

## Board of Directors

### Item 5.4

**Subject:** Integrated Incidents, Complaints and Claims (IICC) Report – Q3/Q4 2023/24

**Date of Meeting:** 28<sup>th</sup> May 2024

**Presented by:** Karan Wheatcroft, Director of Risk and Improvement

**Purpose:** To note

BAF Reference	Impact on BAF
BAF 1	Assurance regarding the process, management and learning from incidents, complaints and claims.

Level of assurance (please tick one)					
To be used when the content of the report provides evidence of assurance					
✓	<b>Acceptable assurance</b> Controls are suitably designed, with evidence of them being consistently applied and effective in practice	<input type="checkbox"/>	<b>Partial assurance</b> Controls are still maturing – evidence shows that further action is required to improve their effectiveness	<input type="checkbox"/>	<b>Low assurance</b> Evidence indicates poor effectiveness of controls

## 1. Executive Summary

This paper provides the Board of Directors with quantitative and qualitative analysis of reported incidents, complaints and claims (IICC). The report focusses on Quarters 3 and 4 2023/24, compared with Q1/Q2 of 2023/24.

The key messages within the report are:

- Incident reporting, learning from incidents, complaints and claims and improving the safety culture, remains a priority for the Trust.
- Incident reporting culture has been maintained in terms of the number of incidents reported and the top 5 themes are administration processes, medications, communication, patient falls, and documentation.
- Swarm discussions, rapid review and MDT reviews are being undertaken with a focus on learning, improvement and just culture.
- There were 3 incidents classified as fatal harm and there has been one Patient Safety Incident Investigation (PSII) in Q4.
- There were 4 RIDDOR (reporting of Incidents, Diseases and Dangerous Occurrences Regulations) reportable incidents in Q3 and Q4.

- The number of complaints remains low, although for 2023/24 there was a slight increase to the previous year. A number of complaints related to cancellations/ waiting for surgery, and work is being done to review and reduce cancellations and improve communications to those on the waiting list.
- There were no concerns/ actions from the coroners cases closed in Q3 and Q4.
- The issues raised through Freedom to Speak Up (FTSU) were largely related to systems and processes, health and wellbeing, working practices, and staff values and behaviours.
- Organisation learning arrangements are strong with additional developments achieved through the embedding of the Patient Safety Incident Response Framework (PSIRF).
- In terms of patient experience, the Trust received excellent results in the NHS Adult inpatient survey. Follow up calls continued to be made to all patients who had an overnight stay in the Trust and these provided positive feedback across a range of indicators, and a small number of areas identified for improvement.
- Patient engagement events have been held and the quality priorities for 2024/25 agreed.

Whilst there was no direct correlation of themes identified, the report demonstrates the learning and agreed actions to drive improvement.

The Board of Directors is asked to note the report and receive assurance of the arrangements in place for the management and learning from incidents, complaints and claims.

## **2. Background**

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

To note, during Q1 the Trust remained to use the Datix incident reporting system, and for Q2 we transitioned to our new system, InPhase. Due to issues collating legacy data for Q1 to present in the usual way, some visual graphs are not available, however a narrative has been provided. LHCH went “live” with the new Patient Safety Incident Response Framework (PSIRF) on 9<sup>th</sup> October 2023, therefore going forward the IICC report will present slightly different to its current format, and as PSIRF encourages and allows – much more qualitative data, including the learnings and improvement will be presented. Under PSIRF we will no longer be carrying out comprehensive investigations and reporting externally on Serious Incidents (SI's), as carrying out an investigation following a patient safety incident is no longer the default position. A patient safety incident investigation is just one type of learning response and encourages providers to refer to the national ‘learning response toolkit’ for support.

In terms of when a patient safety incident investigation (PSII) should take place, PSIRF leaves this up to organisations to decide for themselves, depending on the circumstances and factors such as their patient safety profile - for example, a PSII may be indicated where factors contributing to an individual incident are not well understood.

### 3. Incident Reporting Culture

Since the introduction of Datix in May 2016, incident reporting has remained steady and there is a continued emphasis on the importance of incident reporting in safety huddle and at team brief. A new incident reporting system came into effect in at LHCH in July 2023, InPhase, and since the transition, incident reporting numbers has remained consistent. This has been supported by a well-planned and coordinated transition project, communication throughout the Trust, daily training and support sessions being made available and the assistance of InPhase themselves.

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.

Graphs showing the incident reporting levels are provided in **Appendix A**.

#### **Top five reported incident themes**

In total, there were 1037 reported incidents in Q1-Q2 2023/24, 1075 reported in Q3–Q4 2023/24. The top five reporting themes for the four quarters are shown below.

Theme	Q1	Q2	Q3	Q4	Total	Summary
Administration Processes	72	78	91	88	329	This category includes administrative, clinical record keeping, and communication incidents throughout the Trust, including clinical teams.
Medications	57	60	70	90	277	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, and pharmacy dispensing errors.
Communication	32	46	40	39	157	This category includes communication between teams, handover between teams, communication with patients, communication with other healthcare providers (such as the ambulance service for outpatients' bookings, and referral information not being completed correctly.
Patient slips, trips and falls	33	28	36	35	132	This category includes all records of patient slips trips and falls. Slips, trips and falls happen predominately in the ward areas and can happen at any time of day or night. Delirium and sedation are contributory factors to patients falling
Documentation	25	28	25	23	101	This category includes all documentation communication throughout the Trust, including all forms used i.e. electronically/written.

Learning and actions from the from the top 5 themes are provided in **Appendix B**.

#### **PSIRF methodology in practice**

PSIRF asks us to utilise new tools and methodology when reviewing patient safety events, of any severity, where the opportunity for learning or improvement exists; these may include near me or no harm incidents.

Examples of these tools include Swarm Huddles, MDT Reviews and Rapid Reviews, and

when using these templates we should exercise the SEIPS methodology (Systems Engineering Initiative for Patient Safety). We have undertaken several of these, and the output of learning and improvement has been huge – simply by allowing an open, safe space for teams to engage with the facilitator and each other, the focus turns to the system that supports our staff, rather than the one individual at the centre of the patient safety event.

Swarm Huddles should ideally occur as soon after the incident occurs, to quickly gather those who were involved, discuss what occurred and speak openly about lessons learned, including quick actions and longer terms ones also. We have undertaken several since our “go live” date, facilitated by the Patient Safety and Emergency Planning Lead Nurse for the Trust, as we continue to train and support staff to feel confident to undertake them independently in their areas, and disseminate the learning at our weekly patient safety learning meetings.

Historically, incidents have caused us to seek the root cause and put mitigations in place there. Often, it would result in the individual or team being updated on the incident, communications sent out, with the recommendation of training or refreshing knowledge of the policy. By using SEIPS and gathering core team members, we have uncovered huge amounts of learning and improvements, to be made within our system, that don’t currently support our staff fully in the tasks they undertake.

Som examples of learning from swarm discussions are provided in **Appendix C**.

We have recently inbuilt the learning responses available within InPhase, this allows staff within their own areas to select a PSIRF learning response they undertook in their incident review, if they felt this was required. The initial figures are shown below for Q3/Q4 within InPhase, the Risk Management Team are aware that several more responses have been undertaken within areas however, therefore further communication is required to ensure staff are recording their response within the system:

	SWARM	Rapid Review	MDT Review
Medicine Division	3	4	5
Surgery Division	2	3	2
Clinical Services Division	1	3	0

The learning responses have been positively received throughout the Trust, with increased awareness and knowledge of the purpose of them, focusing on learning, improvement and Just Culture; which continues to grow the more that staff are invited to be involved.

#### 4. Severity of Incidents

No harm/low harm continues to be the main category reported within the incident reporting systems. A breakdown of incidents by severity are presented below.

	No/low harm	Moderate (short term harm)	Severe (permanent or long-term harm)	Fatal
Q1 2023/24	515	21	4	2
Q2 2023/24	413	9	3	0
Q3 2023/24	484	22	2	1
Q4 2023/24	523	35	4	3

The detail for the Fatal incidents are set out below.

<b>Q3</b>	2 iatrogenic injuries secondary to overall poor vascular status
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	<ul style="list-style-type: none"> <li>- Post angiogram femoral artery angioseal failure = emergency vascular repair required</li> <li>- RIJ CVC access for emergency surgery resulted in catastrophic injury to the SVC and subclavian vessels</li> </ul>
<b>Q4</b>	<p>Patient had coronary artery dissection during complex, high risk PCI. Treated with stents but patient subsequently had asystolic arrest on the ward in the evening and died. Discussed in detail in PCI meeting. It was agreed that unfortunately following IVL balloon rupture in a calcified vessel, there was extensive coronary artery dissection leading to death. Procedure was performed as per standard practice and it was recognised that this rare catastrophic event is usually fatal despite any corrective measures (stenting).</p> <p>Patient suffered a PEA arrest after routine removal of pacing wires. CALS on ward, chest reopened &lt;10min. Avulsion injury to vein with flaccid empty heart (i.e. hypovolaemia from massive blood loss). Resumption of spontaneous output with resuscitation. Transfer to theatre for emergency surgery. Sadly had already suffered a hypoxic brain injury despite prompt resuscitation (with carotid pulse palpable during the event).</p> <p>Blood culture taken 04/03/2024 has grown E.coli. Result only available after patient died. Patient was treated for sepsis and transferred to critical care. This incident is still under investigation.</p>

## 5. Patient Safety Incident Investigations (PSII's)

The organisation transitioned to PSIRF in October 2023. One incident has been reported as a Patient Safety Incident Investigation (PSII).

<b>Q3</b>	Transferred to PSIRF in October 2023 and no PSII's reported
<b>Q4</b>	<b>1 PSII reported in March 2024</b> – Failure to send in region of 23,000 letters to GP's and others following the implementation of EPRO. Investigation underway.

A separate PSII report is provided to the Board.

## 6. RIDDOR Reportable Incidents

There have been 5 RIDDOR's reported in 2023/24 (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995)

<b>Q1</b>	<b>Q2</b>	<b>Q3</b>	<b>Q4</b>
No RIDDOR	1 Manual handling	1 Staff fall	1 staff fall 1 manual handling 1 needlestick

The number of RIDDOR incidents remains consistently low throughout the Trust. All have been investigated fully at a local departmental level and no themes have arisen.

## 7. Complaints

Complaints and concerns are managed in line with Department of Health guidance, which

advises 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, detailing the numbers of concerns and complaints received, and the key issues and action taken. Any action plans and learning from complaints are presented by the relevant lead at the relevant Governance Committees.

#### **Formal Complaint Themes for Q3 and 4**

Division	Q3	Q3 23/24 Total= 11	Q4	Q4 23/24 Total = 6
<b>Surgery</b>	<b>5</b>	Clinical care and treatment: 2 Discharge and follow up: 3 Diagnosis: 2 Cancellations/waiting times for cardiac surgery: 3 Waiting times for diagnostic tests: 1	<b>3</b>	Clinical care and treatment: 2 Cancelled Surgery/rescheduled: 2 Diagnosis: 2
<b>Medicine</b>	<b>5*</b>		<b>3</b>	
<b>Clinical Services</b>	<b>1*</b>		<b>0</b>	
<b>Corporate</b>	<b>0</b>		<b>0</b>	

At the end of year 2023/24 we had received 40 formal complaints which was an increase to the previous year. In the first 2 quarters of 23/24 we have received 23 formal complaints. The early intervention from all the divisions is key to acting quickly and resolving concerns before they progress to a formal complaint.

Complainants are contacted at the earliest opportunity to resolve their concerns as soon as possible.

#### **Learning from complaints**

All complaints are discussed in the respective governance committees and any action plans are taken through them.

During Q3 and Q4 there are 8 complaints that were not upheld and 6 partly upheld, 2 still under investigation but within the timeframe and 1 on hold due to the patient having an operation and requiring consent - all actions were taken forward by the divisions.

Summary of learning:

- Discharge and after care advice and support for patients - British heart foundation advice line given to patients.
- Cancelled surgery /rescheduled many times and the impact this is having on patients and their families.

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

### **8. Patient and Family support contacts**

There were 253 contacts in Q3 and Q4 of 2023/24, 135 of which were informal concerns, 118 contacts for advice/information.

Top themes include:

- Waiting times for cardiac surgery- previous multiple cancellations impacting patients- including cardiac surgery and lung cancer surgery.
- Follow up cardiac surgery appointments changed several times over 12 weeks.
- Communication of the cancellations/rescheduled dates- trying to receive updates.

- Administration issues- unable to get through to the access/ bookings teams and secretarial teams, not receiving calls back, messages not actioned

#### Summary of Learning:

- Quick escalation of any themes on a weekly basis at senior nurse meetings and to departments.
- Escalation of concerns around cardiac surgery relayed to certain surgical management to be able to address in a timely manner.
- Administration- issues highlighted to the division leads.
- Divisions are aware of the pathways for patients and trying to plan surgery around strike actions and reduce rescheduling of patients.

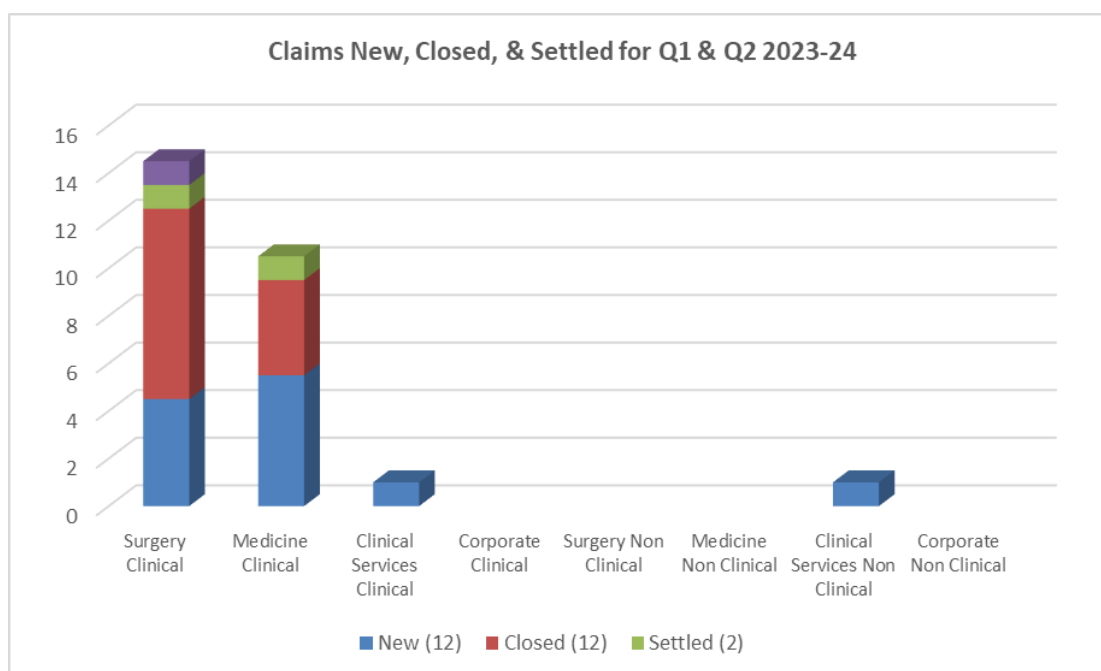
### 9. Claims and Coroners Update

New Requests	Inquests Concluded (see below)	Inquests Scheduled
6	3	3

Inquests concluded					
Trust ref	Date of Inquest	Clinician(s) attended	Cause of death	Conclusion	Concerns/ Actions
880001 (JT)	09/05/2023	Mr Mediratta	1a) Myocardial Failure 1b) Aortic Valve Stenosis (Operated) 1c) Aortic Valve Disease (Operated) 2) Renal Failure	<b>Narrative Conclusion:</b> <i>On the 1st December 2021, JT died of heart failure at the conclusion of surgery to replace a severely stenosed bio-prosthetic valve which had originally been implanted in 2016.</i>	None
976915 (JEJ)	12/06/2023	Mr Kuduvalli	1a) Multi organ failure 1b) Renal and bowel ischemia 1c) Aortic dissection 2) Left ventricular hypertrophy	<b>Natural Causes</b>	None
Cor23/ Misc/ Gr	01/08/2023	Dr Palmer	1a) Myocardial Infarction 1b) Pulmonary Oedema 1c) Severe Coronary Artery Disease 2) Idiopathic Pulmonary Fibrosis	<b>Narrative Conclusion:</b> <i>Consequence of a combination of naturally occurring disease and a recognised complication following a necessary attempted angioplasty procedure.</i>	No concerns. Not an LHCH patient. NP assisted on a procedure at another trust.

There were no concerns/ actions from the closed coroners inquests.

#### Claims Data for Quarters 1 & 2 2023-24 (this reporting period)



No of Claims	Management Status	Potential Claims Letter Before Action or requests for records currently being managed in house	Potential Claims with known Risk Pre-action stage claims managed by NHSR/ Panel solicitors due to existing incident, inquest, or other litigation risk	Letter of Claim/Particulars of Claim Received Active claims being managed by NHSR or Panel solicitors
Clinical Existing (59)		45	3	11
Clinical New (12)		10	2	0
Non-Clinical Existing (3)		0	0	3
Non-Clinical New (1)		0	0	1

When reviewing the individual claims for this reporting period no recurring themes were identified, as the circumstances within each case are different, with different operators and incident dates.

No themes were highlighted within the Letters Before Action or the Claims received.

With the focus on learning and improvement under PSIRF, from a litigation perspective claims and coroners' updates and key learning opportunities will be shared through Trust solicitor and Litigation Administrator updates at the joint Medical and Surgical Audit Days. Any immediate learning will be taken at the time of claim, and shared accordingly. This is also aligns with GIRFT Litigation best practice.

The NHS resolution scorecard is provided in **Appendix D**.

## 9. Freedom to Speak Up

Freedom to Speak Up (FTSU) continues to be integrated at Liverpool Heart and Chest Hospital, alongside the Trusts other forms of Speak out Safely channels. The FTSU network comprises of:

- FTSU Executive Lead
- FTSU Non-Executive Director
- Two FTSU Guardians



- Deputy FTSU Guardian
- 20 multi-disciplinary champions

### **Themes of concerns raised –2023/24**

In 2023/24 there have been 27 concerns raised. All concerns were escalated, addressed and followed-up appropriately as per the FTSU policy. Themes of concerns raised are documented in the table below.

#### **Comparative view of concerns raised in Quarters 1 and 2 of 2023/24 compared with 3 and 4 2023/24**

<b>Themes of concerns as categorised by the NGO</b>	<b>Q1 2023/24</b>	<b>Q2 2023/24</b>	<b>Q3 2023/24</b>	<b>Q4 2023/24</b>	<b>Total</b>
Element of Patient Safety or Quality	3	2	2	0	7
Element of Worker safety, policy or Wellbeing	8	0	3	1	12
Element of Bullying or Harassment	0	2	2	2	6
Number of cases where disadvantageous or demeaning treatment (detriment) from speaking up is indicated	0	0	0	0	0
Other: e.g. Poor communication, health and wellbeing	0	1	1	0	2
<b>Total</b>	<b>11</b>	<b>5</b>	<b>8</b>	<b>3</b>	<b>27</b>
<b>Number of cases raised anonymously</b>	<b>2</b>	<b>0</b>	<b>1</b>	<b>1</b>	<b>4</b>

Overall, the issues coming through the FTSU Guardians relate to systems and processes, health-and-wellbeing, working practices and staff values and behaviors.

## **10. Organisational Learning**

The Trust has an approved Organisational Learning Policy, which sets out the structure by which the organisation identifies and applies learning. The Trust has also developed an organisational learning database which has been rolled out to Divisions and continues to be developed for wider roll out.

To increase the spread of learning, there is now an organisational learning section on the monthly team brief. Team brief is open to all members of staff. Topics covered include incident reporting and coroners application of regulation 28 (preventing future deaths), management of stroke, learning from serious incident (root cause analysis concerning retained secretions), what a mental health section means and communication between teams regarding a patient who underwent an amputation following thoracic surgery.

The Learning and Sharing session, which is chaired by the Director of Nursing, Quality and Safety takes place bi-monthly. The group's remit has now expanded to include learning from each of the Divisions and discussions on human factors elements of learning.

Through the introduction of PSIRF, there has been a weekly patient safety learning meeting set up in October 2023. This will support cross divisional learning, where departmental leads and matrons will present moderate harm or above incidents as well as any severity of incident, but with good examples of learning that will benefit others. PSIRF has taught us that any severity of incident or concern that arises may have a great deal of learning, that may be pivotal in the

prevention of a more serious incident in the future. A forum such as this will also support the open incident reporting culture and encourage team leaders to exercise the new tools and templates in relation to incidents, promoting the no blame Just Culture throughout the Trust.

A network of Patient Safety Champions has been set up throughout the Trust, these individuals have a keen interest in patient safety, and attend quarterly champion meetings where key learning can be shared and taken back to their respective areas to disseminate. To date we have approximately 25 champions from a variety of departments. It is a safe and open forum for people to air patient safety concerns themselves or their colleagues have, seek guidance from their peers, share ideas, and utilise the network along with the leads to advocate for patient safety.

Our quarterly Safety Surveillance Meeting triangulates themes from incidents, claims, complaints and safety huddle to help focus on specific areas which require learning dissemination.

There is also a weekly Patient Safety Learning screensaver, where learning from incidents is captured and circulated Trust wide. This has shown to be very effective and has provided another way of teams to bring learning they wish to disseminate wider. Staff from areas are beginning to utilise this method and approach the Patient Safety Lead Nurse with examples they wish to share. The screensavers are shared every Friday within the Trust Safety Huddle, emailed Trust wide for team dissemination.

The Organisational Learning Sharepoint, holds a variety of shared learning information, with the Learning from Mortalities section initially available, including Mortality Review Group summaries and Audit Day presentations.

The Trust's Organisation Learning Database now has a patient safety section, where we have begun to upload relevant documents. We are also now as a Trust beginning to recognise and understand the importance of sharing learning, especially quick learning, and to the most suitable forum. Staff from various disciplines are also beginning to utilise these forums and the work the Patient Safety and Emergency Planning Lead Nurse is doing, by requesting to engage in not only the SEIPS methodology, but the ways in which we are now sharing learning Trust wide.

Through the Cheshire and Merseyside ICB PSIRF network, a monthly meeting has now been set up, which enables us as a region to share learning more easily, and just as PSIRF encourages, this is a very welcome and safe forum for all Trusts to discuss, learn and then be able to disseminate within their Trust. At LHCH we were the first Trust to be invited to share our learning from recent incidents, this allowed us to showcase our journey since implementing PSIRF, our engagement with staff and the changes we have been able to make in such a short space of time.

## **11. Patient Experience (Q3 and Q4 2023/4)**

### **NHS Adult Inpatient Survey 2023**

Once again LHCH has been rated one of the best hospitals in the country to receive care in this year's NHS Adult Inpatient Survey. The results showed LHCH was rated one of the top two trusts in the country for 'overall patient experience, and best in the Northwest once again, this is according to the Care Quality Commission's 2021 National Inpatient Survey (published on

29<sup>th</sup> September 2022), which reviewed the experiences of patients from 134 NHS trusts who spent at least one night in hospital during November 2021.

Our Patient and Family Centred Model of Care sets out expectations for patients and families at each step of their journey, commencing prior to admission and until after discharge, every decision made is based on what is best for patients and their families.

### **Follow Up calls**

The Trust uses many ways of capturing patient experience, one of which is to contact patients who have had an overnight stay following their discharge home.

**Q3 results** – Of the patients who responded to the Follow Up calls-

- 100% said they felt involved in decision making about their care and treatment.
- 100% said they felt included in their care.
- 100% said they received written information on what they should/should not do after leaving hospital.
- 100% said we kept their belongings safe.
- 100% said all staff were polite and friendly.
- 99% said they did not experience any discharge delays.
- 99% were happy with the hospital facilities and cleanliness.
- 99% were happy with signage.
- 98% were happy with the standard and quantity of the food and drinks they received.

In **Quarter 4** the Follow Up call questions were changed and of the patients who responded -

- 99% rated their experience as very good (91%) and good (8%).
- 99% said that they were offered regular drinks and snacks throughout their stay.
- 98% said that before they left hospital they were given written information about what to do/not to do post discharge.
- 98% said there were varied choices of snacks and drinks offered.
- 94% said that they did not experience any unnecessary delays in being discharged home.

Areas identified for improvement are -

- Helping patients to understand how they are asked their views on the quality of care they have received as an in-patient, (patient satisfaction was 73.5%).
- Provision of bedside televisions.
- Car parking costs and hospital signage.
- Ensure patient contact numbers are accurate and recorded in EPR
- To reduce noise particularly during the night from machinery, phones bleeps and monitors

Themes from the calls have provided action plans for improvement, led by each Division. Any areas for concern are raised with the departmental managers who receive feedback from the calls on a weekly basis. This can assist in reducing complaints and local resolution as issues are dealt with immediately by the ward manager/matron.

The calls have improved patient safety and reduced complaints. Some examples of how the calls have made a difference have been highlighted when specific concerns have been escalated to ward staff, ANP's or doctors which can help to improve patient safety and experience.

Examples of interventions during the Follow up calls to improve patient safety and experience are -

- Advising patients when they need to contact their GP, ring 999 or attend A&E, e.g. when experiencing chest pain, potential infections.
- Providing advice and liaising with Tissue Viability team regarding wound care.
- Ensuring patients have access to their medication and dealing with issues when GP summaries have not been received by the patient's GP.
- Clarifying accuracy of information such as incorrect contact details.
- Ensuring patients have their follow up appointments and escalating if there are concerns.
- Liaising with trust staff to provide medical and care advice.
- Ensuring concerns are escalated if patients need advice regarding equipment, e.g. advice regarding their pacemaker.
- Escalating concerns or complaints
- Providing post care information, e.g. district nurse visits and emotional support.

Information gathered has indicated that the vast majority patients are extremely happy with the care they received. The response to the calls has been overwhelmingly positive and patients have expressed their gratitude for the call. Key themes for compliments have been that patients have received a high standard of safe care, delivered by a kind, caring and responsive team.

### **Patient Engagement events**

The most recent Patient Engagement event was held September 2023 which engaged with patients, families, staff, volunteers, Health Watch and governors. The patient and family feedback was overwhelmingly positive.

Themes for improvement included -

- The need for post discharge psychological support, especially for patients who live alone.
- Psychological support for patients following a traumatic event, such as a cardiac arrest in the community and also for their family who witnessed the arrest via a 24-hour dedicated help line.

In February 2024 a further patient engagement event was held at which the patients and their families selected which quality priorities they felt should be achieved during 2024/25.

The four selected were-

- 1. Improved pathway of care for OOHCA patients & families*
- 2. Improve outcomes for cardiac & thoracic surgery patients by providing pre-habilitation during wait for surgery.*
- 3. To improve contact with elective cardiac surgical patients between referral & admission*
- 4. To improve Patient Flow and discharge experience.*

## **Patient Shadows**

Shadowing is an observation technique that provides an opportunity for a third party to experience and record what happens during interactions along a patient's pathway, including how it looks and feels to the patient. Its aim is to see the care experience through the patient's eyes and forms part of the Patient and Family Centred Care approach.

Patient and Family Shadowing involves a committed, empathic observer to follow a care episode as seen 'through the eyes of the patient' to understand the patient experience and drive improvement work.

Throughout 2023/4, 42 patient shadows have been achieved against a target of 72. Due to ward acuity and staffing levels, it can be difficult at times to release staff to shadow a patient on their journey with us.

Patient shadowing has been overwhelmingly positive with praise for the teams in their communication, information sharing, teamwork, compassion, professionalism and ensuring that the patient's privacy and dignity is maintained. None of the shadows recorded any HALTS or concerns for patient or staff safety.

We are continuing to encourage shadowing for 2024/5 and hoping to increase the number of shadows undertaken. Patient shadowing aids staff in their professional development as they gain a greater understanding of not only the patient journey, but the role of their colleagues across other departments and as such have found it a rewarding experience.

All comments raised are shared with the team to ensure we learn from every patient experience.

## **12. Conclusion**

Incident reporting, learning from incidents, complaints and claims remain a focus for the Trust. Incident reporting remains relatively consistent and continues to be emphasised in team brief, at safety huddle and in the Divisional Governance Committees. Training for incident reporting continues across all areas.

Receipt of formal complaints and claims has remained consistent, when compared to the previous quarters.

The Trust has a strong learning culture. Monthly learning and sharing meetings take place and the organisational learning session has been incorporated into the monthly team brief. All staff are invited to present learning from incidents complaints, claims and patient experience events.

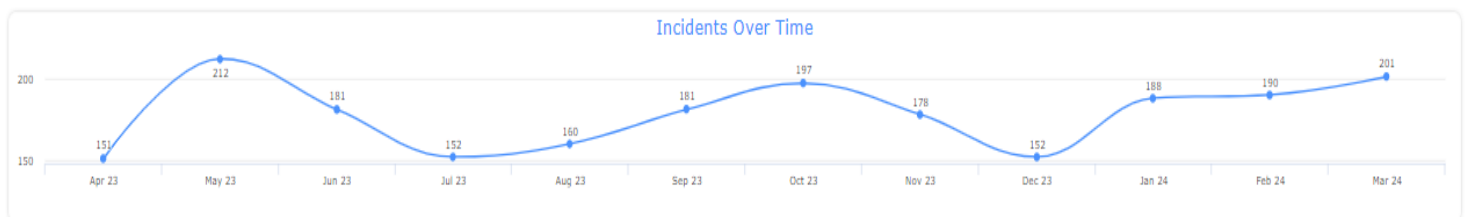
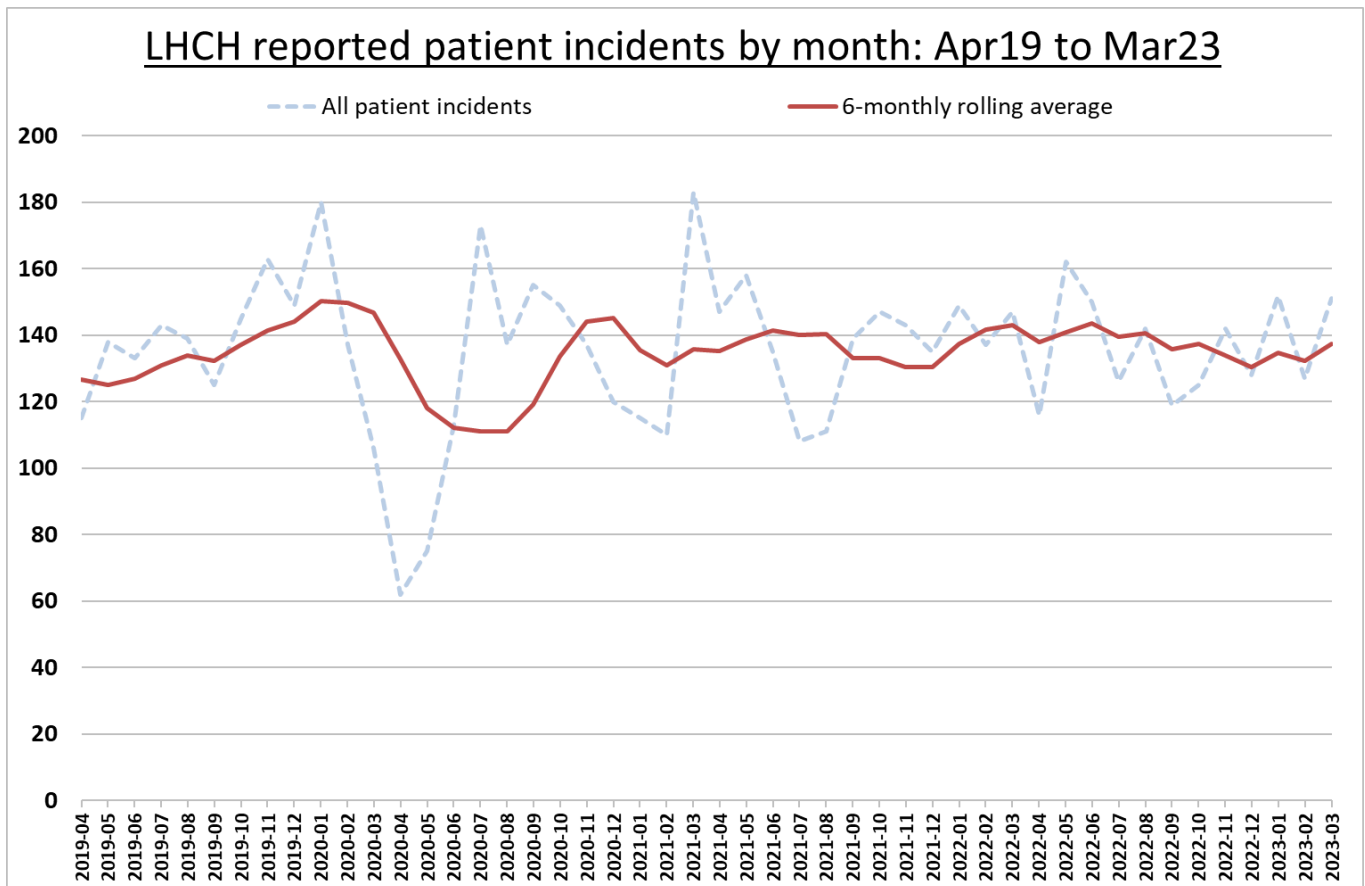
As PSIRF becomes embedded within LHCH, shared learning will increase further, with learning and improvement at the forefront of investigating incidents, complaints, and litigation.

## **13. Recommendations**

The Board of Directors is 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 through the governance structures within the organisation.

## Appendix A – Incident Reporting Levels

The graphs below show the rolling average since April 2019, along with the continued monthly average using InPhase data (April 2023 - March 2024). Since the beginning of 2024, incident reporting numbers have remained at a consistent high level, highlighting a positive reporting culture, which is supported by the Patient Safety Incident Response Framework becoming well embedded.



## Appendix B – Learning and actions from Top 5 reported Incidents

The learning and actions from incidents are provided below.

Theme	Summary of learning and actions
<b>Administration</b>	<p>The following actions are being undertaken to support process improvement and incident reduction:</p> <p>Clinician Engagement</p> <ul style="list-style-type: none"> <li>• Support &amp; ownership for the safer waiting list work</li> <li>• Minimum Referral Data Set to be agreed for all service lines</li> <li>• Service Line leads need to agree escalations and triggers for pathway management</li> </ul> <p>Referral Management</p> <ul style="list-style-type: none"> <li>• System interface leads to be confirmed from other Providers</li> <li>• Agree correspondence to empower patients when outstanding information is required from other providers</li> </ul> <p>Sustainability</p> <ul style="list-style-type: none"> <li>• Support a priority investment decision to Admin through annual planning-</li> <li>• Commitment to a Single PTL (patient tracking list) and a move to standardising processes within the Trust</li> <li>• Agree to the proposed Governance Structure</li> </ul> <p>Oversight</p> <ul style="list-style-type: none"> <li>• Digital Excellence Strategy – supporting process automation (robotic process automation, Patient Portal, Digital Communications, innovation, and technology for administrative processes to reduce human error</li> <li>• Validation of data quality reports, outpatient waiting list and follow up outpatient waiting list processes</li> <li>• Weekly performance operational meetings between admin and divisional leads, supporting closer working and a more aligned approach with clinical divisions</li> </ul>
<b>Medications</b>	<ul style="list-style-type: none"> <li>• On induction, prescribers receive a presentation on medications management from pharmacy, which includes highlighting key prescribing areas to ensure patient safety. Prescribers are also given direction to key prescribing policies that also include high risk drugs e.g., insulin, intravenous antibiotics, and anticoagulation. Prescribers also work through an electronic prescribing and medicine administration workbook and are assessed on completion. They also access a pharmacy session at medical teaching to go through key medicines management issues, and sharing from incidents including trends are shared with prescribers during these sessions, and feedback obtained to make improvements in process and the EPR system.</li> <li>• A medications management training suite has been developed, in conjunction with learning and development, which is available on ESR for nurses. This now forms part of mandatory training for all nurses. This includes a range of training such as policy reading, 1:1 assessment on administration, videos, and a drug calculation test. Newly qualified and overseas nurses also attend preceptorship medicines management training lead by the pharmacy education lead, with medicines safety aspects such as never events and incident trends forming part of the workshop.</li> <li>• A safe medication MDT meets weekly where incident handlers, present medication incidents for discussion and review learning. The meeting quality assesses each incident, to ensure correct classification and scoring of harm/potential risk. Any actions required or lessons learned are discussed and escalated as required. The incidents are often finally approved, which then auto populate the medication incidents dashboard.</li> <li>• The medication dashboard is used to generate a monthly medication incident report, which is then presented at the Safe Medication Practice Committee (SMPC) and the monthly divisional governance meetings. This report focuses on incident causes harm and moderate or high potential risk, as well as reviewing all incidents involving high risk medications. It monitors for trends</li> </ul>

Theme	Summary of learning and actions
	<p>and themes of errors, and documents actions taken, lessons learned and how this has been shared across the Trust.</p> <ul style="list-style-type: none"> <li>• The SMPC meet monthly to review and discuss the monthly report and any incidents trends raised at the MDT. Any medicines related patient safety alerts, e.g. from the MHRA are also discussed and actions agreed during these meetings.</li> <li>• A QSEC medication incident dashboard summarises incidents year to date, focusing on incident trends, pharmacy near miss data, and KBMA closed loop compliance. Actions and lessons learned are also summarised. This is presented to QSEC each quarter.</li> <li>• Key medication safety themes are communicated to the Trust via the monthly safe medication bulletin and ad hoc corporate communications as required. These themes and noteworthy incidents are also cascaded through prescriber teaching sessions, ward safety huddles, pharmacy meetings and are emailed directly to the relevant teams as needed.</li> <li>• The medicines safety strategy also forms part of the Trusts Quality and Safety strategy.</li> <li>• Swarm huddles are now used as a tool to support review of significant medication incidents to identify learning as per the patient safety incident response framework (PSIRF).</li> <li>•</li> </ul>
<b>Communication</b>	<p>Many of these incidents appear to be during handover between teams, both verbally and written i.e. bed numbers/patient names, bedside handovers, the use of "SBAR" to structure the handover. It is encouraging to see these incidents are reported, even though corrective action is taken at the time using PSIRF methodology we used an MDT review approach to look at themes and to create a safe forum for discussion for improvement.</p>
<b>Documentation</b>	<p>A theme of incorrect patient records being stored within their electronic patient record due to mislabelling of ID, or where the checking process of patient ID has not been sufficiently carried out. Many of these incidents were near misses and the error was highlighted promptly to prevent any further risk to the patient. Even as near misses, it is positive to see these incidents reported. Themes are discussed at the Weekly Patient Safety Learning meeting (PSLM), where a learning response maybe recommended to understand the cluster i.e. a swarm with varied.</p> <p>A Swarm Huddle with staff from all areas was held when a theme arose of the new Blood 360 system not being utilised, and near miss or low harm incidents were occurring when taking blood samples from patients. This allowed the staff to air concerns or ideas to improve the compliancy; one example of an action that came from this were equipment availability or connection issues preventing staff usage. These were feedback to the EPR Team afterwards and compliancy has since improved.</p>
<b>Patient slips, trips and falls</b>	<p>The Falls Steering group meets monthly, a 72 hr review of all falls are completed and any learnings are discussed and shared at this group. The group has been strengthened by the addition of a Pharmacist and members of the Quality Improvement team. The falls lead is part of a North West Falls Forum that meets up bimonthly to share ideas/ innovations and bench mark.</p> <p>Falls prevention products are in place Trust wide including the Karebag and Karekit. Ramblegard Bond system was installed on Cedar, Birch ward and ACU in July 23. Existing Ramblegard equipment will be shared between all other inpatient wards. This will enable all inpatient wards to have access to falls prevention equipment.</p> <p>Patients and families are encouraged to get involved in falls prevention, by including them in any post falls debriefs, avoiding medications for insomnia and</p>



Theme	Summary of learning and actions
	<p>ensuring patients use the call bells. Decluttering of the patients bedspace is encouraged to reduce trip hazards and keeping items in reach.</p> <p>There has been targeted Falls training for the staff on the surgical wards and the Falls Lead teaches on Preceptorship, Care Certificate, Safe From Harm module, HCA Pathway and also Volunteer induction.</p> <p>There has been a decrease in falls where new delirium has been a causative or contributory factor. The Falls lead is part of the Delirium Steering group, the enhanced observational care policy has been updated and Activity/distraction and reminiscence work is being encouraged on the wards. A new Delirium assessment tool has been trialled on Cedar ward and has be rolled out Trust wide.</p> <p>Further plans for 23/24 include amending EPR documents in line with new National Audit of Inpatient Falls PSIRF guidance, amending the bed rails assessment and focusing on prescribing of medications for insomnia . Vision Assessments have been introduced on admission for all patients at risk of falls and work is planned to improve the recording of Lying and Standing Blood Pressures and increasing education on postural hypotension.</p>

## Appendix C – Examples of learning from swarm discussions

Some examples of quick informative 30-45 min swarm discussions, are shown below:

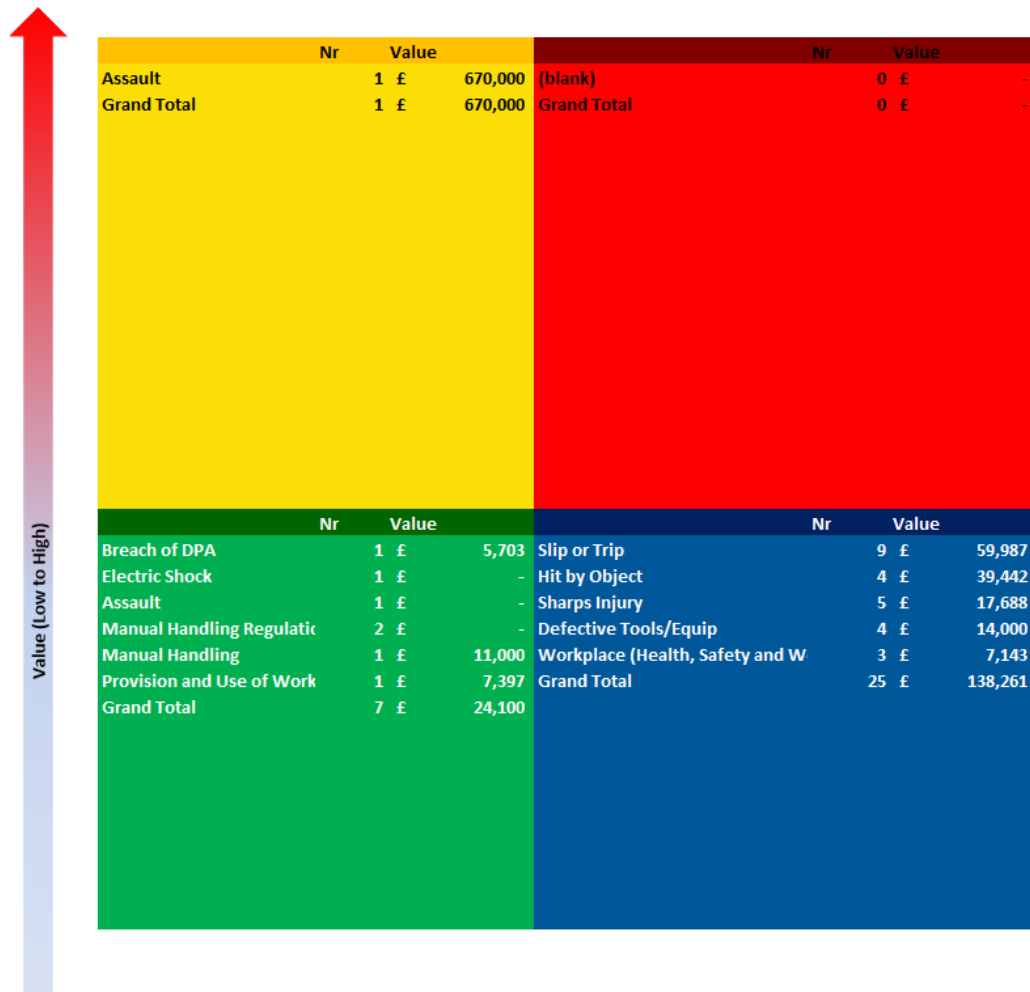
<u>AREA</u>	<u>INCIDENT DESCRIPTION</u>	<u>Learning and Improvements</u>
<p>Maple Suite</p> <p>Pharmacy were encouraged to be included and engaged in this swarm also.</p> <p>Attendees included: Ward Manager, staff nurses, Pharmacist</p>	<p>Patient had INR booked at the GP following discharge from the ward, carried out by discharging RN.</p> <p>GP could not facilitate INR test.</p> <p>Also informed that the patient had been self-administering incorrect dose of warfarin (9mg instead of prescribed 5mg).</p>	<ul style="list-style-type: none"> <li>Policy was not user friendly, and although recently reviewed information was not up to date</li> <li>EPR being reviewed, to be made user friendly for anti-coagulation on discharge</li> <li>Easy-to-read flowsheet guide for staff to be created and put into policy and clinical areas</li> <li>Pharmacy had been dispensing unnecessary additional amounts of tablets (new starter into the Trust): <ul style="list-style-type: none"> <li>Review the process for introducing new starters to the Trust</li> <li>This had been noticed as not part of usual practice by several senior technicians, however staff in pharmacy did not raise concerns – safe culture to be promoted.</li> <li>Yellow book for patient to take home was not filled out, pharmacy were not sure who's responsibility it was to do so, even though this is in the policy.</li> </ul> </li> </ul>

<u>AREA</u>	<u>INCIDENT DESCRIPTION</u>	<u>Learning and Improvements</u>
<p>Theatres</p> <p>Attendees included: Theatre Matron, Manager, OPD, 2 x Scrub Nurse and Surgeon</p>	<p>Wrong valve sizer opened and given to Surgeon for valve operation.</p>	<ul style="list-style-type: none"> <li>Reviewing stock items that we no longer use within LHCH</li> <li>Staff feeling pressured to gather equipment the morning of. Theatre team looking at ways to prepare the evening before where possible. Trialling one surgeon to include valve to be used within the Operating List.</li> <li>Equipment not easily distinguishable, located closely to very similar items, and it was discovered during the swarm, that the equipment does not correspond to the stock sheet devised to help staff.</li> <li>The valve sizer is now also a mandatory requirement to be checked by the Surgeon, as well as the valve itself. EPR has been changed.</li> </ul>

<b><u>AREA</u></b>	<b><u>INCIDENT DESCRIPTION</u></b>	<b><u>Learning and Improvements</u></b>
<p>Holly Suite/Radiology</p> <p>Attendees included: Holly Suite, Radiology and Cath Lab staff</p>	<p>Patient developed pneumothorax post CT Guided biopsy. Miscommunication between ward area and radiology</p>	<ul style="list-style-type: none"> <li>• Chest drain kit to be installed in Radiology &amp; audit daily checks</li> <li>• Radiology staff to use EPR for documentation</li> <li>• Staff across the Trust to feel confident raising concerns and seeking MET call assistance</li> <li>• Porters lunch breaks to be reviewed to ensure transferring of patients is not impacted</li> <li>• MET/medical team to ensure documentation is appropriately completed &amp; insertion documents.</li> <li>• Communication via radiology &amp; wards are strengthened &amp; link together regarding expectation of patient transfers.</li> <li>• Time critical element to be reviewed in order to achieve 1hr post CXR.</li> </ul>

The purpose of the score card is to allow Trusts to view both clinical and non-clinical claims by type and cost and, specifically for clinical claims, to review the associated specialty/cause. NHSR know from feedback that the scorecard has been a valuable improvement tool to enable trusts to understand their claims profile, the associated cost of claims and to assist with prioritising safety improvement initiatives. The scorecards contain ten years' worth of claims data which accurately captures claims that have a long incident-to-resolution timescale.

Data correct at: 30/06/2023												
Volume (Low to High)												
Value (Low to High)	Nr			Value			Nr			Value		
	Cardio Surgery	2	£	2,702,000	(blank)	0	£	-				
	Cardiology	1	£	1,725,000	Grand Total	0	£	-				
	Grand Total	3	£	4,427,000								
	Nr			Value			Nr			Value		
	Radiology	2	£	185,455	Cardio Surgery	40	£	2,399,073				
	Grand Total	2	£	185,455	Cardiology	23	£	986,717				
					Respiratory Medicine/ Thoracic M	4	£	90,867				
					Grand Total	67	£	3,476,658				



### Key:

#### Scorecard Explained

**High Value= £1m and over, Low Volume < 3 claims**

These are high value, low volume claims where learning on an individual basis could be undertaken.

**Low Value < £1m, Low Volume < 3**

These are low value, low volume claims and you may wish to keep a watching brief on these claims.

**High Value = £1m and over, High Volume = 3 claims and over**

These are high value, high volume claims. We suggest that this area is a priority area of focus. Not all trusts will have claims in this area and will therefore move their focus to the amber and blue quadrants

**Low Value < £1m, High Volume = 3 claims and over**

These are low value, high volume claims grouped by specialty. You may consider reviewing any themes that arise.

Volume (Low to high)