**Trust Board Meeting in Public: Wednesday 13 November 2019**

**TB2019.112**

| **Title** | **An Annual Review of the Serious Incidents Requiring Investigation (SIRI) and Never Events reported during Financial Year 2018/19** |
|---|---|

| **Status** | A paper for information and discussion |
|---|---|
| **History** | A summary paper presented to the Committee |

| **Board Lead(s)** | Professor Meghana Pandit, Chief Medical Officer and Sam Foster, Chief Nursing Officer | | | |
|---|---|---|---|---|
| **Key purpose** | Strategy | **Assurance** | Policy | Performance |

## Executive Summary

1. This report presents a review of the Serious incidents requiring investigation (SIRI) during the financial year (FY) April 2018-March 2019. It considers trends over time in incident reporting and the SIRI process and themes that arise from review of all the investigations with descriptions of actions taken to prevent recurrence of adverse events and to support good practice.
2. 116 Serious incidents requiring investigation (SIRI) were declared during the financial year (FY) April 2018-March 2019 (compared with 96 in the previous financial year). 7 SIRIs were subsequently downgraded leaving 109 SIRIs for review in this report. Analysis of trends shows an increase in reporting of patient safety incidents over the past 5 years, from 1,670 to 1,828 incidents per month. Incidents with Moderate or greater harm rose above the 5-year mean of 20 in March 2019 (28 incidents), for the first time since March 2016; it is believed that this reflects change in the Trust's approach to impact grading instigated in early 2019 (see 2.6 below).
3. This report describes work done to identify and investigate SIRIs in line with the national Serious Incident Framework, including implementation of the Never Event Improvement Plan which was introduced in 2017/18. Data is presented showing full compliance with the duty of candour disclosure. Developments such as the weekly global Safety Message, the daily Patient Safety Response meetings, and the weekly Serious Incident Group, are noted.
4. The categories of SIRI which occurred most frequently were
   - Diagnostic (17)
   - Treatment (17)
   - Operative (16)
   - Pressure damage and skin integrity (15)
5. Future plans for further improvements to the SIRI process and overall quality and safety are described.
6. **Recommendation**

   The 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 financial year (FY) April 2018-March 2019. The paper provides information to the Board on actions taken to prevent recurrence of these types of incident and ongoing work to embed both a culture of safety and the duty of candour across the Trust.

## 2. Review of numbers of Incidents and SIRIs

2.1 During the FY 2018/19 116 SIRIs were declared by the Trust via the Strategic Executive Information System (STEIS), NHS England's web-based serious incident management system.

2.2 Seven of these SIRIs were downgraded (with agreement from OCCG) during the financial year, leaving 109 SIRIs in 2018/19. This is an increase of 18 from the previous financial year, and above the mean for the past three years (102).

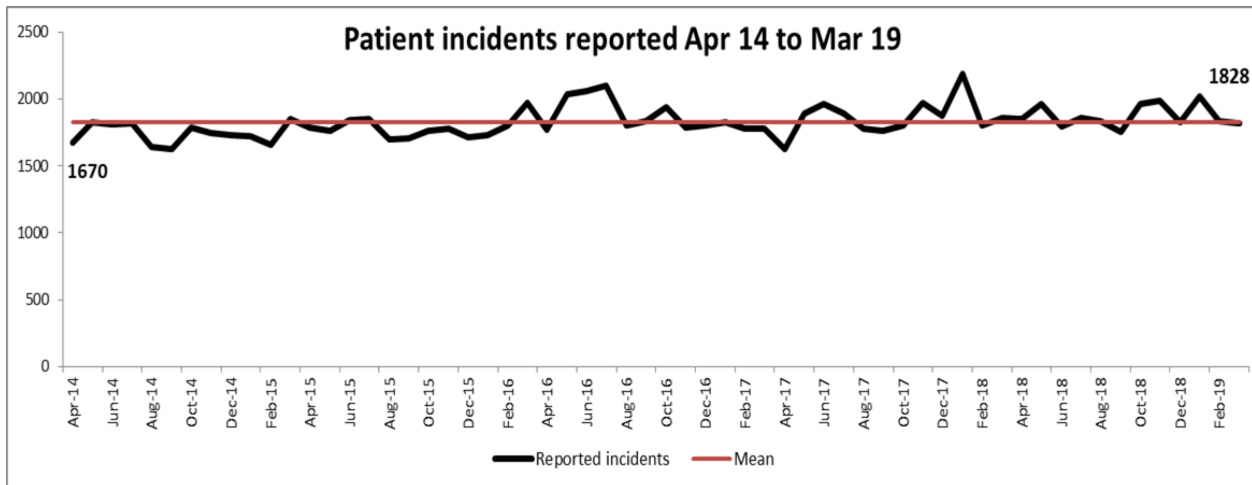
**Table 1:** SIRIs by FY

| FY | SIRIs excluding downgrades |
| --- | --- |
| 1617 | 106 |
| 1718 | 91 |
| 1819 | 109 |

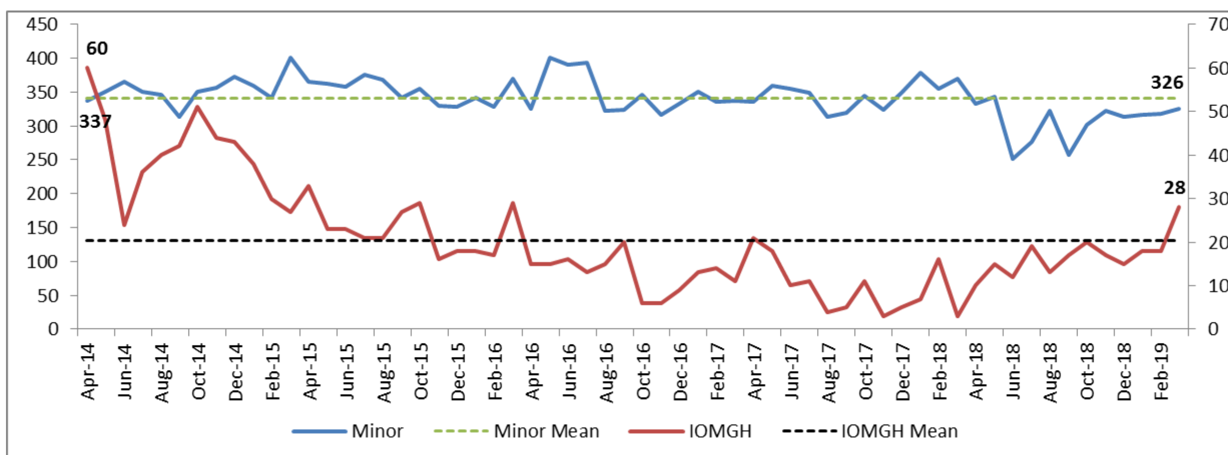
2.3 In 2018/19 0.9% of patient related incidents involved moderate or greater levels of harm, compared with 0.5% in 2017/18 and 0.6% in 2016/17. The increase is potentially connected with a new approach to impact grading that began in January 2019 (see below).

2.4 Graph 2 shows all incidents at Oxford University Hospitals NHS Foundation Trust (OUH) between April 2014 and March 2019. This demonstrates the overall incident reporting culture in the Trust over this period, and demonstrates a small rise in incident reporting numbers over this period (in 2018/19, the monthly figures was above the mean in 8 of 12 instances).

**Graph 2:** Incident reporting trend data for patient safety incidents April 2014-March 2019




**Graph 3:** Trends in number of patient safety incidents showing incidents of no harm, minor harm, and moderate and greater harm (IOMGH) from April 2014 to March 2019



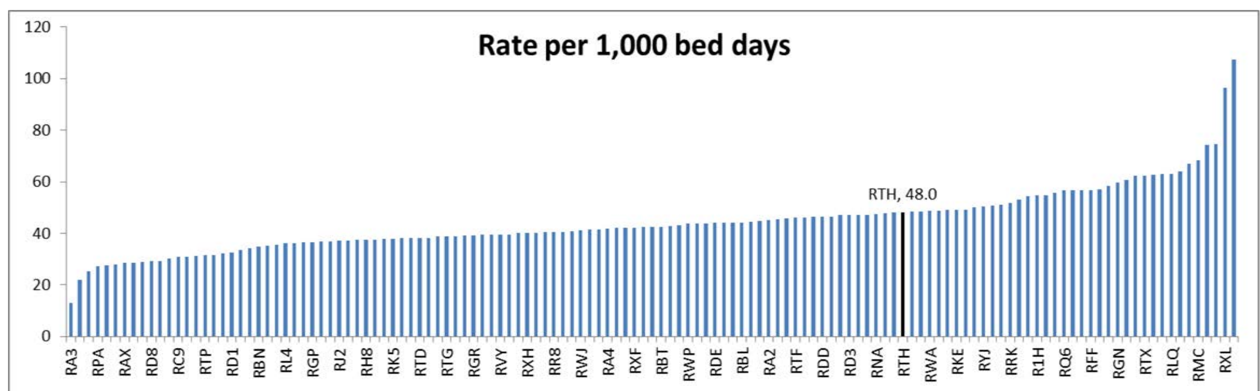

2.5 The number of IOMGHs has been equal to or below the 5-year mean since March 2016, indicating a very clear downward trend, until March 2019 when it was above the mean. This reflects the adoption of changes related to impact grading (see 2.6, below). The Trust's rate has increased significantly since this point last year (48 incidents/1,000 bed days, from 40).

2.6 In January 2019, the Trust changed its policy relating to impact grading for clinical incidents. Prior to this, impact was decided based on the perceived contribution of (in)actions by OUH staff on the outcome; for example, category 3 pressure damage sustained on the ward might be graded as Moderate impact if it was felt that there were omissions in care, and No Harm if it was felt that all steps had been taken during care to mitigate against development of pressure damage. Whilst the IOMGH have therefore increased, representing impact on the patients, there has not been a subsequent increase in the number of SIRIs declared reflecting that the quality of care has not deteriorated.

2.7 The message disseminated in January [which follows the National reporting & learning system (NRLS) guidance] was that impact should be graded literally; for example, all category 3 pressure damage acquired under OUH care would be Moderate, regardless of the care context. Discussions between staff and the Chief Medical Officer and Chief Nurse took place over the following weeks, and

the ethos was beginning to be understood by staff by March for categories such as pressure ulcers and falls resulting in e.g. a fracture neck of femur, hence the rise in IOMGH in that month onwards. By exception additional information regarding impact grading has been disseminated more recently (out of this reports remit) which also includes unexpected and unplanned transfers to theatre or a higher level of care and this explains the gradual and sustained rise in IOMGH. Provisional data for IOMGH in April-June 2019 shows a similar level of IOMGH reporting to March.

**Graph 4:** The rate of incidents reported per 1,000 bed days between October 2018 and March 2019 by acute (non-specialist) organisations each vertical line is an acute provider, OUH is depicted by the black line.

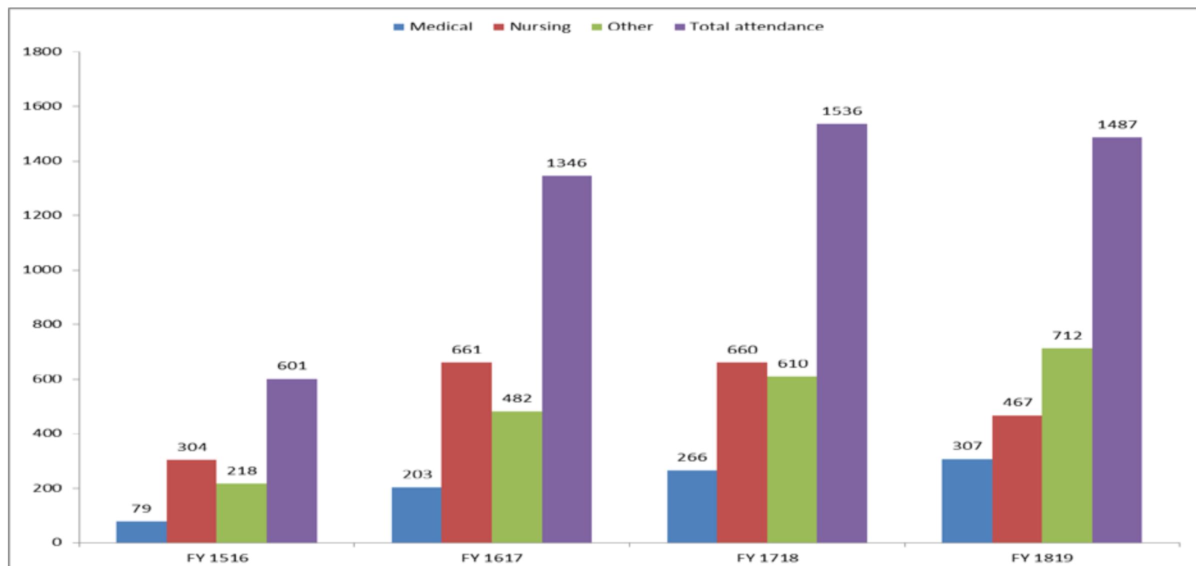



## 3. The SIRI Forum process

3.1 The SIRI forum is a weekly meeting where incidents are presented and the level of investigation and level of impact is decided by a multi-disciplinary team with departments and divisional managers encouraged to attend and to take ownership of decisions made about levels of investigation. It is a forum founded on just culture and mutual respect. This meeting is also attended by subject matter experts such as Tissue Viability, the Chief Clinical Information Officer, Information Governance, human factors leads and the thrombosis lead as required.

3.2 Attendees at the forum during the last FY included executive directors; non-executive directors; clinical directors; consultants from multiple disciplines; matrons and nursing/midwifery staff; and advisors from corporate teams.

**Graph 5:** SIRI Forum attendance by staff group showing the number of nursing staff, medical staff and other staff who have attended. The ‘others’ category includes clinical risk expertise, Information Governance, Pharmacy and laboratory staff, Health & Safety team, and observers such as trainee nurses or medics. (NB the forum began in June 2015, so FY 1516 only covers 10 months)




3.3 All incidents reported on Datix are screened by the central Patient Safety team who meet weekly with the Director for Safety & Effectiveness, Head of Clinical Governance and representatives from Tissue Viability and Falls Prevention with a provisional list of incidents that may meet the criteria of a SIRI or have important cross divisional shared learning.

3.4 Following on from a CQC inspection related to incidents reportable under the Ionising Radiation (Medical Exposure) Regulations (IRMER) it was agreed that the SIRI forum would be an effective place to monitor these incidents. Consequently, Medical Physics review all Datix incidents categorised as Radiation Incidents and inform central CRM which are IRMER reportable; these are then presented at the SIRI forum to raise awareness of issues and actions needed. There has been a marked reduction in IRMER reportable incidents through the year with an extensive program in radiology to prevent unintended or unnecessary X-rays with input from the Patient Safety Academy.

3.5 Monthly meetings occur between central Patient Safety Team and the Trust's Legal team to go through all open inquests. Any inquest that may meet the criteria for a SIRI is cross-checked with the Datix system and a review by the Division is requested. This is an extra safety net for identifying potential SIRIs. There is also an opportunity of issues relating to inquests, claims or complaints to be discussed at the weekly Serious Incident Group meetings (newly formed).

3.6 The Trust's Health and Safety team (H&S) reports any patient harm incidents resulting from a fall to the Health and Safety Executive, where these incidents fit the criteria under the Reporting of Injures and Dangerous Occurrences Regulations (RIDDOR) report. To aid the process of identifying any such incidents, the SIRI forum was identified as a place that can discuss falls where harm has occurred, with minutes reflecting H&S's advice on whether incidents meet these RIDDOR criteria. The adapted initial summary report (ISR) for use in falls incidents, introduced in 2016/17, continues to allow teams to collate suitable data to enable these decisions to be made in the forum.

3.7 The Trust instigated a pilot Patient Safety Response (PSR) meeting on 12 March 2019, in which representatives from Clinical Governance and each Division meet Monday to Friday to discuss all incidents called with Moderate or above impact in the JR 2 and West Wing. The evaluation process for this pilot

took place at the end of July 2019, and the PSR meeting was formally launched Trust wide on 17 September 2019. In 13 meetings held in March 2018, 39 incidents were discussed, of which 9 were downgraded; four departments were visited by a delegation from the meeting, to ensure that patients and staff were suitably supported.

## 4. Additional training and communication activities include

4.1 Training by the Patient Safety Academy has continued to be funded externally and offers training for staff on human factors and quality improvement.

4.2 A root cause analysis (RCA) training course has been delivered by the Patient Safety Team once per month since September 2018. 58 staff members were trained in 2018/19. All staff are welcome to attend, with special emphasis on consultants who may lead SIRI investigations. Attendance is arranged through CRGPs or CRM directly.

4.3 Oxford Simulation Training & Research (OxSTaR) human factors training for multidisciplinary teams continued this year with the same excellent feedback from participants. Data gathered on transfer of training to the workplace has revealed that 86% of staff continues to use safety critical communication tools routinely in their clinical areas over 6 months after completion of the course. We have continued to support the human factors ambassadors trained in previous years by running update sessions and developing new learning materials incorporating learning from real incidents from the Trust. We have also run six bespoke human factors sessions for staff involved in serious incidents to embed learning from these events in a supportive environment.

4.4 Eleven patient safety alerts were created and added to the front page of the Trust intranet in 2018/19, receiving more than 3,500 views in 2018/19. Patient safety alerts are raised in response to some SIRIs, and an alert concerning preventing, recognising and learning from Never Events was created in July 2018; however, with the introduction of the Weekly Safety Messages (see below), fewer issues identified in SIRIs are shared through patient safety alerts.

4.5 Since February 2019 all staff have received a weekly Safety Message from the Chief Medical Officer (CMO) and Chief Nursing Officer (CNO). Topics from the 8 messages sent in 2018/19 include unintended retention of foreign objects post-surgery (see 14.4 below), lowering of beds to reduce falls, direct oral anticoagulation prescription, and the reclassification of pregabalin and gabapentin as controlled drugs.

## 5. Duty of Candour (DoC)

5.1 The legal, professional and regulatory DoC has been embedded into the Trust's day to day processes within the divisions with weekly monitoring via the SIRI Forum (table 8).

5.2 Since January 2017 the CRM team updates Datix as a failsafe system following each SIRI forum's discussion to ensure that it accurately reflects actions relating to the DoC.

5.3 The Clinical Governance and Risk Practitioners (CGRPs), in the divisions, upload the written evidence of DoC onto each incident record in Datix. The SIRI forum's agenda and minutes remind staff that updates and evidence should also be added to the patients' notes.

**Table 6:** DoC compliance from 2018/19 by quarter which shows that written DoC was completed for all patient incidents reported as moderate impact or above in 2018/19.

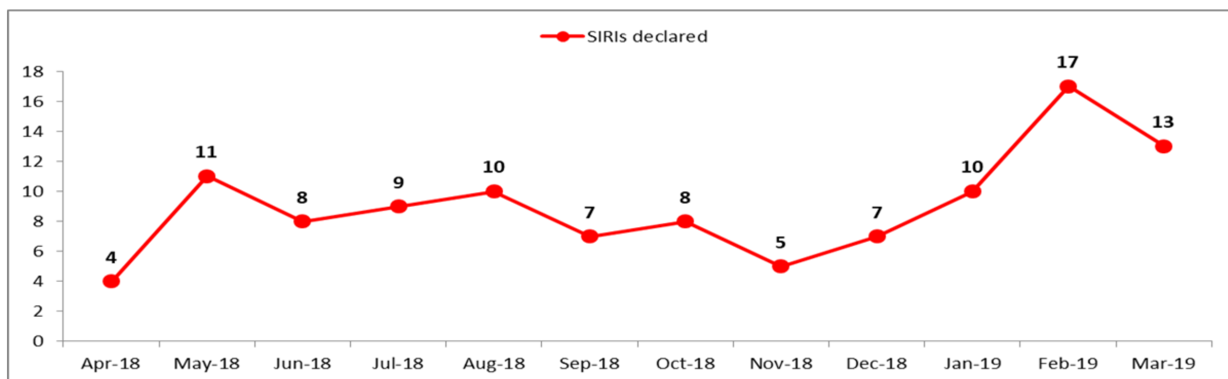
| Financial quarter | Verbal notification | Written notification |
|---|---|---|
| Q1 | 100% (36/36) | 100% (36/36) |
| Q2 | 100% (49/49) | 100% (49/49) |
| Q3 | 100% (52/52) | 100% (52/52) |
| Q4 | 100% (65/65) | 100% (65/65) |

## 6. SIRI overview

6.1 This financial year has seen a small rise in the mean number of SIRIs declared per month from 7.8 to 9.1, and in the median from 7.5 to 8.5.

6.2 Graph 7 shows the number of SIRIs of all types declared during 2018/19, excluding those subsequently downgraded.

**Graph 7:** SIRIs declared, excluding subsequent downgrades




6.3 As in the previous two financial years, there were no delays in completing SIRI reports beyond the national guidance time scale of 60 working days or of an agreed extension from the OCCG. However, 24% of 2018/19 SIRI investigations required an agreed extension (see Graph 8 below). Following discussion with the commissioners the Trust will work to reduce the extension rate in 2019/20.

**Graph 8:** SIRIs extension rates

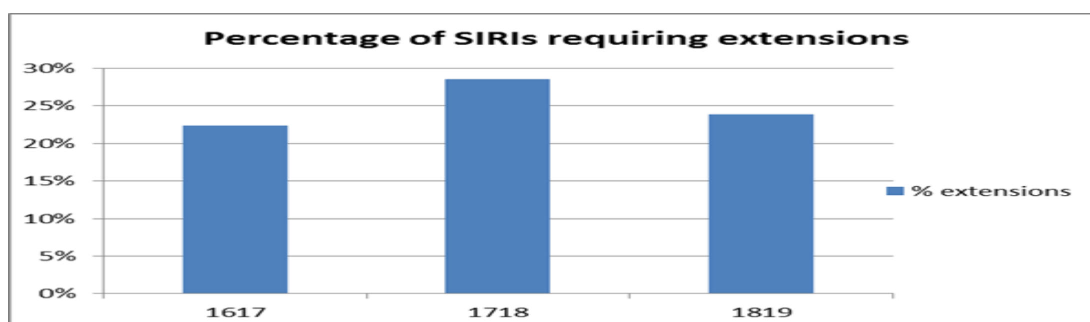


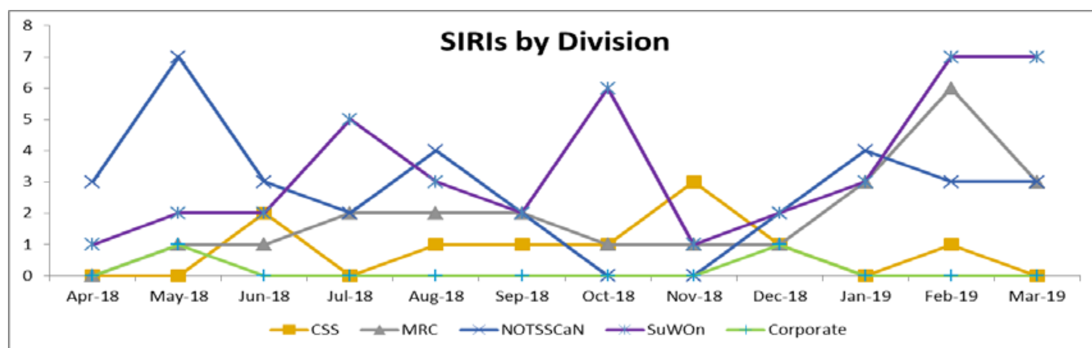

**Table 9** shows the number of SIRIs investigated per Division, excluding downgrades. Please note that the Trust's Divisional structure altered during

2018/19, involving the dissolution of Children's & Women's and the redistribution of its services to the previous NOTSS and S&O Divisions. The data below have been amended to reflect the current structure.

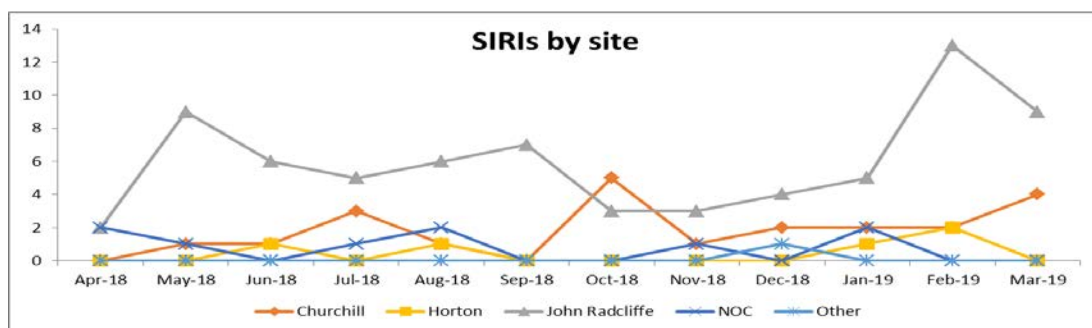
| Division | SIRIs declared |
|---|---|
| CSS | 10 |
| MRC | 23 |
| NOTSSCaN | 33 |
| SuWOn | 41 |
| Corporate | 2 |

6.4 Some SIRIs require cross-Divisional input; table 11 shows the lead Division who will investigate but other Divisions may have had equal input into the findings and conclusions of the report.

**Graph 10:** shows the number of SIRIs declared by Division.




**Graph 11:** shows the number of SIRIs by site. The John Radcliffe consistently reported the most SIRIs, which reflects the fact that it hosts the greatest amount of patient activity.

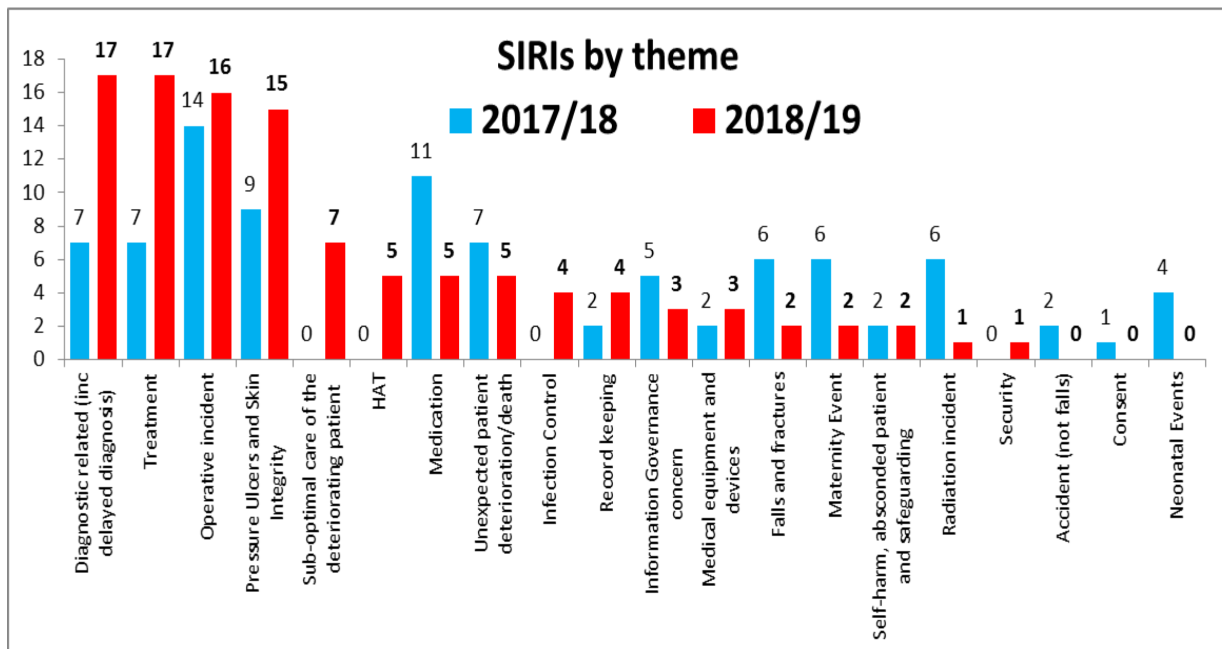



## 7. Downgrades of SIRIs

7.1 Seven of the 116 SIRIs reported on STEIS were downgraded. Downgrades are proposed by the Trust and have to be agreed by OCCG or NHS England.

## 8. SIRIs by Theme

**Graph 12:** provides an overview of the non-downgraded SIRIs reported in the past two years by category.




8.1 The top four SIRI themes were diagnostic related, treatment, operative incident and pressure ulcers.

**Diagnostic incidents**

8.2 There were 17 incidents in the category diagnostic incidents, which occurred in a range of departments. This category includes cases where decision for surgical or no-surgical treatment were delayed or not made, though the issue may not have been a failure in or complication of diagnosis. Two main themes arose from these 17 incidents:

8.2.1 Seven incidents related to a delay or omissions in acting on test results.

8.2.2 Four incidents related to a delay or omission in completing or reporting a test.

**Treatment incidents**

8.3 There were 16 incidents in the category of treatment. The incidents were split between all Divisions, in various departments on the John Radcliffe and Churchill sites. Two main themes arose within this group:

8.3.1 Five incidents related to patients who deteriorated awaiting surgery, or who were discovered to have unexpected pathology when surgery was commenced.

8.3.2 Four incidents related to delays in treatment.

**Operative incidents**

8.4 There were 16 incidents in the category of operative incidents. These incidents covered a range of theatre and non-theatre environments, in all Divisions and on all 4 hospital sites. There was one main theme arising within this group:

8.4.1 Five incidents related to retained items. All of these were investigated as Never Events.

8.5 Learning and actions arising from these SIRIs can be summarised into three main themes:

8.5.1 **Enhancement of electronic systems**:

8.5.1.1 the migration of histopathology results from all areas of the Trust from paper to an electronic system.

8.5.1.2 expedition of requesting and booking of endoscopy procedures on EPR

8.5.1.3 creation of a pool for EPR results in the surgical team

8.5.1.4 amendment of leavers' form to ensure that staff who requested tests or imaging have proxies set up on the departure, and that EPR accounts are deactivated. Also strengthening of local procedures for managing results during staff absence, and inclusion of the importance of reporting pools on medical induction and rotation programmes

8.5.1.5 enable a link between the Xcelera system for managing echocardiogram tests and EPR, and review the criteria for flagging significant findings to referrers

8.5.1.6 amend the Omnilab laboratory IT system to replace certain free text fields with drop-down menus, to eradicate ambiguity.

**8.5.2 Protocol and or process review or development to enable a higher reliability service**

8.5.2.1 creation of a Local Safety Standard in Invasive Procedures (LocSSIP) for interventional radiology procedures, including communication of a standardised list of risks and benefits

8.5.2.2 an increase in the provision of general anaesthesia lists for endoscopy at the John Radcliffe, and establish equivalent lists at the Horton; also increase of endoscopy lists under sedation

8.5.2.3 creation of a flowchart to clarify the process and timeframes for pathology requests for use in the Solid Tumour & Lymphoma MDT, and instigation of automatic weekly relisting of patients with planned surgery at this meeting until pathology results are discussed, or surgery is decided against

8.5.2.4 review the standard operating procedure (SOP) for laboratory tests to cover management of difficult specimens, when to remove a hold on a test, and approaches for repeat tests because of borderline results

8.5.2.5 creation of a robust handover process within Radiology, to reduce delays to imaging

8.5.2.6 initiation of a weekly joint MDT between Cardiac, Acute General Medicine and Infectious Diseases

8.5.2.7 identification of a management lead in Nuclear Cardiology to manage and monitor all referrals against a SOP to be created; cessation of the use of personal email accounts for the receipt of referrals

8.5.2.8 gynae-oncology MDT discussions to include a review of relevant scans, not just written reports; all CT images to be reviewed by the surgeon and a radiologist prior to surgery. Terms of reference for this MDT to be created, and treatment for early stage ovarian cancer to be reviewed to ensure it is in line with national guidance

8.5.2.9 creation of a SOP covering emergency urology procedures undertaken during another specialty operation

8.5.2.10 creation of a SOP mandating the face-to-face review by a gynae-oncology consultant of patients prior to surgery complex surgery

8.5.2.11 investment in additional resource to allow stent change procedures to be completed on a variety of OUH sites; a weekly non-cancer clinical prioritisation meeting will consider patients who are awaiting stent changes

8.5.2.12 review with Wexham Park Hospital of operational policies for managing oesophagogastric cancer patients

8.5.2.13 development of a referral pathway for advanced polypectomy, and addition of a polypectomy referral prompt to the endoscopy reporting software

8.5.2.14 creation of a SOP covering invasive procedures carried out in Neurology outpatient areas, including a standardised checklist in line with the Stop Before You Block procedure for local anaesthetic blocks

8.5.2.15 education for volunteers and sub-contracted housekeeping staff around patients' nutritional and hydration needs

8.5.2.16 a sign to be developed to display on patients' doors for patients with special oral intake requirements

8.5.2.17 creation of a local safety standard in invasive procedure (LocSSIP) for interventional radiology procedures, including communication of a standardised list of risks and benefits

8.5.2.18 revision of appointment information for patients identified as having special communication needs, emphasising the importance of bringing glasses/hearing aids/family members to appointments to ensure communication is optimal

8.5.2.19 development of a flowchart to dictate actions when surgical equipment is found to be malfunctioning intra-operatively

8.5.2.20 confirm positioning for patients requiring calvarial expansion at the weekly MDT, with the intention of avoiding prone procedures for patients with raised intracranial pressure, and to confirm whether tranesxamic acid is necessary

8.5.2.21 embedding of the “VP” sticker system for patients with intentionally retained vaginal packs into Gynaecology, in line with Maternity

8.5.2.22 creation of a LocSSIP for gynaecological examinations involving swabs

8.5.2.23 revision of the colposcopy clinical assessment sheets to include a prompt for swab counts

8.5.2.24 development of a protocol for spinal list planning to include equipment, staffing and skill mix requirements

8.5.2.25 development of a policy for the review of pathology diagnoses by the specialist MDT core pathologist for patients referred from external organisations for radical cancer treatment. This forms part of a review of The Trust's Approach to Cancer Multi-Disciplinary Team Working

**8.5.3 WHO surgical safety checklist related:**

8.5.3.1 creation of a video to demonstrate the WHO checklist process for Endoscopy staff

8.5.3.2 amendment of the Trust's generic WHO checklist to include a question conforming whether any items were intentionally retained during the procedure for later removal, a whether this has been documented

8.5.3.3 extension of the WHO checklist to all invasive radiological procedures, and introduction of short pre-list briefings for staff; procurement of mobile devices to allow access to patient and procedure details at the point of intervention, and amendment of the CRIS radiology software to include laterality of procedures

8.5.3.4 creation of a video to demonstrate the WHO checklist process for Dermatology staff, along with the revision of the WHO checklist and the introduction of wristband use; all elements to be included in a LocSSIP for invasive dermatological procedures

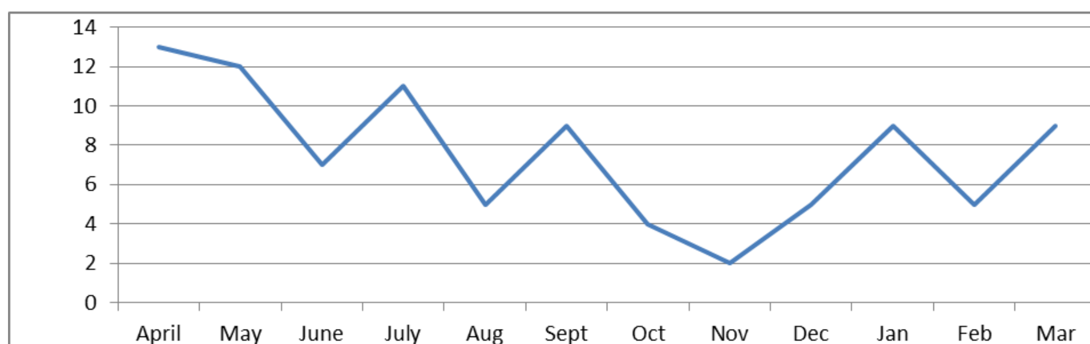
## 9. Pressure ulcer and skin integrity

9.1. All pressure ulceration is reported as a clinical incident on Datix. This is separated into 2 categories, present on admission (POA) and hospital acquired pressure ulceration (HAPU).

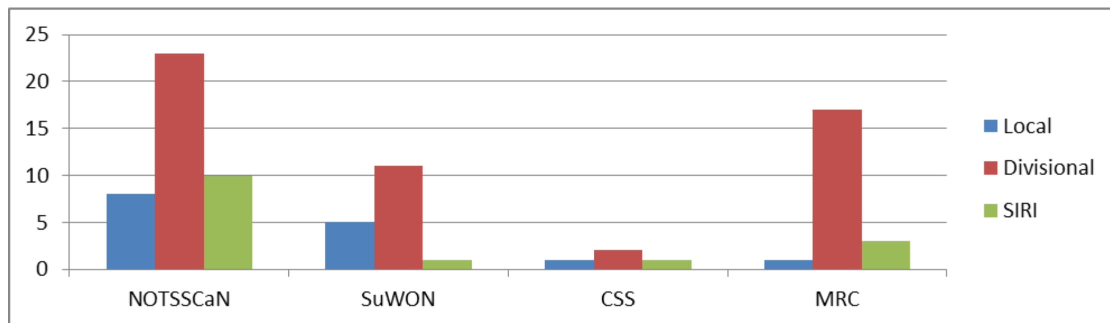
9.2. Any deterioration of a POA pressure ulceration and HAPU are investigated to identify any lapses in care delivery. SIRIs are declared where serious harm to the patient has deemed to have occurred (as defined by the Tissue Viability Society Consensus Paper, 2014), mostly category 3 and 4 pressure damage, along with significant undocumented deviations from the Trust Pressure Ulcer Prevention Policy (2018). Those not reported as SIRIs are investigated within the Divisions.

9.3. During 2018/19, 91 category 3 and 4 HAPUs were reported on Datix. This is an overall reduction of 20% from the previous year of 114. Of the 91 reported, 15 HAPU SIRIs were declared. 14 investigations were for category 3 pressure ulceration, as defined by the European Pressure Ulcer Advisory Panel (2014) and one for category 4 pressure ulceration (the most severe) in December 2018. Graph 13 details all Category 3 and 4 incidents reported by month.

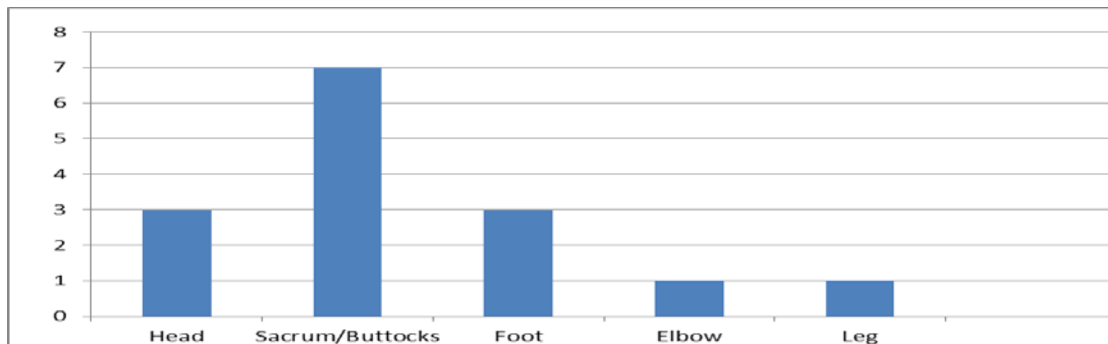
**Graph 13:** Category 3 and 4 incidents 2018/19




**Graph 14:** Category 3 and 4 HAPU investigation levels by Division




**Graph 15:** HAPU SIRIs by anatomical site




9.4. Of the 15 Serious Incidents, 5 were pressure ulceration related to the use of a device, such as cast, oxygen tubing or splints. One Category 4 pressure ulcer was reported in December 2018, which was device related. In response to this specific incident a Safety Alert was cascaded to all OUH email users to warn of the risks and to increase awareness of the vulnerability of skin under devices.

9.5. Aggregate analysis of the investigation summaries was undertaken in order to identify common themes. All Serious Incident investigations identified varying levels of failure to comply with Trust Policy for the Prevention of Pressure Ulceration (2018). Below is an analysis of the common themes.

9.5.1. Risk and skin assessment: In most cases risk assessment was poor, either in terms of timely completion or accuracy.

9.5.2. Care planning: A consistent theme from all investigations continues to be lack of appropriate care planning. Unclear modes of documentation, between paper and electronic form, have been identified as an issue in several of the incidents.

9.5.3. Medical Devices: A project is underway, led by specialist practitioners, to address the education and awareness needs in relation to medical devices related pressure ulceration. A multitude of devices in use has led to increased reporting in an area previously believed to be under reported.

9.5.4. Interventions: The inconsistent documentation of care delivery and planning related to the above themes was common. Lack of robust, individualised, care planning resulted in unwarranted variation of remedial interventions, such as appropriate repositioning schedules or frequency of skin checks. The quality of care delivery and related documentation remain the responsibility of the ward leaders and matrons.

9.5.5. A contributing factor in several of the reports suggests that staffing levels had an effect on the ability of the teams to document or deliver appropriate care.

9.6. Actions identified as a result of these investigations include:

9.6.1. The Pressure Ulcer Prevention Policy was updated in 2018 to reflect guidance related to the use of devices and care of patients with spinal instability.

9.6.2. The Pressure Ulcer Prevention E-Learning module is mandated for all nurses, midwives and allied healthcare professionals. Compliance is now monitored monthly.

9.6.3. The Trust work plan for pressure ulcer prevention was monitored for this time period to reflect the learning and support remedial actions from these incidents to support Trust-wide learning. The work plan is currently under review.

9.6.4. New Trust guidelines are under development for the care of patients with casts and splints to reduce the risks from these specific devices.

9.6.5. Educational videos have been developed by Adult Intensive Care Unit and are available to view on the Tissue Viability intranet, related to the use of Miami collars and the care of patients who are under spinal precautions in response to the patients with occipital pressure ulceration.

9.6.6. Clinical audit of pressure ulcer prevention was conducted in Quarter 1, 2019/20. The audit findings will be communicated across the Divisions for local actions to be decided and supported by the Tissue Viability Team. The audit was carried out in conjunction with NHS Improvement.

9.6.7. The Trust has signed up to an NHS Improvement collaborative, focused on reducing harm from pressure ulceration.

## 10. SIRIs in which the patient died

10.1. 14 SIRIs involved patients who died. In 6 cases the impact of the incident was the death of the patient. There were 8 cases where the patient died but the incident which was the subject of the investigation may not have impacted on the eventual outcome.

10.2. Cases of SIRIs involving a death also have a structured judgement mortality review in accordance with national guidance. SIRIs involving deaths are presented to the Mortality Review Group (MRG) by the investigator to facilitate Trust wide learning. MRG has consultant representation from all divisions.

**Table 16:** SIRIs involving patient deaths, 2017/18 and 2018/19

| Year | 2017/18 | 2018/19 |
|---|---|---|
| Total number of SIRIs involving a death | 17 | 14 |
| Impact of the incident was the death of the patient. | 4 | 6 |
| **Incident categories** | | |
| Diagnosis and treatment | 1 | 6 |

| Year | 2017/18 | 2018/19 |
|---|---|---|
| Unexpected patient deterioration/suboptimal care of the deteriorating patient | 4 | 4 |
| Hospital acquired thrombosis | 2 | 2 |
| Intrauterine and neonatal death | 5 | 1 |
| Fall | 1 | 1 |
| Chemotherapy management | 2 | 0 |
| Equipment and environment | 1 | 0 |
| Self-harm | 1 | 0 |
| **Learning and action themes** | | |
| Review of practice and procedures | ✓ | ✓ |
| Training and Education | ✓ | ✓ |
| Documentation and the electronic patient record | ✓ | ✓ |
| Multidisciplinary team working | - | ✓ |
| Clinical audits and service evaluation | - | ✓ |

10.3. In comparison with 2017/18 death-related SIRIs we can observe:

10.3.1. The number of SIRIs involving deaths has decreased.

10.3.2. Unexpected patient deterioration/suboptimal care of the deteriorating patient remains a common incident category theme.

10.3.3. The number of SIRIs involving deaths related to diagnosis and treatment has increased.

10.3.4. The number of SIRIs related to intrauterine and neonatal death has decreased.

10.3.5. The common learning and action themes have remained review of practice and procedures, training and education, documentation and EPR.

10.3.6. New learning and action themes in 2018/19 are MDT working, clinical audits and service evaluation.

10.3.7. Regarding practice and procedures, there is an increased number of LocSSIPs underway which were instigated in 2018/19, which relates to the increase in death-related SIRIs involving delays to diagnosis or treatment.

10.4. The five themes for learning and actions in SIRIs involving patient deaths were:

10.4.1. Review of practice and procedures e.g. a standardised LocSSIP for patients with liver cirrhosis undergoing paracentesis is being developed by the Gastroenterology Unit which will include the requirement for the clinical team to provide advice to patients about when to stop their anticoagulation.

10.4.2. Training and Education e.g. staff members in the Upper Gastrointestinal team have completed Human Factors training focussing on the Track and Trigger Escalation Pathway.

10.4.3. Multidisciplinary team (MDT) working e.g. joint MDT meetings have been initiated by the Cardiac, Acute General Medicine and Infectious Diseases teams.

10.4.4. Clinical audits and service evaluations e.g. the Trauma Service completed an audit of the care of outlying patients to ensure that the same standard of care is delivered regardless of location.

10.4.5. Documentation and the Electronic Patient Record (EPR) e.g. the 'soft' pop up alerts for VTE prophylaxis, which can be clicked through, were changed to 'hard' pop up alerts, which cannot be by-passed, without completing the required action.

## 11. Never Events

11.1. Eleven Never Events were declared on STEIS in 2018/19. This is higher than the two previous years' totals, 8 in 2017/18 and 2 in 2016/17.

11.1.1. Of note, one of the Never Events declared in 2018/19 referred to an incident that occurred in 2017/18 in which a patient underwent a sigmoidoscopy under another patient's clinical plan, which was identified as part of another investigation. Graph 17 shows Never Events by date of incident, rather than declaration, and so only shows 10 cases, excluding that case.

11.2. In 2018/19, in response to these Never Events the Trust held two Never Event risk summits, in August 2018 and January 2019, concentrating on issues relating to these incidents. These were attended by staff members, executive and non-executive directors, patients, and representatives from our commissioners.

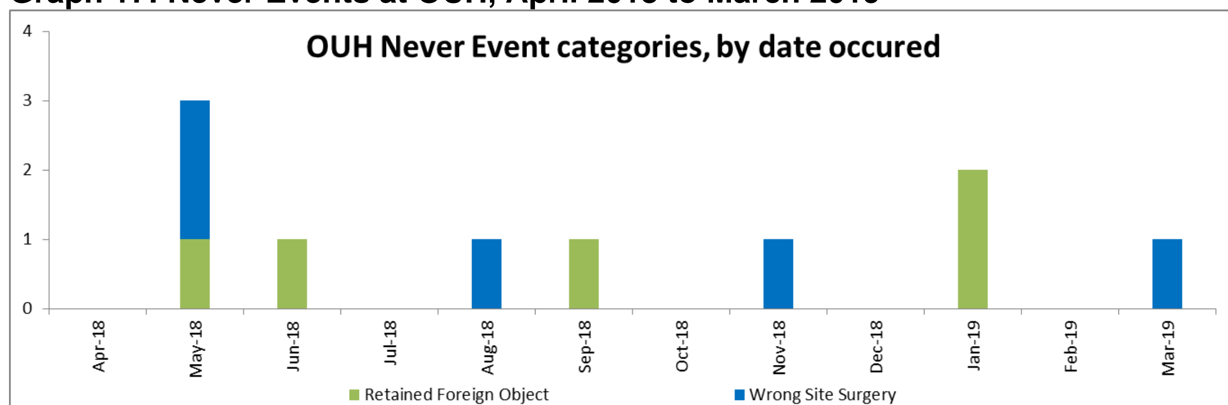
11.2.1. Presentations and discussions included embedding the WHO surgical safety checklist with Bronchoscopy as a case study, national safety standards for invasive procedures (NatSSIPs) and the development of local equivalents (LocSSIPs), the Stop Before You Block local anaesthetic block procedure, the role of human factors in Never Events, and the use of training videos to embed best/required practice, with an example from Endoscopy.

11.2.2. Posters and documents to take away were created detailing the nature of Never Events, and specifics of those that had occurred in the Trust prior to the events.

11.2.3. Further Safety Summits are planned to be held in the Trust in 2019/20.

11.3. As part of an ongoing Never Event Improvement Plan, an external investigator was supplied though NHS Improvement to lead on two Never Events investigated in 2018/19. They also provided training, alongside the Patient Safety Academy, into effective action planning.

**Graph 17: Never Events at OUH, April 2018 to March 2019**



11.4. Assurance visits are undertaken by Oxfordshire Clinical Commissioning Group (OCCG) and, if relevant, NHS England, once action plans are completed before any Never Event can be closed. In order to accommodate the large number of Never Events called in the past 2 FYs for which action plans have been completed, thematic assurance visits were completed to address issues relating to local anaesthetic blocks and positive patient identification. Through this approach 13 Never Events were closed in 2018/19 from 4 assurance visits.

11.5. These events have been reported to the Trust Board and Quality Committee in detail at the time and in the Quality Account. The cases were discussed locally, for example at Mortality and Morbidity meetings, at Directorate and Divisional Clinical Governance meetings, and at departmental staff meetings as well as at the Trust Clinical Governance Committee and Patient Safety & Clinical Risk meetings.

## 12. Future Plans

12.1. A Never Event improvement plan was introduced in 2018/19, and informed work such as the Never Event risk summits and involvement of external advisors in Never Event investigations. Work will continue to deliver this plan in 2019/20.

12.2. Patient safety Team instigated regular training on root cause analysis and the requirements of the Serious Incident Framework in September 2018. 58 staff members were trained in 2018/19, with monthly training sessions continuing in 2019/20.

12.3. During 2019/20 Trust’s incident management software will change to an alternative package. A procurement and implementation process is underway. The new software will allow for improved functionality, including greater connection with EPR, and improved correlation between records relating to incidents, complaints and legal claims and inquests.

12.4. It is envisaged that all actions specified in SIRI reports will be managed through a module in the new software. This will allow instant reporting on compliance with timetables, and the uploading of evidence of action completion to a central repository. In preparation for this, Divisions have been reporting their compliance with 2018/19 SIRI actions to Clinical Governance Committee each month and going forward these will be overseen by the newly formed Serious Incident Group (SIG) which has met weekly since September 2019.

12.5. Weekly patient safety message (see 4.5 above) will continue to be sent to all staff.

12.6. A weekly Serious Incident Group began meeting in August 2019, with a formal launch at the start of September. All SIRI investigations are presented 6 weeks after they have been added to STEIS, and the main themes identified and planned recommendations are discussed. Selected Divisional investigations may also be tabled, if the investigators are encountering any difficulties, or if the investigation level is to be reconsidered. OCCG colleagues will be invited to join the group in January 2020.

## 13. Recommendations

13.1. The Committee is asked to note the contents of this report.

Meghana Pandit, CMO and Sam Foster, CNO

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Helen Cobb, Head of Clinical Governance

Dr Peyton Davis, Director for Safety & Effectiveness

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