Trust Board Meeting in Public: Wednesday 14 September 2016
TB2016.88

<table>
<thead>
<tr>
<th>Title</th>
<th>An Annual Review of the Serious Incidents Requiring Investigation (SIRI) and Never Events reported during Financial Year 2015/16.</th>
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<tbody>
<tr>
<td>Status</td>
<td>A paper for information and discussion</td>
</tr>
<tr>
<td>History</td>
<td>Summary paper first presented for consideration by the Quality Committee at its meeting held on 10 August 2016.</td>
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<tr>
<th>Board Lead(s)</th>
<th>Dr Tony Berendt, Medical Director</th>
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<tbody>
<tr>
<td>Key purpose</td>
<td>Strategy</td>
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TB2016.88 Annual Review of SIRI and Never Events 2015/16  Page 1 of 17
**Executive Summary**

<table>
<thead>
<tr>
<th>179 Serious Incidents Requiring Investigation (SIRIs) were declared to the Oxfordshire Clinical Commissioning Group (OCCG) during the financial year 2015/16.</th>
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<tr>
<td>This report describes the extensive change programme, which has been implemented in 2015/16 to improve the SIRI process and ensure that it is more open and transparent for staff with rapid cross divisional learning via the SIRI forum. It also describes workshops and communication/teaching events, which have been held with frontline staff of all seniorities to help them to better acknowledge and learn from errors and improve practice in the future. Data is presented showing substantial improvement in duty of candour disclosure suggesting cultural change that is now embedded.</td>
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<td>The four categories of SIRIs which occurred most frequently were:</td>
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<tr>
<td>1. Pressure Ulcers (47)</td>
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<td>2. Falls (15)</td>
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<td>3. Diagnostic related including delayed diagnosis (15)</td>
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<td>4. Medication (14)</td>
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<tr>
<td>Themes and actions taken are presented in detail for these categories in the report. Additional information is supplied with respect to no harm incidents and incidents where deaths occurred. The influence of test result and discharge summaries is also considered.</td>
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<tr>
<td>Future plans for further improvements to the SIRI process and overall quality and safety are described</td>
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**Recommendation**

The Trust Board is asked to note the contents of this report.
1. **Purpose**

1.1. The purpose of this paper is to inform the Board of the trends in reported Serious Incidents during the last financial year March 2015-April 2016.

1.2. The summary reports (appendix 1) provide an opportunity for the Committee to familiarise itself with the serious incidents that have occurred over the last financial year and to gain assurance that the proposed actions would prevent a re-occurrence of the event.

2. **Background**

2.1. During the last financial year 2015/16 179 Serious Incidents requiring investigation (SIRIs) were declared via STEIS with 14 being downgraded (with agreement from the OCGG). Therefore, there were 165 SIRI’s in 2015/16 financial year. The number of SIRIs has increased to 88 in the prior year- see section four).

2.2. 1.2% of incidents reported on DATIX involve moderate or greater levels of harm (attributed to the healthcare) and 1.3% of patient related incidents involve moderate or greater levels of harm (attributed to the healthcare) (See graph 1)

Graph 1 – Incidents at OUH including those of moderate or greater harm

2.3. National comparators of incident reporting show that OUH NHS FT is in the highest third of incidents reported per 1,000 bed days in the acute organisations category with 41.86 incidents reported per thousand bed days. This suggests a good reporting culture.

2.4. Graph 2 shows the rate of incidents reported per 1,000 bed days between Apr-15 and Sep-15 by Acute (non-specialist) organisations. (each vertical line is an acute provider, OUH is in black).
Graph 2 - Rate of incidents reported per 1,000 bed days between Apr-15 and Sep-15 by Acute (non-specialist) organisations

3. Proactive changes to the SIRI process Since April 2015

3.1. The SIRI process has undergone extensive changes since February 2016 when staff were specifically encouraged via a communication from the Medical Director and Chief Nurse to escalate safety issues, in part, in response to comments in a Monitor review as part of the Foundation Trust authorisation process. A decision had also been made to recruit a Deputy Medical Director specifically for Quality, Governance and safety in March 2015.

3.2. NHS England issued new guidance about SIRIs and Never events at the end of March 2015.

3.3. Aspects of the Serious Incident process which have been improved include

3.3.1. Incidents that may meet the definition of a SIRI are presented at a weekly SIRI forum where the level of investigation is decided by the multi-disciplinary team with divisions and teams encouraged to attend and to take ownership of the decision about level of investigation. It is a forum founded on just culture and mutual respect. This meeting also has subject matter experts such as tissue viability nurses, the Chief Clinical Information officer (CCIO), Information Governance and the thrombosis lead as required.

3.3.2. All incidents reported on DATIX are screened by the risk management team who meet weekly with the Deputy Medical Director and Head of Clinical Governance.

3.3.3. Serious incident reports are now signed off either by a TME member or the Deputy Chief Nurse (Pressure Ulcers and falls) as per guidance.

3.3.4. Human factors expertise has been provided via the patient safety academy and the Oxford Simulation, Teaching and Research (OxSTaR) for all Never event reports since mid-2015. This has also been applied to other events and a project is currently underway to review 200 SIRI investigations with a recognised methodology related to situational awareness in order to design a targeted training program.

3.3.5. Two separate OCCG closure meetings are held each month between the OCCG and the OUH. There is a Hospital acquired pressure ulcer (HAPU)/falls SIRI closure meeting held with the Deputy Chief Nurse, Tissue Viability Team, Central Risk Management and the OCCG and a SIRI closure meeting for all other SIRI
investigations with the Deputy Medical Director, Central Risk Management and OCCG representatives.

3.4. Additional training and communication activities include

3.4.1. A half day joint workshop for Divisional clinical governance and risk practitioners, Divisional senior nurses, the Clinical Governance risk management team and Ox STaR/Patient safety academy was held in April to redesign training for incident investigation and aspects of the process.

3.4.2. Presentation to board seminars re safety and quality

3.4.3. Presentation to the divisional and clinical director’s away day 2015 and adult ICU and children’s services meeting

3.4.4. Presentation to the Foundation Year 1 Doctors and foundation nurse workshop on professionalism and the FY1 ‘when things don’t go to plan’ session.

3.4.5. Presentations to Medical and Surgical Grand Rounds on Never Event investigations and the influence of situational awareness and human factors in incidents.

3.5. Duty of candour

3.5.1. Significant work has gone on to embed the legal, professional and regulatory Duty of Candour in the Trust. This has involved extensive work in the divisions and monitoring via the serious incident Forum.

3.5.2. DATIX has been redesigned to provide decision support on Duty of Candour for any incidents which are of moderate or above harm.

3.5.3. Graphs 3-5 below show substantial progress in Duty of candour reports on DATIX indicating responses recorded on DATIX about whether the team had been open with patients, offered an apology and given the patient written confirmation of an investigation.

Graph Three shows DATIX responses to ‘Has the affected person made aware of the incident?’

![Graph showing data on Duty of Candour](image)

Responses shown in graph three relate to direct disclosure to the patient but graphs four and five consider apologies or written notifications to either the patient or their next of kin if the patient was too unwell to participate in discussions.
3.5.4. Graph Four shows DATIX responses to ‘Was an apology offered’?

3.5.5. Graph Five shows DATIX responses to ‘Was written notification given?’

3.5.5.1. These results together confirm a robust adoption of Duty of candour into usual practice.

4. An overview of the 165 SIRI’s declared over the last financial year

4.1. The number of SIRIs has increased to 165 from 88 in the prior year. With the exception of a spike in adverse incidents in March the rate of incidents is reasonably consistent with a mean of 13.75 serious incident investigations declared per month and a median of 13 investigations declared per month.

4.2. Some incidents have been investigated in groups or as clusters to maximise the learning from time spent investigating e.g. AAA screening incident, a cluster of wrong drugs injected in eye clinic, pressure ulcers under plaster casts and two ‘stop before you block’ related never events.

4.3. Only two incidents have been completed beyond the national guidance time scale of 60 working days or an agreed extension from the CCG.

Graph Six shows: SIRIs declared during FY 2015/16
Graph Seven shows SIRIs by hospital site – most occur at the JR with the largest patient footfall.

Graph Eight shows serious incidents by division which broadly reflects the size of the division (most are in MRC).

5. Analysis of types of SIRI and themes within these categories

5.1. Graph Nine provides an overview of the 165 SIRI’s and the categories of incident that were reported in 2015/16.
5.2. Some incidents may span two categories for example a venous thrombo-embolism (VTE) may be in the VTE category but also have aspects of medication safety if anticoagulation was not administered appropriately. When reporting on STEIS a single most dominant category is chosen.

5.3. The greatest proportion of SIRIs were pressure ulcers. Detailed analysis of the four most common categories of SIRI including the HAPU group is presented below. In addition SIRIs related to deaths have been reviewed and those incidents that relate to review of test results or problems from discharge summaries have been considered.

5.4. Levels of harm

5.4.1. The level of harm for each incident reported in the Trust is the harm that relates to healthcare at OUH NHS FT. Consequently, an incident that may have resulted in death as the outcome of an admission where the Trust did not cause harm is categorised as a no harm incident. For example a patient with unsurvivable multiple trauma might have a medication error that caused no harm but the patient might still die within a short time of the incident report.

5.4.2. Graph Ten is a pie chart below which shows the levels of harm associated with SIRIs in 2015/16

5.4.3. SIRIs related to deaths are considered as a group in section 10.

5.4.4. The largest category is incidents of moderate harm to patients.

5.4.5. NHS England guidance includes investigating near miss events as serious incidents if there is deemed to be considerable learning to be derived.

5.4.6. Examples of no harm incidents which were investigated in this way include

5.4.6.1. A patient booked for radiotherapy that they did not ultimately need – the error was identified as the patient waited outside the room to begin therapy.

5.4.6.2. Four patients in eye clinic who had injection of the wrong drug through error – their vision did not suffer any deterioration as the drug given was similar to that intended but this was fortuitous rather than by design. New SOPs were put in place to prevent repetition.

5.4.6.3. A neonate whose blood group was unknown received a blood transfusion of adult universal donor blood. The neonate’s blood group happened to be compatible with the blood and no reaction occurred but if this had not been the case it could have been a fatal error. The remote blood fridge storage and access has been redesigned.
6. Category 3 and 4 Hospital Acquired Pressure Ulcers (HAPU)

6.1. SIRIs are declared where there has been an undocumented deviation from the Trust Pressure Ulcer Prevention Policy (2015).

6.2. During this period, 47 HAPU SIRI’s were reported. Two investigations were for Category 4 pressure ulceration (Q2 & Q4) and 45 the result of Category 3 pressure ulceration, as defined by the European Pressure Ulcer Advisory Panel (2014).

6.3. Graph Eleven shows the total pressure ulcers in each quarter and their anatomical locations.

6.4. An increase in incidents occurred in Q2 and Q3 2015/2016. This co-incided with implementation of a weekly incident review meeting, supported by the Divisions and the Tissue Viability Team, to improve decision making in relation to the level of harm attributed to individual incidents. This has led to an increased level of scrutiny, transparency and enhanced clarity about reporting.

6.5. Actions to reduce pressure ulcers over this time included

6.5.1. Recruitment of a large number of new nurses into post including non NHS trained staff (nursing and medical) resulting in increased support required at ward level

6.5.2. The Trust Pressure Ulcer Prevention Policy was updated in August 2015 following new NICE guidance.

6.5.3. The Trust Skin Care Guidelines were launched in December 2015 resulting in further frontline awareness of skin assessment

6.5.4. A pressure ulcer prevention E-Learning module was developed and launched for nursing staff at the end of November 2015 (Completed by 900 nurses by end Q4).

6.5.5. The Pressure Ulcer Prevention Clinical Improvement Group (PUPCIG) is reviewing the sign off process for pressure ulcer action plans.

6.6. Themes-

6.6.1. Aggregate analysis of the investigation summaries has been undertaken in order to identify themes.

6.6.2. Sacral, heel and under medical device pressure ulcers appear to be the most common anatomical locations for SIRI HAPU. The incidence of sacral pressure ulceration declined in Q3 and Q4 following the launch of the E-Learning module and skin care guidelines.

6.6.3. Heel pressure ulceration increased in Q2 2015/2016; no specific correlations between the incidents have been identified, although it is noted that the inpatient Podiatry team had been established by this time, which may have led to increased reporting of heel damage.

6.6.4. Medical device related incidents have increased in Q3 and Q4 2015/2016. The increase in reporting of device related pressure damage has coincided with the
launch of the E-Learning module. The module highlights the requirement for the reporting of device related pressure damage and the need for investigation.

6.7. Root cause themes

6.7.1. Graph Twelve shows common root cause themes in HAPU SIRI investigations

![Common Root cause SIRI themes](image)

6.7.2. **Documentation** - The inconsistent documentation of care given has been the most consistent theme. Education on documentation has been delivered as part of the Tissue Viability Team. Documentation audits and monitoring remain the responsibility of the Ward Managers and Matrons. Discussions are ongoing to consider whether some of these incidents should be declared as SIRIs.

6.7.3. **Risk Assessments** - The Braden risk assessment score was introduced in November 2014 and launched on EPR in August 2015 with care plans remaining in hard copy. Work is ongoing with the EPR team to adapt the Braden risk assessment and build associated electronic care plans.

6.7.4. **Communication** - Themes around communication include poor escalation and management of patients refusing care or poor documentation of patient involvement in care planning, including patient education. A Trust specific Patient Education Leaflet was developed in May 2016 to support patient education.

7. **Diagnostic related serious incidents (including delayed diagnosis).**

7.1. There were 15 incidents which were submitted under the category of diagnostic related incidents. These events are evenly spread across the different divisions.

7.2. Failure to act on incidental findings or results

7.2.1. Five were failures to follow up Incidental findings on imaging requested for other purposes. One related to the national aneurysm screening program and issues with options to record incidental findings in its software. The others relate to original imaging which was performed in 2011, 2013, 2013, and 2015 respectively.

7.2.2. Actions to prevent these issues occurring include the system for endorsement of results on EPR creating a specific opportunity to sign off that the team have seen and acted on the result. Radiology has also developed an SOP to notify clinicians of incidental findings and where appropriate to directly request follow on investigations.

7.2.3. Incidents related to results are discussed in section Twelve.

7.3. Missed diagnoses on imaging

7.3.1. Four delayed diagnoses relate to perceptual errors in reporting radiological imaging or an MRI scan.

7.3.2. Radiology has a well-established discrepancy process where potential errors are blindly reviewed in a learning environment for the wider department and fed back to individuals who then reflect on them through the appraisal process.
7.3.3. Systems for quality control re-reporting of a selection of images reported have been put in place and the divisional director is working on a national resource to test accurate reporting of chest X-rays.

7.4. Levels of harm are shown in Table One below

<table>
<thead>
<tr>
<th>Actual Impact</th>
<th>Diagnostic related SIRIs including delayed diagnosis</th>
</tr>
</thead>
<tbody>
<tr>
<td>No harm</td>
<td>1</td>
</tr>
<tr>
<td>Minor injury/illness</td>
<td>1</td>
</tr>
<tr>
<td>Moderate effect or serious injury (but not long-term)</td>
<td>6</td>
</tr>
<tr>
<td>Major injury leading to long-term disability/ incapacity</td>
<td>4</td>
</tr>
<tr>
<td>Death</td>
<td>3</td>
</tr>
<tr>
<td><strong>Grand Total</strong></td>
<td><strong>15</strong></td>
</tr>
</tbody>
</table>

7.4.1. Two of the deaths were unavoidable due to the severity of the patients’ underlying condition, in one of these cases, although delayed, anticoagulation was already well established for a pulmonary embolus by the time of death. One death was probably avoidable and relates to failure to review ECGs which is discussed in section ten of this paper.

8. Falls and Fractures

8.1. 15 falls were reported on STEIS during 2015/16. The most incidents occurred within four specialties, including Acute General Medicine having the most SIRIs with 3, followed by Gerontology, Ophthalmology and Surgery having 2 SIRIs each.

8.2. Acute General Medicine and Geratology are high risk areas for falls, Ophthalmology has a high volume of elderly frail patients and surgery through the Surgical Emergency Unit also has a high level of elderly frail patients. 33% of falls and fractures had a moderate harm ascribed and 66% were major.

8.3. The majority of falls resulted in a fractured hip, two were peri-prosthetic fractures of hips and knees, two were sub-dural haematomas, and those classified as unknown were unwitnessed falls that occurred outside of clinical areas.

8.4. The distribution of the falls throughout the day in inpatient areas has the highest prevalence in the early morning or when patients are getting up from their chairs or beds unaided for toileting purposes, and then fall, even if they have their call bell to hand and have been asked to call for assistance.

8.5. Review of the root causes in relation to the lessons learnt from SIRI falls – Table Two

<table>
<thead>
<tr>
<th>Root Cause</th>
<th>Lessons Learnt</th>
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<tbody>
<tr>
<td>Falls assessments not acted on / completed / inaccurate</td>
<td>Need for further patient assessment</td>
</tr>
<tr>
<td>Concerns of family not considered</td>
<td>Staff act on any safety concerns of family/carer</td>
</tr>
<tr>
<td>Safety measures not formally documented / implemented</td>
<td>Safety measures to be documented and implemented</td>
</tr>
<tr>
<td>1:1 supervision not provided</td>
<td>Patients with known falls risk to be closely supervised and have formal</td>
</tr>
<tr>
<td>Assessment</td>
<td>Documentation</td>
</tr>
<tr>
<td>------------</td>
<td>---------------</td>
</tr>
<tr>
<td>Bedrails raised / bedrail assessments not completed</td>
<td>Education on causes of falls / prevention of falls</td>
</tr>
<tr>
<td>Ward layout</td>
<td>Falls safe risk assessment and care plans</td>
</tr>
<tr>
<td>Multiple patients at high risk of falls</td>
<td>Lying and standing blood pressure tests</td>
</tr>
<tr>
<td>Failure to identify patients who are at high risk of falls (condition / medication)</td>
<td>Complete falls risk assessments – changes in cognition and physical condition</td>
</tr>
<tr>
<td>Lack of consistency amongst staff / use of temporary staff</td>
<td>Further training on falls for all staff</td>
</tr>
</tbody>
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8.6. Graph Thirteen shows the number of falls each month in 2015/16

![Number of Falls with harm declared as serious incidents]

8.7. The highest prevalence of falls was between June and September. The electronic falls assessment process was introduced early in the summer with a deadline to move to sole use of this assessment in August 2015. In the early part of the year, many investigations revealed a lack of timely risk assessments, and this may have had an impact on the numbers of falls with harm before the risk assessments were fixed in a single place.

8.8. The introduction of education for the Fallsafe care bundle in the latter part of 2015 and the development and training of falls champions in clinical areas may explain the reduction seen at the end of the financial year. This is an ongoing quality improvement programme that is being rolled out to the priority areas initially i.e. those with the highest number of high impact falls with harm.

9. Medication Incidents


9.2. Graph Fourteen shows medication serious incidents by division
9.3. The thematic review supported the Medicines Safety team’s priority work-streams for 2016/17; medicines to manage Diabetes Mellitus, Anticoagulants, Antimicrobials, and the Delayed and Omitted Doses (DODs) of time-critical medicines were identified as medicine-related priorities for the team to focus on.

9.4. Members of the Medicines Safety team have created links with respective teams (the OUH Diabetes team, the Thrombosis Working Group and the Antimicrobial Steering Group, Drugs on Discharge working group) to identify medicines-related patient safety themes, understand them and ultimately reduce the associated potential (or actual) patient harm. Diagnostic Related (Inc. delayed diagnosis)

10. Deaths

10.1. 19 deaths were initially identified as the level of harm graded on DATIX, 12 were reported on STEIS with the level of harm being death which is related to the outcome being that the patient died but that it may prove to be unrelated to the incident. One reported serious incident which was investigated after the patient died was downgraded with the agreement of OCCG because a postmortem revealed an unexpected serious heart condition which was unknown.

10.2. Four deaths were recorded as avoidable deaths through the Trust’s mortality review process. In compiling this paper a further two potentially avoidable deaths have been identified.

Table Three

| Root cause | Action taken | Logbook
|------------|--|--|
| Failure to diagnose and treat a silent heart attack when ECGs were recorded but not shown to or requested by medical staff | All ECGs signed off by medical staff | Systematic notification and documentation (SEND) Ward round checklist
| After cardiac surgery a patient deteriorated on a ward in part due to a pericardial effusion but their chest was not opened for drainage at their arrest | Cardiac surgery standard operating procedure (SOP) Cardiac Advance Life Support protocol for all cardiac surgical patients on wards and CTCCU
| Failure to recognize a cytomegalovirus (CMV) infection in a transplant patient where the result was requested at a | SOP for satellite blood tests EPR access and test requesting to be implemented in satellite clinics
10.3. Eleven of the 19 deaths show communication as an aspect of the incident: examples include miscommunication between a ward and radiology around a patient needing imaging for a bleed – radiology advised the patient needed to be actively bleeding to find the bleed but at this point the ward felt they were too sick to send to radiology.

10.4. Simple communication tools like SBAR (Situation, Background, Assessment, and Recommendation) and read-back can address some of these issues and form part of the OUH human factors training programme delivered by OxSTaR.

10.5. The roll out of SEND is also key to rapid identification of deterioration and appropriate escalation.

10.6. Graph 15- shows the categories of incidents reported with the outcome of death.

10.7. Since re-establishment of the Mortality review group (MRG) all SIRIs where the outcome is death have been presented to the MRG (usually by the investigator) to ensure avoidability has been considered and that actions are robust. The MRG has consultant representation from all divisions except Women’s and Children’s.

11. Never Events

11.1. Seven Never events were declared on STEIS in 2015/16.

11.2. They were
11.2.1. Wrong site surgery
   11.2.1.1. A wrong level spinal disk removal
   11.2.1.2. A wrong site emergency craniotomy
   11.2.1.3. A wrong site approach to a portacath removal
   11.2.1.4. A wrong site incision for an oesophagectomy
   11.2.1.5. Two wrong site nerve blocks

11.2.2. One retained swab

11.3. Actions plans which are closely monitored by divisional and corporate teams are in place to reduce the risk of recurrence.

11.4. These events have been reported to the board and quality committee in detail and some have been the subject of an external review. They will not therefore be further discussed in this report.

12. Discharge summaries

12.1. The impact of discharge summary communication has been reviewed due to the ongoing monitoring of summaries being sent within 24 hours following discharge to the patient’s GP. Currently this occurs in 78% (June 2016) of cases by the 24 hour goal.

12.2. Out of the 165 SIRIs reviewed, two have shown a discharge summary element as being relevant to the incident, however, in each case it was not the lack of provision of a discharge summary in a timely manner that was at issue, it was the accuracy in terms of current medication regime. Systems including upgrades to EPR have been put in place to ensure these incidents do not recur.

13. Test results

13.1. Results endorsement, like discharge summaries have been reviewed as a theme due to the contractual commitment to endorse 95% of all test results within 7 days of reporting. Compliance for June 2016 was at 78% and as this is less than the 95% requirement this has been included in this review to see if any serious issues have arisen as a result of a test not being endorsed within the 7 day target.

13.2. The following themes emerged when any area that may relate to results was considered, this will include some incidents already discussed in other groups above as results is not a specific category on STEIS:
   13.2.1. One incident was aligned to a non-detection issue rather than a result endorsement issue.
   13.2.2. Four incidents related to failures to follow up on incidental findings.
   13.2.3. One was a miss-interpretation of a result and therefore not down to the fact that a result had not been endorsed.
   13.2.4. One incident occurred when multiple layers of results appeared on EPR which meant that a crucial result was ‘hidden’ from direct view this has now been rectified in the system.
   13.2.5. One incident relates to a renal satellite unit requesting tests on a paper-based system which meant that the result was not seen on EPR – this is in the process of being resolved.

13.3. Thus results endorsement specifically was not a root cause of any of these incidents but more work is needed both in EPR endorsement and in timely availability and review of all results (including incidental findings).
14. **Future plans**

14.1. An annual report will be produced for each year going forward and consideration of themes in root causes of incidents will be included.

14.2. Further training program enhancements for investigators are being developed.

14.3. Situational awareness review of 200 incidents will also inform future training and ethics approval is being sought for publication.

14.4. Risk management is developing patient and family information leaflets

14.5. Criteria for report SIRIs including pressure ulcers will be rediscussed at a meeting with the divisional nurses (led by the chief nurse)

14.6. Review of deaths related to SIRIs is now undertaken by MRG to ensure that an objective cross divisional view on avoidability and learning from the incident investigation is taken and to take case examples back to divisions.

14.7. The being open policy is being updated to fully describe Duty of Candour requirements.

14.8. A group is being coordinated through clinical governance to implement National safety standards for invasive procedures (NatSSIPs) as Local SSIPs with first proposals by September 2016.

14.9. The medication safety subgroup of the Medicines Management and Therapeutics Committee has been re-launched

14.10. Other themes from serious incidents are encompassed in the Trust quality priorities and CQUINs such as AKI, sepsis, medication safety, SEND, and human factors. Some of these initiatives are also CQUINs.

15. **Summary**

15.1. This report describes the extensive change programme which has been implemented in 2015/16 to improve the SIRI process and ensure that it is more open and transparent for staff with rapid cross divisional learning via the SIRI forum. It also describes workshops and communication/teaching events which have been held with frontline staff of all seniorities to help them to better acknowledge and learn from errors and improve practice in the future. Data is presented showing substantial improvement in duty of candour disclosure suggesting cultural change that is now embedded.

15.2. The four categories of SIRIs which occurred most frequently were: Pressure Ulcers (47); Falls (15); Diagnostic related including delayed diagnosis (15); Medication (14)

15.3. Themes and actions taken have been presented in detail for these categories in the report.

15.4. Future plans for further development of the serious incident and quality and safety process within the Trust have been described.

16. **Recommendations**

16.1. The Trust Board is asked to note the contents of this report.

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Dr Tony Berendt  
Medical Director  
September 2016
Report prepared by:

Caroline Armitage, Clinical Governance Manager, Clinical Risk
Helen Cobb, Head of Clinical Governance
Dr Clare Dollery, Deputy Medical Director

The sections for Pressure ulcers and Falls were contributed by Liz Wright, Deputy Chief Nurse and her team with input from the tissue viability team and the quality improvement nurse educators.

The section for medication safety was contributed by Clare Crowley, Helen Turner and Boo Vadher from the Medication safety team.