Whittington Health NHS

Meeting:	Quality and Patient Safety Committee
Date:	18th November 2011

Title:	Serious Incident Trend Report (July – September 2011)

Executive Summary:	This report provides an overview of all serious incidents declared by Whittington Health during July to September 2011. There were 26 serious incidents in total (compared with 20 in the previous quarter). 12 of these related to grade 3 and 4 pressure ulcers (11 were community acquired and 1 hospital acquired). NHS London requires trusts to report and investigate all grade 3 and 4 pressure ulcers as serious incidents. Whittington Health has therefore implemented a Pressure Ulcer Serious Incident Panel which includes representation from hospital and community services. The remit of this panel is to review and monitor the investigations and action plans. In addition there is an overarching action plan in place to address the trends identified across Whittington Health which is monitored by the panel.

Action:	For information

Report From:	Phillipa Marszall, Risk Manager

Sponsor:	Bronagh Scott, Executive Director of Nursing and Patient Experience

Financial Validation Lead: Director of Finance	Name of finance officer

1. Introduction

This report provides and overview of all serious incidents reported by Whittington Health during July to September 2011. 26 serious incidents were reported in total, compared with 20 in the previous quarter.

1.2 Process for reporting and investigating serious incidents

The Serious Incident Policy has recently been revised and is in the process of being implemented across the trust. New serious incidents are reported to the Director of Nursing and Patient Experience and the respective Divisional Director, Operational Director and Head of Nursing. A lead investigator and terms of reference are then agreed at a divisional level.

Investigations are undertaken in line with root cause analysis methodology. Regular training sessions are being provided within the trust to ensure there is an adequate pool of people able to lead investigations.

1.3 Process for approval of investigation reports and monitoring of action plans

Investigation reports are approved at a divisional level and then submitted to the governance team for quality assurance. Following this reports are submitted to the Serious Incident Panel for executive sign off prior to final submission to NHS London.

The panel members include:

- Director of Nursing and Patient Experience
- Medical Director
- Director of Planning and Programmes
- Chief Operating Officer
- Assistant Director of Governance

The panel is chaired by either the Director of Nursing or Medical Director and must include at least one other executive director to be quorate.

Following submission to NHS London, implementation of the action plans is a divisional responsibility. The Patient Safety Committee then has overarching responsibility for monitoring action plans across the trust. Progress regarding action plans will be incorporated in future quarterly reports to this committee.

2. Serious incidents

Appendix 1 provides an outline of:

- All serious incidents reported in the quarter (July to September 2011) including those now closed (the current status of each incident is clearly indicated).
- All serious incidents in progress including any outstanding incidents from previous quarters and all those reported to date.

2.1 Serious incidents by division and specialty (July – September 2011)

The table below indicates the number of the incidents reported by division and specialty. Surgery and Diagnostics reported 1 serious incidents regarding MRSA bacteraemia which was subsequently downgraded by NHS London.

Integrated care and Acute Medicine	
Specialty	**Number of serious incidents**
Emergency Department	2
Haringey Community District Nursing	8
Islington Community District Nursing	2
Long Term Conditions (Islington Community)	1
Montuschi Ward	1
Total:	**14**

Women, Children and Families	
Specialty	**Number of serious incidents**
Maternity Services	12
Total:	**12**

2.2 Serious incidents by category

The table below indicates the number of incidents reported by category.

Category	**Number of incidents**
Pressure ulcer grade 3 or 4	12
Unexpected admission to neonatal intensive care unit (NICU)	4
Unplanned admission to ITU	6
Suspension of maternity services	2
Patient confidential information (breach)	1
Delayed diagnosis	1
Total	**26**

3. Trends and learning

The main trend relates to grade 3 or 4 pressure ulcers (13 reported in total). NHS London now require trusts to report all grade 3 and 4 pressure ulcers as serious incidents. The increase in numbers therefore may well be attributable to reporting requirements and is not necessarily indicative of an increase in the actual occurrence of pressure ulcers.

A detailed outline of the main contributory factors was presented in the previous report. A trust wide action plan is underway to address the issues identified, which is being monitored by the pressure ulcer committee. An update on

progress regarding the action plan will be included with the next quarterly serious incident report.

A number of investigations completed in this quarter have identified contributory factors that relate to lack of adherence to policies and guidelines. The Serious Incident Panel will be communicating this to divisional leads to ensure that this learning is shared at a divisional level and to reiterate the importance of adhering to guidance.

Maternity services have identified the need for expansion of the maternity unit to meet the activity levels and the increasing medical and pregnancy related complexities of the population. This has been identified as a contributory factor in a number of reports and a root cause in several (both in this quarter and the previous quarter). A business case has been developed and is currently being considered.

4. Timescales for investigating serious incidents

The majority of serious incident investigations are required to be completed and submitted to NHS London within 45 days of reporting the incident. The exception is for multi-agency investigations which are required to be completed within 60 days. Of the 26 serious incidents reported in July to September 2011:

- 1 was completed and submitted within the allocated timescales.
- 8 are now completed but were submitted late.
- 17 are still in progress and 13 are overdue. Of these 6 are near completion.

Since April 2011 there has been focused work on improving the quality of investigations and reports. This has impacted on the timescales for completing investigations; however the time invested will provide a foundation for ensuring there is meaningful learning and actions from investigations. The improvement in quality has been recognised by the Serious Incident Panel and NHS London. It is anticipated that the trust will be completing investigations within the required deadlines by the end of December 2011.