

**Trust Board Meeting: Wednesday 13 November 2013**

**TB2013.123**

<b>Title</b>	<b>Report on the “Review of the safety culture within the Trust’s Operating Theatre at Oxford University Hospitals” Unit</b>
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<b>Status</b>	For Discussion and Decision
<b>History</b>	Trust Board September 2013

<b>Board Lead(s)</b>	<b>Paul Brennan, Director of Clinical Services</b>			
<b>Key purpose</b>	Strategy	<b>Assurance</b>	Policy	Performance

## Executive Summary

1. This paper presents the Trust's response to the draft report of the "Review of the safety culture within the Trust's operating Theatre at Oxford University Hospitals" received by the Trust Board in September 2013.
2. During the period January 2012 to August 2012, three 'never events' relating to retained swabs occurred in the Churchill Theatres, albeit that the third event did not become evident until January 2013. All three events were subject to a full root cause analysis in accordance with the Trust Incident Management Policy.
3. In December 2012, the Director of Clinical Services commissioned an independent review of theatres by an external nursing practitioner.
4. The review was conducted over the period December 2012 to March 2013 with a subsequent draft report on findings received by the Trust in April 2013. This was reviewed and a number of changes requested. In particular it was considered that the report needed clarification on the evidence and analysis to support the findings. The author of the report did not respond to these requests for clarification despite multiple requests from the Director of Clinical Services.
5. Subsequently at its meeting in September 2013, the Trust Board received and considered the report but did not formally accept the report.
6. The Trust Board did review the recommendations and agreed that whilst the report was not accepted, that there were a number of themes from the recommendations that could be validated. As a consequence, The Trust Board requested that all the recommendations were examined again in detail by the Director of Clinical Services and that a detailed action plan should be submitted to the Trust Board at its meeting in public in November 2013.

## Recommendation

The Trust Board is asked to::

- **Note** the initial work completed in February and March in the Churchill Theatres (in response to the internal scoping exercise)
- **Approve** the actions developed in response to the accepted recommendations as attached at Appendix 2.

## External Review of the Safety Culture in Operating Theatres

### 1. Purpose

- 1.1. This paper presents the Trust's response to the draft report of the "Review of the safety culture within the Trust's operating Theatres at Oxford University Hospitals" for discussion and approval.
- 1.2. The review was commissioned by the Director of Clinical Services in November 2012 and was conducted over the period December 2012 to March 2013.

### 2. Background

- 2.1. In January 2012 and March 2012, two 'never event' incidents occurred in the Churchill Theatres. The two incidents were unconnected but both involved the retention of swab materials following surgery.
- 2.2. Both incidents were reported in accordance with Trust policy and full root cause investigations were completed for each incident. Actions were identified and implemented with the intention of preventing recurrence.
- 2.3. Following the second incident and subsequent discussion with the Medical Director, the Director of Clinical Services decided to scope the possibility of commissioning an independent review of the theatres across the Trust.
- 2.4. Arrangements to implement a review were initiated and a search commenced to identify a suitable external nursing practitioner to conduct the review. An external reviewer was recommended on the basis that he had relevant nursing experience, particularly in relation to operating theatres. He agreed to undertake the review, with the intention of starting in July 2012. However due to communication difficulties, the review was delayed until December 2012.
- 2.5. Terms of Reference were agreed in advance of the review and the review was conducted over the period December 2012 to March 2013.
- 2.6. In January 2013 a third 'never event' was identified although the actual operation had occurred in August 2012. It did not become evident that a swab had been retained until the patient presented for an x-ray as part of the treatment follow-up, in January 2013. A full root cause analysis was initiated at this stage, in accordance with Trust Incident Management Policy.
- 2.7. Following the third incident and notwithstanding the fact that the external review had commenced in December, the Director of Clinical Services requested the Assistant Medical Director (Clinical Governance) to lead an urgent scoping review to identify if any immediate actions were required in advance of the on-going wider review of theatres.
- 2.8. This scoping exercise identified a number of key areas for immediate attention and as a consequence, the Director of Clinical Services implemented a 'rapid response team' from members of the Divisional and Clinical Service

Management Team, with a remit to develop and implement immediate actions to address the issues in the Churchill Theatres identified by the scoping review.

- 2.9. The rapid response team, led by the Divisional Director/Professor of Surgery, identified and implemented key actions to address the concerns over a four week period. These actions were closely monitored and progress reported to the Director of Clinical Services. A copy of the action plan as at August 2013 is provided as Appendix 1.
- 2.10. During this action period in Churchill Theatres, the external review continued to look at the wider theatres situation based on the Terms of reference.

### **3. Process for signing off the review report**

- 3.1. The draft report of this wider review of safety culture was submitted on 7 April 2013 to the Director of Clinical Services for review and consideration. Once the draft was reviewed the Director of Clinical Services provided feedback to the reviewer in a meeting on 17 April 2013.
- 3.2. As part of the feedback, the Director of Clinical Services identified a number of factual inaccuracies which required amendment in the report. Changes were also requested in relation to the layout of the report, with the intention of improving the overall quality and structure of the report.
- 3.3. In addition to the above changes, the Director of Clinical Services requested that the report include a list of staff interviewed (to be identified only by job titles/role descriptions). He also requested that the findings should be organised to demonstrate:
  - 3.3.1. where findings or conclusions were based solely on an individual staff member's feedback/perception; or
  - 3.3.2. where analysis was based on triangulation of staff feedback with actual data and other information provided as part of the review
- 3.4. A revised second draft was received on 17 April 2013. This draft did include the amendments requested in paragraph 3.2 relating to factual inaccuracies and layout. A copy of the second draft report was provided to the Trust Board for consideration in September 2013.
- 3.5. However, the request for clarification on the analysis used in the report was not addressed. Similarly the request for information relating to the number, grades and type of staff interviewed across all theatres was not included.
- 3.6. In the following months, the Director of Clinical Services made several unsuccessful attempts to communicate his on-going concerns with the reviewer regarding the need for the additional information to support the analysis in the report.

- 3.7. In June 2013, the reviewer eventually responded and informed the Director of Clinical Services that due to unavoidable personal circumstances he was unable to discuss the report at this stage.
- 3.8. The Director of Clinical Services, Medical Director and Director of Assurance subsequently met to discuss the status and content of the report. The report was reviewed separately by all three directors to ensure that the analysis was robust and fit for purpose. Advice was sought from the Director of Workforce in relation to the findings on HR issues.
- 3.9. The critique of the report identified that, in the absence of any supporting information from the reviewer regarding his analytical approach, there was little evidence of triangulation of the issues identified by staff. Neither did the reviewer identify what information, data and documentation he reviewed to determine his findings. This did not mean the findings were inaccurate, rather than they could not be substantiated via triangulation of evidence.
- 3.10. Similarly there was a level of concern regarding the breadth and depth of the review. This was difficult to assess due to the lack of information provided by the reviewer regarding the number and grades/professions of staff interviewed or the theatres in which they work. The report makes reference to the need for the Medical Director to take specific actions, however the Medical Director was not interviewed as part of this review. Therefore these issues were never checked with the Medical Director.
- 3.11. It was concerning to note that the reviewer included his own opinion in relation to a number of key areas which are disputed by the directors that have reviewed the report.
- 3.12. Based on these concerns, it was agreed that the Director of Clinical Services should recommend to the Trust Board that the report is received but is not accepted, as it is unclear that it has fulfilled the Terms of Reference in an accurate and analytical manner.

#### **4. Extracted Learning from the Report**

- 4.1. Whilst the view was that the analysis was not clear, it was acknowledged that many of the recommendations described in the report would help the Trust improve the safety culture in the Theatres.
- 4.2. Therefore it was agreed that, despite the concerns regarding the competence of the report in relation to the Terms of Reference, recommendations from the report would be reviewed to identify the valid themes that could be triangulated by management based on internal information and data available within the Trust.

4.3. In summary, some of these themes include:

- Further development of pre-assessment processes
- Management of unacceptable behaviours
- Review of staff allocation mechanisms (including development of dedicated scrub teams)
- Implementation of the workforce plans for theatres
- Compliance with trust policies
- Establishment of a new Professional Nursing and Midwifery Committee
- Focus on improving peri-operative management
- Standardisation of provision of clinical educators
- Strengthening management of Theatres
- Review of Recruitment function

4.4. Further detailed work was completed over the last 6 weeks to determine if any specific recommendations from the report should be accepted as presented and to identify what actions were needed to implement the themes identified in paragraph 4.3.

4.5. It should be noted that a number of the recommendations had already been addressed through actions taken after the Trust's urgent internal review of the Churchill theatres.

4.6. It was recognised from this review process that there was a need to standardise the Trust's approach to commissioning independent external reviews. It was agreed that the Director of Assurance should develop guidance for approval and that this guidance could encompass the approach required for both internal and external reviews.

4.7. The Trust Board agreed that the Chief Executive should have the ultimate responsibility for approving the commissioning of, and arrangements for, external independent reviews on behalf of the Board.

## **5. Action Plan**

5.1. As requested by the Trust Board, the Director of Clinical Services has reviewed the original draft recommendations with colleagues. The resultant action plan is presented to the Trust Board for their consideration and approval of the actions. This is provided as Appendix 2.

## **6. Conclusion**

6.1. Whilst the draft report received did not satisfy the requirements of the Terms of Reference, and was not accepted by the Trust Board, it was agreed that there were a number of valid themes that could assist the Trust in improving the safety culture in theatres.

6.2. Acknowledging that a significant amount of work has already been completed as part of the improvements to the Churchill Theatres and HR issues, a further

detailed action plan and monitoring process was developed and submitted to the Trust Board at its November meeting.

## 7. Recommendation

7.1. The Trust Board is asked to:

- **Note** the initial work completed in February and March in the Churchill Theatres (in response to the internal scoping exercise)
- **Approve** the actions developed in response to the accepted recommendations as attached at Appendix 2.

**Paul Brennan,**  
**Director of Clinical Services**  
**November 2013**

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### Churchill Theatres Action Plan

This action plan details in-depth and immediate interventions by the Divisional and Clinical Service Management teams.

A senior team with expertise in a range of areas (including medical and nursing clinical leadership, HR and Governance) has been brought together to focus specifically on implementing this plan. The members are:

- Professor of Surgery & Divisional Director
- Consultant Anaesthetist & Clinical Lead for CH theatres
- Consultant Surgeon & Clinical Director for Surgery
- Divisional Nurse
- Divisional HR Consultant and
- Divisional Clinical Governance Facilitator.

The action plan will be implemented initially over a 4 week period. Monitoring meetings will be held 3 times/week with intensive support from the team. The action plan will be embedded and sustained by the new Theatres Management Team put into place as part of the new Directorate of Theatres, Endoscopy and Gastroenterology.

#### Compliance with Trust Policies and Standards

Issue identified	Action	Responsibility	Completion date	Evidence required	Status
1. Non-compliance with Trust Policy & Procedure for the Counting of Swabs, Instruments, Needles and Miscellaneous items for Surgical Procedures (referred to in this document as the Swab Count Policy).	1.1 Letter to be sent to all staff and users of CH Theatres Department re-emphasising the importance of adhering to all applicable Trust Policies.	Divisional and Clinical Management Teams	Disseminate to all staff by 05/02/13	Email and hard copies circulated within theatres Newsletter to staff	Completed 02/02/2013.
	1.2 On-going audit of staff competency and adherence with the Swab Count Policy Reported 3 times/weekly <ul style="list-style-type: none"> <li>• All grades of scrub-side Operating Department Practitioners (ODPs) and Nurses</li> </ul>	Divisional Nurse	01/03/2013 for existing staff and on-going for new staff.	Audit analysis and actions taken	Completed and on-going 11/02/2013

## Compliance with Trust Policies and Standards

	<ul style="list-style-type: none"> <li>All grades of surgical staff</li> <li>All grades of anaesthetists</li> </ul>		On-going. Daily from 06/02/2013 until 100% compliance is established. Once achieved, weekly checks. This will revert to daily if compliance falls below 100% at any point.		Completed and on-going 11/02/2013
	1.3 Laminate the A4 appendix Swab Count Policy and displayed in each theatre	Divisional Clinical Governance Facilitator	11/2/13	Laminated copy of Swab Count Policy	Completed 11/02/2013
	1.4 Dedicated Surgical Grand Round to be arranged to review and provide feedback on adherence with Theatre Standards..	Divisional Director	By end of March 2013	Surgical Grand Round Programme and list of attendees	Completed 8/03/2013
	1.5 Assurance that Trust policies and procedures relevant to theatres are fully implemented throughout the Churchill Theatres and Directorates of the Division of Surgery & Oncology:				
	a) Communicate and reinforce key aspects of the Policies at team meetings. Ensure staff have read them.	a) Clinical Lead for CH Theatres,	a) 18/02/2013	a) Team meeting minutes / Newsletter to staff Feb 2013	15/02/2013
	b) At-a-Glance (developed from the policies) to be laminated and displayed in each theatre.	b) Divisional Clinical Governance Facilitator	b) 25/02/2013	b) At a glance posters	11/02/2013
	c) Weekly audit to be conducted of compliance against theatre policies.	c) Divisional Nurse	c) 25/02/2013	c) Audit reports	11/02/2013 and on-going

Compliance with Trust Policies and Standards					
	1.6 Lapses in adherence with policies to be addressed by Divisional and Clinical Management Teams and reported as an incident, in line with Trust standards.	Medical Director via Clinical Lead for CH Theatres, Clinical Director for Surgery, Divisional Director for Surgery & Oncology)	On-going.	Datix reports Examples of follow-up following lapses	04/02/2013 and on-going
	1.7 Review the audits/observations 3 times/weekly initially.  Replace with monthly audits once compliance is achieved.	Divisional and Clinical Management Team	04/03/2013	Overview of findings and actions taken. Divisional Executive meeting minutes	Divisional Exec meeting 10/04/2013

## Leadership and Team Building

Issue identified	Action	Responsibility	Completion date	Evidence required	Status
2. There is a need to improve nursing leadership and ensure there is clearly defined accountability	2.1 Implement new establishment of senior theatre staff team: <ul style="list-style-type: none"> <li>8B matron begins role 18/02/2013,</li> <li>Advertise Band 8A Advanced Practitioner post</li> <li>Advertise vacant Band 7 posts</li> </ul>	Divisional Nurse Divisional Nurse Matron	18/02/2013 18/02/2013 25/02/2013	Posts advertised on NHS Jobs website & Peri-operative practitioners' specialist journal	2.9.13 All senior posts appointed to
	2.2 Provide leadership to staff focusing on improving teamwork, morale, shift patterns, behaviour and adherence to key and relevant policies. This will be achieved through formal and informal approaches.  Once embedded, to be sustained by Matron and Theatres Clinical Management Team.	Divisional HR Consultant	Time frames for initial workshops etc.  On-going	Initially weekly and subsequently monthly staff surveys	Commenced 04/02/2013 and currently on-going as weekly surveys.  Staff feedback obtained via monthly team meetings. For further survey Nov 2013
	2.3 Communicate to staff the role of the 'intervention team' over the next 4 weeks and clarify roles and responsibilities for the future.	Divisional nurse	06/02/2013	Email from Clinical Director dated 31/02/2013	Completed 08/02/2013
3. Inappropriate behaviours have been identified across all professional groups'	3.1 Create a single point of contact for staff who want to raise an incident regarding inappropriate behaviour so that they can be appropriately dealt with.  Once embedded, to be sustained by Matron and Theatres Clinical Management Team.	Divisional Clinical Governance Practitioner	Initial deadline 11/2/13  Ongoing	HR Manager as single point of contact. Monthly staff surveys	Completed 11/02/2013 and ongoing.

## Staffing and skillmix

Issue identified	Action	Responsibility	Completion date	Evidence required	Status
4. Churchill theatres do not currently have the required budgeted staffing establishment.	4.1 Work with HR to expedite the introduction of 23 staff who have been recruited but who are awaiting employment checks.	Divisional HR Consultant	04/03/2013 (ongoing recruitment)	Staffing analysis and updated via Divisional Quality Reports	Progress has been made. 18 of the 23 now in post.
	4.2 Enlist support of HR Deputy Director of Workforce to fill theatre staff vacancies, which are required to cover shifts in theatre activity.	Deputy Director of Workforce	01/05/2013	Workforce plan has been signed off to recruit to additional posts. CH theatres also part of a Trust wide campaign run by TNP worldwide. This will go live in early May with the aim to have interview days in early to mid-June. Unconditional job offers given to all successful candidates required to fill vacancies	On-going – new recruitment programme has commenced.  Aug 2013: recruitment continues, vacancy rate monitored via theatre management board
5. Shift patterns are not compliant with European Working Time Directive.	5.1 Introduce new shift patterns (that include full night shift) following full consultation with all theatre team staff.	Divisional Nurse	30 day consultation starts 13/03/13 and ends 10/04/2013. 30 day review period till 10/05/13	Shift consultation document	Shift consultation commenced 13/03/2013. Night shift to be implemented Nov 2013

## Governance and risk management

Issue identified	Action	Responsibility	Completion date	Evidence required	Status
6. Implementation of the governance programme and the management of risk is not sufficiently robust.	6.1 Continue to implement the team brief, WHO and instrument, needle and swab counts audits, analysis of this data and feedback on a weekly basis.	Divisional & Clinical Management Team	On-going.	Audit reports and action taken	Commenced and On-going
	6.2 Review and amend the risk register	Divisional Clinical Governance Practitioner	11/02/2013	Upload new CH Theatres Risk Register onto HealthAssure	Completed 25/02/2013
	6.3 Implement training on risk assessment training and analysis of incidents for all staff	Divisional Clinical Governance Practitioner	18/03/2013	Staff workshops with list of attendees. Minutes of CH Theatres Clinical Governance meeting	Commenced and aim to complete with all current substantive staff by 10/04/2013.
	6.4 Implement monthly CH Theatre governance meetings to: <ul style="list-style-type: none"> <li>Review incident themes and subsequent action plans on a regular basis, using this as a monitoring tool to review quality of clinical practice.</li> <li>Identify concerns that need to be escalated via Directorate Executive meeting to Division and Trust.</li> <li>Ensure new Trust policies and procedures can be disseminated to all clinical staff.</li> <li>Promote shared learning</li> </ul>	Divisional Clinical Governance Practitioner	01/03/2013	Minutes of CH Theatres Clinical Governance meetings.	Completed: 1 <sup>st</sup> meeting held 18/02/2013.
	6.5 Monitor agency staff competence using competency assessment tool. Feedback to agency if staff are not competent and/or not compliant with policies and theatre surgical procedures.	Churchill Theatre Sisters	On-going.	Assessment tool and NHS Professionals feedback/ complaint forms, which are collated weekly by Deputy Chief Nurse	Completed for all existing long-lines of agency workers 18/02/2013. Evaluation of feedback will be continuous and on-going

## Supporting and developing staff

Issue identified	Action	Responsibility	Completion date	Evidence required	Status
7. Staff have reported that they feel unsupported.	7.1 Arrange workshops and/or small group meetings to help and encourage staff to raise concerns.	Divisional Nurse	Initially multiple workshops over 1 <sup>st</sup> 4 week period then sustain through monthly meetings within theatre teams	Minutes from workshops and meetings	Initial phase completed: regular meetings arranged for March and April: invited facilitators are Rob Bolas, Interim Head of Governance in March and Liz Wright, Deputy Chief Nurse in April.
	7.2 Arrange workshops and small meetings to deliver teaching sessions on professional accountability & responsibilities.	Deputy Chief Nurse	04/03/2013	Outline of teaching sessions provided Monthly staff survey	Completed 22/02/2013.
	7.3 Provide clinical supervision to theatre staff in cases of need. As part of this process, identify their individual requirements, concerns and areas for development.	Matron	On-going	Overview of number and type of sessions held.	Commenced and on-going





## Appendix 2 - External Theatre Review Recommendations October 2013

Ref	Recommendation	Accepted/ Rejected	Agreed Action	Lead	Timescale
4.1 Aim: Considering the quantity and the nature of incidents related to the operating theatre environment reported to the Clinical Risk Department over a two year period, and the Trust's response to those incidents graded as 'orange' or above.					
1.	<ul style="list-style-type: none"> <li>The pilot project on pre-assessment must be rapidly taken forward and it is recommended that whilst the Consultant Anaesthetist remains involved that an experienced Project Manager be appointed as an 'invest to save' initiative and with a reporting line to a Board level Director.</li> <li>Additionally, consent procedures must be reviewed as part of this project to ensure that the importance of consent is understood by all those concerned and that patients re properly consented in a timely manner before procedures.</li> </ul>	Accepted  Accepted	<p>The pilot has been fully funded and implementation commenced in July 2013.</p> <p>The project is being led by the Consultant Anaesthetic lead and the senior nurse reporting through the Divisional Management structure.</p> <p>As recommended this forms part of the roll out of the pre assessment pilot.</p>	John Griffiths Consultant Anaesthetist  John Griffiths Consultant Anaesthetist	12 month pilot for review in August 2014.  July 2013 onwards
2.	Divisional Nurses must work in cooperation with their Divisional Directors to ensure that staffing levels are adequate in all of the Trust's theatres. This may mean moving resource from one Division to another. The Divisional Nurse responsible for Theatres at the Churchill must be actively supported by her Divisional Director, the Chief Nurse and the Director of workforce to resolve the staffing issues at that site as a matter of urgency.	Accepted	<p>A detailed action plan for Churchill Theatres was approved by the TME in May 2013 setting out a range of actions to be completed over a four week period.</p> <p>Staffing levels across the Theatre complexes at the JR, NOC and HGH are being reviewed as part of the wider nurse staffing review.</p> <p>A review of the CH theatre establishment was undertaken and this resulted in an investment to increase the establishment by 70 wte</p>	Divisional Nurse Surgery and Oncology  Divisional Teams and Deputy Chief Nurse  TME	Completed  March 2014  Completed budget approved in May 2013
3.	Clinical Risk Practitioners must ensure that reporting from their areas is consistent Cross Divisionally and that staff within their areas of responsibility understand the importance of reporting. Further, they must ensure that staff receive feedback and so better understand the benefits of appropriate reporting to the quality of patient care.	Accepted	Agreed actions were set out in the Churchill Theatre Action Plan approved by TME in May 2013. Action points 6.1 to 6.5 inclusive responded to governance concerns and the management of risk.	Divisional and Clinical Management Teams Surgery and Oncology and Divisional Clinical Governance Practitioner	Completed

Ref	Recommendation	Accepted/ Rejected	Agreed Action	Lead	Timescale
			This approach will be rolled out across theatres at the JR, NOC and HGH.	Divisional Teams	January 2014
4.	Incidents involving poor professional behaviour must be managed more effectively, especially by Medical leaders. Where necessary, the Trust's disciplinary procedure and, for surgeons, the General Medical Council 'Good Medical Practice: Duties of being a doctor' standard invoked.	Accepted	Agreed actions were set out in the Churchill Theatre Action Plan approved by TME in May 2013. Action points 1.4 to 1.7 inclusive responded to behavioural concerns and adherence to policy.  This approach will be rolled out across theatres at the JR, NOC and HGH.	Divisional and Clinical Directorate Management team.  Divisional Teams	Completed  January 2014
5.	Divisional Nurses must charge Band 6 and 7 Theatres staff with reviewing the ways in which staff are allocated to lists to ensure that surgical colleagues are properly supported. This must be routine practice throughout all of the Trust's theatres. Band 6 and 7 staff must be more willing to step in and support junior staff, particularly with complex cases or lists.	Accepted	The Theatres at the Churchill deployed staff on a rotational basis rather than allocating staff to specific surgical teams. This approach provides a greater level of flexibility but has a recognised downside in respect of consistency. The recommendation relates to the Churchill Theatres.  To deploy theatre staff to surgical teams and assess the workforce implications of adopting this deployment model.	Divisional Nurse Surgery and Oncology	Completed
6.	The only Band 7 post at the Nuffield Orthopaedic Centre is vacant. It is recommended that recruitment is commenced without delay and that this appointment then heralds a review of the role of the Band 6s who should be charged with spending more time in clinical practice, supporting Band 5s, and less time coordinating and managing stores.	Accepted	Recruitment to Lead Theatre Nurse post.	Operational Services Manager Orthopaedics	Completed
7.	The roles of Operating Theatre staff seem to differ across the organisation because the job descriptions have not been consolidated. Human Resources Managers must work together to resolve this as a matter of urgency.	Accepted	Job descriptions for all theatre staff will be reviewed and where appropriate standardised.	Theatre Manager CSS Division, Matrons Orthopaedic, CH Theatres and Cardiology and Cardiac Surgery Clinical Directorates	March 2014

Ref	Recommendation	Accepted/ Rejected	Agreed Action	Lead	Timescale
8.	A multi-disciplinary, Director level, panel should be set-up to manage potential 'Never Events' and catastrophic events and decide upon which events are declared 'Never Events' and then to manage further actions. Efforts should be made to ensure that the Trust is seen as a fair employer where staff are treated equally, regardless of their clinical discipline.	Rejected	The Trust has a robust system in place to assess whether untoward events should be classified as Never Events. This is demonstrated by the Trust openly declaring four Never Events during the past 18 months.		
9.	The Board should discuss and make clear their expectations in relation to transparency and openness versus reputation management as part of their discussion about the Francis Inquiry, particularly in relation to the declaration and report of 'Never Events'.	Accepted	The Trust operates an open culture and supports staff in raising concerns. The Trust Board approved a revised 'Whistle Blowing' Policy in 2013 and provides a range of routes for staff to raise concerns. The Trust Quality Committee endorsed a strong commitment to openness and transparency in considering the key recommendations contained in Francis 2, Keogh and Berwick Reports.		Completed
<i>4.2 Aim: Reviewing existing policies and procedures relevant to the operating theatre environment, with specific emphasis on safety critical policies, and to establish the current level of compliance with the same.</i>					
10.	<ul style="list-style-type: none"> <li>The Policy and Procedure for Counting of Swabs, Instruments, Needles and Miscellaneous items for Surgical Procedures (including Childbirth) (v1.4, September 2012) should be reviewed and the review include input from theatre staff with recent experience of working in other hospitals, together with surgeons and anaesthetists.</li> <li>The audit programme for this policy must be effective and provide feedback for the Board that is open and transparent.</li> </ul>	Accepted	The Policy will be reviewed as part of the scheduled cycle of policy reviews as agreed by TME.	Medical Director	March 2014
		Accepted	The Trust has instigated an audit programme which covers both WHO checklist completion audits and observation audits. The audit outcomes are contained in the monthly performance report provided by each Division and reviewed at the monthly and quarterly Divisional Performance Review Meetings	Divisional Directors	Completed
11.	The Medical Director must charge all senior medical leaders with ensuring 100% compliance with agreed trust policies. Newly appointed medical leaders must receive proper induction and understand their job descriptions, plus be provided with management	Accepted	The Medical Director and Director of Clinical Services have written to all medical staff setting out the Trust Policy and the requirement to complete the WHO Surgical Checklist.	Medical Director and Director of Clinical Services	Completed

Ref	Recommendation	Accepted/ Rejected	Agreed Action	Lead	Timescale
	training and development, if required.		A checklist completion audit is undertaken (see under point 11) and any diversion from the policy results in an individual letter from the Medical Director to the member of medical staff. General Policies are already addressed via the Governance Framework with monthly monitoring audits incorporated in to the Divisional Performance Reports. If agreed by the Trust Board the Quality Committee will receive a report setting out the Safety Policies monitored on a monthly basis.	Medical Director  Divisional Teams	Completed  March 2014
12.	A Nursing & Midwifery Board, chaired by the Chief Nurse, must be established as a key forum for engaging senior nurses and midwives and agreeing policy.	Accepted	A Nursing and Midwifery Professional Forum was established in August 2013.	Deputy Chief Nurse	Completed
13.	The policy on EWTD must be reviewed and audited urgently by the Director of Workforce and consistently implemented throughout all Divisions.	Rejected	The Trust has considered this recommendation however the EWTD Policy clearly sets out the requirements to comply with the Working Time Directive. All theatre staff are deployed by the electronic staff roster so working hours are constantly monitored.		Completed
14.	The policy on Statutory and Mandatory training should be reviewed by the Trust Management Executive to ensure that they really feel that it provides a 'standard that stretches' and is consistent with the organisation's vision and commitment to excellence, particularly in relation to promoting the very best standards of human factors training in the Operating Theatres.	Considered	The policy has been reviewed and will be presented to TME for approval.  Divisions are to report delivery against Statutory and Mandatory training at the monthly Divisional Performance meetings and set out clear plans to achieve compliance.	Director of Workforce  Divisional Directors	November 2013  Completed
15.	The Director of Workforce should review the policy on professional registration to ensure that it is effective, given the two untoward events that occurred with lapses in registration. Whilst outside the scope of this review, these lapses may indicate a wider organisational problem with registration lapses which the Trust Management Executive may wish to investigate.	Accepted	Leadership is provided through the Clinical Management Structure with direct support from ED's as required.  An audit will be undertaken in relation to compliance with the staff professional registration process. A report will be provided with a clear action plan to respond to any discrepancies identified.	Director of Workforce	January 2014

Ref	Recommendation	Accepted/ Rejected	Agreed Action	Lead	Timescale
<i>4.3 Aim: Considering the management structures operated in the Trust's operating theatre environments and to establish their effectiveness in relation to developing and maintaining a positive patient safety culture.</i>					
16.	In the absence of previous papers to formalise the structure and in the light of this report, the 'Never Events' and the views of Divisional staff the Executive should formally confirm its commitment to the existing structure.	Accepted	The Clinical Management Structure implemented in 2010 was approved by the Trust Board.  The existing organisational structure has been reviewed in line with the proposals approved by the Trust Board in 2010 and the revisions were considered and approved by both the Trust Management Executive and the Trust Board in September 2013.	Director of Clinical Services  Director of Clinical Services	Completed  Completed
17.	The Chief Operating Officer should urgently source and select a well-respected, senior leader in the field of perioperative practice to become the strategic 'glue' that holds perioperative practice together at OUH and works freely across all Divisions. They will have a track record of driving up standards of practice and of working collaboratively with all disciplines. This individual is likely to have a strong perioperative nursing, operational and academic background and should have substantial strategic experience. They should report to a Board member.  Additionally, an ODP Professional Leader and Advisor is required to promote the role of the ODP, to support ODPs in practice, to develop their leadership skills and work with students and the universities. Together they would be responsible for providing assurance to the Executive and the Board about the safety and efficiency of perioperative practice Trust wide.	Rejected	The precise recommendation is rejected however a review of the current approach to clinical leadership of perioperative practice will be undertaken.  ODP leadership and broader representation will be reviewed alongside the introduction of the Nursing and Midwifery Professional Forum.  A review of the process by which the Divisions provide assurance to the Trust Management Team will be completed.	Director of Clinical Services  Deputy Chief Nurse  Director of Assurance	March 2014  December 2013  February 2014
18.	Clinical Director and Leads must manage basic Operating Theatre issues, such as start and finish times. In order to do so they must agree on some basic definitions of terms such as 'start time'.	Accepted	A review of operating theatre utilisation and booking was commissioned in 2013 using external expertise (Newton). The review will complete in January 2014.  A daily review of theatre start and finish times has been implemented to monitor actual timings during the previous 24 hours to enable Clinical	Director of Clinical Services  Operational Service Managers for	Review to be completed by January 2014  Commenced in October 2013 and ongoing

Ref	Recommendation	Accepted/ Rejected	Agreed Action	Lead	Timescale
			Directors to follow up on late start times.	Theatres and CH Theatres, Endoscopy and GI	
19.	The Workforce Plan for the Churchill Theatres must be 'signed off' as a matter of urgency.	Accepted	A detailed workforce plan to match staffing resources to demand and operational running of the Theatres to be prepared for consideration as part of the review of the theatre establishment.	Divisional Nurse Surgery and Oncology	Approved by TME in May 2013
<i>4.5 Aim: Establishing the extent to which there is effective team working and, as appropriate, consensual decision making in the theatre environment.</i>					
20.	<ul style="list-style-type: none"> <li>The Trust's approach to recruitment, including overseas recruitment, must be radically reviewed and improved upon, including the introduction of English testing.</li> <li>From initial short-listing to 'on-boarding', overseas recruits do require on-going support and this should be provided.</li> <li>It is recommended that a dedicated recruiter be appointed to manage this process, ideally with an operating theatre background, and that this individual works cross divisionally. The post could be funded as an 'invest to save' initiative by reducing agency spend.</li> </ul>	Accepted	The Trust has implemented a robust framework for the recruitment of overseas staff and utilises the services of an expert recruitment agency.	Deputy Chief Nurse and Deputy Workforce Director	Completed
		Accepted	Arrangements have been established to provide on-going support to staff recruited from overseas. A two week induction programme is provided alongside a clinical buddying programme within clinical areas.	Deputy Chief Nurse	Completed
		Considered	The Trust considered appointing an overseas recruitment officer however decided to utilise the expertise of a specialist agency to support overseas recruitment in conjunction with the local team.	Deputy Chief Nurse and Deputy Workforce Director	Completed
21.	The Chief Nurse and Director of Workforce must work together to design a proper induction programme for new joiners with special emphasis on those candidates coming from overseas and working in the NHS for the first time. The programme should include on-going support and evaluation.	Accepted	On behalf of the Director of Workforce and the Chief Nurse a detailed induction programme has been developed and implemented with additional elements to support staff recruited from overseas.	Deputy Chief Nurse and Deputy Workforce Director	Completed
22.	The Deputy Chief Nurse must re-organise the theatre clinical educators into the central education team that currently just covers the wards and provide all theatres with consistent educational input with proper	Rejected	Additional Practice Development Nurses have been recruited to the JR, Cardiac and Churchill within the Divisions but with clear clinical supervision responsibilities and educational input		

Ref	Recommendation	Accepted/ Rejected	Agreed Action	Lead	Timescale
	cross cover, within existing resources. These educators themselves must receive proper educational support and supervision.		including the fundamentals of perioperative care. The Practice Development Nurses are supported by the Non-Medical Education Team.		
<i>4.7 Aim: Assessing whether the Trust's approach to the management of vacancies in the theatre environment supports safe care.</i>					
23.	The Director of Workforce must urgently re-build Divisional confidence in the role of the Recruitment team. Divisions should not need to employ people within their divisions to chase the Recruitment team and this practice should cease.	Accepted	A new electronic recruitment system (TRAC) has been implemented to support recruitment and improve the tracking of the various stages of the recruitment process.  Performance standards for recruitment from the point of VCF sign off to job offer are to be agreed with a target of eight weeks for the completion of the process.	Deputy Director of Workforce	Completed
24.	<p>The importance of a robust Workforce Plan cannot be over-estimated. The plan must include an assessment of the likely impact of the 'demographic time-bomb' in Oxford and should provide a detailed description of how this will be managed in cooperation with local universities and the increased numbers of ODP places that will be required.</p> <ul style="list-style-type: none"> <li>• For the short-term, it should focus on how turnover will be reduced and rapid mechanisms for reducing vacancies and agency staffing Trust wide.</li> <li>• The plan must also tackle the shortage of anaesthetists and set out a staged approach for ensuring that the Trust has sufficient anaesthetists and that those anaesthetists have sufficient resources to practice efficiently and effectively.</li> </ul>	Accepted	<p>A review of the root causes for turnover over within each Division will be undertaken and Divisional based action plans will be developed alongside a broader corporate plan to reduce turnover levels to 11%.</p> <p>Review the requirements for anaesthetic direct clinical care sessions to meet the demand for operating capacity and linked professional service requirements. Prepare a detailed workforce plan and implement.</p>	<p>Directors of Clinical Services and Workforce with Divisional Teams</p> <p>Divisional Director Clinical Support Services</p>	<p>Complete audit by February 2014 Develop action plan by April 2014 Achieve 11% standard by October 2014</p> <p>Completed; workforce plan approved by TME.</p>

25.	The Deputy Chief Nurse, as the lead for non-medical education, should work with a local university, staff, managers and educators to develop a certificated, post-registration rotation programme in perioperative practice.		Approach will be agreed following the review proposed under recommendation 18	Director of Clinical Services	Post review due to be completed by March 2014.
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**Mr Paul Brennan, Director of Clinical Services**  
**October 2013**