West Hertfordshire Hospitals NHS
NHS Trust

Trust Board meeting
3 December 2015

Title of the paper:	**Serious incident summary update month 6 and 7**
Agenda item:	**13/32**
Lead Executive:	**Dr Mike Van der Watt, Medical Director**
Author:	**Danielle Boyd, Serious Incidents Investigation Team**
Trust objective:	Tick as appropriate: ☒Achieving continuous improvement in the quality of patient care that we provide and the delivery of service performance across all areas; ☐Setting out our future clinical strategy through clinical leadership in partnership and with whole system working; ☐Creating a clear and credible long term financial strategy.
Purpose:	The aim of this paper is to provide a summary of SI Management since the last meeting
Link to Board Assurance Framework (BAF)	**PR1** Failure to provide safe, effective, high quality care (insufficiently robust and embedded quality governance and risk management)

Previously discussed:

Committee	**Date**
Safety and Quality Committee	N/A

Benefits to patients and patient safety implications
To improve patient safety via reporting and learning from incidents.

Recommendations:

For information and assurance

West Hertfordshire Hospitals NHS
NHS Trust

Agenda Item: 13/32

Trust Board Meeting – 3 December 2015

Serious incident summary report (including Never Events) – month 6 and 7

Presented by: Dr Mike Van der Watt, Medical Director

1. Purpose

1.1 The purpose of this report is to provide an update on the management of Serious Incidents (SIs).

2. Background

2.1 Serious Incidents (SIs) are reported by the Trust in line with the revised NHS National Serious Incident Framework 2015. The process supports continuous quality improvement and learning across all Divisions and Departments.

3. Analysis/Discussion

3.1 Number of Serious Incidents and Never Events

3.2 The Trust has 59 open SIs. This includes 23 concerning VTE issues, 19 of which are being addressed as one investigation.

3.3 This investigation report has been submitted to the CCG who are seeking assurances over the action plan prior to closure.

3.4 From 1 April 2015, the Trust has reported a total of 44 SIs to the CCG.

3.5 Four SIs have since been downgraded leaving the total at 40.

3.6 The table below provides a breakdown of serious incidents declared to CCG during September 2015.

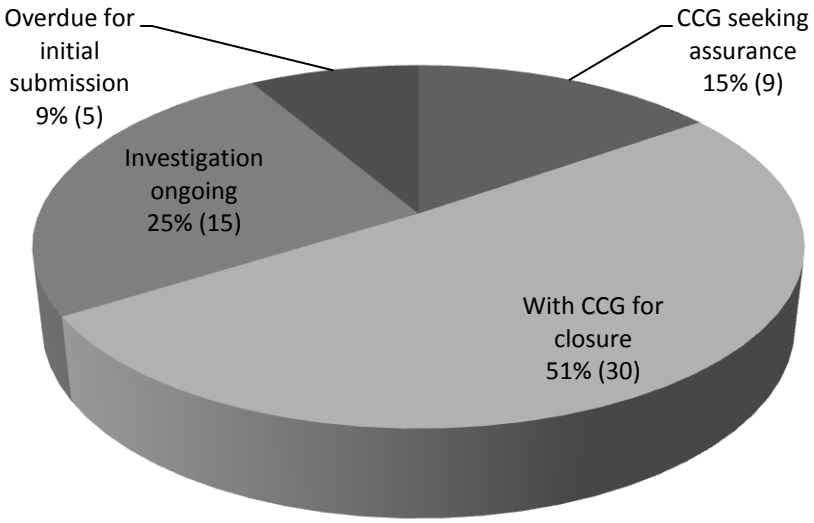
STEIS Category	Number
Maternity Services – Unexpected admission to ITU	1
Diagnostic incident – PE RIP	1
VTE	4
Retained piece of drain	1
Total	**7**

3.7 The table attached as appendix 1 shows the year's cumulative data for 2015/16.

3.8 The Trust is reporting significantly less serious incidents than in the previous year. This is due to the consistent and robust way in which the national criteria for SI is being applied and is in line with the ethos of the new framework to 'do less better'

3.9 The table attached as appendix 3 shows the year's cumulative data for November 2014 to October 2015.

3.10 The chart below presents the position summary of all the SIs open for the Trust as of 8 November 2015.



3.11 This data is pulled from a live database which is constantly updated and can be updated with retrospective data.

4. Outstanding SI reports

4.1 There remains a back log of RCA reports which are overdue which can be grouped into two sections.

a) Reports which are overdue and are awaiting submission
b) Reports which have not been closed due to the CCG requiring further information and assurance prior to submission to the panel for closure.

4.2 The SI team are working with the CCG to progress the SIs which have not yet been closed because the CCG are seeking further assurances around the investigations and action plans

4.3 There are currently 39 investigation reports with the CCG that have not been closed on STEIS (the national database for monitoring SI).

4.4 These SI will be counted as overdue for closure. The final closure of SI investigations can only be 'actioned' by the CCG.

4.5 SIs are closed on STEIS by the CCG once they have been agreed for closure at the SI panel – they are closed on STEIS with the SI panel date and this is done within 5 working days of the SI panel, usually the same or next day.

4.6 Whilst there has been significant progress made against the number of outstanding RCAs there still remain a number (10) that are overdue.

4.7 The report prepared for the previous Trust Board meeting showed 11 overdue reports

4.8 The primary reasons offered by staff as to delays in investigation and responses include:

a) Challenges in ensuring they are released from clinical activities
b) Expertise to undertake investigations
c) The investigation uncovering additional issues
d) Failure of wider staff to engage in the investigation (delays in submitting statements)

4.10 The SI team have reviewed internal processes and added in additional steps of support and escalation which will prevent investigations running overdue. These include planned progress chase dates and an escalation process through line management if progress updates are not forthcoming.

4.9 Bi-weekly meetings are now being held with divisions to track progress of SI in their divisions and to facilitate early identification of any investigations which are not on target for completion within deadline.

4.10 45 day review meetings have commenced which allow the RCA to be discussed and challenged by the relevant clinical and management teams. Formal notes are taken at the 45 day meeting. This then leave a 10 working day period for the divisional action plan to be written and agreed.

4.12 Please see appendix 2 for a list of overdue reports as of 12 November 2015.

5. Never Events

5.1 Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented.

5.2 The table below shows the 3 current open Never Event SIs for the Trust.

Never Event	Date of Incident and Division	Summary	Deadline for completion/Status
Wrong Prosthesis (2014 36942)	06/10/2014 (orthopeadic surgery)	Wrong prosthesis - patient undergoing hip replacement and the wrong prosthesis was implanted, the patient underwent further surgery but for evacuation of a haematoma which was unrelated to the incorrect prosthesis being used. Patient now recovering well. Patient aware of the error under Being Open policy.	With CCG for review – please see 5.3 - 5.5 below An over arching action plan will be discussed at the November CQRM
Retained swab (2014 42148)	24/11/2015 (Gynae Surgery)	Retained swab post vaginal delivery and 3rd degree tear. Patient reattended A&E approx 1 month post delivery reporting pain, discharge and a palpable lump in her vagina. Gynae exam revealed a 'large swab' - patient discharged with 2 weeks antibiotic cover. Patient aware of the error under Being Open policy.	Updated action plan submitted – for CCG closure panel.
Misplaced NG Tube 2015/17537	18/05/2015 Medicine (Stroke)	NG inserted. Documented as safe to feed at 18/5/15 @ 16:55. IT was later discovered that the NG tube was in the lung not the stomach.	The final RCA report was submitted to the CCG on time and is awaiting closure.

5.3 A further report covering the orthopaedic Never Event detailed above has been submitted to the CCG. The Trust have requested de-escalation from the Never Event status due to the fact that the second surgery was not linked to the incorrect prosthesis.

5.4 The CCG have responded to the Trust and are of the opinion that the incident detailed above does in fact meet the criteria for never Events and therefore will remain classified as such

5.5 The Trust will not further challenge this decision.

5.6 The CCG have requested an over arching action plan for the 3 prosthesis incidents.

6. Duty of Candour

6.1 The Duty of Candour is a legal duty on hospital, community and mental health Trusts to inform and apologise to patients if there have been mistakes in their care that have led to harm.

6.2 Duty of Candour is applicable as a legal requirement in cases where harm has been assessed as moderate, severe or death.

6.3 For SIs the Duty of candour will be relevant and applicable to a high percentage of incidents due to the definition of serious harm or death

6.4 Moderate harm incidents are managed divisionally and so these compliance figures are not included below.

6.5 The table below shows how many SI were declared and how many of these the Duty of Candour applied to

	Number declared	DoC Relevant	DoC Actioned	Doc Evidenced
April 2015	10	7 (70%)	3 (42%)	3 (42%)
May 2015	10	9 (90%)	8 (88%)	6 (66%)
June 2015	7	5 (71%)	4 (80%)	1 (20%)
July 2015	2	2 (100%)	2 (100%)	1 (50%)
August 2015	1	1 (100%)	1(100%)	1 (100%)
September 2015	6	6 (100%)	6 (100%)	3 (50%)*
October 2015	7*	6 (86%)	6 (86%)	6 (86%)

6.6 Performance of compliance will be monitored and corrective action planning introduced.

6.7 In some cases (VTE)* there is a documented plan not to communicate the events to the patients until completion of the report.

6.8 Documentary evidence of Duty of Candour could not be confirmed in 3 of the 6 incidents, these were all hospital acquired pressure ulcers.

6.9 RCA reports state that the process was implemented but it was not possible to evidence this without checking the clinical notes.

6.10 Going forward all DoC activity will also be recorded on a specialist template kept outside of the notes and stored electronically on Datix

7. Trends

7.1 Trend analysis of contributory factors to serious incidents will be analysed at the end of each quarter. The next quarter end being Q2 and this will be presented in the month 7 report.

8. Summary of Lessons Learnt and Recommendations

8.1 The table below gives a summary of the lessons learnt and recommendations following the RCA investigations of some of the SIs that have been submitted to the CCG:

Datix no.	Summary	Identified learning/practice change	Date submitted to CCG
62334	Death following sudden deterioration of surgical patient in ITU	Lack of Robust handover and follow up of surgical/vascular patients	30/10/2015
60812	Failure to recognise and action a deteriorating CTG. Baby delivered in poor condition and died the same day	Obstetric team failure to be compliant with mandatory training requirements Failure to use the formal divisional escalation tool – Plan to re launch the SBAR tool.	19/10/2015
59418	Patient admitted to hospital follow a fall at home then had subsequent fall during their hospital stay.	Staff to have micro-teaching on new falls risk assessment and care plans Devise a rolling programme to ensure staff is updated – consider getting non substantive staff involved	22/10/2015
60993	Patient admitted with advanced dementia and SOB. Family had safeguarding concerns including weight loss and care issues	Operational policy for Tudor must be formalised and implemented as priority The MUST risk assessment documentation must be reviewed for the opportunity to further increase its effectiveness Teaching for HCAs on DoLS and MCA must be implemented	19/10/2015

9. Litigation

There are four serious incident cases which have proceeded to a claim within the past year, these are detailed below

Ref	Claim date	Type	Division	Specialty	Description
48320	21/11/2014	Inquest	Surgery	GS	Inquest. Obstructed bowel, cardiac arrest in AAU. Lack of documented plan and failure to check results of investigations ordered.
61524	16/09/2015	Claim	Surgery	Urology	Retained stent identified 6 years post urological procedure
59761	28/09/2015	Claim	Medicine	Respiratory	Ineffective handovers between the clinical teams and time management issues leading to a delay in the CT CAP scan results being reviewed and a subsequent delay in the start of appropriate treatment. Patient RIP
89127	14/10/2015	claim	Unscheduled care	Medical	Patient unfit to transfer transferred from resuss to AAU. RIP failure to recognise a deteriorating patient

9.2 It should be noted that the first stage in legal proceedings, known as 'letter of claim' is not a confirmed claim. The claims listed above are those where full legal proceedings have begun.

9.3 All claims listed above are cases which are to be a coroner's inquest.

10. Recommendation

10.1 The Trust Board is asked to review the report for information and assurance.

Dr Mike Van der Watt
Medical Director
12 November 2015

APPENDIX 1

Quality & Safety Group – 12th November 2015

Serious Incident Summary Report – Month 7 (2015/16)

STEIS Category	April 15	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan-16	Feb	Mar
Assault by Inpatient (in receipt)												
Allegation Against HC Professional			1	1								
Attempted suicide												
C.diff and HCAI	1											
Confidential Information Leak	1											
Delayed Diagnosis						1						
Drug Incident (General)	1											
Environmental incident			1									
Failure to act on results	1											
Other	1	1										
Pressure Ulcer Grade 3	1	2	3			3						
Premature Discharge												
Slips/Trips/Falls	1											
Safeguarding Vulnerable Child												
Safeguarding Vulnerable Adult	1	1										
Surgical Error	1		1				1					
Unexpected Death	1											
Security Threat												
Maternity Services - Maternal Death				1								
Maternity Services – transfer		1										
Maternity transfer to ITU							1					
Maternity Services - Suspension		1										

STEIS Category	April 15	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan-16	Feb	Mar
Maternity Services – unexpected neonatal death		**1**			**1**	**1**						
Never Event	0	1	0	0	0							
Outpatient Appointment Delay	1											
Unexpected Death						1	1					
Communication Issue												
Sub-optimal care of the deteriorating patient		2	1									
Hospital Transfer Issue												
Hospital Equipment Failure												
Health and Safety												
Communicable Disease and Infection Issue												
VTE issues	2						4					
Total	**13**	**10**	**7**	**2**	**1**	**6**	**7**					

APPENDIX 2

Quality & Safety Group – 12th November 2015

Serious Incident Overdue Reports – Month 7 (October 2015/16)

Datix	Title	STEIS cat	Division	Specialty	CCG deadline	Trust deadline
60804	deteriorating patient	Sub-optimal care of the deteriorating patient meeting SI criteria	Medicine	ICU	11-Aug-15	30/09/2015
60861	IMC Sepsis	Sub-optimal care of the deteriorating patient meeting SI criteria	UsC	A&E	05-Aug-15	30/09/2015
62081	Safeguarding vulnerable adults Eliz Ward	Safeguarding vulnerable adults	WACS	Gynae	14 Sep 15	30/10/2015
61395	Partial NICU closure 22/5/15	Major incident/ emergency preparedness, resilience and response/ suspension of services	WACS	Maternity	18-Aug-15	31/08/2015
60993	Safeguarding	Abuse/alleged abuse of adult patient by staff	Medicine	CoE	21-Aug-15	11/09/2015

West Hertfordshire Hospitals NHS
NHS Trust

APPENDIX 3

Quality & Safety Group - Monday 14 September 2015

Serious Incident Summary Report – November 14 to October 15

STEIS Category	Nov	Dec	Jan 15	Feb	Mar	Apr	May	Jun	July	Aug	Sep	oct
Assault by Inpatient (in receipt)			1									
Allegation Against HC Professional		1						1	1			
Attempted suicide		1										
C.diff and HCAI	2					1						
Confidential Information Leak	1			1	1	1						
Delayed Diagnosis											1	
Drug Incident (General)					4	1						
Environmental incident								1				
Failure to act on results						1						
Other	2	1	1		4	1	1					
Pressure Ulcer Grade 3			9	7	3	1	2	3			3	
Premature Discharge	1											
Slips/Trips/Falls	2			1		1						
Safeguarding Vulnerable Child		1										
Safeguarding Vulnerable Adult	1					1	1					
Surgical Error	1					1		1				1
Unexpected Death		1			1	1						
Security Threat												
Maternity Services - Maternal Death									1			
Maternity Services – transfer							1					

STEIS Category	Nov	Dec	Jan 15	Feb	Mar	Apr	May	Jun	July	Aug	Sep	oct
maternity transfer to ITU												1
Maternity Services - Suspension							1					
Maternity Services – unexpected neonatal death							1			1	1	
Never Event	1	1					1					
Outpatient Appointment Delay						1						
Unexpected Death											1	1
Communication Issue				1								
Sub-optimal care of the deteriorating patient				1			2	1				
Hospital Transfer Issue		2	1									
Hospital Equipment Failure	1											
Health and Safety		1										
Communicable Disease and Infection Issue	1											
VTE issues			2		17	2						4
Total	**12**	**8**	**14**	**11**	**30**	**13**	**10**	**7**	**2**	**1**	**6**	**7**