Manchester University
NHS Foundation Trust

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Mr. Christopher Morris
HM Area Coroner, Manchester South
Manchester South
1 Mount Tabor Street
Stockport
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23rd November 2020

Dear Mr Morris,

Re: Mr William Ivan McKibbin, Regulation 28: Report to prevent future deaths

I would like to begin by offering condolences to the family of Mr McKibbin and my unreserved apologies for the failings identified in his care and the subsequent investigation into his fall. The care afforded to him, and to his family, fell far below the standard I would want or expect.

Manchester University NHS Foundation Trust (the Trust) fully accepts the findings in respect of care and the quality of the investigation undertaken. It is to my deep regret that the quality of the investigation and the communication with Mr McKibbin's family, both prior to and after the fall, left them with the view that the organisation was not being open with them. I would like to assure Mr McKibbin's family and yourself I have seen no evidence that the Trust intended to deliberately mislead or withhold key information.

In the new *Patient Safety Incident Response Framework 2020 - An introductory framework for implementation by nationally appointed early adopters*, reference is made to trust, alongside the impact of a poor early organisational response to incidents. It is my view that the quality of the investigation, the presentation of evidence in your court and the communication in respect of the breaks and bed rails have left the family, and yourself, with the view that information was withheld when in fact it was not and for this I apologise unreservedly.

It is my understanding that Mr McKibbin's family are of the view that information had to be extracted from the Trust via disclosure to your court. I would note here that this information was willingly provided to you in advance of the inquest hearing and that the Trust has never sought to cover up this information.

Reflecting upon this, the family may not have thought this information was being deliberately withheld from them if the enquiries as to whether the bed brakes were on and also checks to see if the brakes were working, were openly discussed with the family at the time and fed into the investigation conclusion. Even if the investigation concluded they were on, this would demonstrate the investigation's rationale. This is a significant learning point for the organisation and is informing the changes being made to the investigation process which I will detail later.

I come now to your concern that Professor [redacted] and Managers from the Trust *"were aware at the very least that the breaks simply cannot have been applied at the time he* [Mr McKibbin] *sustained the fall"* and that Professor [redacted] failed to confirm this fact in your court.

The NHS Serious Incident Framework 2015 requires that any NHS body *"Provide an account of the incident which, to the best of the health service body's knowledge, is true of all the facts the body knows about the incident as at the date of the notification."* Our investigation process is designed primarily for two purposes; firstly to provide an account to a patient or their family of what went wrong and secondly to ensure organisational learning. Our staff are asked to ascertain facts and not provide opinion in these investigations unless it is a clinical discussion and NHS investigations do not to reach conclusions on the balance of probability as such. It is not uncommon for conclusions not to be reached on some matters, particularly if an incident is unwitnessed. As unfortunately, this fall was unwitnessed and, as accepted, early checks were not made and documented on the bed brakes, a conclusion was not reached.

Professor [redacted] did not withhold this information from your court or Mr McKibbin's family, the investigation did not conclude that the bed brakes were on, or off, and she therefore did not have that fact to present.

The learning from Mr McKibbin's care and subsequent investigation has been widely shared across our Hospitals and Managed Clinical Services. Reports have been made to the Board of Directors, the Trust Governors, our Commissioners and the Care Quality Commission. The events were also the subject of a Board of Directors Development Session in October.

This was also presented by the Trust's Group Director of Clinical Governance at the September Group Patient Safety Forum, which is widely attended by clinical governance leads across all hospital sites and Managed Clinical Services across the Trust, the learning for onward dissemination at a local level. At the Trust's Wythenshawe, Trafford, Withington and Altrincham (WTWA) site[1] specifically, the learning arising from the investigation and Inquest has been shared via a report delivered by the site Director of Nursing to the Trust's hospital management board, via a paper specifically detailing learning arising following the Inquest conclusion presented to the site Quality and Patient Safety meeting in September 2020, as well as the Trafford General Hospital Quality and Patient Safety meeting, and separately via the September 2020 Division of Medicine documented Governance Summary. The lessons

[1] The Group of Hospitals and services is divided into sites. Wythenshawe, Trafford, Withington and Altrincham hospitals form one site. Hereafter referred to as 'the site'.

learned were also presented at the Trust Falls Collaborative Group meeting. A further session is due to take place in November 2020 at Trafford General Hospital specifically to present and share lessons learned with staff in the form of a patient story, which will then be formulated into a "7 Minute Briefing" document, the purpose of which is to ensure that information is shared in a clear and concise way with a wide group of staff. It is also intended that once presented at Trafford General Hospital, this will again be presented at the Professional Board, the site Quality and Patient Safety Meeting and the Division of Medicine Governance Meeting. This will ensure that all lessons are widely shared and that we have included any concerns raised by yourself or Mr McKibbin's family.

You have set out in your report several matters of concern and I have addressed them below, for ease, in the order in which they appear in your letter.

Delay in diagnosis of peripheral ulcerative keratitis

Noted under circumstances of death rather than a matter of concern but addressed here for completeness.

The Trust accepts that there was a delay in diagnosing Mr McKibbin's peripheral ulcerative keratitis (PUK), which is a rare (approximately 3 cases per million per year) complication of rheumatoid arthritis.

As set out at the Inquest, the initial diagnosis of bacterial conjunctivitis was discussed with the on-call ophthalmologist and treated with chloramphenicol eye drops. As Mr McKibbin's eye condition continued to deteriorate, his management was again discussed by Trafford General Hospital medical staff with the on-call Ophthalmology Registrar, and an eye examination with ophthalmoscope and application of a topical anaesthetic and fluorescein (eye dye) was undertaken which identified corneal abrasions (scrape of the top layer, the epithelium).

Conservative management was advised and it was noted that the on-call Ophthalmology Registrar advised that he did not consider Mr McKibbin needed an Ophthalmology review at this time; it was recommended treatment was changed to chloramphenicol ointment (from eye drops) and Viscotears, but that if there was no improvement to repeat the fluorescein and re-discuss with the results.

Dr [redacted] has reflected on this specific aspect of the care provided and advised that in hindsight when he reviewed Mr McKibbin again and his condition had further significantly deteriorated with severe erythema and swelling in both eyes, he should have obtained an urgent review by Ophthalmology at this point and not delayed this review over the weekend. If the review had been undertaken at this time it is likely that the diagnosis of PUK could have been made and treatment commenced.

Following this incident, the learning was presented as a case study at the Trust's Audit and Clinical Effectiveness (ACE) day on 27th February 2019. This event is undertaken across the Trust, with staff attending according to their relevant speciality/division and provides a forum for clinical staff to contribute to clinical effectiveness and audit activity, sharing governance issues and learning arising in respect of patient safety. Staff are afforded protected time to

allow for full attendance at the ACE day with clinical duties covered to release staff, covering medical, nursing and Allied Health Professional staff. The presentation at the ACE day was led by the site Clinical Head of Division of Medicine to raise awareness of the condition and importance of timely consultation and review by relevant clinical specialists to support diagnosis and treatment. The presentation was then shared with staff who could not attend on the day.

Matters of Concern

1. Residual concerns on the culture at the Trust

The Trust has in place a policy on Duty of Candour which I enclose as appendix 1. This policy sets out clearly the expectation that all staff at every level will be open and transparent when things go wrong and that a clear explanation and an apology must be given. The duty is recorded as part of the incident management process and this is done by recording what has been shared and with whom on the Trust electronic governance system 'Ulysses'. This allows for oversight and monitoring which in turn reminds all staff that duty of candour is a requirement. Compliance with duty of candour is monitored at the Group Clinical Governance Committee and scores are consistently at the 95-100% for stage one (the initial discussion, immediate sharing and apology).

The Care Quality Commission inspected the arrangements on duty of candour in their comprehensive inspection of 2018 and noted them to be good. They continue to have regular discussions on incident investigations, findings and improvements made at their quarterly Engagement Meetings.

The Trust has an agreed Values and Behaviours Framework, this has been communicated to all staff and individuals are held to account on their adherence to it.

The framework comprises of four value statements one of which is Open and Honest (see appendix 2) This statement requires that staff: admit when they have made a mistake, and learn from these; speak out if standards are not being maintained or patient safety is compromised; deal with people in a professional and honest manner; share with colleagues and patients how decisions are made.

This Framework underpins everything we do in the organisation and is widely recognised and understood by staff. In their assessment of the Well led standard in 2018 the CQC noted, "*There was a clear statement of vision and values, driven by quality and sustainability. The Trust executive directors recognised the importance of a shared vision and values. Approximately 5,000 staff had been involved in establishing a set of core values for the new Trust. These values were 'everyone matters, working together, dignity and care and open and honest.' These were incorporated into the recruitment and appraisal process."* With specific reference to Trafford General Hospital they noted that there was a positive culture across the Hospital.

With respect to the wider culture, there are a number of ways in which staff can and are encouraged to raise concerns at the Trust. These include;

Incident Reporting

This is done via an online system and supported by a policy included at appendix 3. The rates of incidents reported are generally accepted as one of the measures of safety culture within NHS Trusts. MFT has consistently been in the top quartile of similar organisations for the last 10 years reporting 53.79 incidents per 1000 bed days in the period October 2019 to March 2020[2]. For context the range of data for the 9 similar organisations in the Shelford Group of NHS Trusts for the same period is 42.04 – 63.76 incidents reported per 1000 bed days with MFT being the fourth highest reporter in the group.

The Trust monitors rates of reporting, themes in respect of what is reported and learning from incidents at a number of forums and shares learning widely through presentations and alerts to staff. The thematic information also informs our patient safety work plans throughout the year and reducing harm from falls has been a significant focus, the work on this is detailed later.

Local Clinical Governance Arrangements

All staff are encouraged to raise any safety concerns and discuss incidents with their line manager and teams. There are local safety huddles and meetings across all clinical areas where concerns can be raised.

Every hospital in the Trust has a local Quality and Safety Committee where concerns and themes from incident reports, Inquest findings, claims, complaints and audits are examined and acted upon. The minutes of these meetings are submitted to the Group Quality and Safety Committee for review and discussion in order that learning is shared across the Trust and beyond. Feedback was provided to the site Hospital Management Board by the site Director of Nursing and site Head of Clinical Governance with a view to sharing the learning, as well as at the Quality and Patient Safety meeting specific to Trafford General Hospital.

Whilst I cannot comment on the concerns about the wider NHS, I am confident that at a Trust level and locally at Trafford General Hospital the prevailing culture is one of openness and transparency. I am deeply sorry, as stated earlier, that the substandard management of the investigation and the poor communication with Mr McKibbin's family left them and yourself with a different view. It is clear that the delays in sharing the report resulted in a lack of timely openness on our part but we sought to be honest at all times.

Bed Brakes and Bed/Safety Rails

I will now address the specific concerns as detailed in the letter in regard to the matter of openness with regard to the bed brakes and safety rails.

I share your concern that the assessment of the brakes was not undertaken immediately post Mr McKibbin's fall. I also accept in full your findings in relation to the report completed, it was not of the quality I would expect and lacked some key questions and lines of enquiry. Those failings acknowledged; it is not accepted that the Managers from the Trust therefore knew the brakes could not have been on. Sadly, Mr McKibbin's fall was unwitnessed and, as confirmed, the brakes were not checked at the time. The Trust position on this was that it could not be ascertained as to whether the brakes were on and that the bed rails were applied. I would draw your attention to page 4 of the report where it is noted that *"Upon entering the room Mr*

[2] NHS Improvement National Reporting and Learning System (NRLS) Data

McKibbin was found on the floor. The bedrails were in an up position as requested by Mr McKibbin and the bed was at the lowest level. The mechanism of Mr McKibbin's fall is unknown". I also draw your attention to page 32 of the investigation report where it is noted that *"Given the nature of Mr McKibbin's injuries it is likely on the balance of probabilities that he fell over the bed rails which will have increased the height of the fall."*

The investigation report notes that the bed rails were in place and this was not questioned at any point in the investigation process. The application of the bed brakes was not confirmed, and this should have been assessed immediately following the fall and then detailed in the report. I apologise for the fact that this was not properly addressed at the time, but whilst the application of breaks was discussed by staff, none of whom were present when Mr McKibbin fell, at no time did any Manager confirm, or escalate, that they were aware that the brakes were not applied.

The investigation relied on the statements of the staff that were present on the ward at the time of the incident and noted that "*staff statements indicate that the brakes were on*." As early checks were not made at the time, the investigation failed to conclude on this matter and that is not acceptable, I will detail later changes we have put in place to address that.

I would like to state again that there was at no time any intention to withhold evidence from Mr McKibbin's family or yourself but it is wholly accepted that an attempt to withhold information was a conclusion that could have been reached on the basis of the quality of the investigation and the evidence presented in your court.

Nursing Documentation

Updated Falls investigation template, Falls Policy and Intentional Rounding

The intentional rounding core documentation (attached at appendix 4) was adapted alongside the Trust's Inpatient Falls Management Policy, Falls Care Plan, and Falls Investigation Template, with changes publicised via the Trust's iNews communication on 9th September 2020 which included a spotlight on falls prevention and management. The updates to documentation were also circulated by the Group Deputy Chief Nurse on 11th September 2020. The changes were also highlighted specifically at Trafford General Hospital via the site Falls Specialist Nurse, with a poster and publicity campaign.

The changes to the investigation templates as a result of the response to this investigation and the recommendations you have made require the Nurse in charge or a delegate to complete appendices to capture the immediate scene of a fall, via a newly developed *"First Responder"* document. Furthermore, changes to the Trust's Falls Policy include reference to the additional falls safety checks in rounding documents, amongst other changes.

The changes to the intentional rounding documentation incorporate additional safety checks, including requiring specific confirmatory checks in respect of patient bed brakes and bed rails. These changes are detailed within the updated Trust Falls Policy (section 4.4), which details that care and communication rounding is to be completed in line with the Trust's and local ward standards. This includes four specific questions which have now been added to the Trust's Care and Communication / Intentional Rounds under the heading *"Patient Safety"* in relation to falls reduction:

1. Have the brakes been applied to the chair/bed/trolley?

2. Is the floor clean/dry/clear of debris?

3. Has the Trust bed rails assessment been completed and are the bedrails in the correct position?

4. Has the Trust falls risk assessment been completed and is this up to date with care planned appropriately?

The Falls Collaborative Research Sub-Group, co-chaired by the Trust's Group Deputy Chief Nurse and international expert Professor [redacted], Director of the National Institute for Health Research's Older People & Frailty Policy Research Unit, has reviewed and approved the Trust's Intentional Rounding documentation. The evidence base for rounding was considered at the Falls Collaborative meeting on 21st September 2020. Subsequently, a Task & Finish Group has been established within the Trust with support from academic partners to review the current nursing documentation and its effectiveness in contributing to the delivery of an individualised care plan for patients. A high-level literature review has been conducted on intentional rounding to inform this work programme. The Task & Finish Group will report to the Trust's Policy & Practice Group, which reports to the Professional Board chaired by the Group Chief Nurse.

First Responder document

In addition, in response to the learning arising out of the review of Mr McKibbin's care, a First Responder document has been developed and brought into use Trust-wide from September 2020, included as part of the updated Falls Investigation template. This document has been designed to support staff in investigating the immediate scene following an inpatient fall. Key considerations for completion of the First Responder document have been disseminated to staff using the *"Feedback Friday"* campaign. This has included communicating that the First Responder document must be completed for all falls, even where patient harm is not suspected. The initial priority is stressed as being to ensure that the patient is safe and that necessary post-fall actions have been completed in line with Trust Falls Policy, however the First Responder document is required to be completed in addition as soon as possible. It has been emphasised that timely completion of the First Responder document is essential; the document must be completed by the first responder to the fall, or if this is not possible the Nurse in charge must complete the document in the course of the same shift during which the fall occurred, after discussion with the first responder. The First Responder document requires completion of a simple but effective diagram to demonstrate the layout of the scene, including the direction the patient is facing, with symbols for ease of navigation, and obvious hazards (wet floors, unlocked brakes, bedrail position) clearly identified. The First Responder document must be filed in the patient's clinical notes and easily accessible to an investigating officer.

An audit of compliance with the First Responder document and gauge of staff opinion was undertaken at two sites, across seven wards at Trafford General Hospital on 13th October 2020, and across seven wards at Wythenshawe Hospital on 14th October 2020. These wards were specifically selected using the Trust's weekly falls report given the most recent falls had occurred at these locations, and the wards include all three clinical divisions. The audit demonstrated a 79% compliance rate in completion of the First Responder document, forming

a basis for future work on embedding and improvement towards an aim of 100% compliance, to be overseen by the Falls Specialist Nurse for the site. The First Responder document is being revised in line with feedback from staff to ensure it is as helpful and user friendly as possible. A further audit is due to be undertaken in December 2020.

2. Proforma / documentation communication paradigm

The matter of the clinical record is a valid concern and one that the Trust has recognised. To that end we have a detailed assessment of the risk and have been working with teams widely on the mitigation of the risks associated with paper and electronic records across our hospitals and services.

In order to fully mitigate the risk the organisation is in the process of establishing a fully electronic patient record across the entire Trust.

The Trust took the strategic decision to go to market and procure a new Trust-wide Electronic Patient Record (EPR) for the MFT organisation in January 2018. The procurement process commenced in August 2018 with a go live of the new EPR in September 2022.

Work to date has included the following: -

- Board agreement of a significant financial investment in the project and on-going support;
- Establishment of the senior leadership and governance arrangements;
- Signed a contract with Epic Systems to provide the system;
- Creation and launch of Innovation Council;
- Significant work on communications and engagement;
- Series of benefit workshops undertaken with staff;
- Creation of five programme work streams.

The programme is now in its start-up phase. Since approval by the Board of Directors and then contract signature with Epic Systems at the end of May we have set up the design authorities and operational readiness board chairs have been identified and they and the design working groups will be setup by March 2021 to support the design process. We expect to setup working groups with subject matter experts including clinicians from all disciplines.

The system is a significant project and is set to revolutionise the way care is delivered across all of our hospitals. That said, the project is of a medium time frame and to that end the Trust is aware of the risks associated with the current hybrid record and the need to communicate clearly on issues of patient care across our own different hospitals and more widely with other referring hospitals. All of our hospitals have a detailed risk assessment in place in relation to the management and quality of the patient record and work with staff on ensuring the safe communication of patient information. That work includes training for staff on the importance of compliance with professional record keeping standards and continued efforts to share the hybrid record across all sites through systems such as All Scripts and Chameleon (existing site electronic records).

With respect to the specific issue of ophthalmology advice, a focus in respect of the evidence arising from Mr McKibbin's review was a failure of communication by Trafford General Hospital's clinical team with specialist colleagues at Manchester Royal Eye Hospital.

Currently specialist colleagues receiving referrals from across the Trust have access to the Chameleon/Sunquest ICE Desktop clinical records system or the Allscripts EPR, containing

diagnostic test results and other specific electronic records such as correspondence. It is acknowledged by the Trust however that not all records will be viewable by specialist colleagues across sites, i.e. those that are paper-based. Therefore, until the Trust-wide Epic EPR is live across the organisation, the usual process for specialist advice would be that relevant information from clinical records would be sought when receiving a request for advice.

Generally, for ophthalmological advice, a request would be made to see the patient physically for a face-to-face assessment. A decision to transfer however is a clinical risk assessment for those who are frail, and at risk from the consequences of transfer. If the patient is clinically able to travel, a transfer to Manchester Royal Eye Hospital would be arranged the same day. The Trafford General Hospital records would be brought to Manchester Royal Eye Hospital with the patient along with the written referral. Manchester Royal Eye Hospital specialists will then assess the patient in person via the emergency eye department or clinic, and the advice, treatment plan and any medication advice will be documented in the Trafford General Hospital notes, which return with the patient. If the patient is not fit for transfer, a specialist from Manchester Royal Eye Hospital will attend at Trafford General Hospital or elsewhere within the Trust to provide face to face specialist review.

The same principles apply to hospitals outside the Trust who access specialist services for advice, as the Trust cannot access notes from hospitals outside the Trust. The expectation would be that relevant clinical information will be sought when receiving a telephone referral for advice.

The use of the Situation, Background, Assessment, Recommendation (SBAR) structured communication tool is recommended to facilitate efficient communication between clinicians or clinical teams. The SBAR allows staff to communicate assertively and effectively, reducing vagueness and the need for repetition. The SBAR process is available for staff to use should they wish but is not always the appropriate format in which to document or structure clinician to clinician discussion. I have asked my Medical Director to explore the use of the tool further to agree in what circumstances it should be used. All clinician to clinician discussions should be supported by professional record keeping and decisions clearly documented. Medical staff have been reminded of this as part of the shared learning in response to the concerns raised with regard to Mr McKibbin's care.

Weekend Care

In respect of the specific point this gives rise to around weekend care, the Trust actively participates in the national improvement project 'Seven Day Hospital Services', which aims to ensure that patients receive consistently high-quality safe care every day of the week.

For context, the inpatient services provided at Trafford General Hospital are non-acute, including day case and short stay elective surgery and reablement. Inpatient medical services are focussed on patients that do not require specialist inpatient care. Trafford General Hospital provides specialist complex rehabilitation to the local population following Fractures Neck of Femur, other fragility fractures and Stroke services.

Patients are Trafford General Hospital have access to a senior clinical decision maker and diagnostics seven days a week. A Consultant is based on site at the weekend, 08.00 – 17.00 hours, and is on call out of hours to provide support and clinical guidance. In addition, two

junior grade doctors, a Registrar and anaesthetist are available on site 24 hours a day, 7 days a week. An 'Out of Hours' nursing team provides support to the on-site medical team.

Specialist advice is available from the relevant clinical specialists based either within Wythenshawe Hospital or Manchester Royal Infirmary (or, as above, in the Trust's other specialist services such as at Manchester Royal Eye Hospital). Advice will either be provided over the telephone, review and assessment if required will either be undertaken at the Trafford General Hospital site, or arrangements made for transfer if clinically indicated, as stated above.

There is 24-hour support for radiology investigations, including CT and x-ray, to be undertaken, with a radiographer on site between 08.00 – 04.00 hours 7 days a week. A Consultant radiologist is also available to discuss any requirements for Magnetic Resonance Imaging (MRI), and if required arrangements would be made for this to be undertaken at either the Wythenshawe Hospital or Manchester Royal Infirmary sites.

Physiotherapy and Occupational therapy are also provided 7 days a week on the elective Orthopaedic ward and the Early Limb Mobility (ELM) rehabilitation unit.

3. Investigation Processes

I will now turn to action in response to the findings in respect of the investigation process.

The Trust operates an Incident Reporting and Investigation Policy which sets out standards for instigation when incidents occur. One of these standards is: "*The report should include evidence found and RCA techniques used and ensure that conclusions are evidenced and reasoned"* It is clear to me that in this investigation and care review that did not happen.

What is also clear to me is that there were a number of red flags (warnings) present early in the investigation process that should have been picked up and addressed at the time. Of particular significance were that Mr McKibbin's family were raising early concerns about the process and that staff statements on the events did not concur.

The early problems with the investigation into the fall should have prompted escalation but did not. This was a fundamental issue and one that has been addressed as part of the response.

The Trust undertakes a number of investigations every year to ensure that explanation is provided to patients and their families, and lessons are learned. Most of the investigations undertaken meet the standards set out but sadly there are a small number that have not. The Group Clinical Governance Team have reviewed these, alongside Mr McKibbin's, and noted that some of these red flags are common to complex investigations[3]. The team have now formalised these and are using them at all initial incident review panels to identify where there may be a risk of the investigation standards not being met. If a risk is identified additional oversight arrangements are made and the issues openly discussed with investigation team members.

[3] Red flags identified include family concerns about the process, early statement discrepancies, the investigation involving more than one Hospital or service, investigation team unplanned absence and unwitnessed events.

Discussion has been undertaken with all Hospitals and Managed Clinical Services across the Trust and all services have reviewed their local incident investigation oversight processes to ensure that they have applied the learning as a result of a review of this case.

The falls investigation template has now been updated (attached at appendix 5) to include more detailed guidance around immediate action, including the requirement for an immediate check and documentation of the environment of a fall, including an unwitnessed fall.

The importance of an immediate review of the environment and gathering of evidence has been reiterated in guidance and shared across our Hospitals and Managed Clinical Services and, as previously stated, added to the Falls Investigation template.

Nationally there has been recognition that the investigation processes in the NHS require review and a framework is currently being tested in a small number of Trusts before National originally planned for roll out in 2021 but now pushed back to 2022 in response to the pandemic.

The National Patient Safety Incident Response Framework 2020 (PSIRF) recognises that the issue faced by many Trusts is the requirement to investigate so many incidents and that that is now hindering rather than supporting progress. The report builds upon the earlier 'Opening the Door to Change' report by the CQC recognising that many of the policy and protocol barriers have now been implemented and that it is culture and behaviour that need to be addressed. The Framework makes it clear that despite the best efforts of staff and the continuing advances in patient care, the inherent risks and complexity of healthcare mean an NHS entirely free of incidents is an unrealistic expectation.

The investigation process and MFT policies on same have largely been informed by the national requirements of the Serious Incident Reporting Framework 2015. This has now been reviewed and the National Patient Safety Incident Response Framework will replace it.

The framework is being trialled by some early adopters and once this is complete a final version will be available for Trusts to implement in 2022. An introductory version was published for review on 11th March 2020 in order that organisations could start to prepare for adoption of this.

In preparation for this the Trust has already implemented some changes including, the implementation of a Rapid Learning Review which includes a process for agreeing the response to each incident and a revised Serious Incident Panel process, this will be supported by the red flag identification described earlier. The Serious Incident Panel process will be a time-limited measure for a period of 12 months to strengthen oversight of investigations whilst the PSIRF is implemented.

The plan for implementation of PSIRF is included in MFT Patient Safety work programme for 2020/21 and key steps have been agreed at the Trust Quality and Safety Committee, whilst timeframes are included some of these may need to move dependent on the final PSIRF publication following the trial within early adopter sites.

In addition to the above changes at Group level Trust-wide, at the WTWA site specifically, a local Serious Incident Panel has been established to review serious incidents requiring further response. This will be overseen by the site Medical Director, Director of Nursing and Head of

Clinical Governance and will support identification of the appropriate independent investigation team. The new WTWA Quality Assurance Serious Incident Panel process will support the identification of clinical incidents that require further investigation, to ensure accountability, oversight and coordination of investigations, with a process aligned with the formal complaints process.

A Mortality Review process is firmly embedded at Trafford General Hospital to facilitate identification of learning arising from patient deaths.

I am of the view that these lessons and the changes implemented following Mr McKibbin's investigation and subsequent Nursing Review will significantly improve processes and mitigate the risk of similar problems arising in the future.

I apologise unreservedly for the failings identified and hope that the content of my letter provides assurance to you and Mr McKibbin's family that significant changes have been made to prevent such events from occurring again in the future.

Yours Sincerely,

Chief Executive