West Hertfordshire Hospitals NHS
NHS Trust

Agenda 24/10

Public Board Meeting, 28 JAN 2010

Complaints, Litigation, Incident & PALS (CLIP) Summary Report Q2 July – September 2009

Presented by: **Colin Johnston, Medical Director**

1. Purpose

The following CLIP summary report has been extracted from the main CLIP report and provides a summary of the key data on incidents, complaints and claims on an aggregated basis. Whilst the analysis provides a good summary it should be noted that the Governance and Risk team are still working on a way to better link the actual complaints and incidents to the actions taken and lessons learnt. In this way it is hoped to be able to show how the actual complaints and incidents drives the actions taken and the changes to clinical practice.

2. Overview

The following tables provide a comparison between Q1 (April – June 09) and Q2 (July – September 09) in terms of the number of reports and the identified themes.

	Q1 April – June 2009	Q2 July to Sept 2009	Reporting
Complaints	137	160	Increase of 23
Claims	27	9	Decrease of 18
Incidents on Main Datix	1701 (73 added since the publication of Q4 report)	1557	Decrease of 144
Pending Incidents (on Datix web)	30	216	Increase of 186
PALS	267	233	Decrease of 34

DatixWeb is the Trust's new electronic incident reporting system; incidents remain on this system pending final review and approval before being added to the main Datix system.

Themes Identified Across Incidents, Complaints & PALS Q2 July – September 2009

	Incidents	Complaints	PALS
1.	Fall on Level Ground	Clinical Treatment	Communication/ Information to patients
2.	Delay	Staff Attitude	Appointments/Delayed/ Cancelled – OPD
3.	Other Incident Related to Infrastructure	Admissions/Discharge/Transfer Arrangements	Appointments/Delayed/ Cancelled – IPD
4.	Fall from a Height, Bed or Chair	Appointments/Delayed/ Cancelled – OPD	Clinical Treatment

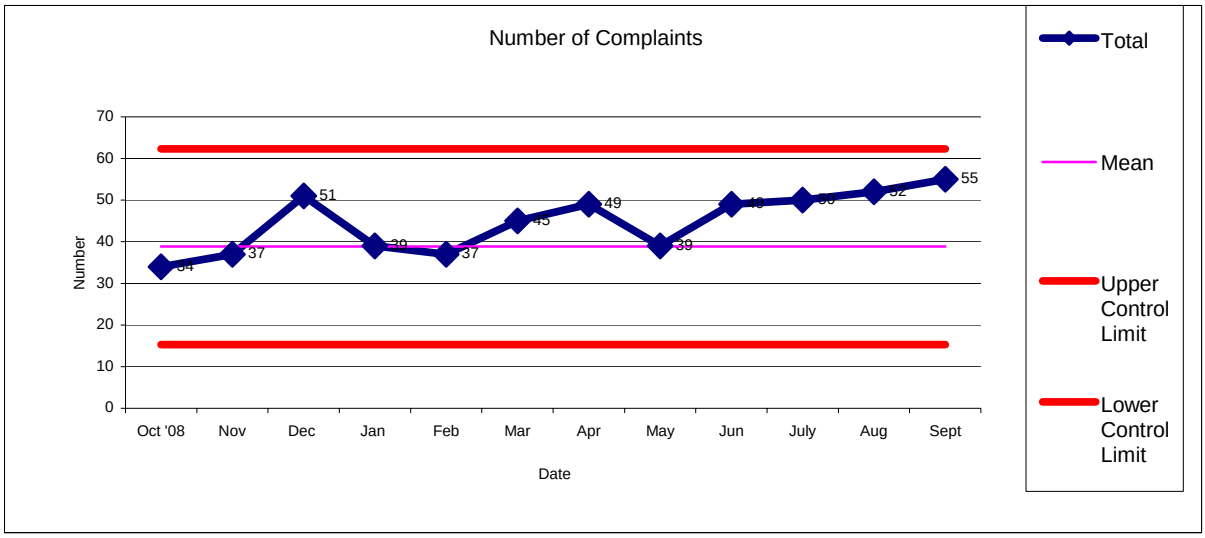
Patient falls were among the highest reported incidents in quarter 2 followed by the 'Delay'. 30% of the 'Delay' incidents related to the management of operations and treatment – with nearly a half of these incidents being attributed to a lack of staff in theatres.

A further 30% of the 'Delay incidents related to delays in transfers, the majority of these incidents were attributed to delays in transferring patients from ITU to beds in specialst/step down wards. .

The shaded areas identify the trends in complaints and PALs.

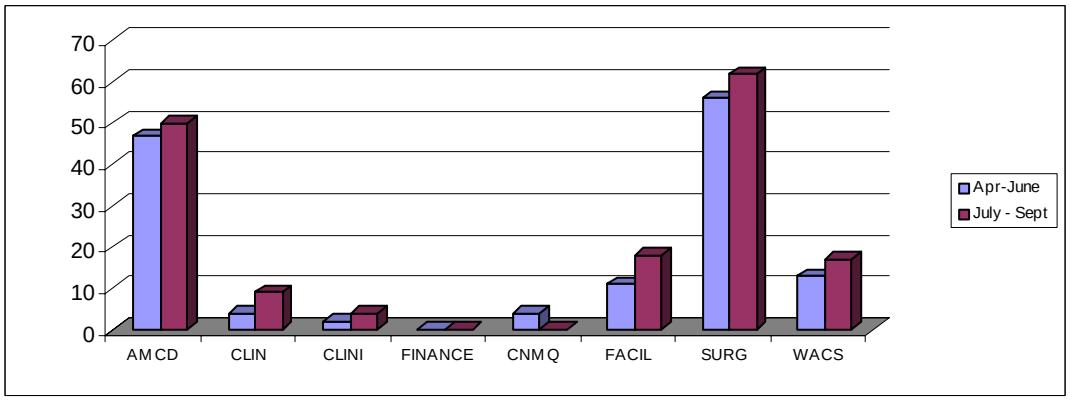
2.1 Complaints

Complaints over the last 12 months



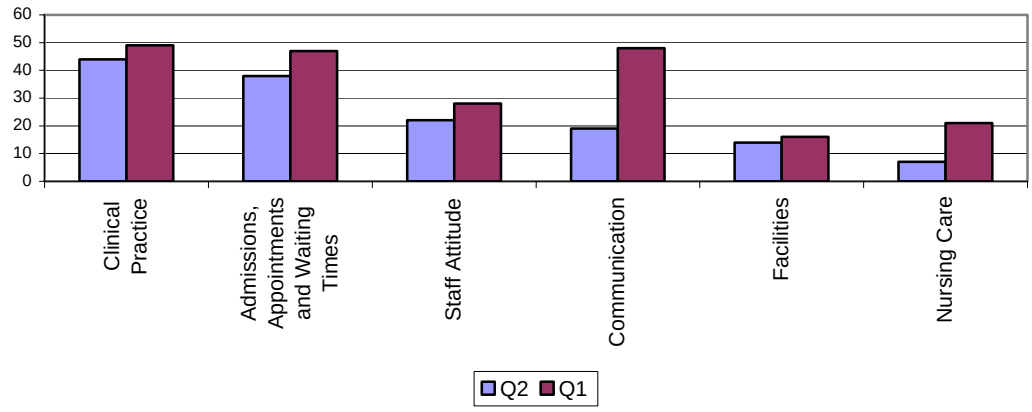
The above graph shows that the average number of complaints is 39 per month. It should be noted the number is close to the upper control limit.

Total No of Complaints Received by Division



With the exception of Corporate divisions, there has been an overall increase in the total number of complaints received for each Division from the previous quarter.

Top 6 Complaints by Subject



Although the table states the top 6 complaints by subject it also identifies any significant changes from Q1 / Q2.

Table 6 - Activity Data

The following table shows the levels of patient activity within the Trust and how the number of complaints received compare in percentage terms. *Data obtained from Which Doctor*

No of Complaints	**Q3 (08/09)**	**Q4 (08/09)**	**Q1 (09/10)**	**Q2 (09/10)**
No of Complaints (Including Enquiries)	158	169	182	188
Finished Consultant Episodes Inpatient (Percentage)	21,364 (0.6%)	21,754 (0.7%)	24,141 (0.8%)	24,419 (0.7%)
A&E Attendances (Percentage)	30,124 (0.5%)	29,692 (0.6%)	31,300 (0.6%)	28,952 (0.6%)
Outpatient Attendances (Percentage)	81,668 (0.2%	119,001 (0.2%)	92,822 (0.2%)	94,685 (0.2%)

2.2 Litigation and Claims

The table shows the total number of claims made against the Trust from 1st July – 30th September 09. The table illustrates if the claim was preceded by a complaint.

Claim date	Incident date	Division	Specialty	Description	Total reserves
7-Jul-2009	26-Mar-2005	SURG	Trauma & Orthopaedics	Letter of Claim - Patient was told that she had a small fracture, her knee was fine & sent home on crutches and Velcro cast. Not seen for MRI until 2006 where advised had serious injury, and not to walk on it.	£90,000
14-Jul-2009	04/07/2007	CLIN	Histopathology	Letter Before Action - Claiming clinical negligence-relating to a pathology test error that resulted in patient being wrongly diagnosed as suffering from tuberculosis rather than non-Hodgkin lymphoma. Complaint	£30,000

21-Jul-2009	28-May-2008	SURG	Trauma & Orthopaedics	Letter Before Action - Claiming clinical negligence after an operation on 28 May 2008, care was alleged to be substandard. The NG tube was fixed too tightly causing a pressure sore on the patient's nose.	£12,000
22-Jul-2009	5-Jun-2007	WACS	Obstetrics	Letter Before Action - Contemplating a claim for damages for personal injuries suffered as a result of negligence in her treatment at Watford General Hospital during the labour of her son, who died.	£20,000
28-Jul-2009	23-Dec-2004	WACS	Obstetrics	Letter Before Action - Claiming for personal Injuries arising out of care and treatment received at Watford General Hospital during the pregnancy and labour and neonatal period of her twin's birth, and whether this has caused disabilities.	£3,100,000
4-Aug-2009	11-Nov-2008	WACS	Obstetrics	Letter Before Action - Delivered first child after being induced. Patient sustained a severe 3rd degree tear, has been left with permanent bladder and faecal incontinence - Complaint	£80,000
19-Aug-2009	tbc	SURG	Urology	Letter Before Action - Failure to test for an infection in the penis following operation.	£15,000
11-Sep-2009	22-Mar-2009	AMCD	Emergency Care	Letter Before Action - Alleging that they were was not properly diagnosed at time of attending A&E and suffered bowel perforation. That Trust failed to conduct proper examination, failed to detect signs & symptoms of her condition, failed to admit for further investigations in time and failed to properly diagnose	£29,000
29-Sep-2009	28-May-2009	AMCD	General Medicine	Letter Before Action - No specific allegations other than underwent keyhole surgery to repair a Hiatus Hernia on 28 May 2009 substandard treatment received.	£25,000

Potential Cost for Claims received is approx £3,401.00

On 4 occasions, the Claims Department failed to meet the 40-day response timescale, due to volume of copying. Solicitors were kept informed.

An audit was recently carried out and one of the issues the audit highlighted was that some staff/public litigation claims were not included in reports to the Board – these will be included in future.

2.3 Incidents

The Trust reported 1557 incidents in Q2 July to September 2009 the number has decreased by 9% from Q1 April to June 09, when 1701 incidents were reported.

The Risk Management Department has started to analyse the number of incidents reported by patient bed days used and spells.

The two tables below are calculated using **patient safety incidents only** over the last 12 months measured against bed days used and spells (the spell refer to the dominant consultant specialty from the patients admission to discharge).

	Oct '08	Nov	Dec	Jan '09	Feb	Mar	Apr	May	Jun	July	Aug	Sept
Bed days Used (all wards inc maternity)	21005	20686	21560	22320	19532	20407	19733	20173	19839	20417	19307	20060
Patient Safety Incidents	329	324	292	401	321	381	371	409	408	420	332	241

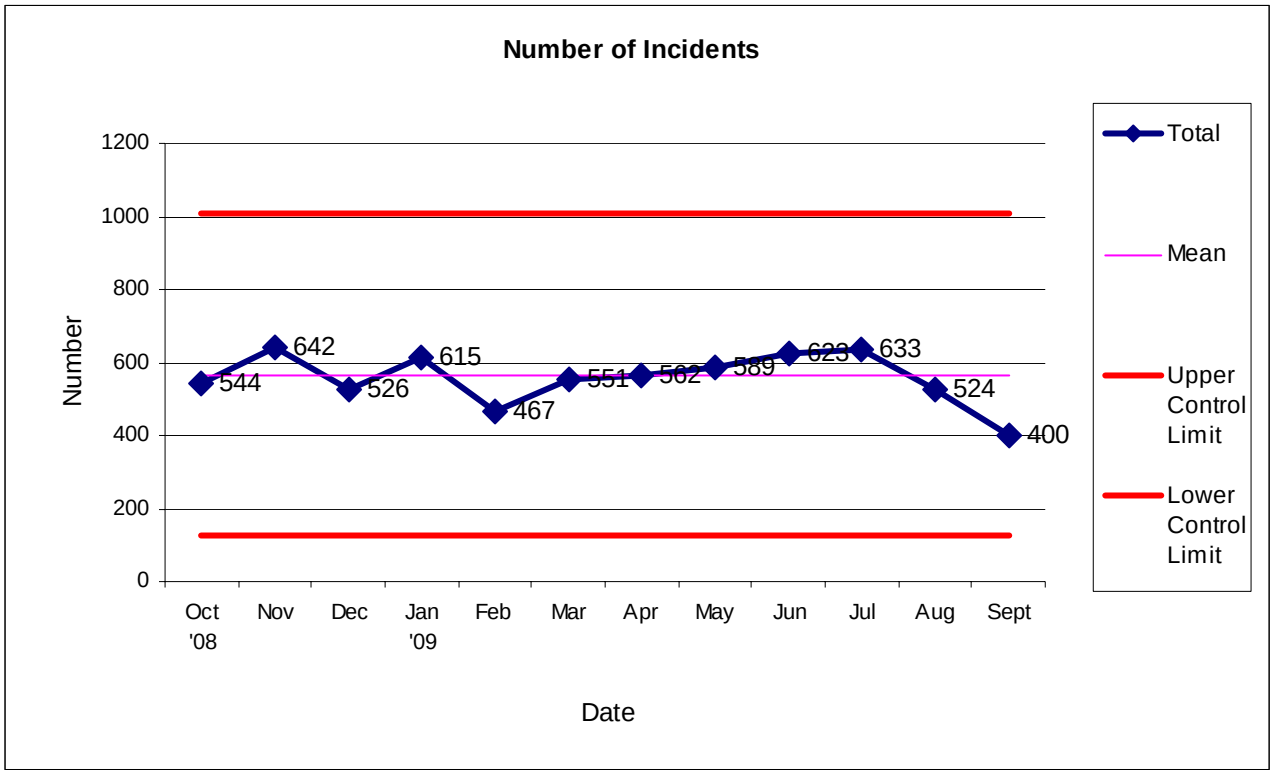
Patient Safety Incidents per 100 bed days	1.6	1.6	1.4	1.8	1.6	1.8	1.9	2.0	2.0	2.0	1.7	1.2

	Oct '08	**Nov**	**Dec**	**Jan '09**	**Feb**	**Mar**	**Apr**	**May**	**Jun**	**July**	**Aug**	**Sept**
Main Consultant Episodes within Patient Spell	6718	6469	6266	6433	5686	6727	6613	6774	7045	7372	6586	7056
Patient Safety Incidents	329	324	292	401	321	381	371	409	408	420	332	241
Patient Safety Incidents per 100 Spells	4.9	5.0	4.6	6.2	5.6	5.6	5.6	6.0	5.8	5.6	5.0	3.4

The information in these tables has been obtained from 'Which Doctor'

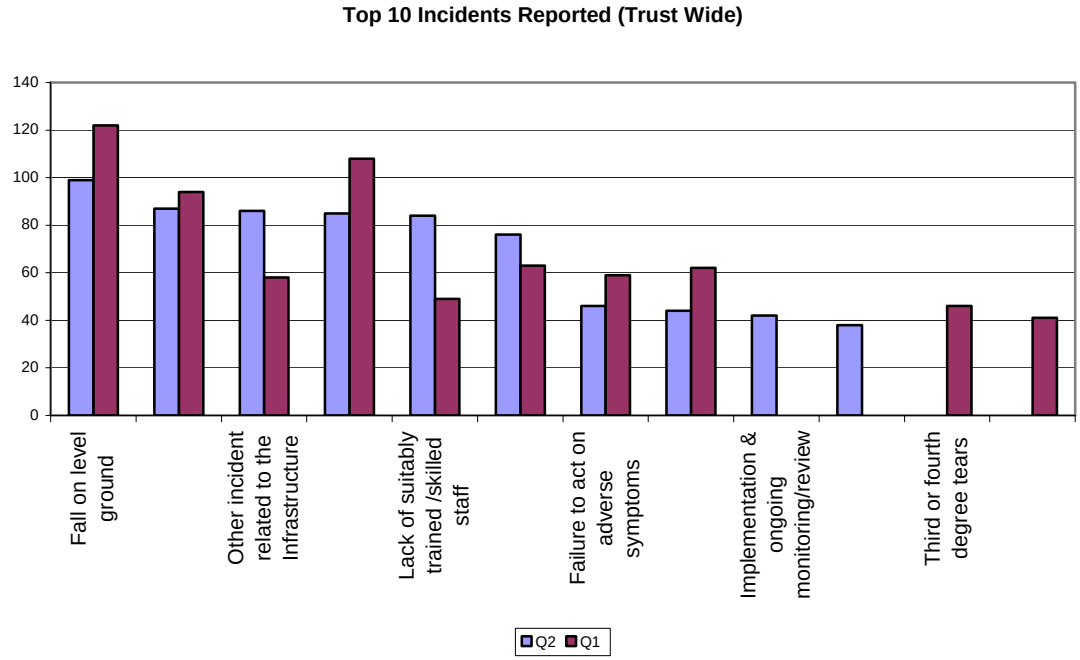
The remaining incident charts below report on all incidents (clinical and non-clinical). A total of 6732 incidents have been reported over the past 12 months.

Graph 1 SPC - Number of incidents (by incident date) Oct 08 – Sept 09



The average/mean number of incidents, which were reported per month, stood at 556.

Top 10 Reported Incidents by Trust wide (by incident date)



There has be a significant increase in the number of incidents reported that relate to lack of staff on the ward. There was decrease in the number of incidents where there was either a Fall On Level Ground or Fall From a Height.

SUI's

The Board receives a summary of Serious Untoward Incidents in the Trust's performance report.

Electronically Reported Incidents via DatixWeb

DatixWeb is now being widely used throughout the Trust, with very few areas needing training.

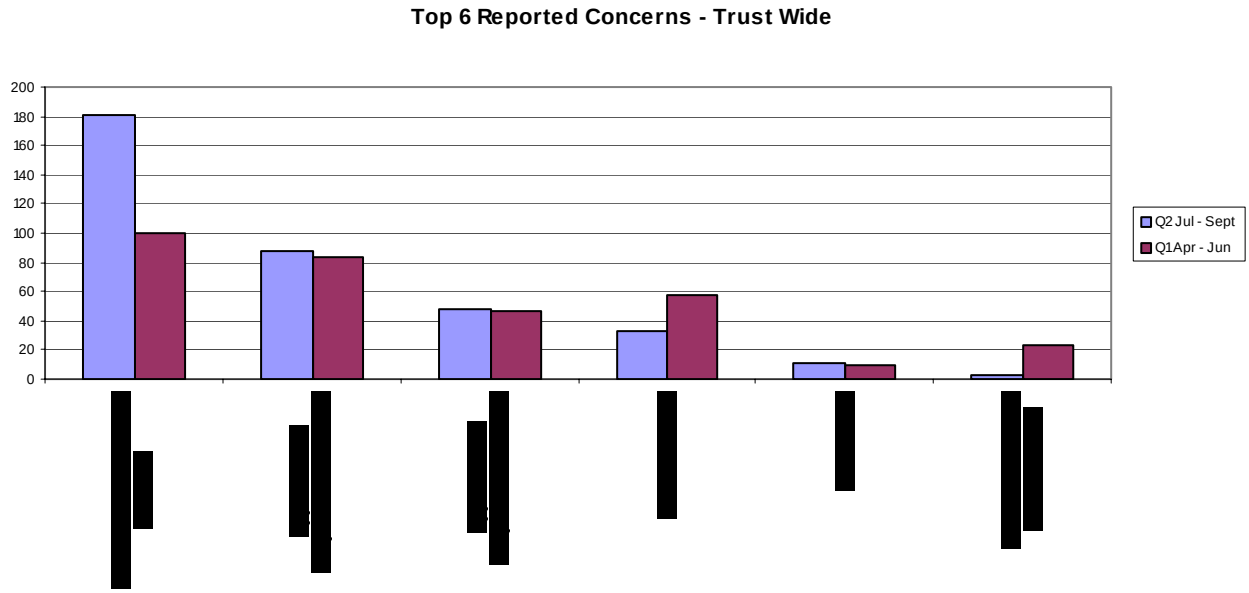
The below table shows there are 216 incidents, still on DatixWeb, for Q2, (as of 19th October 2009) which still need to be processed. In the report for Q1, it was noted that there were only 30. Measures have been put in place by the Systems Administrator to 'combat' this problem and a report on DatixWeb and the current backlogs in approving reports is being presented at the 21 January meeting of the Clinical Quality Committee.

	Awaiting Initial Review	Still Being Reviewed	Awaiting Final Approval
Acute Medicine	13	1	90
Clinical Support	7	0	2
Surgery & Anaesthesia	0	0	0
Women's & Children's	90	4	9

2.4 PALS

The total number of reported PALS concerns from 1st July 09 to 30th September 09 was 233 which is a slight decrease. In addition, the PALS team have made over 3000 calls relating to the 48 Hour Post Discharge Project.

Graph 3 - Top 6 Reported Concerns Trustwide



Communication/information to patients was the highest reported concern with 181, a significant increase from the previous quarter.

3. Lessons Learnt & Actions

Recommendations arising from the investigation of SUI WEB 3898

Recommendations discussed and agreed at a meeting involving Deputy Director of Nursing on 2nd November 2009.

Recommendation	Rationale	Objective	Completion Date
Review the access points to the Ward	There are 3 possible ways into the ward which are difficult to manage/observe when the staff are busy and otherwise engaged in patient care	To minimise the possibility of someone entering the ward unnoticed	**4 months** (March 2010)
Review and monitor future similar incidents	To monitor themes and be alert to possible similar incidents and if same staff are involved.	To recognise if anything similar happens again and be able to review and act quickly to minimise any serious untoward incidents	**Ongoing**

Recommendations arising from the investigation of SUI: 090329, Vasa Praevia & Unexpected Admission To NICU of A Term Baby & Subsequent Neonatal Death.

ISSUE	RECOMMENDATIONS	DUE	PROGRESS/COMMENTS
1.0 Communication issues around: (a) Informing the lab of urgency of x-match for blood.	a) Operational policy to clarify the process of communication between the Delivery Suite and Haematology when requesting urgent x-matched blood. With delegated responsibilities and clearly identified leads.	27 11 09	
2. Documentation issues around: a) Storage of scan images. b) Retrospective documentation; use of record sections to highlight high risks and management plans for labour; Annotation of events that occur in labour on the CTG. c) Contemporaneous documentation of the classification of decision for Caesarean section. Within the maternity records.	a) - Scan images not to be clipped to the front of the written report. - Business case for scanning imaging package, to enable scanning images to be stored and retrieved electronically b) - All staff involved with the case to meet with Investigating Officers /Supervisors of Midwives, to reflect on events and monitor future record keeping in accordance with professional guidelines. - Anonymised feedback to all staff via Maternity Unit Newsletter and at Clinical Governance ½ day with direct reference to professional guidelines. c) – Amend clinical guideline to expressly state the requirement for classification to be documented at the time of decision for Caesarean section is made. - Feedback to obstetricians involved in the case. - Induction course content for new rotations of obstetricians. - Continuous Caesarean section audit to include monitoring of contemporaneous documentation of classification for Caesarean section	30 11 2009 31 12 2009 31 12 2009 30 11 2009 20 11 2009 30 11 2009 01 02 2010 31 12 2009	

3. Guidelines: issues around: a) Scanning for low lying, placenta praevia and succenturiate lobe/bipartite placenta. b) Antepartum Haemorrhage c) Classification of Caesarean section	a) - Review emerging evidence, informing practice around the use of Doppler's when succenturiate lobe/bipartite placenta is suspected. If and where appropriate, revise guidelines. – Consider training implications see 4c. b) – Amend existing guideline to expressly state a trigger threshold for the decision to proceed with Caesarean section c) - See 2c above - Amend existing guideline to expressly state the acceptable length of time from decision to proceed with Caesarean section to time of birth.	31 12 2009 31 12 2009 21 11 2009 21 11 2009	b) Initial suggestion on statement for trigger threshold to read: 'Grade one Caesarean section to be considered when there is an acute antepartum haemorrhage of 500mls or less if CTG abnormality identified.'
4. Training: issues around: a) Haematology and Blood labelling. b) CTG interpretation c) Doppler training for sonographers	a) – Feedback to staff responsible for taking blood. - Staff member and all maternity staff to complete mandatory blood competency training and assessment, in accordance with NPSA directive. - Liaisons with Bank office to ensure Bank staff receive mandatory training. b) - All staff involved with the case to meet with Investigating Officers /Supervisors of Midwives, to reflect on interpretation of CTG monitoring. - Staff members to ensure completion of mandatory training requirements. c) - Consider feasibility of training all sonographers in the use of Trans-vaginal Doppler testing		

The Trust is currently updating is Serious Untoward Incident Policy and reviewing processes to ensure better management of the process of learning and sharing lessons resulting from serious untoward incidents. The Trust is also developing a recommendations follow up which will be reviewed by the Clinical Quality Committee to ensure that actions are implemented and that clinical divisions are monitoring progress.

Colin Johnston
Director of Patient Safety, Medical Director

January 2010