West Hertfordshire Hospitals NHS
NHS Trust

PART 2 TRUST BOARD MEETING – 31st May 2012

Title of the Paper:	**Serious Incident Summary Report**
Agenda item:	**92/12**
Author:	Dr Colin Johnston, Director of Patient Safety, Medical Director
Trust Objective:	Provide safe patient care

Purpose

This report apprises the Board of the serious incidents reported since the previous Board meeting, the current status of open investigations and details of incidents closed since the last report.

Risk Implications for the Trust (*including any clinical and financial*	**Mitigating Actions** *(Controls):*
Risks to patient safety if the Trust does not robustly investigate root causes identify remedial actions required and ensure cross Trust learning to prevent recurrence of SIs.	Implementation of serious incident reporting processes and robust monitoring of progress in relation to investigation, learning, improving and closing incidents.

Level of Assurance that can be given to the Trust Board from the report

Significant

Links to Board Assurance Framework, CQC Outcomes, Statutory Requirements (i.e. BAF risk reference, CQC outcomes linked to report)

BAF and NHSLA

Legal Implications:

Recommendation to the Trust Board:

The Trust Board members are asked to:

- note the content of the report, details of the 11 recent serious incidents declared and identify any areas for which further assurance is sought.

West Hertfordshire Hospitals NHS
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Part 1 Board Meeting 31 May 2012

Agenda Item xx/xx

Serious Incident (SI) Summary Report

The table below sets out the serious incidents reported since the previous Board meeting (appendix A provide further detail), the current status of open investigations and details of incidents closed since the last report. The Board can take significant assurance from the current position regarding Serious Incidents.

Assurance Assessment

1. The majority of serious incidents reported relate to the requirement to report all Grade 3/4 pressure ulcers. Those reported are currently being investigated to determine whether they were avoidable. Pressure ulcers deemed to be unavoidable are downgraded.

2. Part of the Trust process following a serious incident is to ensure immediate risks are managed and that timely action is taken to minimise recurrence – this is core to the management of serious incidents.

3. The Trust has confidence in the processes in place for managing pressure ulcers, which have been discussed at length at the Clinical Quality Assurance Committee.

4. SI 27315, the lack of agreement by East of England Ambulance Trust to divert ambulances away from Watford in response of high levels of attendance with lack of capacity in the Trust to continue to treat patients. The divert was agreed by NHS Hampshire and the Strategic Health Authority. Investigation of the incident is underway and is expected to highlight the issues regarding the ambulance transfer of patients from the St Albans/Hatfield area to Watford.

5. All serious incident reports are reviewed at the Serious Incident Group and learning shared as relevant. Where appropriate, serious incident reports form the basis of case studies presented at governance meetings and at Patient Safety Grand Round meetings.

6. A Patient Safety booklet has been developed by the Risk Department to be provided for junior doctors – this provides guidance on the importance of reporting incidents, how to, using a doctor's only reporting form and on information about Never Events.

7. Learning from incidents is shared through the CLIP summary reports and through regular articles in In-Focus and On the Pulse.

Summary of Incidents

8. Since the last report ,11 Serious Incident (SI) cases have been declared to the PCT:

- SI27564 Grade 3 HAPU (hospital acquired pressure ulcer)
- SI27463 UCC Contractors' Fumes (required the evacuation of staff and patients)
- SI26375 Grade 3 HAPU
- SI27315 Ambulance Divert
- SI26240 Grade 3 HAPU
- SI26853/57 HHGH – (Allegations against a contractor)
- SI26202 Grade 3 HAPU
- SI26218 Maternity Unit Closure
- SI26153 HCT/WHHT C-Difficile
- SI65206 Grade 3 right heel HAPU
- SI24332 Grade 3 right heel HAPU

9. As indicated, the majority of the incidents reported are for pressure ulcers and not all will be deemed avoidable. The Trust's performance in identifying and managing pressure ulcers remains exemplary. The incident involving allegations made against a contractor are currently being robustly investigated and are also the subject also of a police investigation. Despite the report of an Clostridium Difficile incident, the Trust remains well within trajectory for hospital acquired infections.

10. **Forty one** SI cases are progressing through various stages of investigation. Of these:

- There are **4 for 2010/11, 31 for 2011/12 and 6 for 2012/2013.**

- The PCT agreed that **4 HAPUs were unavoidable** and are no longer SIs:

  1. SI26202 Grade 3 HAPU
  2. SI25648 Grade 4 HAPU
  3. SI23328 Grade 3 HAPU
  4. SI22881 Grade 3 HAPU

- **10 SIs are being put through the closure process**

- **9 SIs have been closed by the PCT** in March 2012

  - SI23126 Flaunden Self Harm
  - SI21611 MRSA Bacteraemia
  - SI19055 Complaints loss of confidential information by email
  - SI16552 UCC Chest pain and A&E Cardiac Arrest
  - 55540 Croxley Ward Closure
  - SI15654 C-Diff
  - SI15394 Stillbirth
  - SI14360 Deteriorating Baby
  - SI14334 Stillbirth

- **4 SIs require the submission of evidence of action plan implementation** once the actions are complete in order to be considered for closure by the PCT.

11. The Being Open Policy has been subject to further review, following concerns about lack of consistency in Being Open practices relating to two serious incidents. However both incidents occurred before the new policy was implemented and the Trust acknowledges it has strengthened its SI processes to ensure that good

communication lines remain open between staff and patients and or relatives affected by serious incidents. A Being Open training package is now available on line to staff.

12. Finally, the Trust has been asked to participate in an Independent External Investigation into the care and treatment of a patient . The investigation has been commissioned by NHS Midlands and East who are required by Department of Health Guidance HSG (94) 27 (amended 2005) to undertake an independent investigation 'when has homicide has been committed by a person who is or has been under the care, ie subject to a regular or enhanced care programme approach, or specialist mental health services in the 6 months prior to the event, in which the SHA is required to commission such an investigation. Prior to the incident, the patient was treated within a pathway that included admission to the AAU. The investigation started on 16th April and a report is expected within 6 months.

Dr Colin Johnston
Director of Patient Safety, Medical Director