Medicines Safety Group.
- A Trust wide view will be presented on a quarterly basis at the patient safety board starting from Q3 2017-18.

The ward teams are being supported to actively mitigate the risk of missed doses, especially those where omissions can rapidly have significant and serious consequences for patients' health and outcomes. Regular progress updates will be provided to the Board until we are assured that the right safety culture is embedded and part of routine clinical practice.

4. Never Events and the CQC

The Trust had received a Letter of Concern from the CQC following five never events involving surgical procedures reported by the Trust between October 2016 and July 2017. The CQC were concerned that further never events might occur if the Trust failed to identify root causes and effectively learn from historic never events to drive improvement. They therefore sort assurance from answers to the following questions:

- What role specific training do staff involved in surgical procedures receive in relation to the WHO surgical checklist and human factors?
- What does this training consist of?
- How do you gain assurances that staff are competent following training?
- Had the staff involved in the latest five never events received this training?
- How will you ensure new starters will receive the appropriate training?
- How do you ensure the culture within the surgical services allow for open and honest discussions?
- How do you ensure the WHO surgical checklist is used correctly in all settings performing surgical procedures?
- What actions have you taken to ensure learning from never events is disseminated to all staff working in the surgical service?
- What actions did you take to support the staff involved in the never events to prevent reccurence?

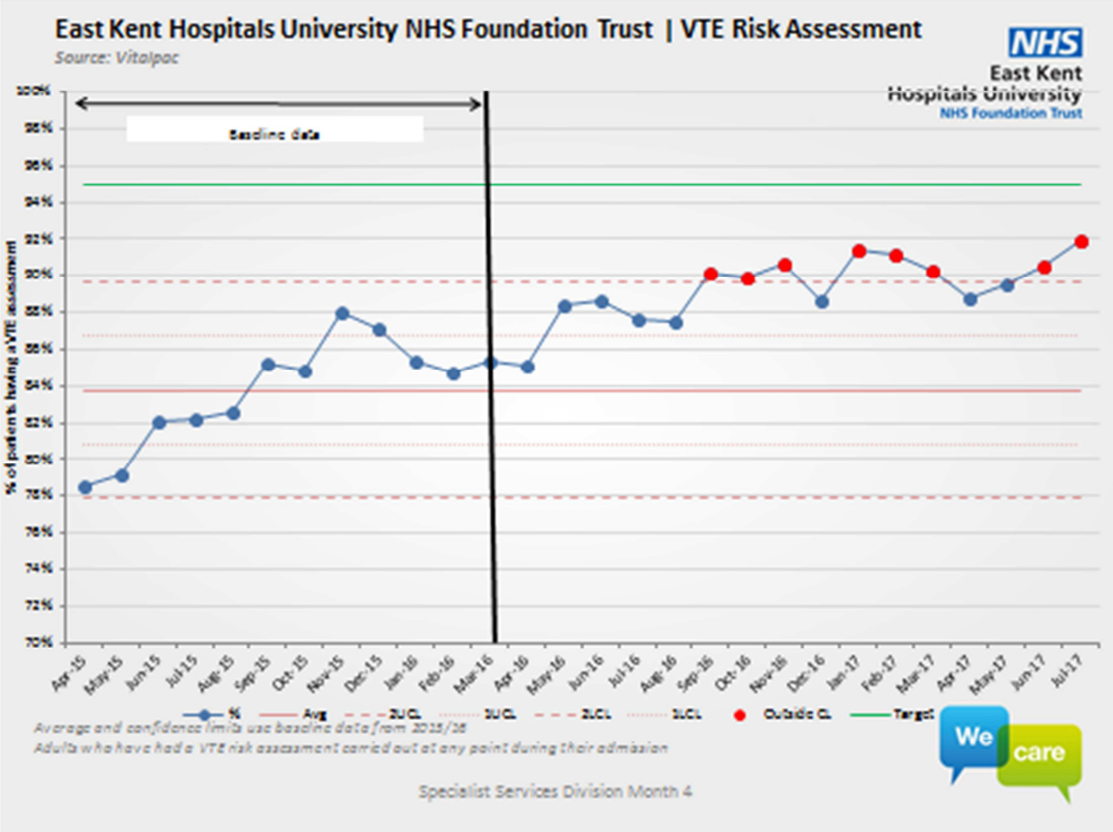
A full report detailing responses to these questions together with evidence and data to support the responses was sent to the CQC on the 22 August and also shared with our CCG colleagues (response letter attached at Annex A). The Trust has since received a letter in return from the CQC indicating that no enforcement action is required (CQC latter attached at Annex B).

5. VTE Update

VTE assessment recording continues to be given a high profile in the monthly performance reviews and is also subject to a regular contract performance meeting with the CCGs. Overall Trust performance is 92% (charted in the figure below). The best divisional performance is from the Specialist division who have now achieved

95.6%, 96.5% and 96.2% in the last 3 successive months, Urgent Care and Long Term Conditions achieved 90.4% in August and Surgical Services 89.5%.

VTE performance data



Annex A: Response to CQC Letter of Concern

East Kent Hospitals University NHS Foundation Trust

Our Ref: MK/

22 August 2017

Mr Alan Thorne
Head of Hospital Inspections
CQC HSCA Compliance
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA

Trust Offices
Kent and Canterbury Hospital
Ethelbert Road
Canterbury
CT1 3NG

Web: www.ekhuft.nhs.uk

***From the Chief Executive: Matthew Kershaw***

Dear Alan

**Re – Issues of concern following a never event in June 2017**

Thank you for your recent letter of 08 August 2017 outlining the number of never events reported by the Trust and specifically involving patients undergoing surgical procedures.

There have been five never events reported by the Trust from 03 October 2016 to 31 July 2017. Four of the five were associated with procedures within the Surgical Division and one, the wrong site surgery, from within the specialty of dermatology, which falls under the responsibility of the Specialist Division and was undertaken within a dedicated, but separate, operating theatre. I have briefly outlined the issues in the table below and the completed Root Cause Analyses are available should you wish to wish to review these as part of this process. We are still investigating the two latest never events reported and, therefore, we are still to extract the key learning points.

**Table 1 – Surgical never events**

| Incident date | Never Event category | Division | Severity |
|---|---|---|---|
| 03/10/2016 | Wrong site anaesthetic block (wrong leg) | Surgery | Low harm |
| 04/12/2016 | Wrong site surgery (dermatology) | Specialist Services | Severe harm (due to permanent scarring) |
| 08/12/2016 | Wrong site surgery (tooth extraction) | Surgery | Moderate harm |
| 08/06/2017 | Wrong site anaesthetic block (wrong leg) | Surgery | Moderate harm |
| 31/07/2017 | Wrong implant (femoral nail in error for tibial nail) | Surgery | Moderate harm |

I have responded to each question posed within your letter in order and I hope this provides you with sufficient detail. The responses outline the specific training and development within theatres/anaesthesia and also from a corporate perspective where there is a more detailed programme of training in Human Factors and simulation.

1. What role specific training do staff involved in surgical procedures receive in relation to the WHO surgical checklist and human factors?

1.1. Theatres and anaesthetics
All new anaesthetic trainees have mandatory Simulation Centre training, all of which incorporates human factors training as part of the programme. All anaesthetists are required to attend the Trauma Team Members (TTM) training as part of their mandatory training – this has a strong focus on human factors training. Pre-course material must be studied www.learn-ed.org.uk/ttm. The dedicated SIM centre runs 10-12 courses per year; the course must be done by substantive staff every four years and by staff on rotation every two years.

All new trained nurses and operating department practitioners (ODPs) receive a local induction to the operating theatre areas, which includes compliance with the WHO safer surgery check list and team briefing structures and competency in all relevant equipment. They are supported through this initial development period by a dedicated mentor. Nurses and OPDs in training are supported by a nurse educator and are also allocated a mentor throughout their period of placement.

The Trust also employed a dedicated theatre facilitator from late 2010 to support the three main theatre complexes to enable the Trust to introduce and support the productive theatre programme effectively. This role supported the WHO safer surgical checklist implementation and audit as well as monitoring teamwork and behaviours in the three sites.

1.2. Corporate
Training in Human Factors is delivered by the Corporate Team in a variety of ways in order to meet the needs of staff and to ensure the operational service is delivered. The programme is of half day introduction; more detailed full days are integrated into our existing programmes, which include Teams Improving Patient Safety (TIPS), Clinical Leadership and Consultant Development Programmes. The Trust Board have also had training in Human Factors as part of recent Board Development Days (one half day session on 5 March 2017 and a shorter follow up session on 10 May 2017).

2. What does this training consist of?

2.1. Theatres and anaesthetics
Safety checks are performed in the anaesthetic room and comprise of a formal sign in and checking against the Stop Before You Block (SB4UB) and against the WHO safer surgical checklist. An email was sent to all anaesthetists, with a link to the Safe Anaesthesia Liaison Group page, summarising the key messages and required actions from the SB4UB campaign. All anaesthetists were asked to confirm their understanding of these safety checks in the anaesthetic room and that they currently comply. Surgical teams are trained in the use of the team brief process and the three stages of the WHO safer surgical checklist. This is covered in local induction for all new members of staff to the area.

During the development of the WHO safer surgical process, it was felt that there was much duplication of areas, therefore in early 2011/12 the three sections of the WHO (sign in, time out and sign out) were split and added to the relevant section of the standard operating theatre documentation. There have been a number of iterations to the documentation over time and changes planned in the short term are to link the National Safety Standards for Invasive Procedures (NatSSIPs) and LocSSIPS with the WHO checklist requirements.

There is an on-going programme of observational audit covering the entire process and this will continue as an integral part of the clinical audit programme for 2017/18 in the division. The site leads have been communicated with separately to stress the importance of ensuring the teams work hard to complete the above actions.

2.2. Corporate

The half day corporate training comprises a definition of Human Factors, how behaviours affect patient safety and an exploration of how and why errors in clinical practice occur. We use case studies to illustrate situational awareness, reliable design to reduce variation (i.e. checklists), how to mitigate Human Factors issues using non-technical core skill and tools and how to improve communication within teams.

The full day training includes all the areas above together with how to manage difficult behaviours, decision-making, task management, teamwork/role play exercises, how to recognise and manage "Burn out" in staff, the use of PDSA cycles for improvement and standardising a model for Human Factor analysis called SHEEP (Systems, Human Interaction, Environment, Equipment and Personal).

3. How do you gain assurances that staff are competent following training?

3.1. Theatres and anaesthetics

The WHO safety checklist is audited in each theatre complex i.e. main theatres, day theatres and obstetric theatres daily; this includes a random review of 10 sets of healthcare records from each area. The recovery staff review each set of documentation across the three sections of the WHO checklist, sign in, time out and sign out and input the findings into the electronic audit tool. The data is pulled into Qlikview, an electronic reporting tool, and performance is presented quarterly within the division. The data is shared within the quarterly surgical division report.
A SB4UB knowledge and observational audit was completed in 2016, and a repeat audit is currently in progress. The findings from the 2016 audit are attached; figures for the 2017 audit can be provided if required. Trauma Team Members competency is assessed during the day to ensure full participation and engagement. The same process is in place for all trainee Simulation Centre Training. These courses address Human Factors competency rather than the WHO safer surgical checklist

3.2. Corporate

All Teams Improving Patient Safety (TIPS) courses have a pre and post-course questionnaire which records a self-assessment. There is a separate safety culture survey. There is a detailed peer review checklist of all TIPS presentations and these include elements of Human Factors. Students undertaking Masters level accreditation with the University of Kent are expected to evidence application of Human Factors in their portfolio submissions. The next TIPS cohort starting in January 2018, will be requested to identify a Human Factor change they intend to make and to provide evidence of follow up after two months.

The trust wide Collaborative Patient Safety Visits (CPSVs) include elements of Human Factors as an integral part of the process; this is discussed with multidisciplinary teams and senior members of divisional leadership teams during each visit.

4. Had the staff involved in the latest five never events received this training?

4.1. Theatres and anaesthetics

Staff involved in these cases were actively involved in the investigation; part of this process involved an exploration of the causal factors, Human Factors, distractions and gaps in training. A team from theatres were recruited into the Teams Improving Patient Safety programme; this project explored in detail the points of system failure and how well embedded was the WHO Safer Surgical checklist. This was all supported

by a series of training sessions on improvement modelling, measurement for improvement and cultural assessment.

4.2. Corporate
Sixteen members of staff are identified separately on Datix as being involved in the last five never events. Only one has attended the specific Human Factors training provided by the Corporate Team to date. A detailed breakdown of information is provided within the supportive documentation requested.

5. How will you ensure new starters will receive the appropriate training?

5.1. Theatres and anaesthetics
Each new trainee and any existing member of staff who has yet to confirm, will be asked to affirm in writing, receipt of the "safety checks" letter originally sent to all staff in December 2016. All new trainees starting work in theatres in August 2017 received an email detailing the Trust requirements in order to fulfil the WHO safety surgical checklist and the SB4UB checklist to prevent a wrong sided block. This was confirmed by a test of recalling the necessary steps and by an email to confirm they had read the required information. All new trainees receive Human Factors training during their local induction period.

The training is delivered as part of a standardised programme of training for each new member of the theatre/anaesthetic team as part of local induction. This process is also in place for staff working with agencies or with NHS Professionals.

5.2. Corporate
Corporate induction for doctors includes Human Factors training. A new integrated clinical induction programme is planned for autumn 2017, where the focus will be on multidisciplinary team working and understanding how errors in clinical practice occur. This is being coordinated with the Director of Human Resources.

6. How do you ensure the culture within the surgical services allows for open and honest discussions?

6.1. Theatres and anaesthetics
There are regular specialty audit Mortality and Morbidity meetings where learning from specific case reviews is discussed. The divisions review all Root Cause Analysis reports and learning is shared with all anaesthetic and surgical staff. Lessons learned from incidents, complaints and claims is shared at Board committees and at the quarterly multidisciplinary audit meetings.
The surgical division produces a regular learning document (OWL) "outcomes with learning" which is shared with members of the Surgical Governance Board, and in turn is then shared across all clinical areas. There is detailed feedback added and shared on Datix, which is used at all local team meetings. As outlined in my response to question 4, a significant component of the Human Factors and TIPS training we currently undertake is focused around cultural aspects and effective team working.

6.2. Corporate
The Trust is currently negotiating some external Human Factor consultancy with a nationally recognised provider. The technical specification is attached for information and the plan is to commence this work in September 2017.

7. How do you ensure the WHO surgical checklist is used correctly in all settings performing surgical procedures?

There is a regular and on-going audit of compliance. The table below is an extract of performance from January to July 2017, with a rolling 12 month rate of nearly 98%.

| Theatre | TOTAL | ← Select from drop down box for Theatre | | | |
|---|---|---|---|---|---|
| Month | Total Score of Audited Patients (ie Ticked) | Total patients audited | Maximum Possible Score (ie To Tick) | Total (%) | 12mths |
| Aug-17 | 295 | 37 | 296 | 99.66% | 97.88% |
| Jul-17 | 3,898 | 495 | 3,903 | 99.87% | |
| Jun-17 | 4,729 | 606 | 4,733 | 99.92% | |
| May-17 | 4,962 | 636 | 4,966 | 99.92% | |
| Apr-17 | 4,229 | 540 | 4,230 | 99.98% | |
| Mar-17 | 5,364 | 685 | 5,385 | 99.61% | |
| Feb-17 | 4,448 | 571 | 4,473 | 99.44% | |
| Jan-17 | 3,683 | 481 | 3,731 | 98.71% | |

In addition, there was an observational audit undertaken by a multidisciplinary team. The results of this audit are included within the supporting documentation. This audit also looked specifically at the team brief as part of the process. Of note in the recovery section of the observational audit SB4UB was clearly documented in 93% of cases although 100% of anaesthetic nursing and ODP staff surveyed said they were aware of the SB4UB campaign.

8. What actions have you taken to ensure learning from never events is disseminated to all staff working in the surgical service?

8.1. Theatres and anaesthetics

There is good clinical engagement in the RCA process from the teams involved and locally the Outcome With Learning (OWL) newsletter is distributed across the surgical division on line to share learning. There are SB4UB champions designated on each site to share learning across all teams. The divisional governance team coordinates the presentations for the quarterly audit sessions which include:

- Incidents reported with themes and trends highlighted;
- Never events and Serious Incidents occurring within the speciality or areas of learning identified from other divisions;
- OWL (Outcomes With Learning) is shared across speciality and professional groups.

8.2. Corporate

In addition to the local learning from these incidents, the corporate patient safety team produce a quarterly publication called "Risk Wise". These series of publications include at least six case reviews in each document where the issues are explored and lessons learned identified. I am happy to share an example of some of these publications if you would find this helpful. There are regular presentations of learning at the monthly Patient Safety Board, at regular learning events scheduled throughout the year and through presentations to audit meetings. The corporate team meets with each division weekly to coordinate investigations and attempts to share areas of common learning using these Reports to Division Governance Boards

9. What actions did you take to support the staff involved in the never events to prevent reoccurrences?

9.1. Theatres and anaesthetics

There have been regular facilitated case discussions around each RCA investigation and staff have been supported throughout in order to encourage open discussion about root causes and associated causal factors; the views of staff have been incorporated into the learning process and their ideas to prevent recurrence added to procedural and policy changes and to the audits around these areas. These discussions have been supported by the corporate patient safety team at all stages. Updated Standard Operating Procedures (SOPs) on SB4UB, implant checking and the WHO safer surgical checklist have been circulated requiring staff to acknowledge receipt. Open discussions have also been held within local team and specialty

meetings, as these meetings are with smaller groups of staff, open dialogue is supported.

9.2. Corporate
We propose to obtain an external review of the behaviours and team working relationships, which may well be influencing these incidents occurring. An expert in Human Factors has been asked to undertake this detailed project, which will incorporate observational audit of process and the effectiveness of team working, a thorough review of the investigations into these incidents, interviews with the individual and teams involved and a site visit to another acute teaching hospital where, following a similar series of never events, significant changes were made to the processes in theatre.

10. Any other information you consider the Commission should take into account
We have a robust system for data collection and reporting of WHO safer surgical checklist compliance and, more recently, with the compliance with SB4UB process. The next step is to share these data with our commissioners and any other associated assurance they may need. We intend to ask our commissioners to assist in this audit process in future.

All the investigation reports have been shared with the patients involved and we have tried to actively engage patients with the investigative process throughout. We have also shared this letter with our commissioners and have copied it to NHSI for information. We will continue to work with all parties to support the extensive work we have in place to address the specific and more general issues that these never events have highlighted.

I hope you can see we have taken this issue very seriously as we should and I trust this is all the information that you require. If you have any further questions or would like more information please do contact me and we will provide more details for you. I would also be grateful if you or your team could talk with Paul, Sally, Helen or me regarding any views on next steps and any actions so we can input into those discussions before they are concluded.

With best wishes.

Yours sincerely

Matthew Kershaw
Chief Executive

Encs Staff training log
Duty of Candour letters

cc NHS England
NHS Improvement
Clinical Commissioning Groups

Annex B: CQC letter indicating lack of enforcement action

CQC HSCA Compliance

Citygate

Gallowgate

Newcastle upon Tyne

NE1 4PA

Mr Matthew Kershaw
Chief Executive
Kent And Canterbury Hospital
Ethelbert Road
Canterbury
Kent
CT1 3NG

31 August 2017

**Issues of concern following a Never Event in June 2017**
**Provider:** East Kent Hospitals University NHS Foundation Trust RVV
**Our Reference Number:** MRR1-4057068003

Dear Mr Kershaw,

Thank you for your response to our letter of concern dated 8 August 2017 regarding the recent never events at East Kent Hospitals University NHS Foundation Trust.

We have reviewed your letter and accompanying evidence which included training records, stop before you block audit, letters to all five patients demonstrating the duty of candour and three actions plans following root cause analysis.

The contents of your correspondence and the efforts made to address the issues giving rise to the never events have been considered and duly noted. We understand you will be carrying out further work to reduce the impact of human error and we would expect to see a reduction in the number of never events in the future.

We have therefore decided not to take enforcement action at this stage, however we will continue to monitor the trust closely through regular engagement.

Yours sincerely

Alan Thorne
Head of Hospital Inspections (South East)

CC: NHS England, NHS Improvement, Clinical Commissioning Groups