Nursing and Patient Experience
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Whittington Health
May 2017

Title:	Serious Incidents - Monthly Update Report			
Agenda item:	**17/063**	**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 March 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:				

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 Incident 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 March 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 4 serious incidents during March 2017 (please note: 5 SIs were declared in February not 7 as previously reported to Board) bringing the total of reportable serious incidents to 58 since 1st April 2016

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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
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 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)

Category	Month Declared	Summary
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 (Declared March 2017)	Patient stood to use commode and fell sideward resulting in a fractured neck of femur.
Unexpected Admission to NICU Ref: 6159	Feb 17 (Declared March 2017)	Following an emergency caesarean section infant was born in poor condition requiring resuscitation. The baby was transferred to the Neonatal Intensive Care unit.
Treatment Delay Ref:7557	Mar 17	Unexpected patient death following an elective procedure.
Sub optimal Care of deteriorating patient Ref:7662	Mar 17	Patient death following emergency surgery

The table below details serious incidents by category reported to the NEL CSU. The Trust reported 4 serious incidents during March 2017.

STEIS 2016-17 Category	Apr	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar	Total
Safeguarding	0	1	1	0	1	0	1	0	0	0	1	0	5
Attempted self-harm	0	0	0	0	0	0	0	1	0	0	0	0	1
Confidential information leak/loss/Information governance breach	1	2	1	0	1	1	0	0	0	0	0	0	6
Diagnostic Incident including delay	2	1	0	0	0	1	1	1	0	1	1	0	8
Failure to source a tier 4 bed for a child	0	0	0	1	0	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	0	1
Maternity/Obstetric incident mother and baby (includes foetus neonate/infant)	1	1	1	0	0	2	1	0	0	0	0	1	7
Maternity/Obstetric incident mother only	0	0	0	0	1	0	1	0	0	0	0	0	2
Medical disposables incident meeting SI criteria	0	0	0	0	0	0	1	0	0	0	0	0	1
Nasogastric tube	0	0	0	0	0	0	1	0	0	0	0	0	1
Slip/Trips/Falls	0	0	0	1	0	0	0	0	2	3	0	1	7
Sub optimal Care	0	0	0	0	0	0	1	1	0	0	1	1	4
Treatment Delay	0	0	0	0	0	0	1	0	0	0	1	1	3
Unexpected death	0	1	0	1	0	1	0	5	1	0	1	0	10
Retained foreign object	0	0	0	0	0	1	0	0	0	0	0	0	1
Total	4	6	3	3	3	6	9	**8**	**3**	**4**	**5**	**4**	**58**

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 March 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 March 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 March 2017.

Summary	Actions taken as result of lessons learnt include;
Sub optimal care of deteriorating patient • **Ref: 30716**	• New guidines are being produced that clarify the pathway and timeframe for emergency laparotomy patients, which will include senior surgical review and operative waiting times. • Robust mechanisms are being put in place to recognise patients arriving in ED who have been directly referred to specialty teams. This is especially important for those unaccompanied, vulnerable patients. • An e learning module has been developed re;implications of antibodies in serum of surgical patients. This has been made mandatory for all surgical registrars and consultants within 2 months of arrival in trust. • To ensure wide learning from this incident, the ICSU has arranged for an educational half day event regarding use of treatment escalation plans.
Sub Optimal Care of Patient Ref: 28091	• The skin bundle used in acute paediatrics is being implemented in community services for both Islington and Haringey and pressure area risk assessment training is being provided to all Community Children's Teams. • An review of wheelchair services has been undertaken to ensure that vulnerable sick children are not transported great

Summary	Actions taken as result of lessons learnt include;
	distances without pressure relieving cushions.
Patient Fall **Ref: 33339**	• Falls prevention and awareness training is provided to all newly appointed staff nurses, doctors and Allied Health Professionals. Considertion is also being made as to whether falls training should be mandatory for all staff.

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. 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.