NHS
University Hospitals of Derby and Burton
NHS Foundation Trust

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9 June 2023

PRIVATE & CONFIDENTIAL
FAO: Dr E Didcock
HM Assistant Coroner for Nottingham & Nottinghamshire
The Council House
Old Market Square
Nottingham, NG1 2DT

[redacted]

Dear Madam

I am writing in response to the Regulation 28 Report dated 28 April 2023, following the Inquest relating to Ms McCann's death.

As a Trust we fully accept that there were significant and serious issues in the care provided to Ms McCann. We have apologised to Ms McCann's family for these failings and taken this Notice with the seriousness that they and yourself would rightly expect.

We know that investigating incidents that have led, or could lead to harm is a vitally important feature of safe organisations. UHDB is committed to continued openness and transparency, and to making sure that we investigate, communicate and learn when things go wrong so that we can embed improvements that can support safer care.

Enclosed you will find commentary that details the robust actions taken as a result of the learning from Ms McCann's sad case, as well as details of future planned work around our mortality governance processes, for assurance.

The Trust has also retained 360 Assurance to audit the actions taken following this incident.

Should you require any additional information please do not hesitate to contact me.

Yours sincerely

[redacted]

[redacted]
Chief Executive

Response to concerns identified in the Regulation 28 Report to Prevent Future Deaths issued on 20 April 2023

1. **There is limited evidence to date for the introduction and continuing use of comprehensive airway strategies, with structure planning and preparation, when a difficult airway is anticipated. There should be airway plans A, B and C recorded, shared and the equipment and skills to carry them out must be available.**

Following Ms McCann's death, the Intensive Care Unit at Queens Hospital Burton (QHB) has introduced a Critical Care Airway Plan for all patients on the unit. A copy of this care plan is attached and indicates the airway status and plan for each patient indicating whether the patient has a Red, Amber or Green Airway. For patients who have a Red or Amber airway, the clinical teams are responsible for making and documenting an airway management plan. This includes what equipment is going to be required and whether Consultant assistance will be required in the event of an emergency. It is the responsibility of the named Consultant to review this plan on the morning and evening ward round to ensure that the plan is appropriate and up to date.

This airway plan is now displayed above the patient's bed and the airway trolley containing all vital equipment is stored in each area of the Unit with clear laminated copies of the NAP4 algorithms displayed on the airway trolley.

Together with the NAP4 algorithm laminated sheets, the airway trolley also contains an Intubation Checklist which is to be used by the medical team when a patient is intubated. This ensures that all the necessary equipment is available and provides a structure for how the intubation is to be carried out and preparation for any airway difficulties. Once completed, these are filed into the patients notes and kept by the bedside.

Patients who have an airway plan (patients who have a Red or Amber airway) in place are now included in the staff handover of information so that it is clearly handed over between shifts and patients with difficult airways are highlighted to the staff caring for them. The Nurse in Charge is expected to check that all patients with a Red and Amber airway have an airway management plan and confirm that this is located above the patient’s bed.

In terms of equipment required, the nursing staff on the unit now carry out daily checks and complete a daily sign sheet. This is to check that all equipment required is available on the airway trolley and that the NAP4 algorithm is attached to the airway trolley. Evidence of compliance with this is indicated by signature sheets for each bed which are checked by the Nurse in Charge to ensure that these have been completed daily. If the airway trolley is used, the Nurse in Charge will check and restock the airway trolley and sign to confirm that this has been completed.

2. **<u>There is limited evidence to date for the universal use of the NAP4 algorithms and checklists, which should be available on the difficult airway trolley, and be familiar to all ICU nursing and medical staff, and to the wider anaesthetic team.</u>**

As outlined above, the NAP4 algorithm and checklists are available on the airway trolley and daily checks are undertaken to ensure that these are available to staff.

In terms of airway education, the following training events have been carried out:

1. The process surrounding use of Airway Care Plans, NAP4 algorithms and emergency intubation checklists were circulated to all medical staff on 18 April 2023 and has been re-iterated in person to attendees at the Surgical Divisional day on 18 May 2023;
2. To complement this, an Airway Study Day was carried out on 22 October 2022 by [redacted], Consultant in ICU which contained theory and simulation training around airway management, airway trolley orientation and intubation checklist and management of a dislodged tracheostomy. This airway study day is to be repeated on 21 and 28 June 2023 (this was planned for April but was impacted by the junior doctor strikes);
3. A Local practical session was carried out on 27 April 2023 for all the Band 6 and 7 nursing teams performed by [redacted], Consultant in ICU;
4. Airway management is to be added to the junior doctor induction training programme which covers intakes in August and February. This is being developed for the next cohort of trainees by [redacted], Consultant and College Tutor;
5. There is an Airway Education Board on display within the unit displaying the Airway Care Plan, Learning on a Page document, advice surrounding using a TrachSeal Closed Suction System and further advice regarding tracheostomies.

3. **<u>There is limited evidence to date, for the robust daily checking of all necessary equipment on the difficult airway trolley, to ensure immediate replacement of all key equipment if it is broken or misplaced</u>**

<u>Review of processes for ensuring availability of essential equipment</u>

The Trust has up to date policies for 'the management of medical devices' and 'the competency and training requirements connected with medical devices'. The policy for the management of medical devices is currently undergoing a full review. These policies set out requirements for maintenance, service, repair, and replacement of medical devices within the organisation. This includes all loan devices too.

It is the personal responsibility of every equipment user to ensure the devices are available and fit for purpose prior to every use. It is the additional responsibility of the clinical department manager/lead to ensure all equipment used in the department is

in good repair, and “in service” and making this equipment available for maintenance.

Currently the Engineering Department provide prompt lists on a regular basis to the clinical area based on information available from the Trust information portals. However, the Trust are in the process of implementing a new asset management database which will allow clinical areas to view their live equipment data. This functionality will be available by the end of 2023 and will provide greater overview for clinical areas as to what equipment should be in the department and when it is due for service.

The Clinical Engineering Department have also recently introduced e-Quip, which is a medical devices training system. This system enables the Trust to have access to individual and departmental records of all medical devices. This system will allow reports to be generated of department competency percentages. These records will be monitored by departmental leads and will be overseen by the Trust Medical Devices team to monitor compliance. Department leads will be expected to attend Medical Devices Procurement User Group (MDPUG) to present their compliance of all medical devices going forwards.

Each area is responsible for reporting through Business units to division where maintenance compliance deficit action plans will be discussed before presentation at MDPUG, with non-compliance escalated to Medical Devices Group (MDG).

If equipment is broken, missing or otherwise unavailable, the process for escalation requires the clinical areas to contact Clinical Engineering confirming:

- Equipment Identifier (Asset/Maintenance number) and a description of the equipment.
- A description of the fault
- The name and position of the person reporting the faulty equipment.
- If a declaration of contamination status has been completed.

Clinical Engineering will thereafter assume responsibility for ensuring the equipment is repaired and advising on the replacement process if this is required. Timescales will be provided where possible. Where purchase of new equipment is required, the Trust has defined procurement processes in place for both revenue and capital equipment. Replacement of Capital Clinical Equipment (over £5,000) is now a centrally managed process. This will mean that equipment will be replaced in a timely manner than had been the case historically.

Service and maintenance of equipment is undertaken by Clinical Engineering as per manufacturer's guidelines (the general rule is annually).

Where equipment is unavailable at any given time, Clinical Engineering will identify if a temporary loan is available either from the manufacturer or from elsewhere within the Trust, following an appropriate risk assessment with the departmental leads. If a loan is not available, the clinical area is required to escalate through the Business Unit to consider whether procurement of additional equipment is proportionate. Emergency procurement requests are made to MDPOG who will review and send on to the Chair of MDG for authorisation.

The Trust has recently undertaken a review of medical devices governance which was presented and considered at the Quality Improvement Group. This included a review of roles, responsibilities and the governance structure related to the management and procurement of medical devices. In summary, the current governance structure is as follows:

- Medical Device Group (MDG) receive escalations on replacement and new medical device requests from the Medical Devices Procurement Operational Group (MDPOG).
- Medical Devices Procurement Operational Group (MDPOG) provides the governance framework of clinical equipment management and clinical supplies procurement across UHDB. MDPOG provides MDG with monthly updates on the Trust's medical devices rolling replacement plan.
- Medical Devices and Product User Group (MDPUG) is a division and business unit linked group, reviewing Training/Competency and Maintenance compliance levels and action plans. Non-compliance is an escalation to MDG. Medical Devices related incident reports are reviewed monthly at this meeting.

Availability of Equipment in ICU QHB

At the time of Ms McCann's admission, the piece of equipment that was not available on ICU was an Ambuscope (bronchoscope) as the screen which the scope attaches to was broken and could not be repaired. One was available for use in Theatre at QHB but this was not obtained at the time of the airway emergency.

Since the death of Ms McCann, the ICU at QHB has purchased a new intubating bronchoscope to replace the broken screen and has on order an additional machine so that there are two options for clinicians in terms of use of bronchoscopes. The unit also has a stock of scopes which can be used in conjunction with the screen units and will be compatible with the additional unit that is on order.

4. **<u>The Mortality review policy was not followed, leading to a significant delay in completing the serious incident review, delaying trust learning, and delaying the family's understanding of the circumstances of JM's death. There is limited evidence of progress in implementing the national Patient Safety Incident Response Framework at the Trust.</u>**

Review surrounding Mortality Governance Processes and revision of the Monitoring Mortality and Learning from Review Policy

As a result of Ms McCann's death, the Trust is undertaking a robust review of its current Monitoring Mortality and Learning from Reviews policy which will be bench marked against policies at neighbouring Trusts and will reflect national best practice and guidance.

The revised policy will be completed by the end of June 2023 with approval by the Learning from Deaths Group on the July 2023 agenda. This will be escalated upwards to the Learning Review Group for approval.

The revised mortality policy, in association with the Trust policy for incident reporting, management and learning will specifically address the failings identified by the coroner and will reflect the following changes that have been implemented:

1. The corporate clinical governance team issued guidance (Actual impact definitions) in May 2022 to ensure appropriate grading of incidents is undertaken at the time of reporting and through the incident review process. The Divisions carry out a daily review of all incidents which are classed as low or no harm in order to sense check the grading is correct. If there are any concerns about the grading of an incident, this will be escalated and discussed at the weekly Virtual Incident Review Group (VIRG) within each Division, as outlined below.

2. Divisions hold a Virtual Incident Review Group (VIRG) to review incidents graded as moderate harm and above at a weekly meeting. This includes clinical governance facilitators with senior nurse and medical input to discuss incidents and will act as a safety net to reduce the risk of incidents or unexpected deaths being inappropriately downgraded. If they remain unsure as to whether an incident has been appropriately graded, this will be escalated for corporate clinical governance review.

3. In addition to this, the Corporate Governance Team are currently undertaking an audit of incidents graded as moderate, severe or death as the level of harm to validate the accuracy of grading. The results of this audit will be reported to Quality Review Group in June 2023 for assurance. The Corporate Governance Team are also completing a data analysis on incidents reported as no harm, near miss and low harm in 2022/2023 which will be received by the Quality Review Group in July 2023. This is to look for themes and trends and to inform any quality improvement requirement moving forwards.

4. For incidents with an actual impact of severe harm/unexpected death or any other incident of concern, these are reviewed at Divisional level and a 72-hour

report is now generated by Divisions. The 72-hour report provides assurance that a proportionate review of incidents is completed. The 72-report process commenced in December 2022 and an audit was presented to the Quality Improvement Group (QIG) in April 2023. The audit concluded that 89 cases were escalated for review. 24 required a PSII or PMRT, 44 required a divisional review and the remainder were outstanding (72-hour reports not yet received by the corporate clinical governance team) or required no further action. Ongoing audits are planned for ongoing assurance.

5. Medical Examiners (ME) review all non-coronial deaths in the Trust. The ME determines if an SJR is required and will activate the established protocol. The revised mortality process will include an undertaking that if the ME identifies an incident, which was missed by the division, they will escalate via the Datix process to allow for timely investigation via VIRG and the 72 hour process.

6. A structured judgement review (SJR) was requested for this patient and was completed but this was not communicated to the Division for consideration under the patient safety processes. A monthly report is prepared by the Mortality Assurance Support manager to all Assistant Clinical Directors which provides an overview of all deaths within their speciality from the previous month. This allows for oversight of mortality and allows specialities to identify patients who require SJRs to be completed. In addition, SJRs are completed via an electronic platform, CORS and are graded accordingly which can be accessed and reviewed by the Division.

7. The mortality policy review will include a more detailed section regarding the SJR process including the criteria for SJRs, the responsibilities for allocating SJRs to clinicians (via Assistant Clinical Director [ACD]) and the timescale for completion with a reporting structure to include the divisional mortality reporting process and corporate via the Learning from Deaths Group. If the SJR reviewer identifies an incident, which was missed by the division, they will escalate via the Datix process. Compliance and escalation of this is monitored by the Learning from Deaths Group monthly.

To summarise, any individual clinical team should raise a Datix if they detect an incident, but a safety net is now established within Divisions (via VIRG), the ME service and colleagues completing SJRs.

The Learning Response Review Group, which commenced in January 2023, will enhance organisational learning from safety incidents by providing a corporate oversight of incidents which have been reviewed by the divisional clinical governance teams. Common themes and learning points will be extracted and shared throughout the organisation.

A communications strategy is planned to disseminate the revised Monitoring Mortality and Learning from Deaths Review policy which will include presentation to Divisions and discussion at Trust learning fora including the Learning from Deaths

Group and Learning Review Group. The weekly 3.13 Senior Leaders forum will include a presentation regarding the mortality process.

An audit for the 72-hour report has been completed and further audits will be required to confirm compliance with incident reporting at VIRG, the ME service and SJRs.

Implementation of Patient Safety Incident Response Framework (PSIRF)

The aim of the project is to transition from an early adopter of the PSIRF framework to 'Version 1' which has been published based on the learning from the pilot sites.

This framework replaces the Serious Incident Framework and focuses not on the volume of incidents investigated but the quality of the response following a patient safety incident. Transferring importance to improvement projects to reduce the risk of similar incidents reoccurring, demonstrating that reporting an incident leads to improved patient safety.

We strive to learn from all that we do and to share this learning across the organisation to make UHDB a better place to work and a safer place to be a patient.

The implementation team meets monthly and comprises of experts within relevant given fields and with representation from the Clinical Divisions. A patient safety partner (a lay person who works with the NHS to make care safer for patients) has attended the PSIRF future state process mapping event to reflect the 'voice of the patient' and is invited to Trustwide future PSIRF events.

The next key step is to agree a Trust wide process and policy for the management of incidents which incorporates and strengthens PSIRF within the organisation.

The management of incidents (incorporating PSIRF) policy, as outlined above and the response plan are required to be live by the end of September 2023. A copy of the Patient Safety Incident Response Plan can be made available, if required.