Appendix 4

Whittington Health NHS

ITEM: 12/19

Meeting:	Quality Committee
Date:	17th February 2012

Title:	Serious Incident Trend Report (October – December 2011)

Executive Summary:	This report provides an overview of all serious incidents declared by Whittington Health during October to December 2011. There were 30 serious incidents in total (compared with 26 in the previous quarter). Of the serious incidents reported: • 14 of these related to maternity services • 11 of these related to grade 3 and 4 pressure ulcers (8 community related and 3 hospital). 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 October to December 2011. 30 serious incidents were reported in total, compared with 26 in the previous quarter.

2. Serious incidents

Appendix 1 provides an outline of:

- All serious incidents reported in the quarter (October to December 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 (October – December 2011)

The table below indicates the number of the incidents reported by division and specialty.

Integrated care and Acute Medicine	
Specialty	**Number of serious incidents**
Haringey Community District Nursing	5
Islington Community District Nursing	5
Prison Healthcare	1
Infection control (ward areas)	2
Total:	**13**

Surgery, Cancer and Diagnostics	
Specialty	**Number of serious incidents**
Bariatric Surgery	1
Trauma and Orthopaedics (Coyle Ward)	1
General Surgery (Victoria Ward)	1
Total:	**3**

Women, Children and Families	
Specialty	**Number of serious incidents**
Maternity Services	14
Total:	**14**

2.2 Outstanding serious incidents from previous quarters

Integrated care and Acute Medicine still have 1 outstanding serious incident from quarter 1. This is in progress and it is anticipated that this will be completed by March 2012.

2.3 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	11
Unexpected admission to neonatal intensive care unit (NICU)	4
Unplanned admission to ITU	6
Suspension of maternity services	2
Unexpected death	2
Communicable disease and infection issues (clostridium difficile)	2
Retained swab (never event)	1
Hospital equipment failure	1
Death in custody*	1
Total	**30**

*It is likely that this SI will be downgraded.

3. Trends and learning

Pressure ulcers
The main trend relates to grade 3 or 4 pressure ulcers (13 reported in total). A separate report has been submitted to the committee regarding the issues identified and actions taken. In summary actions taken have focused on:

- Assessment – a single PU risk assessment and core PUP care plan
- Pressure Ulcer prevention – agreed policies and care pathways
- Communication and escalation of concerns – Patients of concern discussed in clinical supervision and GPs informed of Pus on hospital discharge letters
- Information for patients and carers – completed patient and carers information leaflets
- Audit – an agreed programme of audit of all PU data and a quarterly VSL audit in the Whittington wards.

Further actions are focused on:

- Ensuring high risk patients of concern are case managed by a named band 5 or 6 nurse who will be responsible for the management and evaluation of care, with complex cases managed through effective MDT working.
- Implementation of monthly review of all patients with pressure relieving equipment.
- Completing training for all staff on ordering and using pressure relieving equipment and organising further study days on PU prevention.
- Inform GPs in writing where patients on DN caseload have PUs as a routine.
- Working with Commissioning to involve all formal carers in pressure ulcer prevention through agreed proficiency and shared care planning.

Maternity Services

Capacity - 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. As with previous quarters this has again been identified as a contributory factor in a number of reports and a root cause in several. A business case has been developed and is currently being considered. Consideration is also being given to capping the number of women booked with the service.

Being Open

It has been identified that there is inconsistency in providing feedback to patients and relatives following serious incidents. The Being Open policy has been revised in line with the national framework and is in the process of being implemented across the trust.

Cell salvage

The potential benefit of having access to cell salvage as an alternative to blood transfusions; has been highlighted in several recent investigations. It is planned that a review will be undertaken of this approach.

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 30 serious incidents reported in October to December 2011:

- 6 were completed and submitted within the allocated timescales.
- 14 are now completed but were submitted late.
- 10 are still in progress and 5 of these are overdue. Of these all are nearing completion.

Serious incidents reported in quarter 1 are on track to be completed within allocated timescales.

The quality of investigations and reports has continued to improve and there is now focused work on ensuring that action plans are implemented within specified timeframes and learning is shared appropriately. Progress on action plans is being monitored through the Patient Safety Committee and a quarterly progress update will be provided to the Quality Committee. The first of which will be presented to the Quality Committee in May 2012.