West Hertfordshire Hospitals NHS
NHS Trust

Agenda 52/10

Public Board Meeting, 25 March 2010

Complaints, Litigation, Incident & PALS (CLIP) Summary Report Q3 October – December 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 table provides a comparison between Q2 (July – September 09) and Q3 (October – December 09) in terms of the number of reports and the identified themes.

	Q2 July to Sept 2009	Q3 Oct to Dec 2009	Reporting
Complaints	160	119	Decrease of 41
Claims	9	24	Increase of 15
Incidents on Main Datix	1809 (Increase of 252 since the last report was published)	1593	
Pending Incidents (on Datix web)	216	224	Taking into account the incidents on DatixWeb the total for Q3 will be **1817** (very small increase of 8)
PALS	233	183	Decrease of 50

DatixWeb is the Trusts new electronic incident reporting system; incidents remain on this system pending final review and approval before being added to the main Datix system. This Report will *only* include information of the 1593 incidents – the additional 224 incidents will not be taken into account due to longstanding Datix Web issue.

Themes Identified Across Incidents, Complaints & PALS Q3 October – December 2009

The shaded areas of the table identify the trends in complaints and PALs.

	Incidents	Complaints	PALS
1.	Other	Clinical Treatment	Communication/ Information to patients
2.	Lack of Suitably Trained/Skilled Staff	Staff Attitude	Appointments/Delayed/ Cancelled – OPD
3.	Fall on Level Ground	Admissions/Discharge and Transfer arrangements	Appointments/Delayed/ Cancelled – IPD
4.	Fall from Height, Bed or Chair	Communication/Information to patients	Clinical Treatment

It is disappointing that so many incidents are logged under the category of 'Other' as this compromises full analysis of the incidents.

The risk department undertook a manual review of incidents logged as 'other' and an emerging theme related to patients being admitted to hospital from nursing homes for pressure sores. There are specific codes to be used for the reporting of pressure sores, and it is hoped that the problems coding these incidents will be resolved in readiness for the Q4 Report. It should be noted that the Trust's pressure sore incidence is also obtained via the Infoflex system from which is produced the data presented by the Tissue Viability Nurse and reported via contract monitoring.

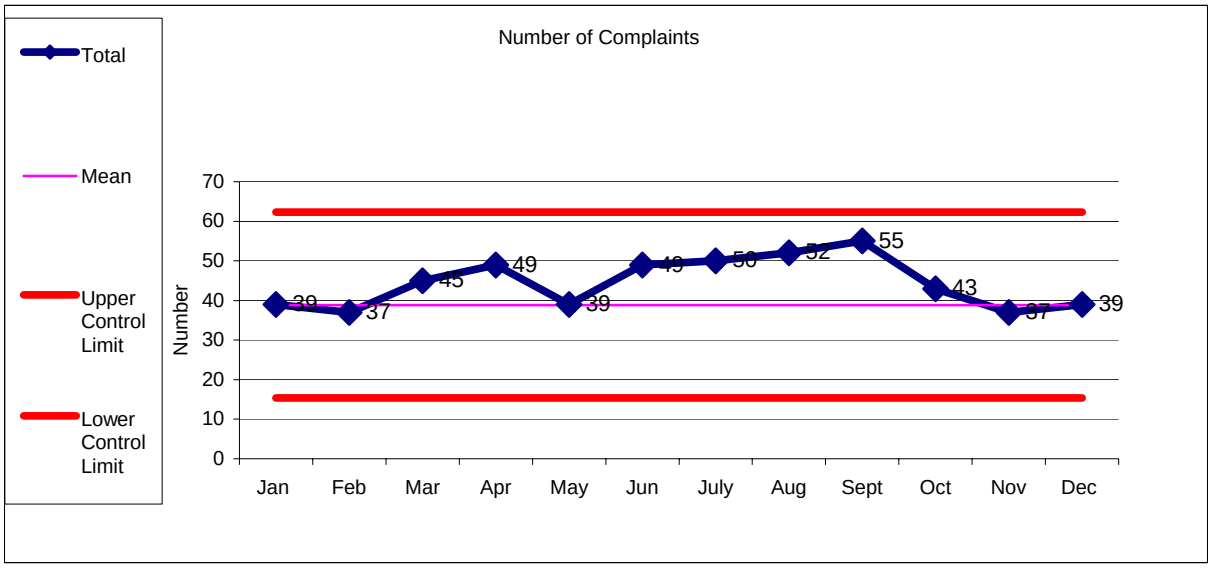
From registration, all pressure sores will have to be reported to the Care Quality Commission. All level III and level IV pressure sores recorded in the Trust are subject to root cause analysis.

Another area of concern relates to the 'fall' categories, which feature in the top 4 incident types for Q2

The shaded areas identify the trends identified in reports emanating through complaints and PALs. 'Clinical Treatment' was also a theme for both PALS and Complaints in the quarter 2 report.

2.1 Complaints

Complaints over the last 12 months
The average number of complaints received per month for Q3 is 38 compared to 39 per month for Q2.

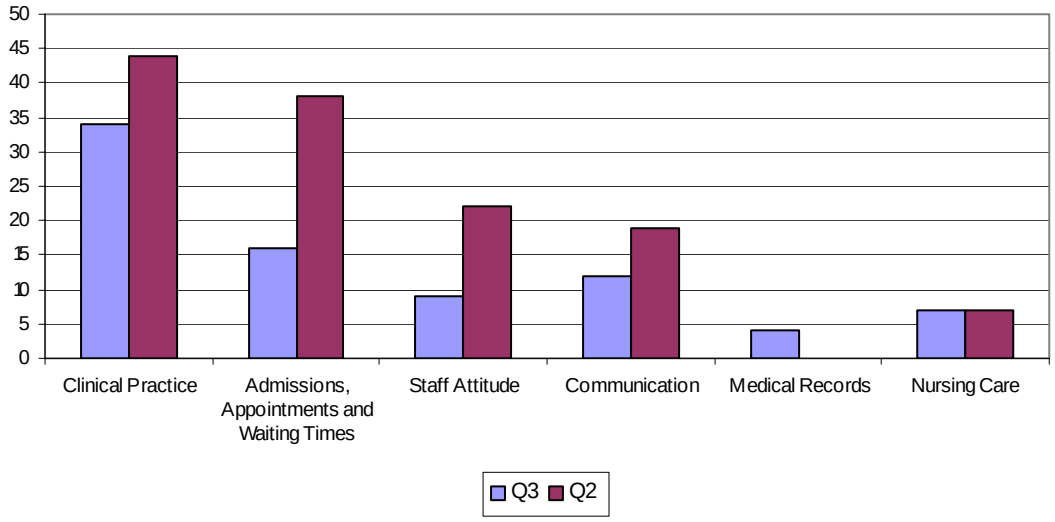


Total No of Complaints Received by Division
There has been an overall decrease for each Division from the previous quarter, more noticeably in Surgery and Estates and Facilities.

Please note that the total number of complaints for December is not a final figure as we are not yet in a position to confirm the final number due to the Triage process.

Top 6 Complaints by Subject

Although the table states the top 6 complaints by subject it also identifies any significant changes from Q2 / Q3.



Top Complaints by Main Subject by Division

The table shows complaints by main Subject and by Divisions for Q1, Q2 and Q3.

Top Complaints by Subjects per Division	Apr – Jun 09	July – Sept 09	Oct – Dec 09
Acute Medical Care Division			
Clinical Practice	20	39	17
Communication	18	32	7
Polices and Procedures (Discharge)	12		3
Admissions/Discharge		14	3
Nursing Care	19	25	4
Staff Attitude	10	10	3
Clinical Support			
Staff Attitude	1	5	1
Clinical Practice	1	1	1
Communication	3	1	
Policies and Procedures	0	5	
Facilities, Estates, Clinical Engineering and Fire Safety			
Parking			2
Facilities	9	16	
Surgery & Anaesthesia			
Admissions, Appointments and Waiting Times	35	32	8
Clinical Practice	20	27	9
Staff Attitude	11	10	3
Communication	17	21	5
Womens and Children Services			
Clinical Practice	8	16	9
Staff Attitude			2
Communication	6	9	
Staff Attitude	5	5	5

Activity Data within the Trust

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	**Q4 (08/09)**	**Q1 (09/10)**	**Q2 (09/10)**	**Q3**
No of Complaints (Including Enquiries)	169	182	188	130
Finished Consultant Episodes Inpatient (Percentage)	21,754 (0.7%)	24,141 (0.8%)	24,419 (0.7%)	24,480 (0.5%)
A&E Attendances (Percentage)	29,692 (0.6%)	31,300 (0.6%)	28,952 (0.6%)	28,706 (0.5%)
Outpatient Attendances (Percentage)	119,001 (0.2%)	92,822 (0.2%)	94,685 (0.2%)	134,473 (0.1%)

2.2 Litigation and Claims

The total number of claims made against the Trust from 1st October – 31st December 09. The table illustrates if the claim was preceded by a complaint.

Table 1 - Claims Opened Within Quarter 3 (Oct to Dec 09)

Claim date	Incident date	Division	Specialty	Description
5-Oct-2009	21-Feb-2008	WACS	OBSTER	**Letter of Claim** - Claims that due to traumatic birth, suffers from signs and symptoms associated with traumatic stress. that paemergency c/section, had PPH of 2600 mls and left ureter was inadvertly clamped. Senior medical assistance called including on call obstetrician, major Obstetric haemorrhage call instigated.
9-Oct-2009	10-Nov-2008	SURG	ENT	**Letter Before Action** - Alleging clinical negligence, following a myringoplasty operation to repair a hole in her eardrum on 10 November 2008.
19-Oct-2009	28-Nov-2008	WACS	MIDWIF	**Letter Before Action** - Alleging negligence after a delay in diagnosing a prolapsed disc at Watford General Hospital on 28 November 2008.
20-Oct-2009	12-May-2004	WACS	OBSTER	**Letter Before Action** - Claiming clinical negligence for damages resulting from the management of labour and the birth of her son, and subsequent assessment and management of birth injury.
28-Oct-2009	4-Feb-2009	WACS	OBSTER	**Letter of Claim** - After delivery of baby, mother was diagnosed with urinary retention and alleges her bladder was damaged. Also had a prolonged labour after her waters had broke apparently 48 hours before. **Complaint**
28-Oct-2009	09/04/2008	SURG	TRAU	**Letter of Claim** -Seeking compensation for a long scar inflicted to her right arm whilst having a PoP removed Watford General Hospital.
29-Oct-2009	10-Oct-2008	SURG	GSUR	**Letter of Claim** - Patient had a recurring umbilical hernia, which was not successfully operated upon. That she developed further complications and received poor after care. Went on and had a second operation which she claims was not necessary had the first procedure been done satisfactorily.
2-Nov-2009	2-May-2007	SURG	TRAU	**Letter Before Action** - Had knee replacement and knee arthroscopy & discharged after 3 weeks with antibiotics. But then had an inflammatory reaction & infection but an exploratory operation was still carried out. A Patch test was done a year later & found to have an allergic reaction to nickel sulphate.

Claim date	Incident date	Division	Specialty	Description
4-Nov-2009	1-Aug-2008	SURG	TRAU	**Letter of Claim** - Patient suffered from Charcot's Neuropathy, surgery was undertaken without consultation with the diabetologist and vascular surgeon.. Alleges that it is unlikely that the wound will heal and chances of re-ulceration are high.
5-Nov-2009	10-Nov-2008	SURG	TRAU	**Letter Before Action** - No details other than it relates to Orthopaedic treatment
5-Nov-2009	13-May-2008	WACS	OBSTER	**Letter Before Action** - Claims delay in diagnosing pulmonary embolism. After giving birth the patient suffered postnatal collapse. She was then admitted to A&E and this when she was then diagnosed with pulmonary embolism and multiple clots on her lungs
5-Nov-2009	14-Dec-2007	WACS	GYN	**Letter Before Action** - The Claimant alleges that the treatment that his wife received at WGH fell below an acceptable standard, in that there was a failure to remove the uterus at the time of the surgery to remove the ovaries and that as a result of this the cancerous cells remained in the endometrium and subsequently spread. **Complaint**
25-Nov-2009	5-Oct-2006	AMCD	EMERC	**Letter of Claim** - Protective Proceedings issued - Alleges that treatment received in A&E on transfer from Beds & Herts Ambulance Service caused/materially contributed to his T4 ASIA A motor and sensory complete paraplegia
2-Dec-2009	29/01/2008	SURG	GSUR	**Letter Before Action** - Alleges that haemorrhoids injected with Phenol was wrongly injected in prostate gland vesicles - **complaint**
8-Dec-2009	1-Dec-2006	AMCD	COTE	**Letter Before Action** It is alleged prior to her death, she was admitted between Dec 06 & Jan 07 with a Urinary Tract Infection but subsequently diagnosed with C-Difficile
8-Dec-2009	3-Feb-2007	AMCD	GENM	**Letter Before Action** - Allegation of negligent treatment after suffering a wrist fracture. Initially on 3/02/2007 was recommended a reconstruction of the extensor pallicis longus tendon, which was never carried out on 19/10/2007. It is alleged the delay caused her to undergo a different surgery to the original one & resulted in a poorer outcome.
8-Dec-2009	24-Oct-2008	AMCD	EMERC	**Letter of Claim** - Alleges that fracture was not identified did not return to Trust, decided to go private requesting reimbursement of excess. Claim rejected awaiting documents from small claim court. **Complaint**
9-Dec-2009	5-Dec-2008	WACS	OBSTER	**Letter Before Action** - Alleges substandard care, May 08 operation at SACH to correct over healed cervix. Nov 08 had further surgery to dilate her cervix & scan was done which showed an 18.5-week viable pregnancy. Dec 08 was induced; baby was still born at less than 20 weeks.
9-Dec-2009	21-Jan-2009	SURG	TRAU	**Letter of Claim** - Alleges extreme negligence in treatment received. Had arthroscopy & told did not require a knee replacement for another 5 years. Was not given option of a second opinion. Pain continued, went private for further arthroscopy & then told that a knee replacement was required which was undertaken. **Complaint**
14-Dec-2009	22-Apr-2009	AMCD	EMERC	**Letter of Claim** - Claiming damages for personal injury arising out of medication provided to during an attendance at Urgent Care Centre

Claim date	Incident date	Division	Specialty	Description
15-Dec-2009	29-Mar-2008	SURG	TRAU	**Letter Before Action** - Failure to act upon abnormal ECG trace obtained prior to surgery, which was carried out under general anaesthetic when with underlying heart condition a local anaesthetic would have been appropriate.
17-Dec-2009	17-Jul-2009	SURG	TRAU	**Letter Before Action** - Alleges failure to diagnose and to appropriately treat her Cauda Equina Syndrome on or around 17 July 2009
21-Dec-2009	24-Apr-2008	WACS	OBSTER	**Letter Before Action** - Alleged negligence for mother being assessed as a low risk & a delay in recognising & responding to foetal distress. Baby suffered permanent injury & loss. Baby is now diagnosed having moderate to severe Hypoxic Ischaemic Encephalopathy & Cerebral Palsy. **Complaint**
21-Dec-2009	24-Aug-2009	SURG	UROL	**Letter Before Action** - Alleges failure to fully investigate lump prior to surgery & failure to identify lack of blood supply to right testicle. Had agreed to a bilateral vasectomy to remove a lump in right testicle diagnosed as an epididymal cyst at the same time. A day after surgery was admitted to A&E & scan done. Found circulation to testicle cut off & a right-sided Orchidectomy done. **Complaint**

During October & November 2009 the department failed to comply with the 40-day timescale - on 4 occasions due to volume of copying, solicitors were kept informed.

Staff Claims - Member of staff slipped on a wet floor in ward kitchen, currently with NHSLA but looking to involve Compass Group
Public Liability Claims - Member of public attended A & E following a fall, wheelchair used to transport back to car. Patient stood up footplate came down causing a further injury and had to return to A & E - complaint

2.3 Incidents

The Trust reported 1607 incidents in Q3 October to December 2009.

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).

Table 1 Reported Patient Safety Incidents by Bed Days

	Jan '09	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Bed days Used (all wards inc maternity)	21295	18593	19306	18646	18975	18712	19064	18244	18920	19933	19653	19551
Patient Safety Incidents	403	321	381	372	412	412	422	381	350	404	361	302
Patient Safety Incidents per 100 bed days	1.9	1.7	2	2	2.2	2.2	2.2	2.1	1.8	2	1.8	1.5

Table 2 Reported Patient Safety Incidents by Main Consultant Episode

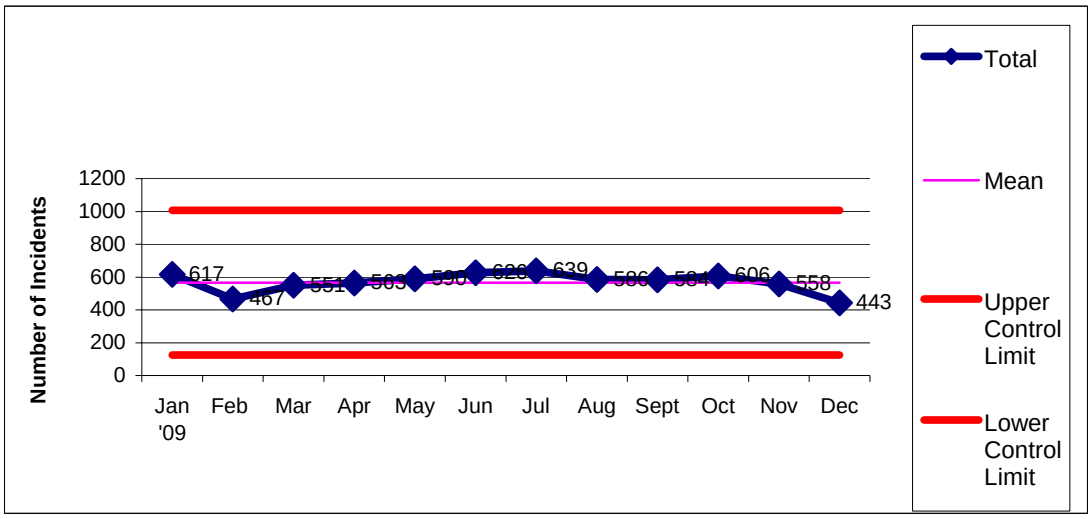
	Jan '09	Feb	Mar	Apr	May	Jun	Jul	Aug	Sept	Oct	Nov	Dec
Main Consultant Episodes within Patient Spell	6433	5686	6737	6587	6687	6988	7305	6579	7060	7262	7020	6538
Patient Safety Incidents	403	321	381	372	412	412	422	381	350	404	361	302
Patient Safety Incidents per 100 Spells	6.3	5.6	5.6	5.6	6.2	5.9	5.8	5.8	5.0	5.6	5.1	4.6

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

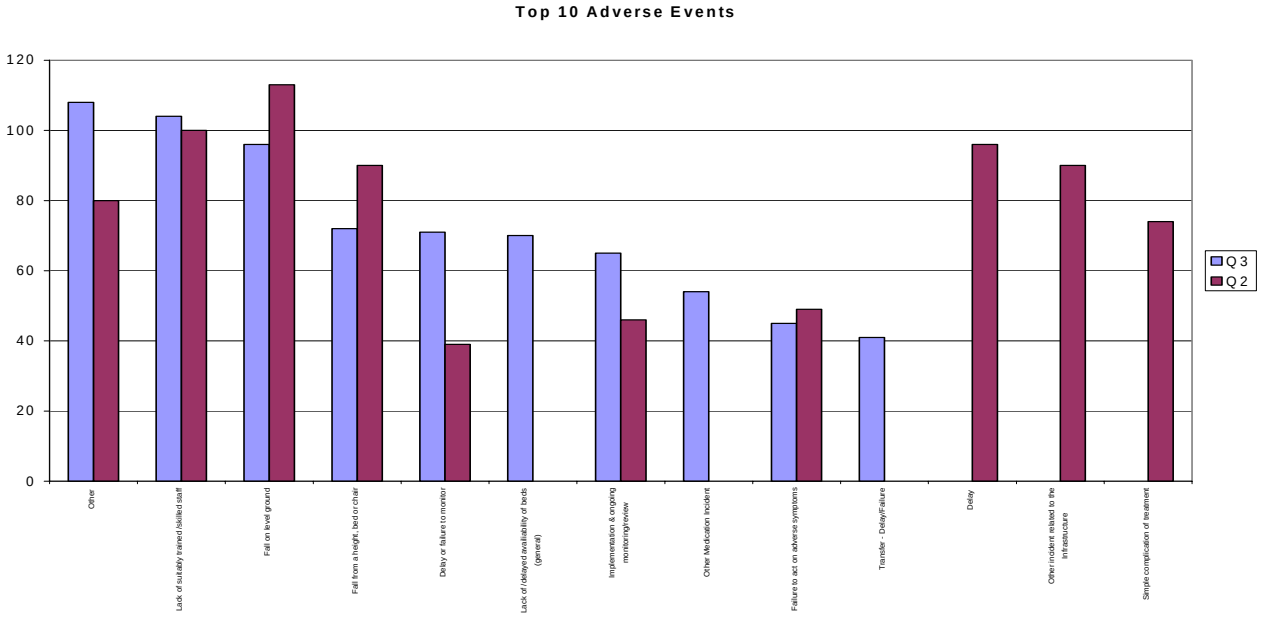
Number of incidents (by incident date) Jan - Dec 09

A total of 6830 incidents have been reported over the past 12 months. The incident charts below report on all incidents (clinical and non-clinical).

The average/mean number of incidents, which were reported per month, stood at 556 – which are the same as the average number for Q2 see below chart.



Top 10 Adverse Events Reported Trust wide (by incident type)



An increase in the number of 'lack of staff' incidents was noted in the Q2 report and as the above graph shows, there has been another increase in this quarter. The top 2 wards affected by a lack of staff, during this quarter, were within the division of medicine. When looking at these top 2 wards, a total of 19, lack of staff incidents happened because of staffs being transferred between wards to assist – in particular, staff were being moved to help on Croxley ward. This issue has been monitored closely and a decision was made to close 3 beds on Croxley Ward in February to addressing staffing concerns.

The below table shows the above information in terms of percentages of the total number of incidents:

	Q3	Q2
Negligible	43%	41%
Minor	35%	39%
Moderate	20%	18%

Serious Untoward Incidents -SUI

Three Serious Untoward Incidents were reported in Q3, this is the same number, which were reported in Q2. Details can be found in the below table:

Date of Incident	Nature of SUI	Trust Ref No.	Division	Lead Investigating Officer	Lead Director	SUI Description	SUI Reported to PCT / SHA	Date final report completed and sent to the PCT	Was the final report sent within 45 day Timescale? Y/N

16.10.09	Patient suddenly dies on second Post-op day	WEB 4770	Gynaenae	Margaret Cronin	Colin Johnston	Patient was admitted for routine vaginal hysterectomy & repair for prolapse on 14 10 2009. Pre Operative Assessment had identified three Venous Thromboembolic risk factors indicating thromboprophylactic treatment. Patient showed a good recovery on the first post-op day. At about 06.45 hours on the morning of the second post-op day, she became suddenly breathless and collapsed. Resuscitation attempted and the patient subsequently died. This was reported through the incident reporting system at the time. Subsequent preliminary investigations have required re-scoring of the incident, as it was revealed that there were no clear instructions for thromboprophylaxis recorded.	Yes. 28.10.09	02/02/2010	No
01/11/2009	4000 doses of swine flu vaccine having to be discarded	WEB5125	Clinical Support	Luke Bonci	Colin Johnston	The walk in fridge in the Pharmacy Stores "went out of range" at 8.32am on 1/11/09 resulting in stocks of medicines held including 4000 doses of swine flu vaccine having to be discarded subsequently. (The temperature should be maintained at 2-8 C in accordance with the manufacturers requirements to appropriately store "fridge" medicines). The fridge recording identified that the temperature went down to -5C at 8.32am on 1/11/09. This activated an alarm in the switchboard. The Manufacturer of swine flu vaccine confirmed on 2/11/09 that the 4000 doses in the Pharmacy fridge had to be discarded due to temperature reaching minus –5C.	Yes. 06.11.09	07/01/2009	Yes
02/12/2009	Breach of Patient Confidentiality	WEB5650	AMCD	Nicola Bateman	Nick Evans	A Railway Manager found approximately 6 outpatient clinic letters and loose medical documentation, all displaying patient identifiable information, on a Virgin Train travelling to Carlisle. The Railway Manager subsequently passed them onto his wife, an NHS employee, for safekeeping. The NHS employee contacted the Trust at 09.30hrs on the 2nd December 2009, to advise of the incident and left her contact details.	Yes. 03.12.09	13/01/2010	Yes

Electronically Reported Incidents via DatixWeb

The below table shows the number of incidents, reported electronically, for quarter 2 and quarter 3:

Quarter 2	Quarter 3
1347 (87% of all incidents)	1534 (95% of all incidents)

The numbers of incidents, which are still on Datix, for Q3, as of 19th January 2010 are shown below.

	Awaiting Initial Review (Q3)	**Still Being Reviewed (Q3)**	**Awaiting Final Approval (Q3)**
Acute Medicine	65	1	58
Clinical Support	3	0	3
Surgery & Anaesthesia	7	0	0
Women's & Children's	66	15	3
Totals	**141**	**16**	**64**

2.4 PALS

The total number of reported PALS concerns from 1st October to 31st December was 183.

Surgery received the highest number of concerns in Oct – December 09 with 86 (47%) of the total concerns, AMCD received 60 (33%).

Top Reported Concerns by Division

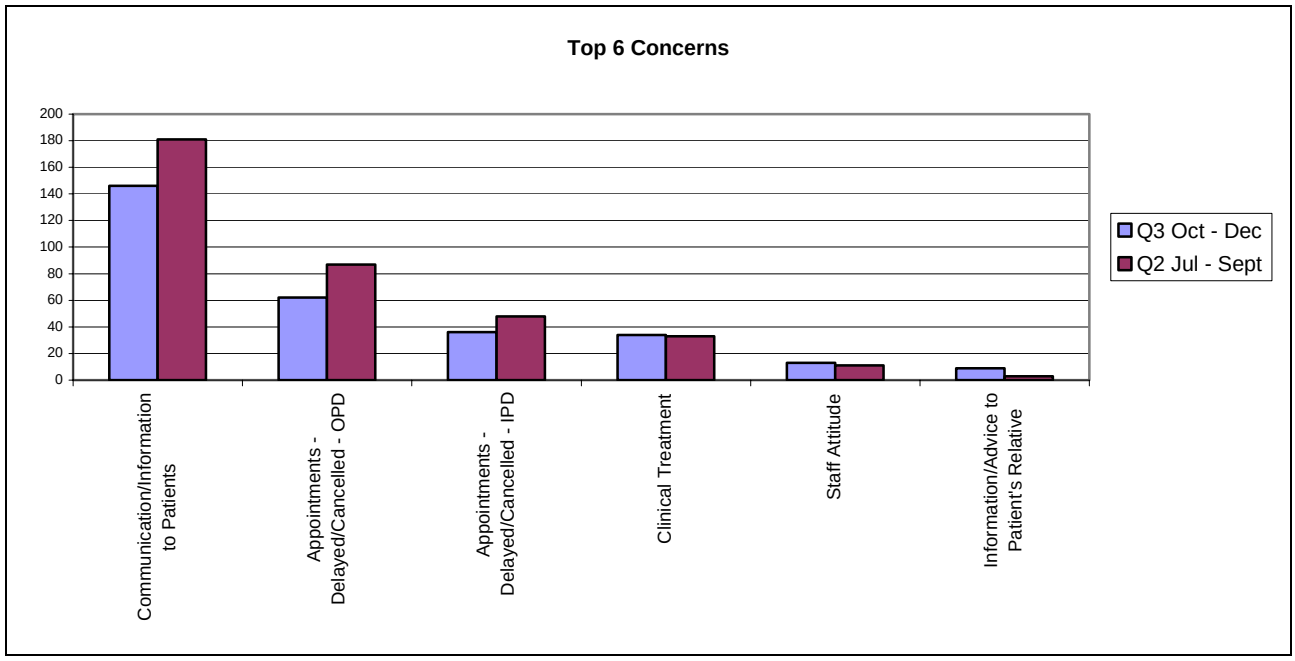
This table relates to the reported number of subjects raised in the concerns for the top three divisions. (Note that many PALS concerns have more than one subject)

Top Concerns Reported by Division	**July - Sept 09**	**Oct – Dec 09**
Acute Medical Care Division		
Communication/Information to Patients	45	46
Appointments - Delayed/Cancelled – OPD	24	22
Clinical Treatment	10	20
Surgery & Anaesthesia		
Communication/Information to Patients	82	69

Appointments - Delayed/Cancelled – IPD	40	31
Appointments - Delayed/Cancelled – OPD	38	23
Admissions/Discharge/Transfer	5	1
Women's and Children Services		
Communication/Information to Patients	13	10
Appointments - Delayed/Cancelled – OPD	6	5
Appointments - Delayed/Cancelled – IPD	4	3

Top 6 Reported Concerns Trust wide

Communication/information to patients was the highest reported concern with 146, a significant increase from the previous quarter.



2.5 Lessons Learnt & Actions

Recommendations arising from the investigation of SUI WEB 5125 - 4000 doses of swine flu vaccine had been discarded:

As detailed above, the incident was caused by a technical fault, which has subsequently been rectified. However, the report contains one recommendation.

Recommendation	Rationale	Objective	Completion Date
To explore the possibility of installing a text alert system for occasions when the pharmacy fridge may go out of range.	Relevant staff are alerted should technical fault develops enabling necessary measures to be put in place immediately	To prevent recurrence and further wastage of vaccines in future.	Cost of implementation in progress.

Recommendations arising from the investigation of SUI: WEB5650 – Breach Of Confidentiality:

Recommendation	Rationale	Objective	Completion Date
Consultant A to attend Information Security & Confidentiality awareness training	To ensure Information Instructions and Training has been provided; to ensure sufficient awareness has been created.	Preventing recurrence and safe guarding confidentiality.	28th Feb 2010 **Completed**
All Trust staff to be reminded of the guidelines for ensuring	Reminder to all staff of the need for the provision of sufficient	Preventing further breach of	31st Jan 2010

personal identifiable information is kept secure while in transit	Information, instructions and training for their staff and themselves, to create awareness of the requirements and the significance of safeguarding confidentiality and the lessons to be learnt from the Incident.	Confidentiality within the Trust and to remain fully compliant.	**Completed.**
A review of Trust policies to ensure they are up-dated to include guidelines around keeping personal identifiable information secure while in transit	To ensure Policies & procedures are up to date with the current legislative requirements and are clear about the need to safeguard confidentiality and responsibilities of the staff who has access to confidential information.	Preventing breach of Confidentiality at all times	28th Feb 2010

Recommendations Arising From the Investigation of SUI WEB4770 - Thromboembolic (VTE)

Recommendation	Rationale	Objective	Completion Date
1. To review the VTE risk assessment undertaken for all gynaecology patients.	1. To prevent misunderstanding and confusion about individual consultant preference concerning VTE prophylaxis.	1. To standardise the practice within the Division to ensure all medical and nursing staff have clear guidance.	31 May 2010
2. To review the process of undertaking the Theatre checklist and documentation.	2. To provide a clear process that can be used repeatedly for all theatre checks required.	2. To review the existing documentation and rewrite to include full VTE check list/action plan.	30 June 2010
3. To implement pharmacy involvement for gynaecology patients in POA	3. To provide another safety net for those patients coming in for gynaecology surgery.	3. To ensure that patients are being seen and medication issues and risks associated with surgery picked up, escalated and managed appropriately.	30 April 2010
4. Urgent review of policy for ad hoc Consultant cover and pooled procedures	4. To ensure patients are assessed in a timely manner when being operated on by another Consultant	4. Review the existing mechanism for covering theatre lists and implement processes to ensure patients are reviewed prior to admission.	30June 2010

Colin Johnston
Medical Director
March 2010