NHS
Brighton and Sussex
University Hospitals
NHS Trust

[redacted]

17 December 2018

Miss Veronica Hamilton-Deeley
HM Senior Coroner for Brighton and Hove
The Coroner's Office
Woodvale
Lewes Road
Brighton
BN2 3QB

Brighton and Sussex University Hospitals
NHS Trust
Trust Headquarters
Royal Sussex County Hospital
Eastern Road
Brighton
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Dear Miss Hamilton-Deeley

The late Joan Catherine Blaber

Thank you for your letter of 2 October 2018 enclosing your report written under Paragraph 7, Schedule 5 of the Coroner's & Justice Act 2009 and Regulations 28 and 29 of the Coroner's (investigations) Regulations 2013, and the Record of Inquest.

Mrs Blaber's inquest has truly resulted in a culture shift at the Trust, with substantial improvements in our systems and processes; some of which you are already aware of from our SI report and CQC action plan, and some new improvements in addition, of which I will detail below.

Control of Substances Hazardous to Health Regulations (COSHH)

Every ward and department has a revised and up to date COSHH folder listing all COSHH products, their proper usage, risk assessments, and the COSHH guidelines. The CQC at their recent inspection confirmed they were impressed with our COSHH folders and staff knowledge and compliance in relation to COSHH.

Training

[redacted], Clinical Director for Facilities and Estates has confirmed that our COSHH training has been reviewed and updated. Our training includes anonymised extracts from evidence given at Mrs Blaber's inquest to ensure our staff can actually relate to the content and are aware of the seriousness of COSHH products in our hospitals.

Roles

I am pleased to say the roles of Hosts and Housekeepers has been split and clarified as recommended by you at the inquest. We now have dedicated Catering Assistants who have no cleaning duties outside the kitchen. Housekeepers are now tasked only with cleaning duties and do not deal with patients' food or water. These new clearer roles have started in the Barry Building, Sussex Eye Hospital and the Nursery and there is a roll out programme in progress so the whole of the Trust will be incorporated by the end of March 2019. To

make these distinct roles clearer for patients, families, visitors and staff, new uniforms have been ordered so the uniforms of the two distinct roles are not confused and are well differentiated. Furthermore, the management structure has been updated. Catering Assistants (Hosts) are now managed by the Food Safety Manager so they are not under the same managerial line as the Housekeepers. When each member of staff has moved across to the new management structure, there has been a review of the training they have received, they have received refresher training whether they were due this or not, under their new management structure. The training records are securely stored and regularly reviewed to ensure training is up to date.

Coloured jug system

All patient jugs are now clear so the contents can been easily seen. All opaque coloured jugs have been removed from use. The training our staff have received confirms that clear jugs are the only jugs to be used, and they are only to be used for patients' drinking water.

Agency staff

Following Mrs Blaber's inquest we have not employed any Agency Housekeepers or Catering Assistants. It is our intention to remain in this position as there is a full recruitment programme in place to recruit permanent members of staff to any vacancies. Any new members of staff will attend Trust Induction (no matter what role they undertake) and undertake the Trust's programme of statutory and mandatory training (this portfolio includes Health and Safety Training). All Facilities and Estates staff training is monitored by the Facilities and Estates Learning and Development Manager and kept in date.

Education and understanding

Owing to the culture change brought about by Mrs Blaber's experience, COSHH management is a regular agenda item on many of our meeting agendas. For example, it is now routinely discussed at the Patient Led Assessments of the Care Environment (PLACE) meetings, the Weekly Operational Look Forward Meeting and teams' safety huddles. Terece Walters is the Chair of the Food Improvement Group and Ms Walters has ensured the group monitor and maintain the systems and processes we have put in place and there is a clear governance reporting escalation channel up to the Executives and the Board, for any concerns. The Head of Nursing for Practice Development has become a member of this Group, to ensure that learning is spread across the organisation and any new initiatives are widely communicated to all groups of staff.

[redacted] also designed a presentation using the learning from Mrs Blaber's inquest which she has delivered to her teams and a wider audience, being open and frank about what happened, the system failures and our organisational learning. This presentation encourages staff to report any concerns about patient safety / COSHH management immediately to their line manager and to report it as an incident on Datix.

Learning from Mrs Blaber's inquest has been spread (without using names) throughout the Trust in a variety of mediums, such as internal Newsletters, daily team huddles, and debriefs. Teams discuss the use of COSHH products in their areas and have a clear understanding of their roles and responsibilities in relation to this and what is acceptable practice.

I have been assured that any breaches (however minor they may seem) are recorded on Datix and investigated formally by the Facilities and Estates Directorate and our HR team; staff involved are removed from duty immediately and receive retraining during the investigation process. Any actions identified as necessary from the investigation are put in place and monitored by the Senior Management team in Facilities and Estates who report actions and learning to the Health and Safety Committee.

Cleaning Cupboards and Cleaning Trollies

The Trust's cleaning cupboards have been modified now to swipe card access only to guarantee they are secure at all times and we have a record of who has accessed the cupboards and when. Only with permission from [redacted] can staff have their ID cards updated to include access to a cleaning cupboard. The introduction of swipe card access has meant we have significantly reduced the number of staff who have access to COSHH products and the staff who do have access have all received the appropriate COSHH training. This alone has made our hospitals much safer for patients, visitors and staff.

There has been a review of our cleaning trollies and where we store the cleaning trollies. Now, if trollies are not able to be stored in a locked cleaning cupboard, for example, if the space does not allow, the trolley itself is locked and there is a sign identifying where the trolley's designated area when not in use is, which has been risk assessed as a safe place, and the trolley must be returned to the designated area when not in use.

[redacted] undertakes scheduled walks around the hospitals to conduct environmental checks and non scheduled checks too so she, and I, can be assured that the correct safety standards are adhered to in relation to the safe storage and use of COSHH products throughout our hospitals.

Learning from incidents

Following the inquest, [redacted], our Deputy Chief of Safety has commenced a wide ranging appraisal of the Trust's Incident Reporting system. This piece of work is still in progress, the preliminary recommendations include:

- A review of all the existing specialty (i.e. obstetrics, paediatrics, etc.) and specialist interest Datix clinical incident forms (i.e. pressure ulcers, falls, MET calls etc.) to provide assurance that the data currently captured is utilised, and to identify whether further information tailored to specific incidents should be captured.

The model for this recommendation is the successful programme of work on the incident reporting of patient falls. When an incident report of a patient's fall is submitted, the incident reporting system generates a series of questions which facilitate the systematic review of trends and patterns in relation to inpatient falls. This information is collated monthly allowing ward managers to compare their performance with the rest of the Trust and identify issues that need to be addressed.

The second recommendation proposes:

- Reviewing the categorisation of clinical incidents.

The taxonomy for categorising patient safety incidents was developed over 15 years ago by the National Patient Safety Agency, whilst the categorisation of incidents has evolved over the years, it is now in need of a major overall, removing those incident types that are not

used, and developing incident descriptors that make it easier to visualise an incident. Improving the coding will have two benefits:

1. Easier for reporters to accurately code the incident they are reporting.
2. Better coding should result in better trend analysis.

One of the challenges faced is the exponential year on year increase in the number of clinical incidents reported. In the past 10 years the number of reported incidents has more than doubled from 5,685 in 2008 to a projected 11,800 in 2018. There is a paradox when it comes to constantly increasing the number of incidents reported in that the time available to investigate and share learning is stretched more tightly. This reality makes the management of this information more critical, the final draft recommendation is that the twelve thousand Datix incident reports received each year need a better methodology for analysing the data and that this information needs to be more widely disseminated. As part of this proposal, it has been suggested that Statistical Process Control methodology is piloted at the Trust to see whether this approach is helpful in identifying unusual patterns and trends in incident reporting. It has also been proposed that the number of clinicians receiving data from clinical incident reporting needs to be widened and that this data should also feed into the Divisions, Directorates and Speciality governance structures.

As you have said, it is unlikely that we will ever know how Flash cleaning fluid got into Mrs Blaber's water jug, and I agree. However, I wish to reassure that we have discussed the tragic incident at very high level meetings, including our Board Meetings and Trust Executive Committee meetings, to ensure we have learnt and to embed this learning from the top down, as well as from the 'hands on' Housekeepers and Catering Assistants up, and we continue to encourage an open culture of learning at all levels.

My heartfelt condolences and a sincere apology go to Mrs Blaber's family and friends.

Yours sincerely

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Chief Medical Officer and Deputy Chief Executive