Nursing and Patient Experience
Direct Line: 020 7288 3589
www.whittington.nhs.uk

The Whittington Hospital NHS Trust
Magdala Avenue
London N19 5NF

Whittington Health

April 2017

Title:	Serious Incidents - Monthly Update Report		
Agenda item:	17/046	**Paper**	03
Action requested:	For Information		
Executive Summary:	This report provides an overview of serious incidents (SI) submitted externally via StEIS (Strategic Executive Information System) as of the end of February 2017. This includes SI reports completed during this timescale in addition to recommendations made, lessons learnt and learning shared following root cause analysis.		
Summary of recommendations:	None		
Fit with WH strategy:	1. Integrated care 2. Efficient and Effective care 3. Culture of Innovation and Improvement		
Reference to related / other documents:	• Supporting evidence towards CQC fundamental standards (12) (13) (17) (20). • Ensuring that health service bodies are open and transparent with the relevant person/s. • NHS England National Framework for Reporting and Learning from Serious Incidents Requiring Investigation, • Whittington Health Serious Incident Policy. • Health and Safety Executive RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013).		
Reference to areas of risk and corporate risks on the Board Assurance Framework:	**Corporate Risk 636.** Create a robust SI learning process across the Trust. Trust Intranet page has been updated with key learning points following recent SIs and RCA investigations.		
Date paper completed:	30/03/2017		

Author name and title:		**Jayne Osborne, Quality Assurance Officer and SI Co-ordinator**		**Director name and title:**		**Philippa Davies, Director of Nursing and Patient Experience**	
Date paper seen by EC		**Equality Impact Assessment complete?**	**n/a**	**Risk assessment undertaken?**	**n/a**	**Legal advice received?**	**n/a**

Serious Incidents Monthly Report

1. Introduction

This report provides an overview of serious incidents submitted externally via StEIS (Strategic Executive Information System) as of the end of February 2017.

The management of Serious Incident's (SIs) includes not only identification, reporting and investigation of each incident but also examples of recommendations following investigation and dissemination of learning to prevent recurrences.

2. Background

The Serious Incident Executive Approval Group (SIEAG) comprising the Executive Medical Director/Associate Medical Director, Director of Nursing and Patient Experience, Chief Operating Officer, the Head of Integrated Risk Management and SI Coordinator meet weekly to review Serious Incident investigation reports. In addition, high risk incidents are reviewed by the panel to ascertain whether these meet the reporting threshold of a serious incident (as described within the NHSE Serious Incident Framework (March 2015).

3. Serious Incidents

3.1 The Trust declared 7 serious incidents during February 2017 bringing the total of reportable serious incidents to 56 since 1st April 2016.

.

All serious incidents are reported to North East London Commissioning Support Unit (NEL CSU) via StEIS and a lead investigator is assigned to each by the Clinical Director of the relevant Integrated Clinical Support Unit.

All serious incidents are uploaded to the NRLS (National Reporting and Learning Service) in line with national guidance and CQC statutory notification requirements.

3.2 **The table below details the Serious Incidents currently under investigation**

Category	Month Declared	Summary
Safeguarding Incident Ref:13782	May 16	Safeguarding incident in relation to a patient on a current caseload.
Sub Optimal Care of Patient Ref:28091 (submitted 10/03/2017)	Oct 16	Patient developed pressure ulcers due to pressure relieving equipment not being provided.
Suboptimal Care of Deteriorating patient. Ref: 29018 (submitted 10/03/2017)	Nov 16	Patient admitted to ITU with a type 2 respiratory failure and acute kidney injury.
Unexpected Death Ref:29379 (submitted 30/03/2017)	Nov 16	Patient assessed and discharged and was subsequently found unresponsive.

Category	Month Declared	Summary
Unexpected Death Ref:31941	Dec16	Patient assessed and discharged by the Mental Health Liaison Team with referral to the crisis team. Patient was subsequently found unresponsive.
Patient Fall (ward 1) Ref: 33339 (submitted 31/03/2017)	Dec 16	Patient fell from standing position resulting in a fractured skull and intra-cerebral bleed.
Patient Fall (ward 2) Ref:390 (submitted 10/03/2017)	Jan 17	Patient fell forward from the bottom of the bed resulting in a subdural haematoma
Patient Fall (ward 2) Ref:2718	Jan 17	Patient had an unwitnessed fall resulting in a fractured neck of femur.
Delayed Diagnosis Ref:2722	Jan 17	A delay in diagnosing a perforation of the gastrointestinal tract.
Patient Fall (ward 3) Ref:2706	Jan 17	Patient had an unwitnessed fall resulting in subdural haematoma.
Sub optimal care of deteriorating patient Ref: 4094	Feb 17	Patient was admitted with exacerbation of Chronic Obstructive Pulmonary Disease (COPD)
Treatment Delay Ref: 4095	Feb 17	Patient underwent planned surgery was discharged home, and later presented to a neighbouring hospital with a CVA.
Unexpected Death- Influenza Ref: 4856	Feb 17	Patient was admitted and treated for community acquired pneumonia.
Safe guarding Incident - patient absconding from ward Ref: 4788	Feb 17	Teenager detained under section 5.2 of the Mental Health Act absconded prior to completion of essential treatment.
Delayed Diagnosis Ref: 5501	Feb 17	Delay in follow up CT scan and subsequent diagnosis.
Patient Fall Ref:6087	Feb 17	Patient stood to use commode and fell sideward resulting in a fractured neck of femur.
Unexpected Admission to NICU Ref: 6159	Feb 17	Following an emergency caesarean section infant was born in poor condition requiring resuscitation. The baby was transferred to the Neonatal Intensive Care unit.

The table below details serious incidents by category reported to the NEL CSU. The Trust reported 7 serious incidents during February 2017.

STEIS 2016-17 Category	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Total
Safeguarding	0	1	1	0	1	0	1	0	0	0	1	5
Attempted self-harm	0	0	0	0	0	0	0	1	0	0	0	1
Confidential information leak/loss/Information governance breach	1	2	1	0	1	1	0	0	0	0	0	6
Diagnostic Incident including delay	2	1	0	0	0	1	1	1	0	1	1	8
Failure to source a tier 4 bed for a child	0	0	0	1	0	0	0	0	0	0	0	1
Failure to meet expected target (12 hr trolley breach)	0	0	0	0	0	0	1	0	0	0	0	1
Maternity/Obstetric incident mother and baby (includes foetus neonate/infant)	1	1	1	0	0	2	1	0	0	0	1	7
Maternity/Obstetric incident mother only	0	0	0	0	1	0	1	0	0	0	0	2
Medical disposables incident meeting SI criteria	0	0	0	0	0	0	1	0	0	0	0	1
Nasogastric tube	0	0	0	0	0	0	1	0	0	0	0	1
Slip/Trips/Falls	0	0	0	1	0	0	0	0	2	3	1	7
Sub optimal Care	0	0	0	0	0	0	1	1	0	0	1	3
Treatment Delay	0	0	0	0	0	0	1	0	0	0	1	2
Unexpected death	0	1	0	1	0	1	0	5	1	0	1	10
Retained foreign object	0	0	0	0	0	1	0	0	0	0	0	1
Total	4	6	3	3	3	6	9	**8**	**3**	**4**	**7**	**56**

4. Submission of SI reports

All final investigation reports are reviewed at weekly SIEAG meeting chaired by an Executive Director (Trust Medical Director or Director of Nursing and Patient Experience) comprising membership from the Chief Operating Officer, Executive Operational Team and Integrated Risk Management. The Integrated Clinical Support Unit's (ICSU) Operational Directors or their deputies are required to attend each meeting when an investigation from their services is being presented.

The remit of this meeting is to scrutinise the investigation and its findings to ensure that contributory factors have been fully explored, root causes identified and that actions are aligned with the recommendations. The panel discuss lessons learnt and appropriate action, both immediate if applicable, and planned to prevent future harm occurrences.

On completion of the report the patient and/or relevant family member receive a final outcome letter highlighting the key findings of the investigation, actions taken to improve services, what has been learnt and what steps are being put in place. A 'being open' meeting is offered in line with duty of candour recommendations.

The Trust has executed its duties under the Duty of Candour for the investigations completed and submitted during February 2017.

Lessons learnt following the investigation are shared with all staff and departments involved in the patient's care through various means including the 'Big 4' in theatres, 'message of the week' in Maternity, Obstetrics and other departments. Learning from identified incidents is also published on the Trust Intranet making them available to all staff.

4.1 **The Trust submitted 6 reports to NELCSU during February 2017.**

The table below provides a brief summary of lessons learnt and actions put in place relating to a selection of the serious incident investigation report submitted in February 2017.

Summary	Actions taken as result of lessons learnt
• **Ref:25397**	**2016.25397 Unexpected death of patient with bilateral pulmonary embolism**. • A review has taken place of all team email addresses and contact numbers and all 'old' groups have been deleted. • Patient Information Leaflets are being provided to all patients referred to the District Nursing (DN) Service including 'virtual ward' referrals prior to discharge. • The Trust is continuing its work in improving the safety-netting of the discharge of complex or vulnerable patients and considering extra measures on discharge (e.g. engaging family, contacting GP, telephone call to DN coordinator). • Capacity assessments are now formally documented on ICE (Electronic patient record system) in addition to being referenced in the medical notes.
• **Ref:30701**	**2016.30701 Inappropriate surgical referral and delayed diagnosis.** • Introduction of a new surgical booklet with integrated monitoring plans and treatment escalation plan to improve compliance across the surgical ICSU. • An Audit to be undertaken to determine theatre utilisation of specific lists in hours and out of hours to determine whether opportunities are missed to operate on specific patients sooner.
• **Ref:30095**	**2016.30095 A delay in reviewing biopsy results, led to delay in diagnosis.** • A clear and robust standard operating policy in line with the guidelines is being produced which will be reviewed annually • Recruitment and retention plans in place to ensure that the service has a full complement of staff**.** • A review of the service to be undertaken.

5. Sharing Learning

In order to ensure learning is shared widely across the organisation, a dedicated site has been created on the Trust intranet detailing a range of patient safety case studies.

6. National Reporting and Learning System (NRLS)

The latest Organisation Patient Safety Incident report from the National Reporting and Learning System (NRLS) recently released for incidents occurring between 01 April 2016 to 30 September 2016, shows the Trust to be in the highest 25% of reporters (across 136 Acute organisations) . We reported 48.6 incidents per 1000 bed days. The lowest reporting rate was 21, with the median being 40.02 per 1000 bed days.

The report states the following: "*Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are.*" It goes on to say "*An NHS trust where staff feel encouraged and supported to report should show a higher rate of incident reports, a higher proportion of no harm reports, and staff survey responses about incident reporting behaviour that are above average*".

This is a great achievement for the Trust and we hope to maintain (and improve on) this positive reporting culture.

7. Summary

The Trust Board is asked to note the content of the above report which aims to provide assurance that the serious incident process is managed effectively and lessons learnt as a result of serious incident investigations are shared widely.