

Board of Directors (in Public)

Item 6.1.4c

Subject: Integrated Incidents, Complaints and Claims (IICC) Report – Q1/Q2 2024/25
Date of Meeting: 28th January 2025
Written by: Ria Carter, Patient Safety Lead Nurse
Presented by: Ben Vinter, Director of Risk and Corporate Governance
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					
<input checked="" type="checkbox"/>	Acceptable assurance Controls are suitably designed, with evidence of them being consistently applied and effective in practice	<input type="checkbox"/>	Partial assurance Controls are still maturing – evidence shows that further action is required to improve their effectiveness	<input type="checkbox"/>	Low assurance 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 1 and 2 2024/25, compared with Q3/Q4 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, health and safety, medical devices, and communication.
- Swarm discussions, rapid review and MDT reviews continue to be undertaken with a focus on learning, improvement and just culture.
- There was 1 incident classified as fatal harm, which is being investigated as a Patient Safety Incident Investigation (PSII) in Q2.
- There were 3 RIDDOR (reporting of Incidents, Diseases and Dangerous Occurrences Regulations) reportable incidents in Q1 and Q2.

- The number of complaints remains low, compared 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 Q1 and Q2, and any lessons learnt have been shared accordingly.
- 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).
- Follow up calls continue to be made to all patients who had an overnight stay in the Trust and these provided positive feedback across a range of indicators.
- Patient engagement events have been held and further planned for 2024/25.
- We have created a “Good Care” reporting option within InPhase, for staff to report incidences of good care, as well as positive outcomes and interactions with colleagues.

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 Quality, Safety and Experience Committee six monthly providing concurrent information pertaining to incidents, complaints, and claims, reported within the organisation.

Using PSIRF to ensure learning and improvement is at the forefront when reviewing patient safety incidents, it also allows a more collective approach, promoting safety culture and a recognition of trends and themes, not just on the basis of harm.

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

Incident reporting remains steady and consistent, with a general overall slight increase in monthly reporting figures. This highlights an positive reporting culture within the Trust, and also the user friendly ability of the new system (Jule '23) InPhase.

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 1060 reported incidents in Q1-Q2 2024/25. The top five reporting themes for the four quarters are shown below:

Theme	Q1	Q2	Q3	Q4	Total	Summary
Administration Processes	104	83			187	This category includes administrative, clinical record keeping, and communication incidents throughout the Trust, including clinical teams.
Medications	55	46			101	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.
Health and Safety	42	45			87	This category includes injuries to staff such as needle stick injuries, staff falls, contact/collision with fixtures, furnishings, equipment and machinery, lifting/manual handling, PPE and temperature/ventilation related incidents.
Medical Devices, Equipment and Supplies	23	48			71	This category includes all records of equipment malfunction/failure, broken furniture, devices and equipment damaged, incorrectly maintained and wrong device/equipment used.
Communication	40	30			70	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.

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

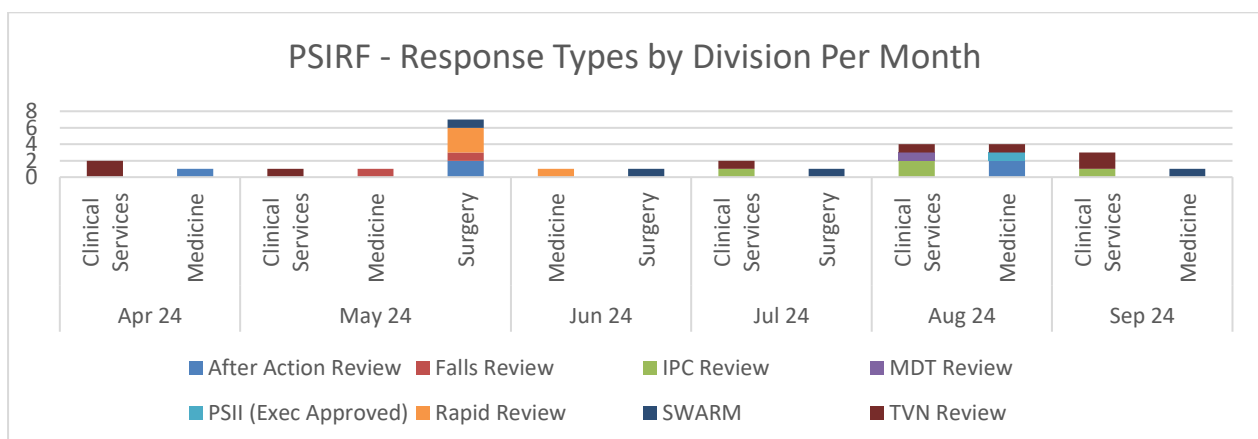
quick actions and longer terms ones also. We have undertaken several since our “go live” date, facilitated by the Patient Safety and Emergency Planning Lead Nurse for the Trust, as we continue to train and support staff to feel confident to undertake them independently in their areas, and disseminate 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. This application within InPhase can be broken down per division also and filtered by date. Work is ongoing to develop this application and function further.

The figures for Q1/Q2 24/25 are shown below:



As the chart above shows, the learning responses continue to be positively and consistently 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. Staff are increasingly becoming confident in facilitating the learning responses, taking the learning, and sharing it wider at a variety of forums.

We have created a “Good Care” reporting option within InPhase, for staff to report incidences of good care, as well as positive outcoms and interactions with colleagues. In Q1 and Q2 there were 40 submission reports, some examples are listed below:

Positive feedback received on relatives comments board from 3 relatives in Critical Care

“Patient attended their Knowsley Community Heart Failure Team appointment. At the end of the assessment, he told me directly and wanted me to extend to the rest of the team that he has found the care to be outstanding. Went on to say that he has more faith in our care than he does from any other health care professional and that he feels listened to and supported.”

Training

To date, LHCH has invested in two of the nationally mandated training providers from NHS England to ensure those with responsibility for responding and supporting patient safety events have adequate skills and knowledge to support those involved. Training and education surrounding PSIRF continues, with AQUA (NHSE accredited) commissioned to deliver Lots a-c on PSIRF standards January – March 2025. We endeavour to train a further 15 staff, in addition to our current figures below:

- Staff trained to undertake PSIRF learning responses (Lot 4a) = 27
- Staff trained to be Engagement Leads for those affected during a patient safety event (Lot 4c) = 23
- Staff trained to support oversight and governance of PSIRF (Lot 4b) = 30

Our divisions will ensure that required Learning Response Leads have completed the required NHSE training and will adhere to the PSIRF Standards. Our mandated NHSE Patient Safety Syllabus modules, Levels 1 and 2 (dependent on Band) continue to maintain at >90% compliant Trust wide. Our updated PSIRF Training Needs Analysis included within Appendix E.

All PSIRF learning responses and PSII's have all been undertaken by staff who have met the relevant training compliancy.

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 2024/25	502	17	3	0
Q2 2024/25	513	22	2	1

5. The detail for the Fatal incident is set out below:

Q2	A surgical patient passed away from a retroperitoneal bleed on Critical Care, after a cardiology procedure. Several areas for learning and improvement during a mortality screen and review were highlighted and the patient's death was agreed to be avoidable (>50%). Patient's INR was 3.6 on the morning of the procedure, however recommended INR documented by the Consultant was <2.0. Potential areas for learning include: management of coagulation, particularly in patients with mechanical valves, missed acknowledgement of the result and diagnosis of the bleeding complication post.
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6. Patient Safety Incident Investigations (PSII's)

One incident has been reported as a Patient Safety Incident Investigation (PSII) for Q1/Q2.

Q1	0 PSII's reported
Q2	1 PSII reported in August 2024 As per description above.

	<p>This is an ongoing current PSII, due to be presented to the Trust Executive Incident Panel for approval on 28th November 2024, following the draft report being circulated for comments. This is a cross-divisional incident which the Medicine Division will lead on and manage any recommendations/actions going forward.</p> <p>Key learning and recommendations:</p> <ul style="list-style-type: none"> • Daily review of coagulation status including INR for all critical care patients • Checklist for patients being transferred from critical care to Cath Lab to include important organ function information • Formalise and standardise cardiology pre procedural checks for GA cases with Femoral Access • Combine sign in and consultant cardiologist brief in one process • Sign out / handover process Cath Lab to Critical Care, include risk assessment for post op haematoma <p>The patient's family were involved in agreeing the Terms of Reference and have been regularly updated throughout. They will also receive a copy of the report (if they wish).</p> <p>To ensure timely shared learning, the incident, findings and recommendations is due to be shared at the Clinical Joint Audit Day to maximise the recipients; conscious that a joint meeting is only bi-annually.</p>
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A separate PSII report is provided to the Board.

7. RIDDOR Reportable Incidents

There have been 3 RIDDOR's reported in Q1 and Q2 2024/25 (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995).

Q1	Q2
1x Dirty Needle Stick Injury	2x Staff Falls

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

8. 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 Q1 and 2

Division	Q1	Q1 24/25 Total= 4	Q2	Q2 24/5 Total = 3
Surgery	3	Clinical care and treatment: 1 Delay in cardiac surgery: 1	2	Clinical care and treatment: 2 Diagnosis: 1
Medicine	2*		1	
Clinical	0		0	

Services		Communication: 1		
Corporate	0	Falls related: 1	0	

We have made a good start to 24/25 with only 7 formal complaints in the first 2 quarters, in comparison to 17 in Q3 and 4 in the year 23/24. This is a collaborative effort from all the divisions in acting quickly and resolving concerns before they progress to a formal complaint. Matrons hold monthly clinics where patients and families can discuss any feedback or concerns they may have.

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 Q1 and Q2 there are 5 complaints that were not upheld and 1 partly upheld, 1 still under investigation due to being multiple trusts involved- all actions were taken forward by the divisions.

Summary of learning:

- Heart failure nurse clinic letters state the consultant's names and give perception the patient will be seen by the consultant. Template letter to be reviewed and changed accordingly.

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

9. Patient and Family support contacts

There were 175 contacts in Q1 and Q2 of 204/25, 133 of which were informal concerns, 42 contacts for advice/information.

Top themes include:

- Waiting times for cardiac surgery- previous multiple cancellations impacting patients physical and mental health.
- Communication of the cancellations/rescheduled dates- trying to receive updates.

Summary of Learning:

- Quick escalation of any themes 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.

10. Claims and Coroners Update

Coroners Update

New Requests	Inquests Scheduled* (see below)	Inquests Concluded* (see below)
16	2	0

Inquests Scheduled							
Trust ref	Date of Inquest	Coroner	Clinician(s) attending	Provisional Cause of death	Details	Concerns/Actions	Panel Instructed?
Cor24/989796-EJ	05/02/2025	Manchester South	Dr Vasileios Papaioannou	1a) Congestive cardiac failure 2) Atherosclerosis, atrial septal defect, mitral valve regurgitation, atrial fibrillation, aortic stenosis	ACHD death	Patient treated at MUH and LHCH. Both trusts are IP's	No

Inquests Concluded				
Trust ref	Date of Inquest	Clinician(s) attended	Conclusion/ Notes	Cause of Death
Cor23/216557-RS	15/05/2024	Mr Khosravi	Narrative Conclusion: <i>RS died on 28/12/2022 at Ysbyty Gwynedd where the time it took for advice sought by YG for specialist intervention from LHCH and for the images and report to be sent electronically with a formal diagnosis meant he did not undergo specialist cardiac surgery which may have optimised his prospects of recovery</i>	1a) Myocardial infarction with mitral valve prolapse
Cor23/226831-EG	24/05/2024	Ms Susannah Love	Narrative Conclusion: <i>Elizabeth Gibson, known as Betty, died as a consequence of intra operative complications that arose during an elective left upper lobectomy for squamous cell carcinoma.</i>	1a) Squamous Carcinoma Left Lung (operated) 2) Mediastinal Sarcoid
Cor24/Griffin	17/09/2024	Omar Nawaytou	Narrative Conclusion	1a) acute thrombotic occlusion of the grafted aortic stent 2) Previous congenital heart disease namely coarctation, the repaired thoracic aortic aneurysm

* Where Trust attendance required

Cor24/EG Lessons Learned
<p>It became clear during pre-inquest discussions that awareness of the urgent OOH node was not as it should be among PACS users. The following plan was put in place:</p> <ul style="list-style-type: none"> Email regarding urgent OOH node to be sent to all PACS users every month for 12 months @David McCreavy @David McCreavy to liaise with the Digital team to expand the current PACS training to include a section covering the use

of the urgent OOH node for all new registrars and consultants from 1st November 2024

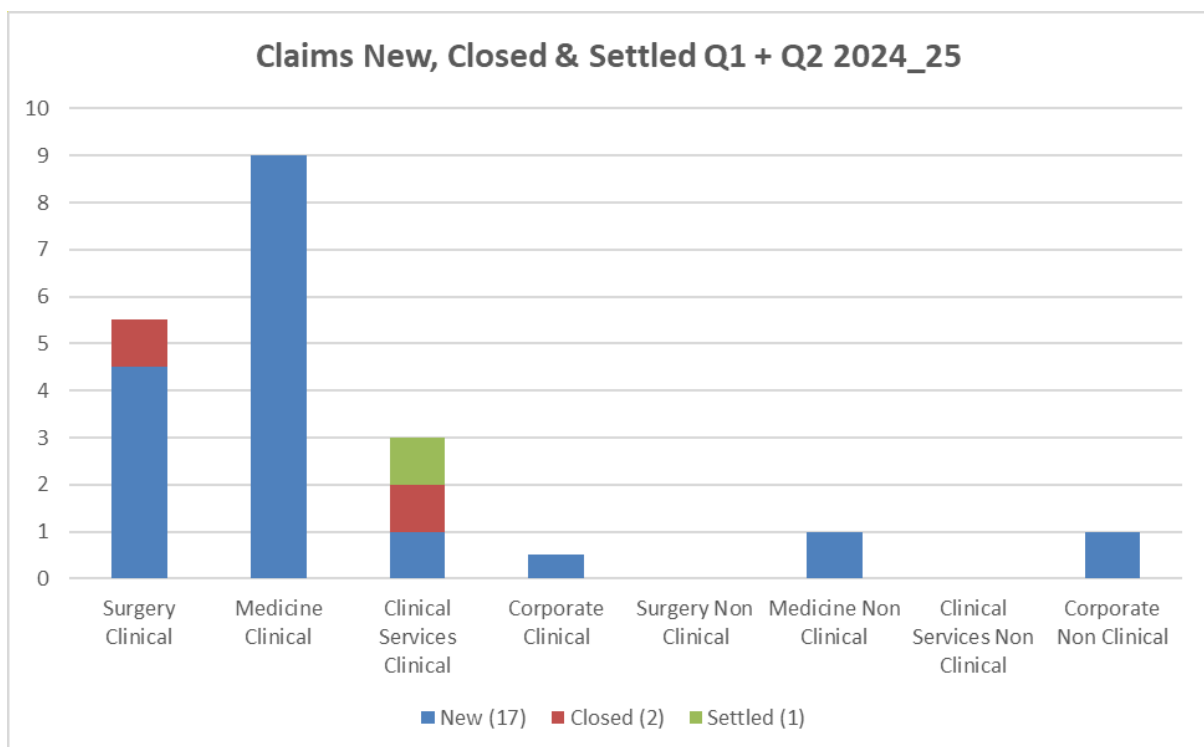
- [@David McCreavy](#) to attend audit day in November to present this information
- Information to be circulated via the Divisional Boards

Please can we ensure that steps are taken to raise awareness of the urgent OOH node, particularly among registrars and consultants, to avoid any future litigation risk.



IMPORTANT PACS
URGENT Out of Hou

Claims Update



No of Claims & Management Status as of 25/11/2024	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 NHR/ Panel solicitors due to existing incident, inquest, or other litigation risk	Letter of Claim/Particulars of Claim Received Active claims being managed by NHR or Panel solicitors
Clinical (86)	61	4	21

Non-Clinical (3)	0	0	3
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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:

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
- 28 multi-disciplinary champions

Themes of concerns raised –2024/25

In Q1&2 2024/25 there have been 7 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.

Themes of concerns as categorised by the NGO	Q2 2024/25	Q1 2024/25	Q4 2023/24	Q3 2023/24	Q2 2023/24
Element of Patient Safety or Quality	0	1	0	2	2
Element of Worker safety, policy or Wellbeing	2	0	1	3	0
Element of Bullying or	2	2	2	2	2

Harassment					
Number of cases where disadvantageous or demeaning treatment (detriment) from speaking up is indicated	0	0	0	0	0
Other:	0	0	0	1	1
Total	4	3	3	8	5
Number of cases raised anonymously	1	1	1	1	0

Q2 has seen a slight increase from Q1 but is at a similar level to Q2 last year. Unfortunately, inappropriate behaviours / bullying continues to be a theme. Below, showcases some of the work our Freedom to Speak Up Guardians do each month, in relation to the themes that emerge.

Meet with HR regularly	Meet with our Staff Side colleagues and will be meeting regularly from now on	Sat on the EDIB steering group and HWB / Culture Strategy Steering Group
Work closely with our EDIB and Wellbeing Officer and staff networks.	contributed to the recent World Café workshops on the subject of a relaunch / update of the Be Civil, Be Kind and It's Not OK campaigns.	Support and advocate for more proactive work within teams.
Continue our awareness raising and visibility around the trust and at Health Innovation North West Coast	In the early stages of setting up a meeting with some of our internationally trained colleagues in conjunction with our EDIB and Wellbeing officer and International Nurse Advocate, with the aim of amplifying voices and so be able to look at ways of addressing possible concerns or issues.	A guardian attended their recent wellbeing day and has presented to the team.

We also continue to work closely with our champions and have recently had quite a few volunteers who also help raise awareness and are a first point of contact.

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 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 supports the open incident reporting culture and encourages team leaders to exercise the new tools and templates in relation to incidents, promoting the no blame Just Culture throughout the Trust. This continues to have good attendance, chaired by the Deputy Director of Nursing.

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 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 network, a monthly ICB Community of Practice 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.

LHCH continues to host PSIRF training by external providers, with more booked for January 2025. This will support the Trust's ongoing campaign to raise awareness of learning and improvements generated from patient safety events and prepare colleagues to be able to facilitate these discussions successfully and confidently.

LHCH also hosted the first QI and Patient Safety regional collaborative meeting, where we invited local Trusts to come along and view our PSIRF and QI journey so far and allowed an open discussion to take place. We agreed following this that we would meet quarterly, alternating between providers.

11. Patient Experience (Q1 and Q2 2024/5)

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.

Due to sickness within the team, the overall data has been unable to be collated, however follow up calls continue to take place, with any areas for concern 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

Patient Engagement events continue to take place, with further planned for 2024/25. The most recent event was a Learning Disability event, led by the Learning Disabilities Team. This was a

well-received and positive event with good attendance from patients and their relatives and carers.

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.

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.

PSIRF continues to be well embedded within LHCH, with the terminology and purpose now well-known and welcomed. Shared learning and improvement continues to be at the forefront of investigating incidents, complaints, and litigation.

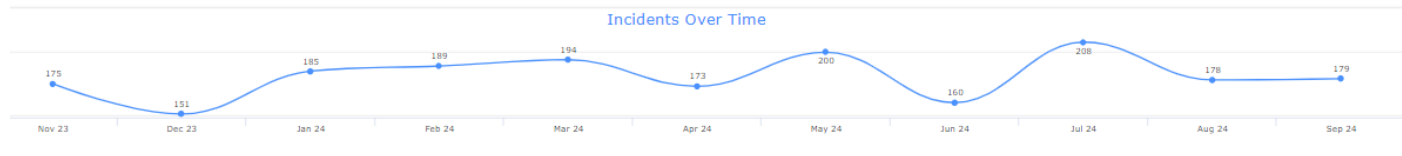
13. Recommendations

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 monthly average using InPhase data (Sept '23 - Sept '24), 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
Administration	<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"> • Support & ownership for the safer waiting list work • Minimum Referral Data Set to be agreed for all service lines • Service Line leads have agree escalations and triggers for pathway management <p>Referral Management</p> <ul style="list-style-type: none"> • System interface leads to be confirmed from other Providers • Agree correspondence to empower patients when outstanding information is required from other providers <p>Sustainability</p> <ul style="list-style-type: none"> • Support a priority investment decision to Admin through annual planning- • Commitment to a Single PTL (patient tracking list) and a move to standardising processes within the Trust • Agree to the proposed Governance Structure <p>Oversight</p> <ul style="list-style-type: none"> • Digital Excellence Strategy – supporting process automation (robotic process automation, Patient Portal, Digital Communications, innovation, and technology for administrative processes to reduce human error • Validation of data quality reports, outpatient waiting list and follow up outpatient waiting list processes • Weekly performance operational meetings between admin and divisional leads, supporting closer working and a more aligned approach with clinical divisions
Medications	<ul style="list-style-type: none"> • 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. • 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. • 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. • 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

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"> • 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. • 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. • 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. • The medicines safety strategy also forms part of the Trusts Quality and Safety strategy. • 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). •
Communication	<p>Many of these incidents appear to be during handover between teams, both verbally and written, as well as communication from transferring and referring hospitals, i.e. changes to plans not always verbally communicated, and not being accessed on EPR in a timely manner.</p> <p>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. There is also work being undertaken to assist with handovers between teams, in the review of the bedside patient boards being redesigned and utilised more</p>
Documentation	<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.</p> <p>Some other incidents relate to pharmacy and discharge related documentation. These themes are regularly reviewed, with ongoing pharmacy related workstreams to make improvements to the discharge processes.</p> <p>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>
Health and Safety	<p>A recurring theme identified in health and safety incident reports involves staff slips, trips, and falls due to uneven surfaces, poorly marked pathways, or obstructions in key operational areas. One specific incident involved a staff member who slipped on loose gravel near a portacabin, resulting in minor injuries. This incident highlighted several risk factors, including inadequate pedestrian pathways and poorly designated parking areas for community rapid response vehicles.</p> <p>To mitigate these risks, a multidisciplinary review was conducted, bringing together representatives from Facilities, Estates, Health & Safety, and Capital Projects. The review resulted in a detailed action plan, which includes:</p>

Theme	Summary of learning and actions
	<ul style="list-style-type: none"> • Redesigning pathways to create clearly marked and safe pedestrian routes. • Improving parking layouts to reduce obstructions near portacabins. • Installing physical barriers to deter staff from using unsafe shortcuts. • Conducting staff awareness sessions to ensure adherence to new safety measures. <p>These findings and actions were shared at Health & Safety forums and departmental meetings to reinforce the importance of reporting environmental hazards. Ongoing monitoring has been implemented to assess the effectiveness of these changes, ensuring sustained improvement in workplace safety. Additionally, themes such as near misses involving equipment in restricted areas or incidents stemming from poor visibility in storage spaces have prompted reviews of lighting and signage. Actions include installing additional lighting and clearly labeling high-risk zones, ensuring a safer environment for all staff.</p> <p>A recurring theme in health and safety incident reporting has been the risk of patient falls related to environmental factors. On Cedar Ward, the ward manager and the falls lead identified shared restroom facilities as a particular area of concern during a targeted falls review. Historical flooding in four shared bathrooms led to the installation of fixed raised lips to prevent water ingress. While this measure was successful in resolving the flooding issue, the raised lips created a new hazard by posing a trip risk, especially for patients moving between hand wash basins and toilets.</p> <p>Recognising the risks, a project was initiated to replace the fixed lips with collapsible alternatives. These collapsible lips effectively contain water during use but compress under pressure, eliminating the trip hazard and improving safety and accessibility. This solution has been successfully implemented on Cedar Ward, significantly reducing the risks associated with the bathroom layout. Lessons learned from this initiative are now being applied across other wards with similar restroom configurations. Reviews are underway to identify additional areas where collapsible lips may enhance patient safety. This approach demonstrates the organisation's commitment to learning from incidents and proactively mitigating risks to create a safer environment for all patients and staff.</p>
Medical Devices, Equipment and Supplies	<p>With the continued issues the Trust has been having with pressure transducers, Medical Engineering have requested that all incidences involving transducers are raised as an Inphase, with Medical Devices flagged and sub category "Pressure Transducer Issues". This has seen 14 incidents since late July. This approach has enabled Medical Engineering to trend and report the issues with the manufacture, record product complaint numbers and store images of faults in one location.</p> <p>Secondly, the Trust rolled out the new Braun infusion pumps between April and July. These pump as well as being new, with associated teething problems, store keystroke and alarm histories, these can be downloaded by Medical Engineering to aid with incident investigation. As staff have become aware of this, incidences involving pumps have increasingly had that device recorded in the incident. Increased staff awareness has seen far more pumps being correctly removed from use follow incidents, where previously they would have bene returned into normal use without them being detailed.</p> <p>Some issues with telemetry transmitters reported, not recording or discharging patients. New local procedures developed for admitting patients on to telemetry. Draeger have also carried out user training, and have visited on-site to review the system alongside our user groups.</p> <p>Also, the two above themes have increased the awareness of being able to easily flag and detail medical equipment involvement, coupled with a general increase in recording incidents.</p>

Appendix C – Examples of learning from Swarm Huddles and After Action Review discussions

Some examples of quick informative 30-45 min swarm discussions and 1-2hr After Action Reviews, are shown below:

<u>AREA</u>	<u>INCIDENT DESCRIPTION</u>	<u>Learning and Improvements</u>
SWARM Cath Lab and Coronary Care Unit Attendees included: Nursing staff Matron SPR	“While reading cath lab doctors note, heparin infusion to be started once IABP insitu. The heparin infusion was not prescribed and not handed over from day shift to night shift.”	<ul style="list-style-type: none"> • Electronic handover to be made live within EPR • Implement and embed within the relevant departments (ensuring feedback is maintained throughout and any teething issues reviewed) • Communicate to relevant clinical colleagues the importance of prescribing once requesting medications within EPR • Communicate to relevant clinical colleagues the importance of completing procedural operation notes within EPR as soon as possible

<u>AREA</u>	<u>INCIDENT DESCRIPTION</u>	<u>Learning and Improvements</u>
SWARM Cherry Ward Attendees included: Nursing staff Ward Manager Pharmacist	“Patient was administered Aminophylline 1000mg in 1000ml prescribed at a rate of 42ml/hr. Patient had approximately 420ml administered over 1 hour, as drug library was overridden and manually input. Patient mentioned to nurse that it was going quickly and nurse raised error and actions were taken.”	<ul style="list-style-type: none"> • IV medication to be pre-prepared by pharmacy (this is already in process, waiting for this to be completed) • More staff to be available on shift, on other areas there is a NIC who is not in the numbers, on Cherry Ward the NIC has a group of patients. This would assist in the preparation and administration of medications. • Meet with CF nurse specialists, see how we can incorporate them into the administration of IV medications. • Pumps need to reflect the medications that are used on Cherry Ward. These need to be updated to ensure that staff are no longer required to bypass the drug library. This includes the prescribed rate of infusion and not the dose that the pump has calculated. • Staff to ensure that the independent 2nd check is completed throughout each process of the IV administration policy when possible. • Staff to revert from administering

		<p>meropenem and ceftazadine in a syringe and administer via a bag.</p> <ul style="list-style-type: none"> • Staff to ensure that they access the drug library at all times prior to the administration of medications. If this was utilised the pump would have alerted staff that a high dose had been set. • Further education be given to staff with regards to the infusion pumps. • Policy to reflect the agreed process of IV medication administration on Cherry Ward.
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<u>AREA</u>	<u>INCIDENT DESCRIPTION</u>	<u>Learning and Improvements</u>
<p>SWARM</p> <p>Theatre</p> <p>Attendees included:</p> <p>Directorate Manager Ops Manager Matron Sister RN HCA</p>	<p>“During an OPCABG case, there was no immediately available intra-coronary shunt. I was initially given a coronary blocker, then when it was pointed out that this was the incorrect device, it became apparent that no suitably sized shunts were available in the theatre. I used an incorrectly sized shunt whilst awaiting the correct size, but in the meantime, the heart [anterior wall, which was the coronary territory which had been opened] function deteriorated, the heart developed ventricular fibrillation, and the patient had to receive CPR to place them on cardiopulmonary bypass. The rest of the case proceeded as planned and the patient was transferred to POCCU in a stable condition.”</p>	<ul style="list-style-type: none"> • Coronary occluders no longer to be stocked in Theatre. • To include SWARM event & training around implant verification checking • Shunts to be stored in Omnicell's in each theatre. • Alternative/new items to be communicated via whiteboard in storeroom & potential WhatsApp group • Baxter communications regarding investigations/packaging similarity

<u>AREA</u>	<u>INCIDENT DESCRIPTION</u>	<u>Learning and Improvements</u>
<p>AAR</p> <p>ACU</p> <p>Attendees included:</p> <p>Nursing staff Ward Manager ACP Cardiologist Tier 1 Dr's</p>	<p>Unwitnessed fall outside just after 2am. Extensive bruising with a drop in Hb over the next 48hours. Collapse in bathroom, monitor showed VF, no shock delivered as patient had DNA-CPR order in place.</p> <p>Additional queries identified by the Mortality Group review, following full mortality screen: Escalation of the fall (seen by a Tier</p>	<ul style="list-style-type: none"> • Devise an MDT document for falls – with medical, nursing and pharmacist review. • Tissue viability to implement body map on EPR. • Weekend ward round process to be cascaded (all patients to be seen unless documented otherwise, those documented that don't need review

	<p>1 only), no senior review over the weekend. No review of the Hb drop over the weekend.</p>	<p>should be discussed with nurse in charge to ensure no change in condition / nursing concerns).</p> <ul style="list-style-type: none"> • Poster on wards for nurses with weekend ward round process. • Pharmacy to look at the process of reviewing pharmacy queries over the weekend (highlight what is a priority), to ensure outstanding pharmacy queries are actioned over the weekend. • Nursing pharmacy query (nursing to pharmacy).
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Appendix D – NHS Resolution Score Cards 2024 – CNST & LTPS

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.

CNST (Clinical Claims) Data

CNST

Liverpool Heart and Chest Hospital NHS Foundation Trust

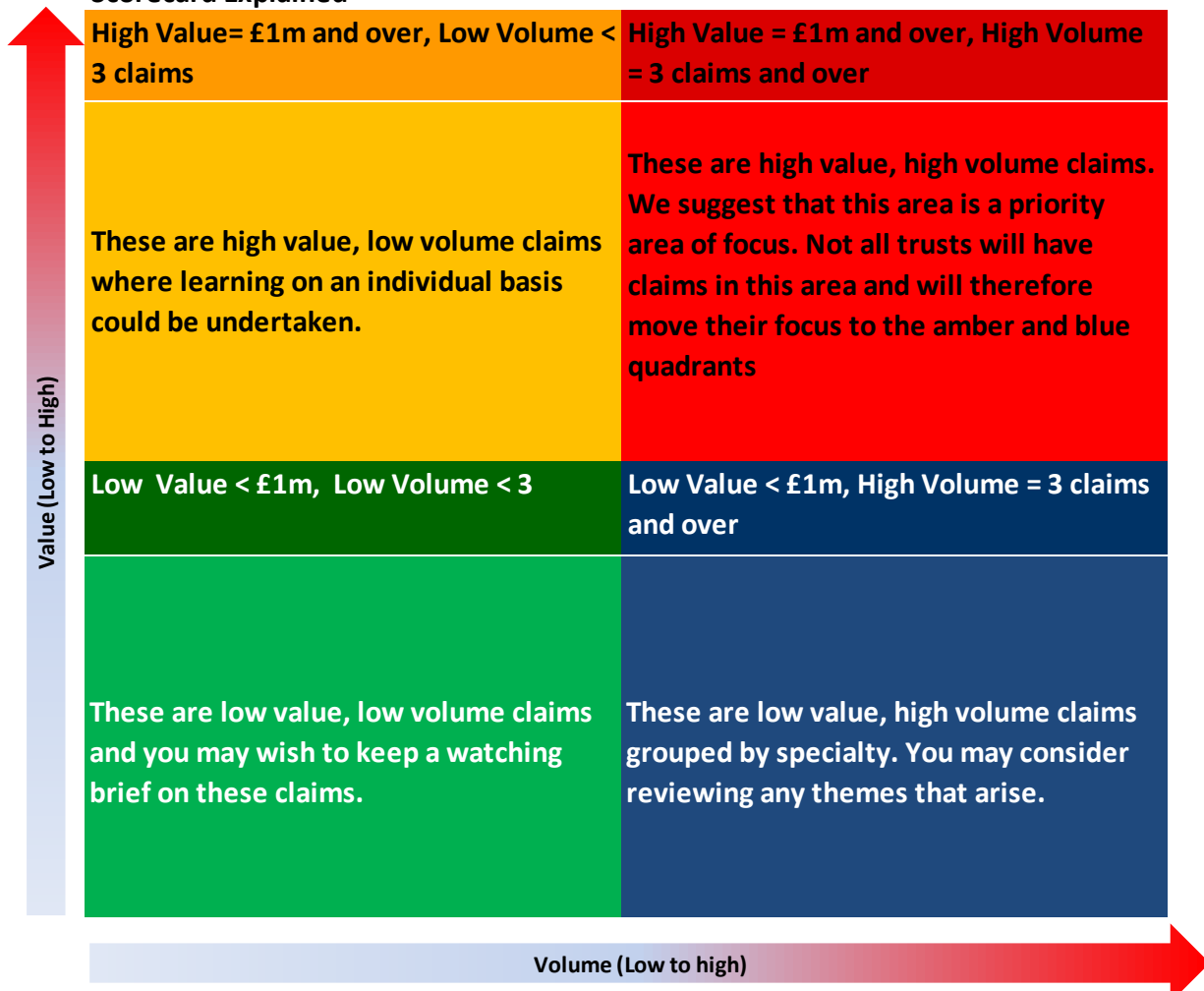
The data presented in these spreadsheets is provided to Trusts to consider their claims and learning that can be determined by using different approaches according to the quadrant description presented below.

Selection Criteria: CNST claims received with an Incident Date between 01/04/2014 and 31/03/2024

Total number of claims for this Trust: 73. Total value of claims for this Trust £12,151,312

Data correct at: 30/06/2024

Scorecard Explained



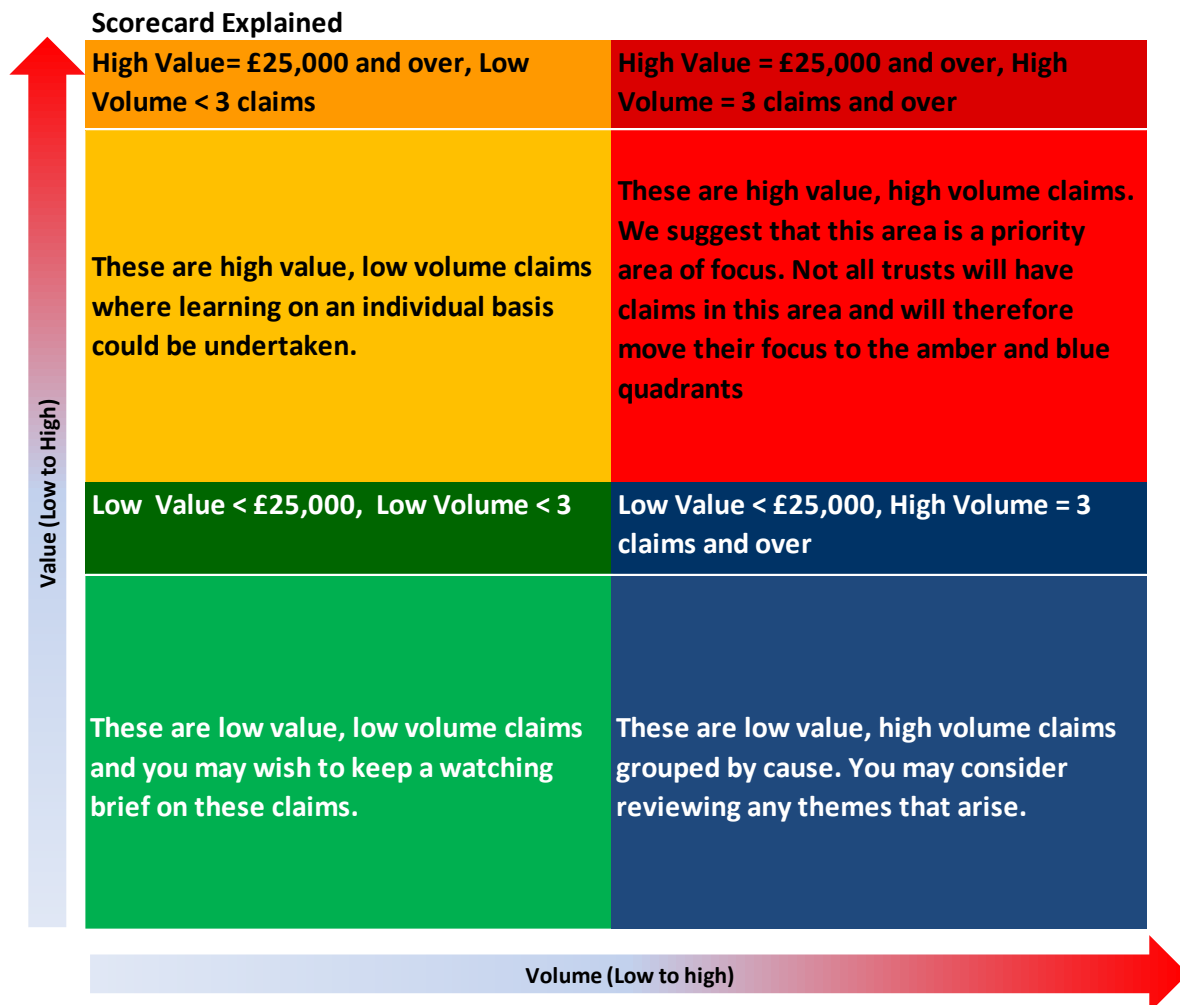
Liverpool Heart and Chest Hospital NHS Foundation Trust

The data presented in these spreadsheets is provided to Trusts to consider their claims and learning that can be determined by using different approaches according to the quadrant description presented below.

Selection Criteria: LTPS claims received with an Incident Date between 01/04/2014 and 31/03/2024

Total number of claims for this Trust: 26. Total value of claims for this Trust £828,155

Data correct at: 30/06/2024





Appendix E – Training Needs Analysis PSIRF

Liverpool Heart and Chest PSIRF Training Needs Analysis 2023-2025

Title of Training	Lead	Availability	Frequency of Training	Content Description & Delivery Mode	Staff Groups								
					All	Band 6 and above	Band 8a and above	PSIRF Learning Response Leads	Engagement Leads	PSIRF Oversight and Governance	Local learning response leads using SEIPS	Patient Safety Specialist	Patient Safety Team
Patient Safety Syllabus Level 1: Essentials for patient safety	Ria Carter	Anytime	Once	E-Learning The systems approach to safety									
Patient Safety Syllabus Level 1: Essentials for Patient Safety for Boards and senior leadership teams	Ria Carter	Anytime	Once	E-Learning Additional session for senior leaders and executive teams									
Patient Safety Syllabus Level 2	Ria Carter	Anytime	Once	E-Learning Further in-depth intro to systems thinking, risk, safety culture and human factors.									
Patient Safety Syllabus Level 3-5	Ria Carter	Loughborough University Course No availability 2023/24											
Systems Approach to learning from patient safety incidents Lot 4a	Ria Carter	Anytime	2 days or 12 hours Once, with expected CPD to include 1 x safety event to support/year.	Face to face <i>Introduction to complex systems, systems thinking and human factors</i> <i>Learning response methods: including interviewing and</i>									

				<i>asking questions, capturing work as done, data synthesis, report writing, debriefs and after-action reviews.</i> <i>Safety action development, measurement, and monitoring</i>										
Systems approach to learning from patient safety incidents oversight training Lot 4b	Ria Carter	Anytime	1 day/7.5 hours Once, with expected CPD to include 1 x safety event to support/year.	Face to face <i>NHS PSIRF and associated documents</i> <i>Effective oversight and supporting processes</i> <i>Maintaining an open, transparent and improvement focused culture</i> <i>PSII commissioning and planning</i>										
Engaging with patients, families, and staff following a patient safety incident training Lot 4c	Ria Carter	Anytime	1 day/7.5 hours Once, with expected CPD to include 1 x safety event to support/year.	Face to face <i>Duty of Candour</i> <i>Just culture</i> <i>Being open and apologising</i> <i>Effective communication</i> <i>Effective involvement</i> <i>Sharing findings Signposting and support</i>										
PSIRF Awareness Training	Ria Carter	Upon Request	As required	Face to Face										

Key: **A** - Advisory **D** – Desirable **E** - Essential