

## Board of Directors (in Public)

### Item 3.5

**Subject:** Integrated Incidents Complaints and Claims (IICC)  
Report - Quarters 3 & 4 (October 2106 – March 2017)  
With comparison to Q1 & 2 (April 2016 – September 2016)

**Date of meeting:** 30<sup>th</sup> May 2017

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**Presented by:** Dr Mark Jackson, Director of Research & Informatics

BAF Ref	Impact on BAF
1.1	None

## 1 Executive Summary

This paper will provide the Board of Directors with quantitative and qualitative analysis of reported incidents, complaints and claims (IICC). These results relate to quarters 3 and 4 of the financial year 2016/17.

Incident reporting, learning from incidents, complaints and claims and improving the safety culture remains a focus for the Divisions.

The top five incidents remain relatively unchanged from the previous reporting quarters.

The implementation of Datix has provided clearer reporting on actual incidents and near misses, supplying the organisation with a focus for improvement of near miss reporting. To assist the clinical areas, dashboards are in development in order for managers to compare their own rates of near miss v incident reporting.

A National Learning from Deaths initiative is being implemented across Trusts which should provide a platform for increased reporting. The Divisions will play a principle role in ensuring any learning from the mortality reviews is embedded within clinical practice.

The Trust has seen a decrease in formal complaints being received. The Divisions take an active role in leading on embedding the findings from the action plans developed as a result of a complaint.

The number of new clinical and non-clinical negligence claims received has seen a decrease compared to previous quarters.

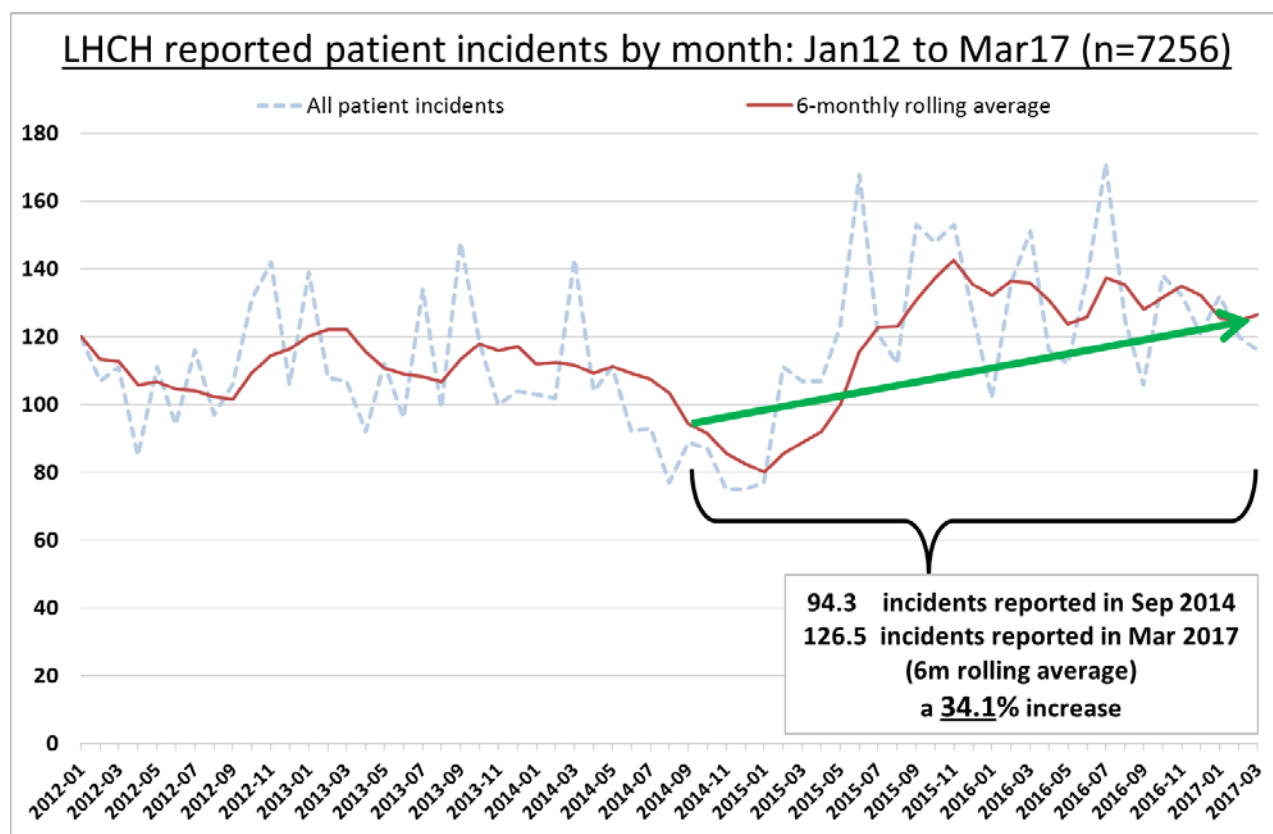
Opportunities for organisational learning include staff attendance at bi weekly learning and sharing events and quarterly organisational learning sessions.

Patient Experience events take place quarterly in a variety of areas across the country.

## **2 Background**

This report is presented to the Board of Directors six monthly and reports concurrent information pertaining to incidents, complaints and claims reporting within the organisation.

### 3 Reporting Culture



Datix incident reporting was introduced on 31<sup>st</sup> May 2016, accompanied by intense training for staff on the use of the system.

Since the introduction of the system, incident reporting has remained steady and there is a continued focus on the importance of incident reporting in safety huddle and at team brief. The Risk and Safety Lead has met with lower reporting departments to discuss the importance of incident/near miss reporting by all staff and the definitions of what constitutes an incident/near miss. These meetings will continue in order to encourage staff to report. In addition, the Information team are developing a dashboard so that staff can easily see the rate of incident reporting v near miss reporting.

As part of the Sign up to Safety campaign, the organisation set itself a target to increase incident reporting by 50% over the three years of the campaign. On entering the third year of the campaign, the Trust has seen an achievement of an increase of 34.1% when taken as a rolling average (as per chart above)

#### Divisional Reporting Culture

The tables below show the numbers of reported incidents in each of the Divisions. The three clinical divisions show an increase in incident reporting in 2016/17 compared to 2015/16. Meetings are taking place with the Managers in the corporate division to highlight the need for better incident reporting. Although, staff in the corporate division will often report incidents and it will be managed in the area where the incident has happened, which gives the impression that teams in the corporate division are not reporting as highly as other teams.

Learning from Deaths initiative is being implemented across Trusts which should provide a platform for increased reporting.

#### **Surgery**

Q1 15-16	Q2 15-16	Q3 15-16	Q4 15-16	Annual total
182	158	207	134	681
Q1 16-17	Q2 16-17	Q3 16-17	Q4 16-17	
173	187	167	167	694

### Medicine

Q1 15-16	Q2 15-16	Q3 15-16	Q4 15-16	Annual total
115	138	118	134	505
Q1 16-17	Q2 16-17	Q3 16-17	Q4 16-17	
136	181	158	178	653

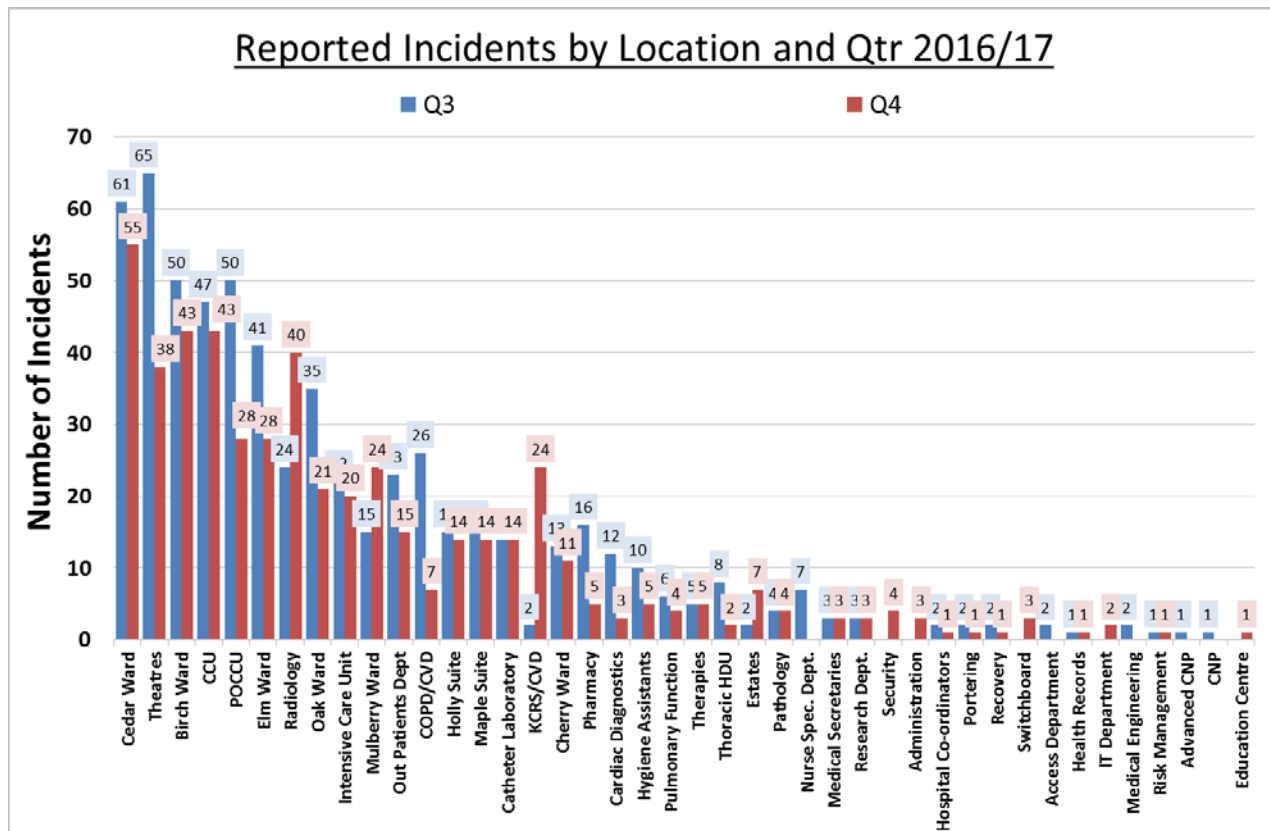
### Clinical Services

Q1 15-16	Q2 15-16	Q3 15-16	Q4 15-16	Annual total
85	82	102	115	384
Q1 16-17	Q2 16-17	Q3 16-17	Q4 16-17	
92	100	135	120	447

### Corporate

Q1 15-16	Q2 15-16	Q3 15-16	Q4 15-16	Annual total
80	75	67	65	287
Q1 16-17	Q2 16-17	Q3 16-17	Q4 16-17	
45	28	20	35	128

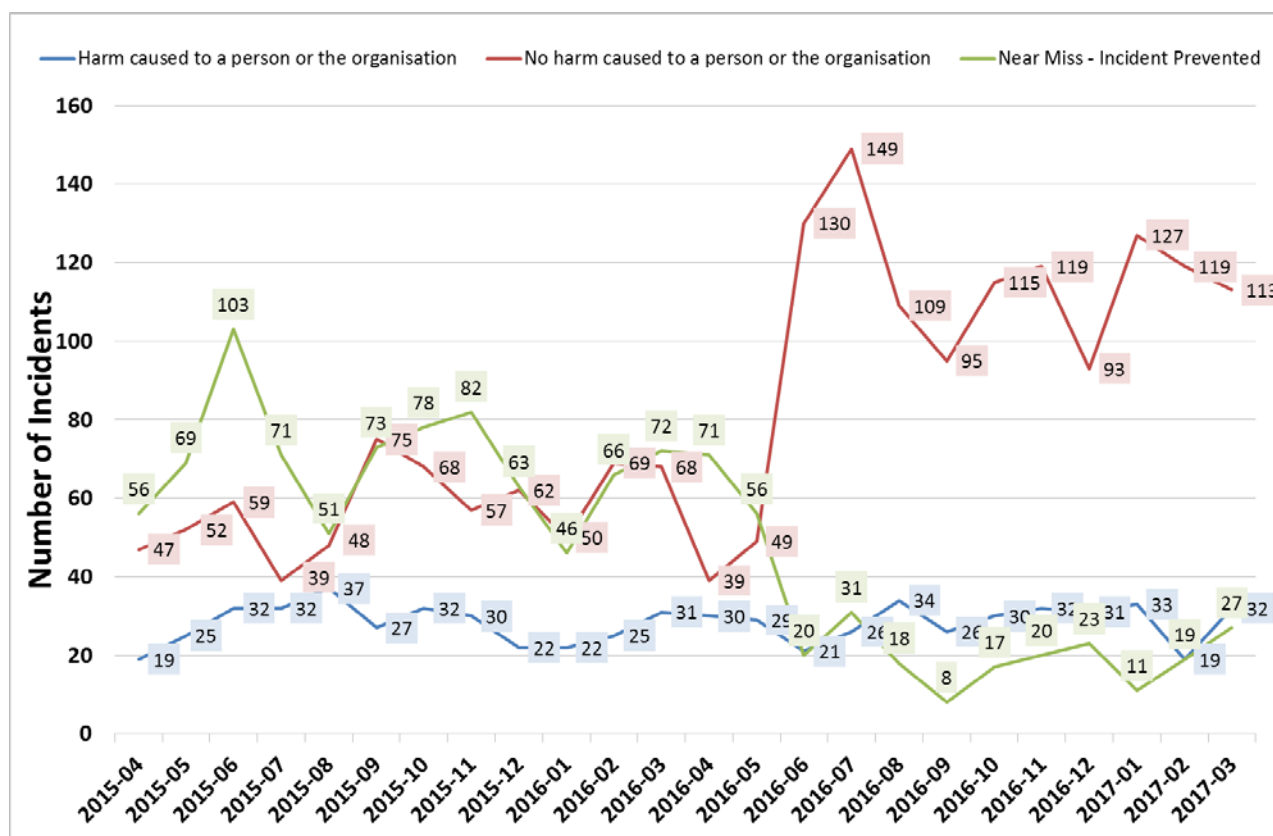
A breakdown of the number of reported incidents within the areas can be seen by location as detailed below. Blue Q3 Red Q4. The wards and theatres report the highest number of incidents. Some departments, such as the security team will report incidents that are assigned to the area where the incident is located. Therefore for several teams, it appears as though they are low reporters.



The importance of incident reporting continues to be highlighted through team brief, the daily safety huddle, senior leads and manager meetings and within the Divisional Governance meetings which supports the Sign up to Safety Campaign.

## Incidents v Near Miss Reporting

The graph below shows the figures for near miss versus actual incident reporting since April 2015. Research shows that an organisation with a good reporting culture will find that more near misses are reported than actual incidents. The introduction of Datix has allowed staff a choice of result of an incident i.e. near miss, adverse event – no harm, adverse event – harm caused. The old risk management software, Prism did not allow this separation, allowing only near miss or adverse event. From the chart below it can be seen that reports showing near miss and incident reporting detailing harm/no harm is reported with more accuracy. When using Prism, staff would report a no harm incident as a near miss thus not presenting an accurate picture. As an organisation, there is still work to do to increase the number of near misses reported as this is probably an area of under reporting. Training on incident/near miss reporting with staff continues.



## National Reporting and Learning Service (NRLS) (1<sup>st</sup> April 2016 – 30<sup>th</sup> September 2016 – latest report from NRLS)

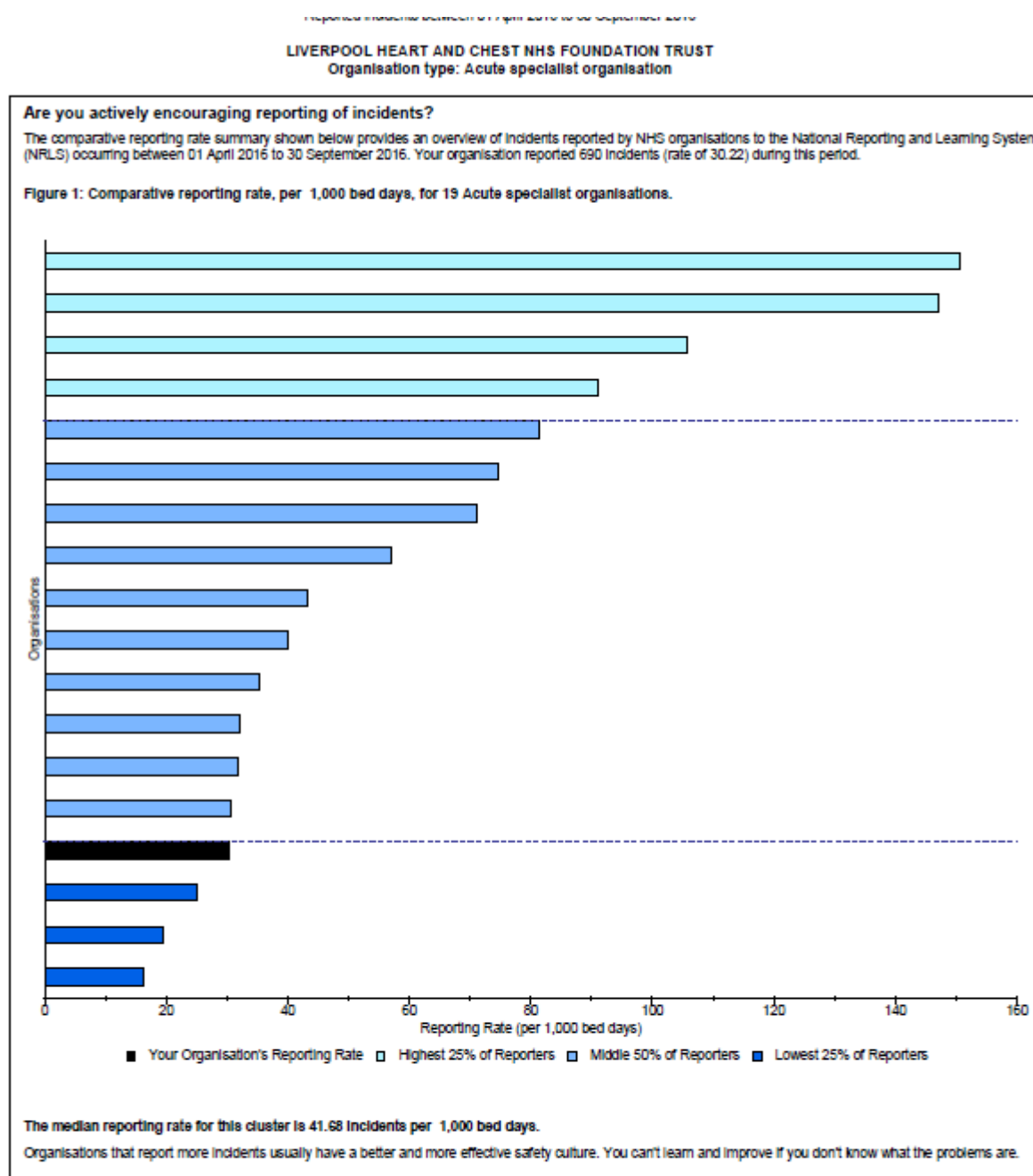
The chart below is received from the national reporting and learning service (NRLS). It demonstrates that the organisation is in the lower tercile for incident reporting.

LHCH has a policy to support the actioning and closing of incidents in a 28 day timeframe. This is monitored via Divisional Governance meetings monthly, with all staff that have incidents open being reported within the committee. The NRLS report details that the organisation submitted closed incidents on average 57 days after the incident occurred which is deterioration on the previous count of 42 days after the incident occurred reported in the last report received by NRLS. More timely closure of incidents would see learning from investigating the incident being achieved closer to the incident date. Moreover, timely incident closure would see the organisation move up in the league table of reporting for the cluster.

To assist the Divisions in the closure of incidents, the Risk Team now provide a weekly report to the

Divisional Heads of Operations which details the incident handlers who have incidents open over 28 days.

The Executive Team, along with the Divisions have developed an incentivised accountability framework which has included incident reporting as a KPI.



**How regularly do you report?**

Your organisation reported incidents to the National Reporting and Learning System (NRLS) in 6 out of the 6 months between 01 April 2016 to 30 September 2016.

**Report regularly:** Incident reports should be submitted to the NRLS at least monthly.

Fifty per cent of all incidents were submitted to the NRLS more than 26 days after the incident occurred. In your organisation, 50% of incidents were submitted more than 57 days after the incident occurred.

## **Top five reported Incidents**

In total, there were 984 reported incidents in Q3-Q4; of these there were:

**Medications Q3: 57 incidents, Q4: 49 incidents = 106**

These include

- dose omitted
- drug given by wrong route
- Wrong dose administered
- Wrong dose dispensed
- Wrong dose prescribed
- Wrong drug administered
- Wrongly prescribed and administered
- Prescribed duplicate
- Pharmacy dispensing errors

Drug incidents occur in all wards across the Trust. All the categories of the above have been identified as no /minor harm.

Medication training is provided to new Doctors when they arrive at the hospital.

The Safer Medication Committee review and discuss all medication incidents that happen in all divisions, identify trends, reclassify incidents that require escalation and offer feedback to divisional meetings.

Work has been ongoing with nursing staff regarding the safe administration of medications which includes having all staff who administer medications read the Safer Administration of Medications Policy with a signature required to validate that they have read it; ward managers complete daily observations of medication rounds; the process for recording CD's has been strengthened; staff who are administering medications are to adhere strictly to the wearing of red tabards to try to limit interruptions and enforcing the second individual signature process for signing for medications administered.

**Medical Devices, Equipment and Supplies Q3: 45 incidents, Q4: 29 incidents = 74**

User error/user damage is the highest reported sub category within this group, with theatre and POCCU reporting the highest number of incidents. Any incident relating to user error/user damage is copied into the Education Practice Facilitator to include within training.

**Slips trips and falls Q3=36, Q4=26 = 62**

Ward managers and the Service Improvement Lead are continuing to work closely with staff to reduce the numbers of patient falls. Measures put in place include staff being situated in bays with patients; call don't fall initiative; hourly comfort checks.

They are working in collaboration with OT and Physiotherapists to encourage patients to mobilise sooner wearing their own clothes and not in pyjamas as this has proven beneficial in uplifting patients spirits and preparing them for discharge. Work is ongoing with patient flow across the Divisions.

**Documentation Q3=22, Q4=18 = 40**

Themes within this category include

- Incorrect entry in patients notes
- Filing errors
- Letters sent to incorrect GP

Processes exist and staff are reminded to follow process when checking patients documentation in records, when sending letters to patients or on theatre lists to ensure the correct patient is being identified and that all demographics and information is correct.

### Administration processes Q3=16 Q4=16

Themes within this category include

- Delay in clerking patients
- Incorrect details on admission letters to patients
- Letters being sent to incorrect address
- Filing not being completed in a timely manner

Many of the incidents reported in this group can be attributed to human error and not checking on work that is being carried out.

### Severity of Incidents

	No/low harm	Moderate (short term harm)	Severe (permanent or long term harm)	Death
Q3 2016/17	468	10	0	0
Q4 2016/17	499	6	0	0

The grading of incidents has changed slightly with the introduction of Datix and is now reflected as no/low harm; moderate – short term harm; severe - permanent or long term harm and death. This coincides with harm categories as per Duty of Candour.

No harm/low harm continues to be the main category reported within the incident reporting systems

### Serious Incidents (SI's)

In quarters 3 & 4 there were four incidents that met the criteria of the NHS England serious incident framework and were reported via StEIS.

- 1 NEVER EVENT (wrong patient received implant – investigation complete) - November 2016
- 1 communication error leading to a delay in diagnosis (investigation complete) - November 2016
- 1 information governance breach – a third party company was hacked and LHCH staff data was compromised (investigation complete) - February 2017
- 1 NEVER EVENT (double stenting to patient coronary artery when one stent was intended – investigation underway) – March 2017

The incidents are in the process of being investigated or have been fully investigated with actions put in place to mitigate reoccurrence.

### Duty of Candour

The Duty of candour process was followed in all applicable incidents. The process is overseen by the Risk and Safety Lead who produces a quarterly audit of compliance with the system.



## RIDDOR Reportable Incidents

(Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995)

In quarters 3 & 4 there were four reportable incidents. These equate to one patient fall, one violence towards staff, one staff struck by an object and one staff sharps injury.

## Speak out Safely

The Speak out Safely campaign has been supported in the organisation since April 2014. During that time there have been 55 reports made using this mechanism.

Reporting themes are; working practices (10), values and behaviours (19) clinical care (7) and care environment (1), reporting using HALT- verbally reported at daily Safety Huddle (18)

Staff who report under this mechanism are contacted and offered feedback regarding their concern or in meetings with the Senior Leaders who are investigating their concerns.

The Freedom to speak out Guardian has been introduced, with Champions situated in areas around the Trust.

## 4 Complaints Analysis

Complaints and concerns are managed in line with DOH guidance who advise that that all complaints are dealt with using the same process. The Patient & Family Support Manager produces a monthly complaints report that is presented to each Divisional Governance Meeting which details the numbers of concerns and complaints received, the key issues and action taken. Any action plans and learning from complaints are presented by the relevant lead at the relevant Governance Committees.

### Complaint Themes (comparison of Q1&2 with Q3&4 (this reporting period))

	Q1 & Q2 2016/17	Q1 & Q2 Themes Total = 36	Q3 & Q4	Q3 & Q4 Themes Total = 28
<b>Surgery</b>	<b>16</b>	*Clinical Care including nursing (23) Communication/Information (5) Waiting times OPD (2) Facilities/Services (2) *Referral process (1) Administration process (1) Staff behaviour/clinical care (2)	<b>8</b>	Clinical Care (19) Cancelled surgery (1) Private Patient Invoicing (2) Ethnicity Data Collection (1) OPD clinic arrangements (1) Privacy/dignity (1) Consultation -conduct of patient/Dr (1) Patient Property (1) 1 withdrawn – clinical care/experience
<b>Medicine</b>	<b>15</b>		<b>14</b>	
<b>Clinical Services</b>	<b>4</b>		<b>3</b>	
<b>Corporate</b>	<b>0</b>		<b>3</b>	

## Learning from complaints

All complaints were discussed in the respective governance committees and all closed complaints were responded to within the negotiated timeframe, although a number of response dates were re-negotiated because the investigations from the divisions took longer than anticipated. If immediate action was taken, therefore no action plans were required but discussed in detail in relevant governance committee.

Any complaint that generated an action plan was discussed and action plans were presented at relevant division governance committees to support organisational learning.

Summary of learning from Q3 & Q4 has included:

- Improved communication, listing and cancellation procedures for cardiac surgery
- Improvements in discharge process & medication teach back
- Addition of ethnicity category for patient administration system
- Improvements in processing private patient invoicing
- Improved process for handover from theatre to the Critical Care Unit
- Reviewed & improved patient information
- Reviewed delirium policy and guidance for communication with families
- Improved processes/communication for radiology alerts

All complaint responses either verbal or written were honest and open in line with the statutory Duty of Candour.

## **PATIENT & FAMILY SUPPORT CONTACTS**

Q1 & 2 2016/17, 167 contacts from patients, families and carers asking for advice/raising an informal complaint were received.

Q3 (130) & Q4 (96) 2016/17 226 contacts from patients, families, carers requesting information/advice or raising an informal concern were received.

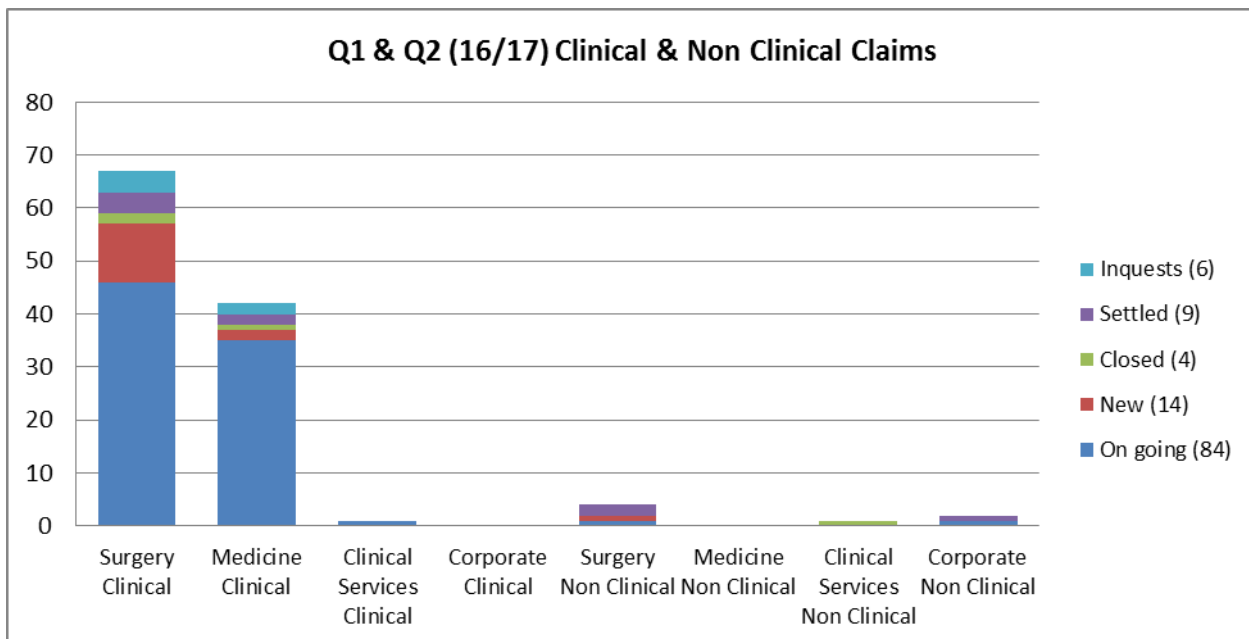
**Top themes from Q3 & Q4 include:**

- Communication – administration – no answer when calling/not returning calls
- Clinic appointments being cancelled and the length of time until next appointment.
- Enquiries relating to Adult Congenital Appointments
- Referrals and waiting times for procedures/surgery
- Interpreter enquiries
- Car parking enquiries (charges/concessionary passes)

All learning from complains/concern is presented to the relevant governance committee.

## **5. Claims analysis**

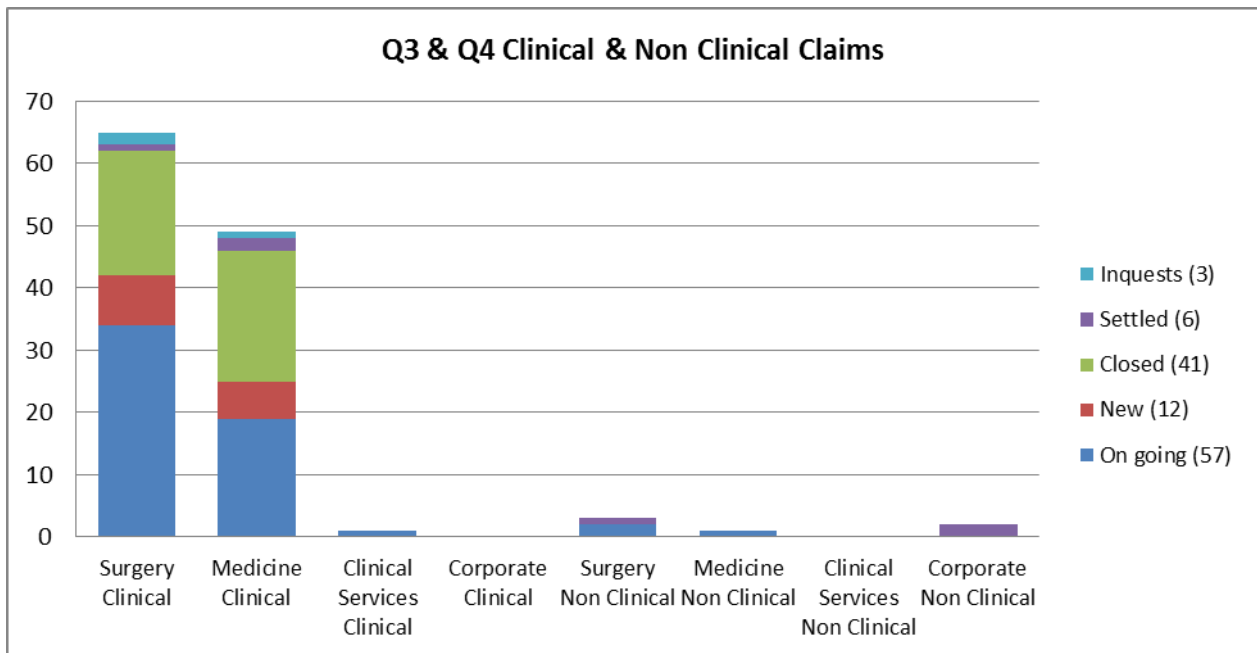
**Data relating to claims Quarters 1 & 2 (April 2016 – September 2016) for comparison with Quarters 3 & 4 (this reporting period)**



No of Claims	Management Status	Letter Before Action – Pre Action stage claim currently being managed in house by the Trusts Legal Services	Letter of Claim/Proceedings – Formal claim being managed by the NHSLA	Letter of Claim/Proceedings – Formal claim being managed by Panel Solicitors, Hill Dickinson
<b>Clinical Existing (82)</b>		69	1	12
<b>Clinical New (13)</b>		12	1	0
<b>Non Clinical Existing (2)</b>		0	1	1
<b>Non Clinical New (1)</b>		0	1	0

No themes have been highlighted within the letter before action or the claims received.

**Data relating to claims Quarters 3 & 4 (October 2016 – March 2017)**

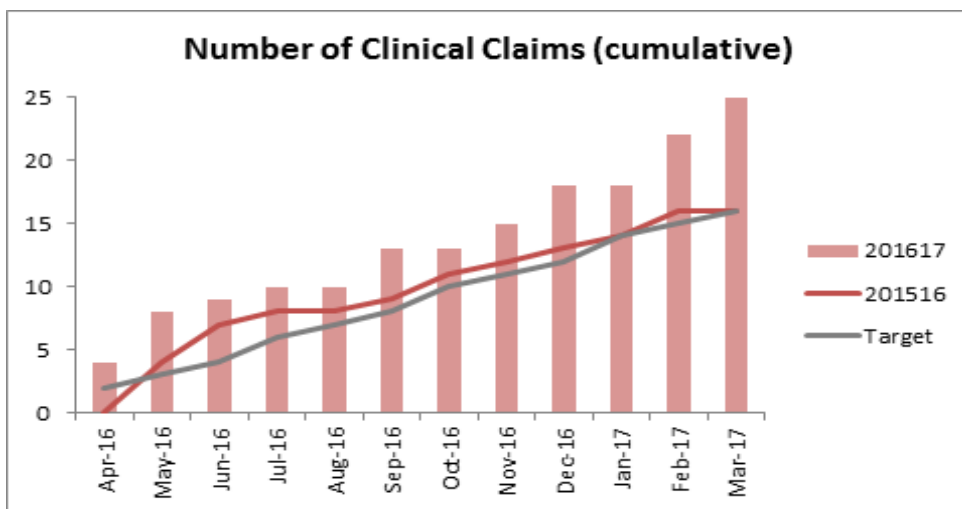
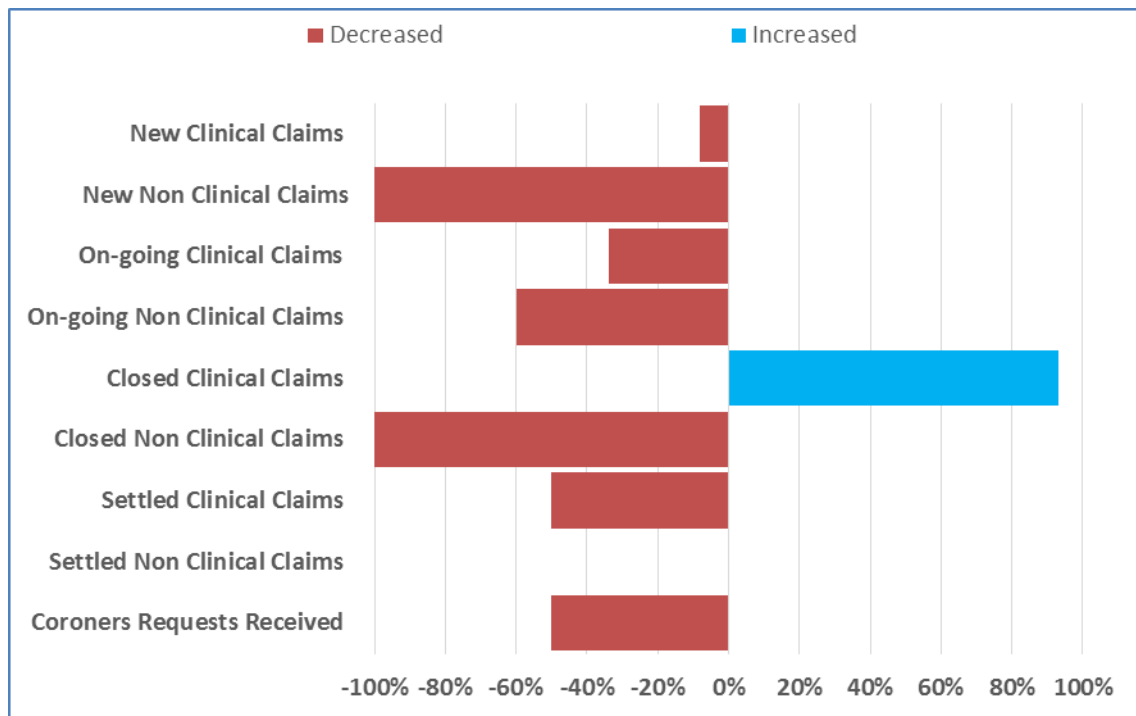


Please note that in 2 instances for new clinical claims, the claimants have received treatment and care under both the Medicine and Surgery Divisions. These are both early stage claims and the solicitors have not yet provided us with enough information to determine which directorate the claim relates to. The claims have therefore been marked as new for both medicine and surgery until further information is received or the claim progresses to a formal claim.

When reviewing the individual claims no recurring themes were identified as the circumstances within each case are different, with different operators and incident dates also range from 2000-2016.

No of Claims	Management Status	Letter Before Action – Pre Action stage claim currently being managed in house by the Trusts Legal Services	Letter of Claim/Proceedings – Formal claim being managed by the NHSLA	Letter of Claim/Proceedings – Formal claim being managed by Panel Solicitors, Hill Dickinson
<b>Clinical Existing (54)</b>		48	1	5
<b>Clinical New (12)</b>		11	1	0
<b>Non Clinical Existing (3)</b>		0	2	0
<b>Non Clinical New (0)</b>		0	0	0

Over the 6 month period of quarters 3 and 4 (2016/17) in comparison with the previous 6 month period:



The chart above indicates the number of new clinical claims received each month and is a graphical demonstration of the information portrayed in Quarters 3 & 4. From the above graph we can see that we have exceeded the cumulative target since the beginning of the financial year, as a result of this the RAG rating is currently red.

## 6. Integration of incidents, complaints and claims

The diagram below depicts the integration of incidents, complaints and claims for quarters 3 & 4



There have been:

- 0 Incidents reported as a complaint:
- 1 Incidents reported as a complaint and a claim
- 1 Incidents also reported as claim
- 3 Complaint reported as a claim

## 7. Organisational Learning

The Trust has an approved Organisational Learning Policy, which sets out the structure by which the organisation will apply learning. A quarterly Organisational Learning session is held which has an open invite to all staff to attend or present learning from events in their areas of work or Divisions. Topics covered in the last sessions include the learning from the Serious incident concerning delay in communication of test results and a Never Event regarding implantation of a device into the wrong patient. Both events identified weaknesses in the communication processes. Other topics covered relate to patient safety alerts regarding the administration of high strength insulin and the use of air flow meters in the clinical areas.

8. There is also a fortnightly Learning and Sharing session chaired by the Director of Nursing, which enables teams to come together to discuss the key lines of enquiry set by the CQC and how each team prepares their own area to comply with the standard.

### Patient Experience

LHCH was recognised in 2016 National survey as being in the top for nursing care and cleanliness. Friends and Family Test results are consistently high, achieving an average positive response of 99%. The trust also undertakes a Family FFT where family members are asked the question. This scores on average 98%. The test has been implemented in Outpatient Department, with improved response rates this year.

The Trust has continued to develop the vision for a patient and family centred care approach to truly involve

families and carers in care. Its care partner programme has been rolled out across all wards and department, giving an opportunity for patients and families to be involved in care if they wish and the Trust no longer has fixed visiting hours, welcoming families and carers to be with their loved ones at times that suit them. This involves staff asking family's members/carers if they would like to be involved in the care of their relative and which aspects of care they would like to take part in. This is a fundamental part of the Trust's family experience vision and is one of the ways in which LHCH articulates to patients its ambitions for them and their families to be partners in care. The care partner is now identified on the EPR system to facilitate audit of this in.

The trust conducts 4 patient and family listening events per year. The aim of engaging with patients and families is to enable us to truly understand their experience and to highlight any improvements required. This will then provide an opportunity to embed improvements where applicable.

The Trust facilitated four events this year, including a session specifically looking at discharge planning. More than 150 patients and their families have attended this year's events in a wide variety of locations including the Isle of Man. The Trust always asks if patients and families benefitted from attending the events. The response has always been positive and some families have suggested that these events should be like a monthly drop in.

Learning from the events has included improving communications and obtaining take home medications on the day of discharge; improving access to restaurant facilities at night for families; dietary needs if patient has allergies; toilet facilities for relatives available on ward areas.

Patient and family Shadowing has been implemented across the Trust since April 2012 and to date 442 staff have been trained with over 200 shadows completed. Shadowing involves a committed empathic observer to follow and observe a patient and or a family member throughout a selected care experience, to observe and gain insight on the patients and families experience. The gathering of information through observation, discussion and analysis is used by care staff to understand, and thus perfect, the patient and family experience.

The trust also hosted a listening event with Health watch Liverpool earlier in the year and a further event is currently in planning. This was an extremely positive event. This was performed by visiting wards, to outpatient areas, and by approaching people in the main foyer between 10am and 4pm on the day. The aim was to get as much independent patient and visitor feedback as possible on wards, in outpatient areas, and in the main foyer of the hospitals.

In order to provide consistency, respondents were asked questions that had been jointly agreed between Health watch and the Trust. So as to ensure their anonymity patients were not asked for their names or addresses, but were asked for the first part of their postcode as well as some questions about their background for equality and diversity purposes. During the event Health watch Liverpool staff and volunteers spoke with 33 patients, 8 visitors.

The trust continues to undertake patient stories and a focus this year has been equality and diversity. We have undertaken a number of video stories when the patient has been unable to write their own.

An annual assurance report is presented to the Quality Committee which details specific measures and scores for patient experience – see appendix 1

## **9. Summary and Conclusions**

Incident reporting, learning from incidents, complaints and claims and improving the safety culture remains a focus for the Divisions. During the reporting period, the Trust has seen a decrease in formal complaints being received.

Complaints action plans are reviewed on a monthly basis in the relevant Directorate Governance

Committees, allowing the committee an opportunity to challenge actions put in place by the investigating leads.

The number of new clinical and non-clinical negligence claims received has seen a decrease compared to previous quarters.

The process to implement the Datix risk management software is complete and staff report on its ease of use and functionality. Incident reporting remains steady with on-going training continuing across all areas. However there is more work to do to increase near miss reporting. The timely closure of incidents remains a focus with weekly open incident reports being sent to the Divisional Heads of Operations for action.

Bi weekly learning and sharing events have been reintroduced and quarterly organisational learning sessions continue with Divisions being invited to present learning from incidents complaints, claims and patient experience events.

Patient Experience events take place quarterly in a variety of areas across the country and are always positively evaluated.

## **10. Recommendations**

The Board of Directors are asked to:

- Receive assurance that mitigation to prevent harm to patients and staff by the reporting of and learning from reported incidents, complaints, claims and patient experience events continue to be monitored by the Divisional Governance Committees.
  - Receive assurance that the National Learning from Deaths initiative will provide a further platform for Divisions to take a principle lead in ensuring changes to clinical practice as a result of a strengthened mortality review process.
-