West Hertfordshire Hospitals NHS
NHS Trust

Serious Incidents Annual Report

Analysis of Serious Incidents
01 April 2015 – 31 March 2016

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1. Introduction

This report provides information and assurance to the Trust and external partners about the Trust's position and progress in relation to the management of, and learning from, Serious Incidents from 01 April 2015 – 31 March 2016.

The Trust is committed to working in an open and honest environment and this includes supporting staff to report incidents. All potential Serious Incidents are discussed at a Serious Incident Panel, held three times a week, chaired by either the Medical Director or Chief Nurse, or their deputy. The harm level reported is clarified and updated, if required, to ensure accuracy of reporting. This is also included as part of the completion and sign off of Root Cause Analysis investigations to ensure accuracy and validation of data.

A serious incident (SI) is described as "any event which has given rise to potential or actual harm or injury, to patient dissatisfaction or to damage/loss of property" (Ref: NHS Executive). This definition includes patient/service user injury, fire, theft, vandalism, assault and employee accident and near misses. The Trust reviews reported incidents against the classification of a Serious Incident (SI) as defined within the Serious Incident Framework (NHS England, 2015)[1]. In broad terms "serious incidents are events in healthcare where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare". All SIs are fully investigated in line with the national guidance and are internally and externally scrutinised and reviewed by the Trust Board.

During 2015/16 the Trust reported 69 SIs, which is a significant reduction on 2014/2015 figure of 207. This reduction may be partly due to the changes set out within the updated NHS England Framework, which reduced the number of externally reported Serious Incidents.

The purpose of this report is therefore to:

- Provide assurances that the trust follows the Incidents and Serious Incident Trust policy
- Provide an overview of the analysis of the Serious Incident that were declared in 2015/16

[1] Serious Incident Framework, Updated March 2015, NHS England.

- Show examples of Serious incident investigations that have been used to assist in learning and to improve the quality of patient care during the year.
- Set out recommendations where further improvement can be made to monitor the trends identified from the serious incidents and initiate learning from this data when correlated with complaints and legal cases.

1.1 Compliance with national standards and guidance

In 2015/16 the Trust Serious Incident Team focused on embedding the strengthened governance processes in order to manage SIs and to reflect the updated Trust policy written in response to the new NHS England Serious Incident Framework. The significant changes were to:

- Remove the different levels of investigation and move all investigations to a 60 day timeframe inline with the NHSE Framework
- Ensure the completion of a 72 hour report providing evidence of immediate actions taken from any SI
- Appoint a lead investigator from the Corporate SI Team, who are experts in root cause analysis (RCA) methodology, and who will work alongside subject matter experts within the Divisions who provide the clinical expertise, analysis and interpretation of findings.
- Appoint experts outside of the corporate team, to investigate specialist SIs, these include falls, infection control, IT issues, and safeguarding.

The Trust's policy focuses on ensuring a quality investigation is completed, with tangible learning outcomes identified. All SI investigations will be approved by The Divisional Management Team before final approval by The Medical Director and The Chief Nurse.

The monitoring of action plans is through the Divisional Governance Groups and the Serious Incident Review Group, chaired by the Medical Director. Every completed SI is discussed and the Divisions provide evidence of actions taken in order to sustain and embed change as a result of the investigation.

The significant backlog of historical SI investigations were closed in December 2015. All SI investigations have been closed and submitted to the Commissioners in line with the 60 day deadline.

In January 2016 all Serious Incidents were migrated to the Trust's electronic incident reporting software Datix. This enabled a fully operational SI tracker which supports user friendly reporting functions and greater control for data capture

2. Never Events

The Trust reported two never events in 2015/16, a reduction from three in 2014/15, yet meant we did not meet our target to have zero Never Events. A Never Event is an event that should never happen and a pre defined list is provided under the Never Event framework. Also updated was the Never Events Framework, where although the list of never events was not changed, the 'need for harm' has been removed from all incidents so that it is the event itself that triggers the 'Never Event' and not the outcome.

The two Never Events reported in this year were

- A misplaced NG Tube through which the patient was fed
- A retained surgical tampon

These never events were subject to intense investigation and scrutiny with action plans drawn up with the inter-professional teams to ensure that there are changes in practice to prevent these occurring again.

3. Analysis

3.1 Breakdown of Serious Incidents

Fig 1 The number of Serious Incidents declared, by month, in 2015/16

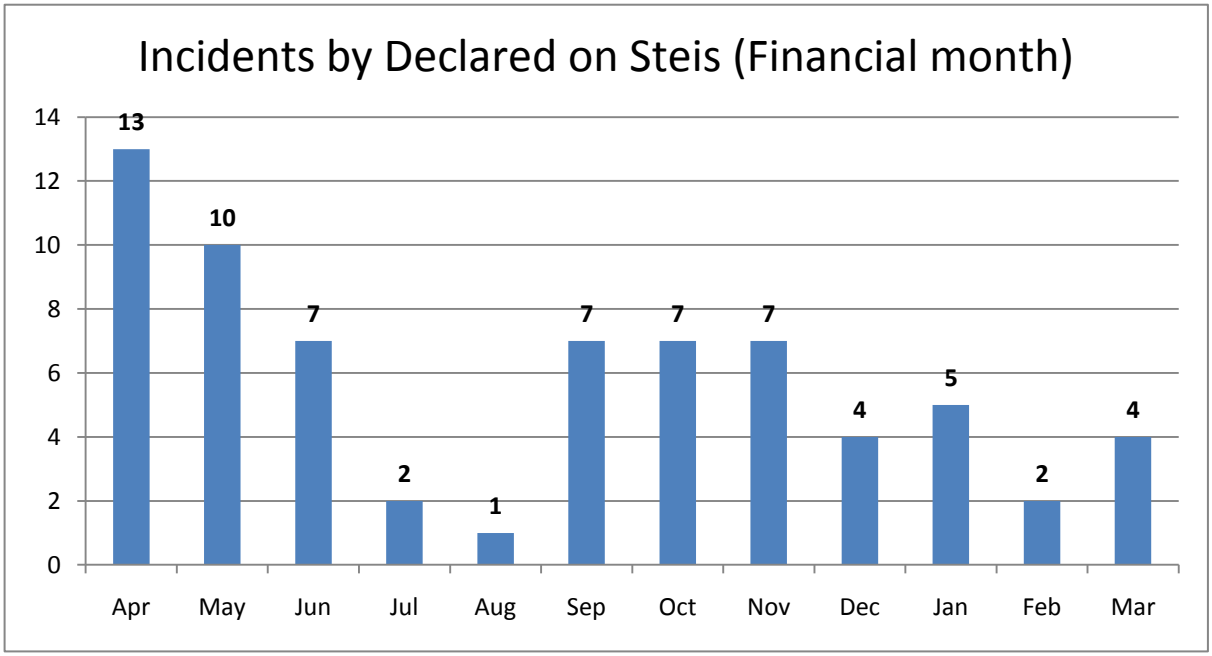


Fig 2 Number of Serious Incidents declared from 2013 - 2016

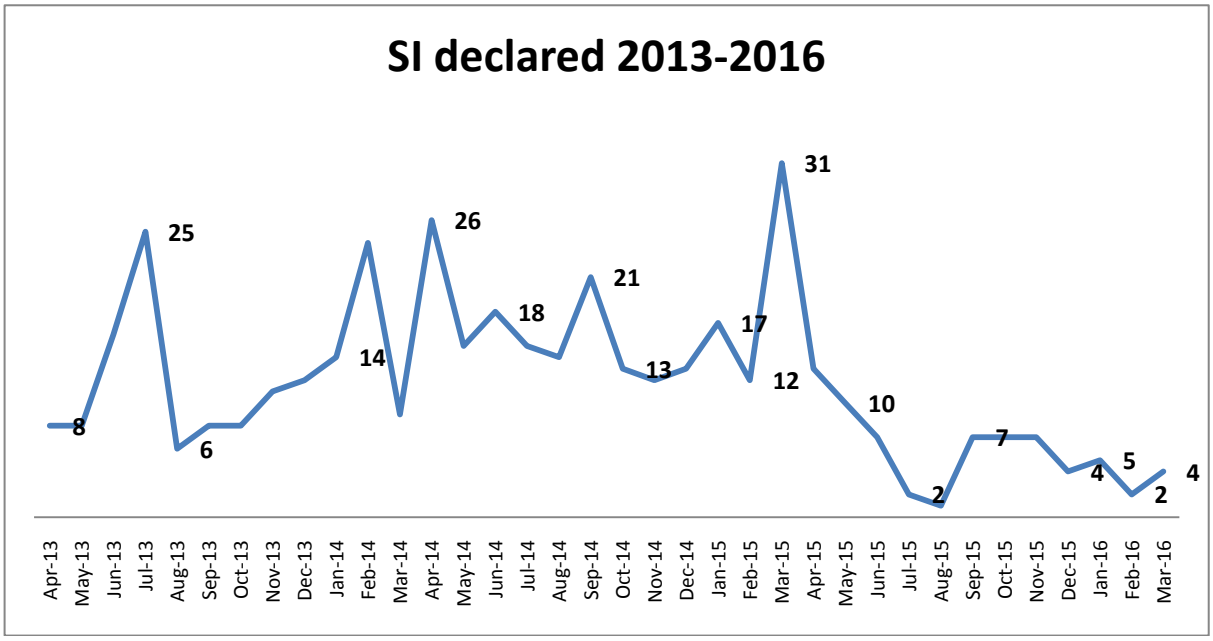


Fig 3 Number of Serious Incidents declared in 2015-6, by division

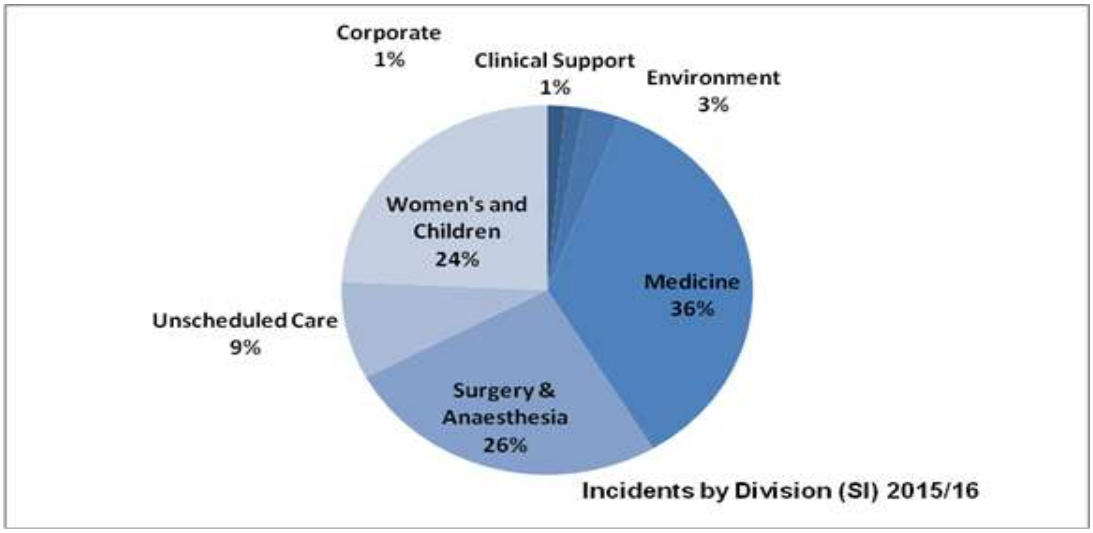
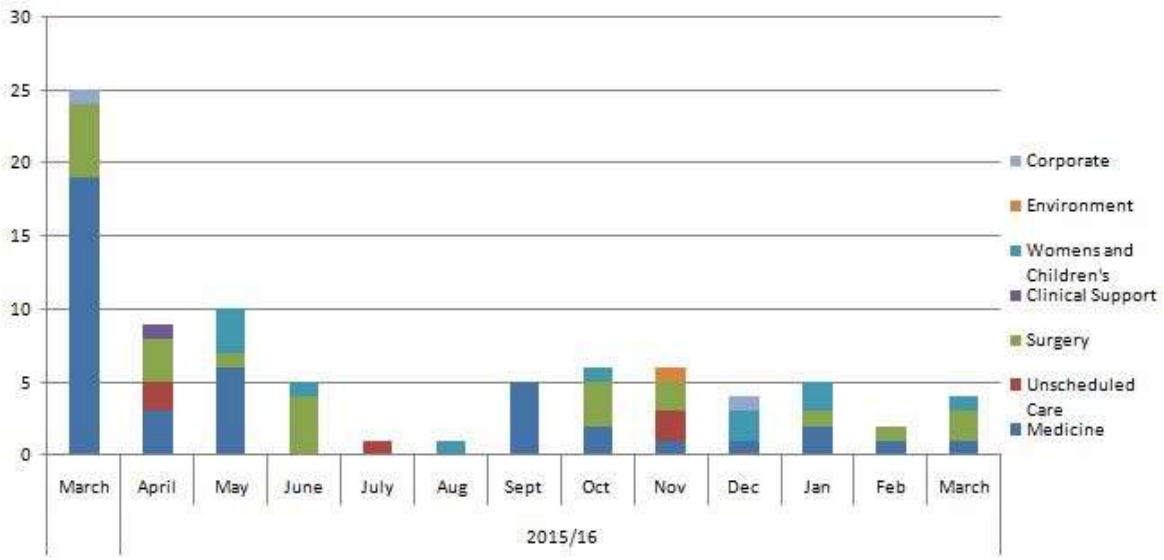


Fig 4 Table and graph to show number of Serious Incidents, by Division, by month

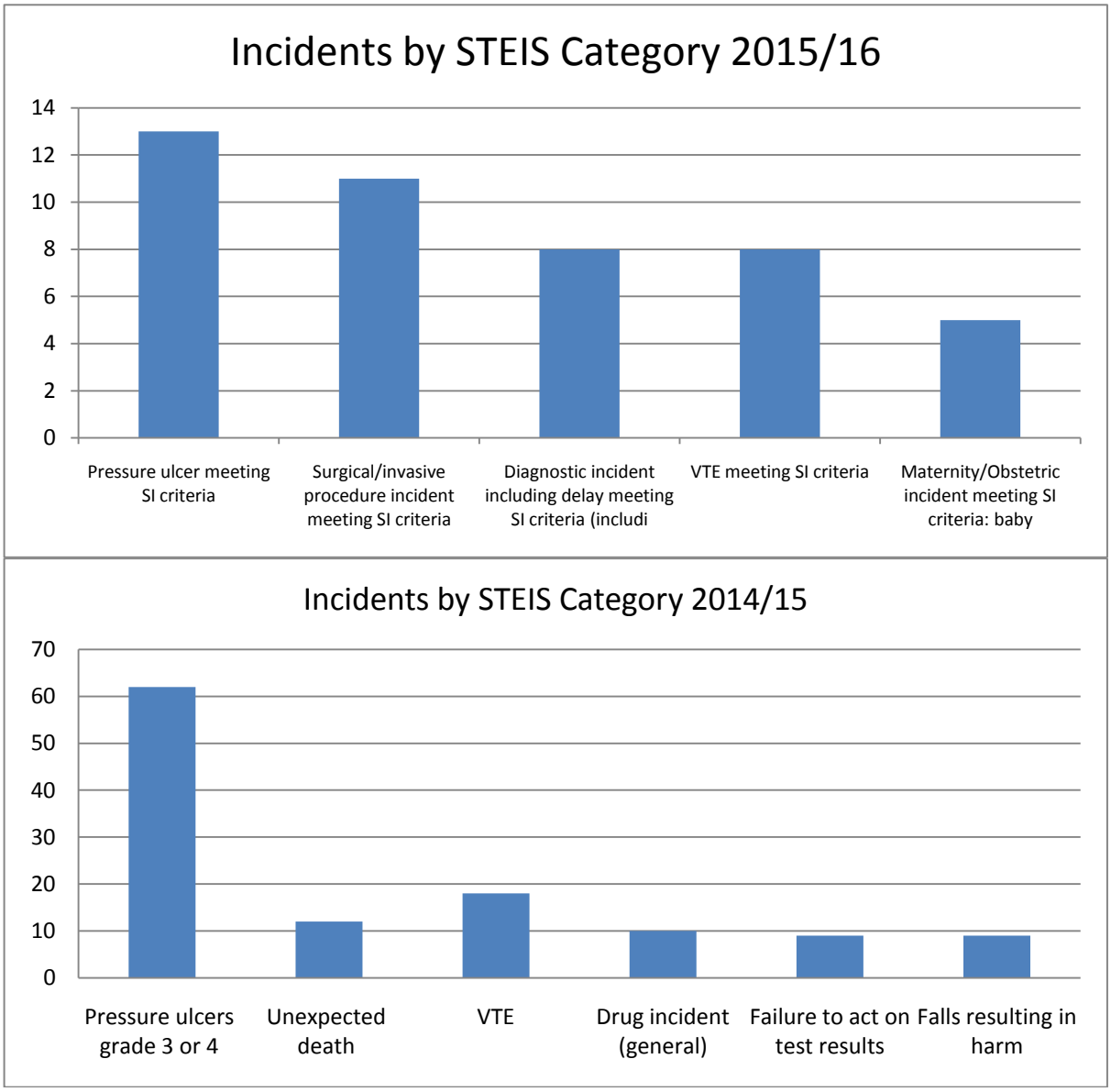


	2015/16											
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
Medicine	3	6	0	0	0	5	2	1	1	2	1	1
Unscheduled Care	2	0	0	1	0	0	0	2	0	0	0	0
Surgery	3	1	4	0	0	0	3	2	0	1	1	2
Clinical Support	1	0	0	0	0	0	0	0	0	0	0	0
Women's and Children's	0	3	1	0	1	0	1	0	2	2	0	1
Environment	0	0	0	0	0	0	0	1	0	0	0	0
Corporate	0	0	0	0	0	0	0	0	1	0	0	0
Total	**9**	**10**	**5**	**1**	**1**	**5**	**6**	**6**	**4**	**5**	**2**	**4**

3.2 Thematic breakdown of Serious Incidents

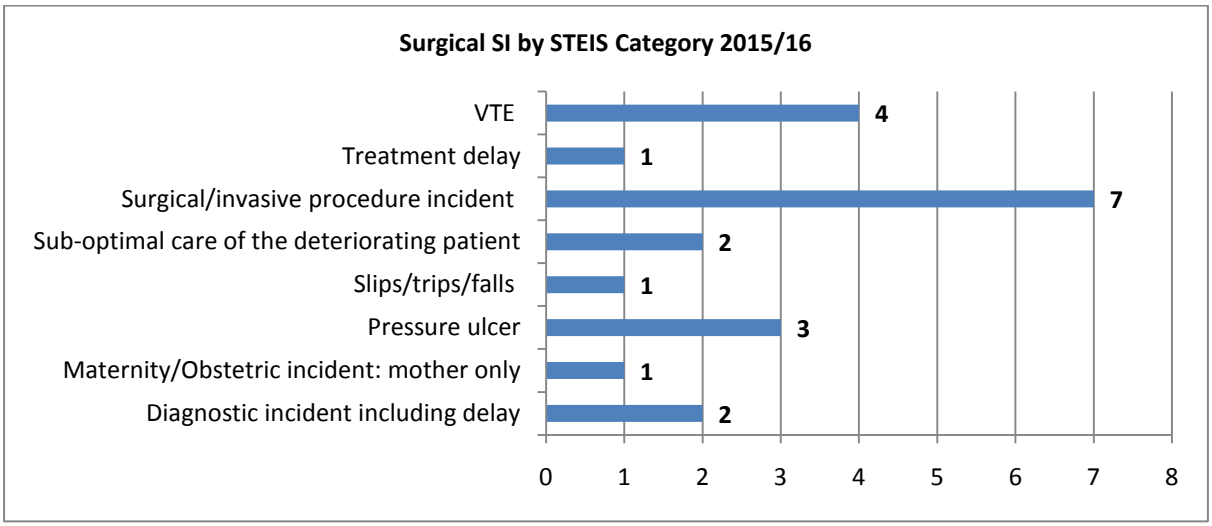
Serious Incidents reported in 2015/16 have been themed using nationally defined categories as reported through STEIS (Strategic Executive Incident System).

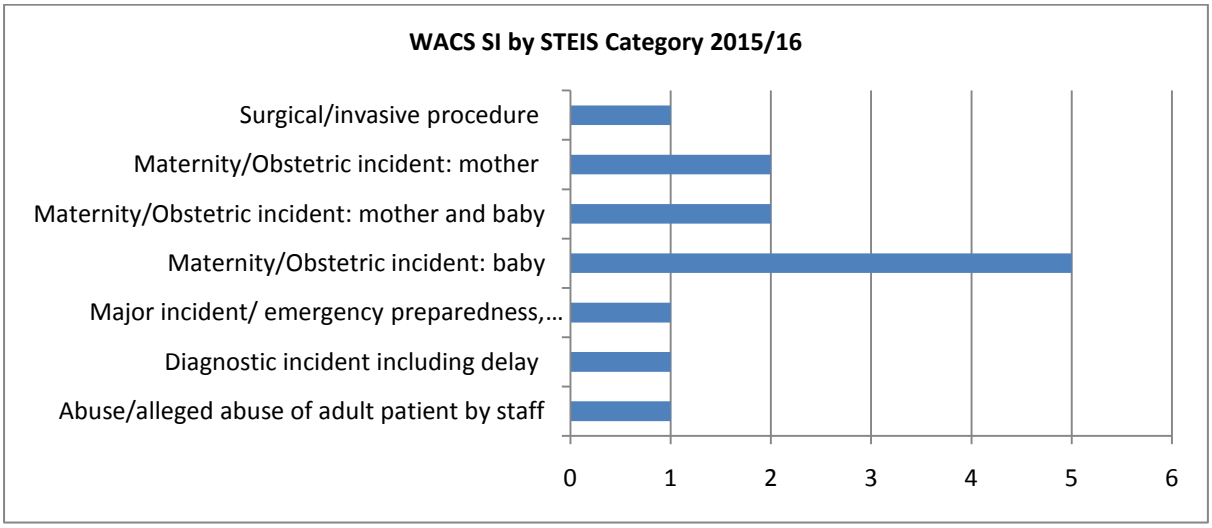
Fig 5 below presents themes of Serious Incidents in 2015/16 compared to 2014/2015.

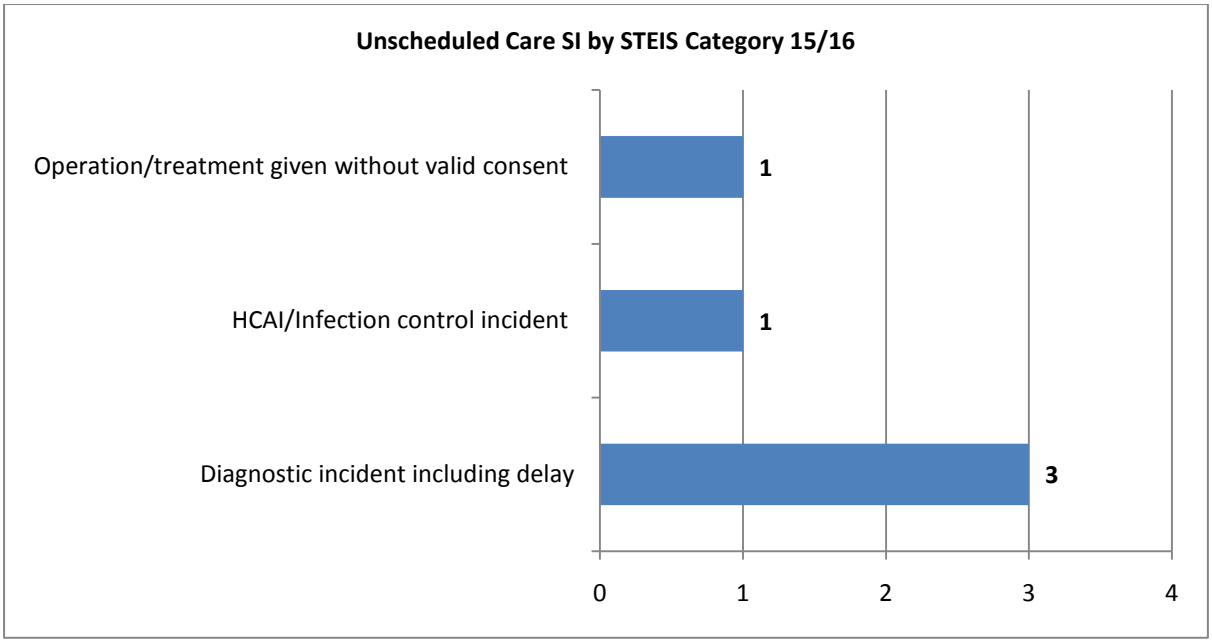


3.3 Thematic breakdown of Serious Incidents by category, by division.

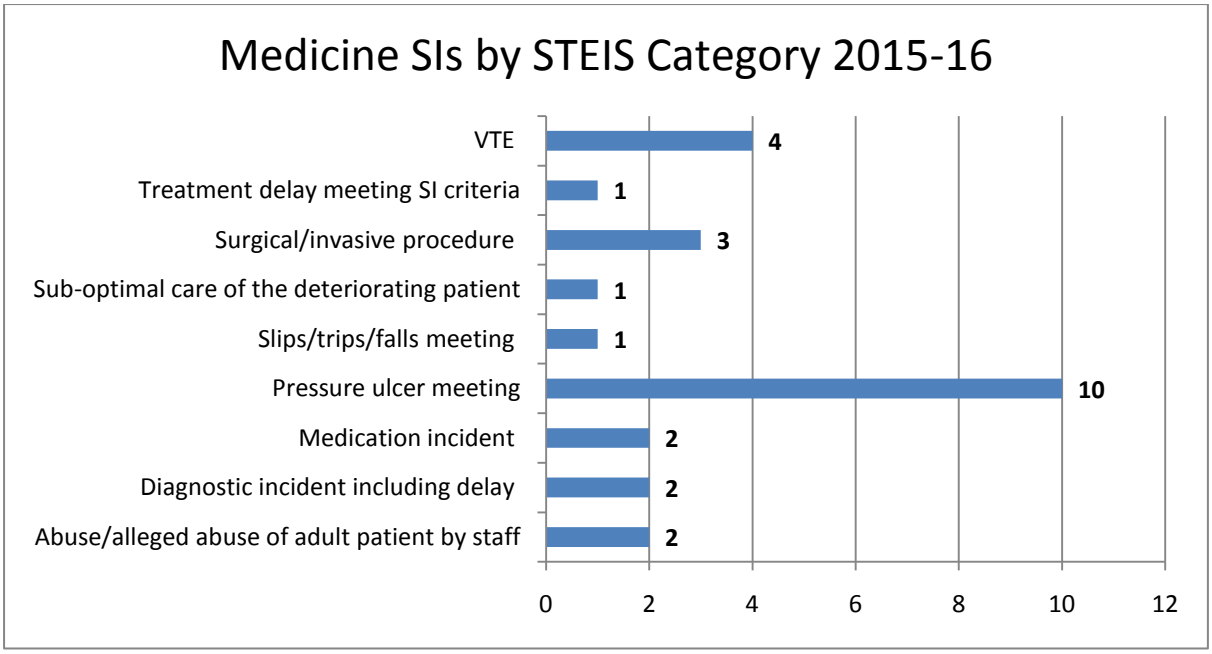
Figs 6 – 10 showing breakdown of Serious Incidents by category, by division

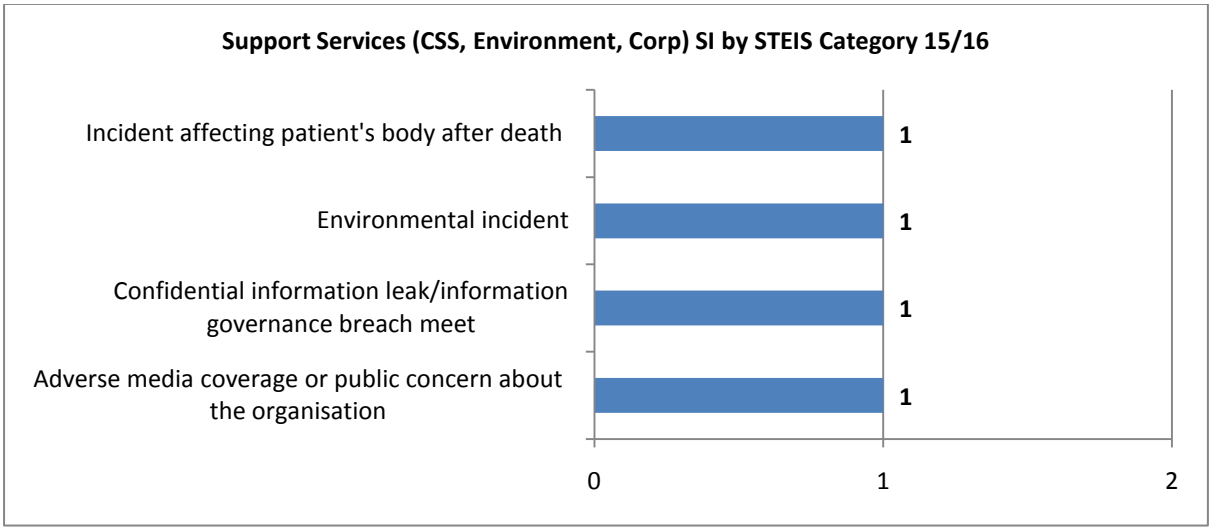






*NOTE: for Unscheduled Care the total number of SIs was 5.





*NOTE the number of SIs declared within Clinical Support services, Corporate and Environment was 4 in total.

3.4 Compliance with Key Performance Indicators

The National Framework states that all Serious Incidents should be declared to commissioners via STEIS within 48 hours of occurrence. However there is a nationally recognised issue with this indicator in that through the divisional identification and review process this is not achievable within this specific timeframe. This has led to a local agreement with the CCG that in 2016/2017 the target of 48 hours will begin once it has been agreed that an incident meets the SI criteria.

Table 1 showing compliance against Key Performance Indicators

Indicator	Number
SIs declared	69
Downgraded	10
Extension requests *20 concern VTEs under thematic review	25
45 day review meeting attended *45 day reviews are not held for pressure ulcers	45
Submitted within 60 days	59
Duty of Candour (DoC) initiated *DoC only relevant in certain cases	48 of 65

3.4.1 Monitoring of compliance against Key Performance Indicators

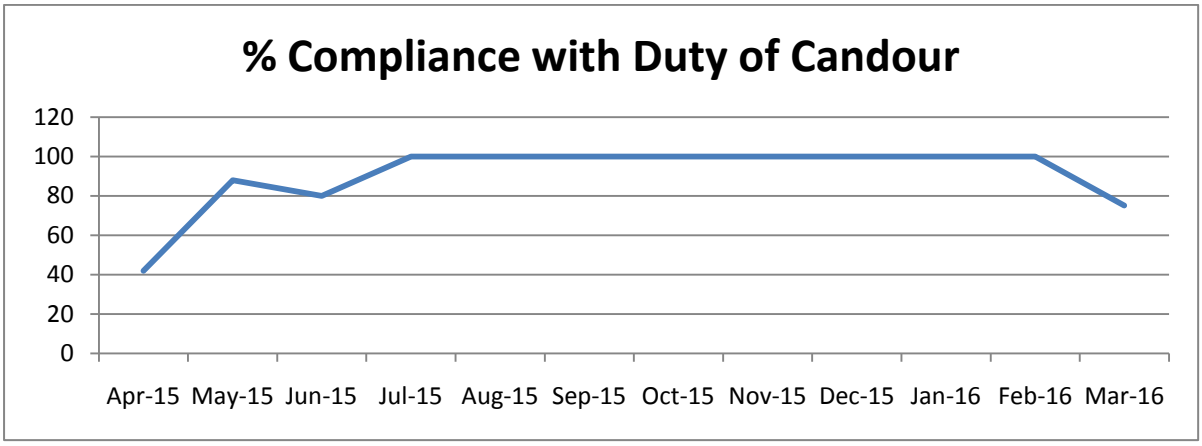
- Serious Incident Key Performance Indicators are monitored monthly by the Trust Board, and in detail at the Safety and Quality Committee, a sub committee of the Board
- Divisional performance is monitored through the Quality and Safety Group, chaired by the Chief Nurse, and through the Divisional Performance Reviews, held monthly and chaired by the Chief Executive.
- Ownership of the creation and monitoring of action plans resides with the Divisional Director, through the Divisional Governance Group. SMART[2] action plans are developed, reflecting the recommendations and ensuring that learning is specific to that Division.

3.5 Duty of Candour

The Trust is compliant with the statutory Duty of Candour obligations to notify patients within 10 days of an incident where moderate harm or above has occurred .

[2] Specific, Measurable, Attainable, Relevant and Timely

Fig 11 shows the level of compliance on a monthly basis for 2015/16



100% compliance with Duty of Candour was maintained between July 2015 and February 2016. Exceptions were made for one of the cases which was discussed with the Caldicott guardian and felt that it would not be in the best interests of the patient and family to be candid. The Commissioners were aware and informed.

In the first quarter of this year systems were in development to ensure the systematic application of the Duty of Candour requirements, which reflects compliance figures presented. A database is used to track Duty of Candour to ensure that all incidents where harm has occurred are identified and the process of Duty of Candour is managed. Support documents for the staff are in place and ad-hoc training/support has been provided.

4. Learning from Serious Incidents

4.1 Hospital Acquired Pressure Ulcers

The most significant reduction from 2014/15 (n = 62) to 2015/16 (n = 13) was in the number of Hospital Acquired Pressure Ulcers (HAPUs) reported as Serious Incidents. This significant reduction is in line with what was seen nationally. In 2015/16 a new process for investigating and reporting grade 3 or 4 pressure ulcers was devised and agreed with the CCG. This now consists of completing a nationally recognised concise RCA tool that guides staff to making a decision if the pressure ulcer was avoidable (hospital acquired) or unavoidable. All Grade 3 and 4 pressure ulcers that are deemed avoidable (hospital acquired) will be declared, and investigated, as a Serious Incident. These investigations are completed by the Senior Sister on the ward and supported by the Tissue Viability Team.

The Pressure Ulcer Review Group (PURG), chaired by The Chief Nurse, is responsible for reviewing and monitoring the learning identified through the Pressure Ulcer investigations and will ensure that learning is shared and disseminated through

the Divisions. The following actions were taken resulting in the reduction in Hospital Acquired grade 3 and 4 Pressure Ulcers:

- Implementation of the 'BEST SHOT' prevention and treatment care plans
- Monthly monitoring of completion of BEST SHOT assessment and care plan
- SSKIN champions identified in every area; supported with training programme

4.2 Neonatal Deaths Review

The Trust has commissioned an external review into the four neonatal deaths that were investigated internally as Serious Incidents (see appendix 2) in 2015/6. The document reports the findings of an independent inquiry into the perinatal care of four cases identified by the internal processes of the West Hertfordshire Hospitals NHS Trust as raising potential cause for concern. The relevant records for each case were extracted by staff from the Trust and transferred to the TIMMS (The Infant Mortality and Morbidity Studies) office at the University of Leicester. This investigation was undertaken by an independent team consisting of an obstetrician, neonatologist and midwife and was led by Professor Fields. The purpose of the investigation is to identify any failings in the care of the four babies to ensure that the Trust can share the learning and improve the safety for Mothers and Babies in Watford General Maternity Unit. This report was reviewed by the divisions and the executive team areas of learning and improvements were identified. It was then sent to the families of the babies that were reviewed for their review. A meeting has been offered by the Trust should they wish to discuss the results further.

4.3 Retained Tampon

Following a retained surgical tampon Never Event in The Women's and Children's Services Division, the investigation identified that the documentation in the maternal notes was not robust in allowing accurate recording of insertion and removal of surgical swabs or tampons. This initiated a complete re write of the maternity notes and the introduction of stickers that are now mandatory and ensure there is a record which counts tampons in and out. This has been disseminated to all teams and ensured that on induction new staff receive this information. Laminated copies and supplies of the stickers are kept on each instrumental delivery and suture trolley. The assurance for this process will be reflected in two audits as noted in the action plan from the RCA. The Obstetric and Midwifery team updated and amended their suture guidelines to support the new documentation.

4.4 Respiratory Services

A Serious Incident was investigated into why a Pleural Tap was undertaken using ultrasound in Radiology rather than a real-time ultrasound on the ward. A number of

developments were made across the Respiratory services as a consequence of this investigation including:

- Increasing the number of respiratory consultants with a view to expanding the service for patients and providing training for all junior doctors
- The respiratory department have revised and re written their Guidelines for the care of Pleural Taps, offering clear and concise instructions with verbal checks, consent and barriers to ensure X marks the spot procedure is not an option for treatment and diagnosis
- Initiation of a Pleural procedures register which is mandated and ensures that training and tracking of procedures is robust and evidenced

5. Priorities and focus for 2016/7

There are number of priorities and objectives that the Serious Incident team will focus on in 2016/17. These include:

- Working alongside the Complaints and Legal Services to devise a uniform method of recording trends and themes within actions that arise from investigations. This is in order to identify areas of focus for improving services within the Trust. The below narrative identifies two examples of change in practice and learning that resulted from two Serious investigations declared the latter being a never event.

- Ownership of the creation and monitoring of action plans is with the divisions. This is to help ensure that the actions identified to minimise the chances of recurrence are SMART[3] compliant and specific to that division.

- To ensure the Duty of Candour process is initiated in all moderate harms and above, as per Trust Policy, which will include incidents declared as divisional RCAs not Serious Incidents.

- Focus on applying principles and reporting in place for Serious Incidents for all incidents where harm has occurred, for example, incidents that are investigated as Divisional Root Cause Analysis.

- The SI team are reviewing the Duty of Candour training and clarifying definitions of harm levels and time frames to ensure they are robustly followed. They are currently working on a project to spread awareness of the guidance but also to ensure targeted training achieves high level of compliance in the coming months.

[3] *Specific, Measurable, Attainable, Relevant and Timely*

- To further improve the quality of investigations and reports

- To devise and implement a system to monitor open actions associated with Serious Incident action plans and provide assurance as to the level of compliance within each division.

- To initiate higher levels of support and guidance for staff, using written and targeted training methods to achieve this goal. This will include documents for staff to refer to on what their responsibility is in a moderate harm incident and also what happens in the SI investigation process.

- To strengthen closer links with the Divisions through the Quality Governance Facilitators Leads to ensure that they remain focused on supporting investigations, embedding learning and providing assurance to the organisation.

- The team will introduce an investigation closure form, which will measure new performance indicators to assess local quality of the service being delivered. This will feed into a programme of internal self assessing audits that will advise the Board and Trust stakeholders as to the quality of the investigation process.

6. Summary and Conclusion

Significant achievements have been made during 2015/16 including the elimination of the backlog of overdue investigations, the timely completion and submission of Serious Incident investigations, the consistent and accurate application of the national criteria and the ongoing compliance with the Framework which provides a better experience for the patients and families of those affected.

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2016

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2016