Patient Safety Report

Annual Headlines 2017/18

SIGN UP TO SAFETY

In September 2014 Leicester's Hospitals signed up to the national 'Sign Up to Safety' campaign.

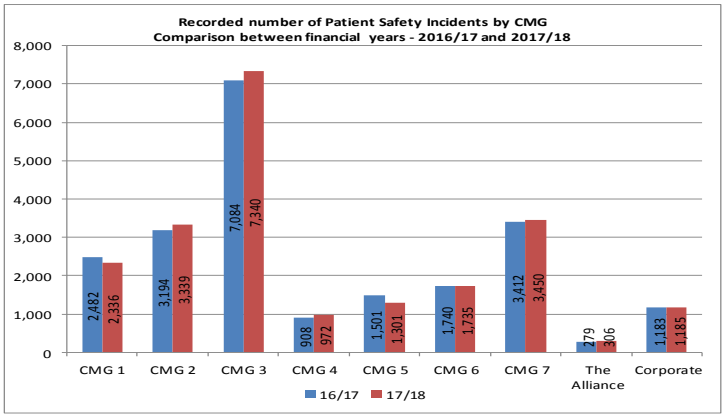
The campaign aims to halve avoidable harm and save an additional 6,000 lives over three years. Our 'Sign up to Safety' safety improvement priorities are aimed at improving the recognition, escalation, response and effective on going management of the deteriorating patient.

In 2017/18, as the continuation of the 'Sign up to Safety' campaign we have:

- Recruited a dedicated Sepsis team with the Emergency Department, dedicated to the recognition and management of Sepsis
- Created the "The Little Voice Inside" obstetric training package (TED) to share best practice and improve patient safety. This has been shared nationally
- Continued to further develop the Patient Safety Portal functionally and user experience, through valuable feedback received from our stakeholders
- Implemented the 5 e-learning modules hosted on HELM, which provide a more in-depth understanding of Human Factors and Ergonomics
- Continued development and roll-out of electronic observations across all specialties within the trust.

Going forward our Sign up to Safety patient safety improvement plan will be fully integrated into our dedicated Patient Safety improvement work within our Quality Commitment.

Number of Patient Safety Incidents occurring in 2017/18



2017/18 saw an increase of 1% in the number of Patient Safety Incidents being reported compared to 2016/17.

The increase in the number of incidents is reflected across the board with the exception of CMGs 1 & 5 (CHUGGS & MSKSS) who both saw decreases of 6% & 13% respectively.

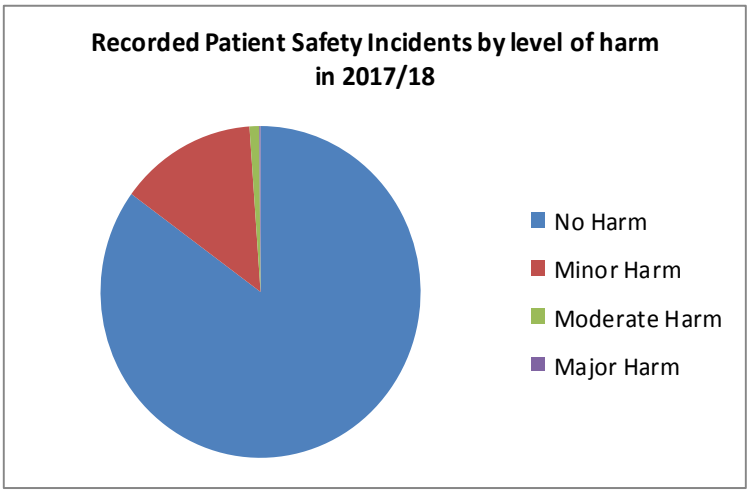
A total of 21,964 Patient Safety Incidents have been recorded for 2017/18 of which 243 (1.1%) caused Moderate or Major Harm (including death) to patients.

Clinical Management Groups (CMGs) and Corporate Directorates
CMG 1 (CHUGGS): Cancer, Haematology, Urology, Gastroenterology & Surgery
CMG 2 (RRCV): Renal, Respiratory, Cardiac & Vascular
CMG 3 (ESM): Emergency & Specialist Medicine
CMG 4 (ITAPS): Intensive Care, Theatres, Anaesthesia, Pain Management & Sleep
CMG 5 (MSK&SS): Musculoskeletal & Specialist Surgery
CMG 6 (CSI): Clinical Support & Imaging
CMG 7 (W&C): Women's and Children's
The Alliance: Community Hospitals
Corporate Directorates

Levels of harm of Patient Safety Incidents in 2017/18

Of the 21,964 recorded patient safety incidents for 2017/18 a total of 18,680 (85%) did not cause any actual harm to patients.

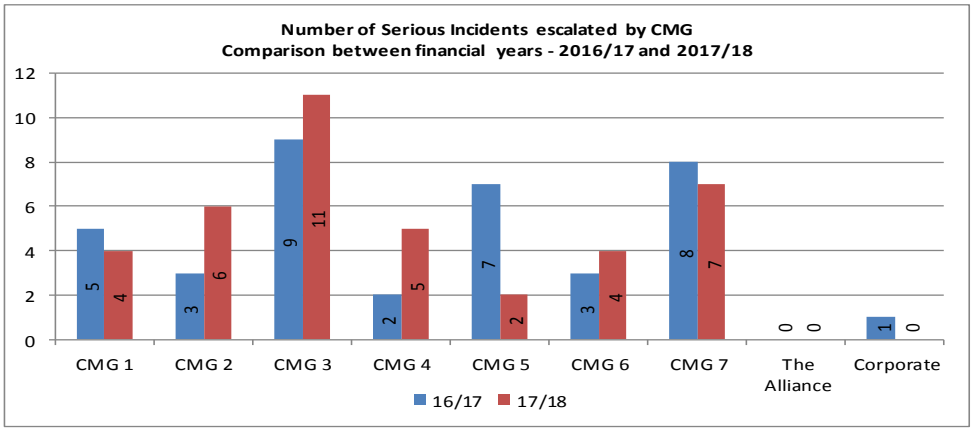
The Trust continues to record a large number of incidents but the actual harm to patients was seen in less than 1.5% of incidents.



As a trust we are open and honest about incidents that have occurred and been investigated on behalf of our patients and feel that this data should be shared openly.

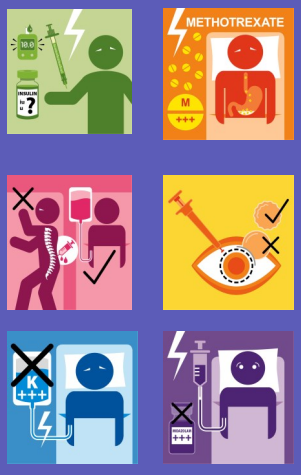
Serious Incidents escalated by CMG in 2017/18

2017/18 saw a **3% increase** in the total number of Serious Incidents (SIs) escalated compared to 2016/17 with the majority occurring in CMGs 2, 3 & 7.



Actions from Never Events

- Every Never Event is to be presented at the monthly Chief Executive briefings
- Never Event safety information is included in all Staff Induction sessions
- If the Trust has a never event then the Director on Call will meet with the relevant department and it's senior management team to understand the incident and agree immediate actions



Reported Never Events in 2017/18 & identified learning

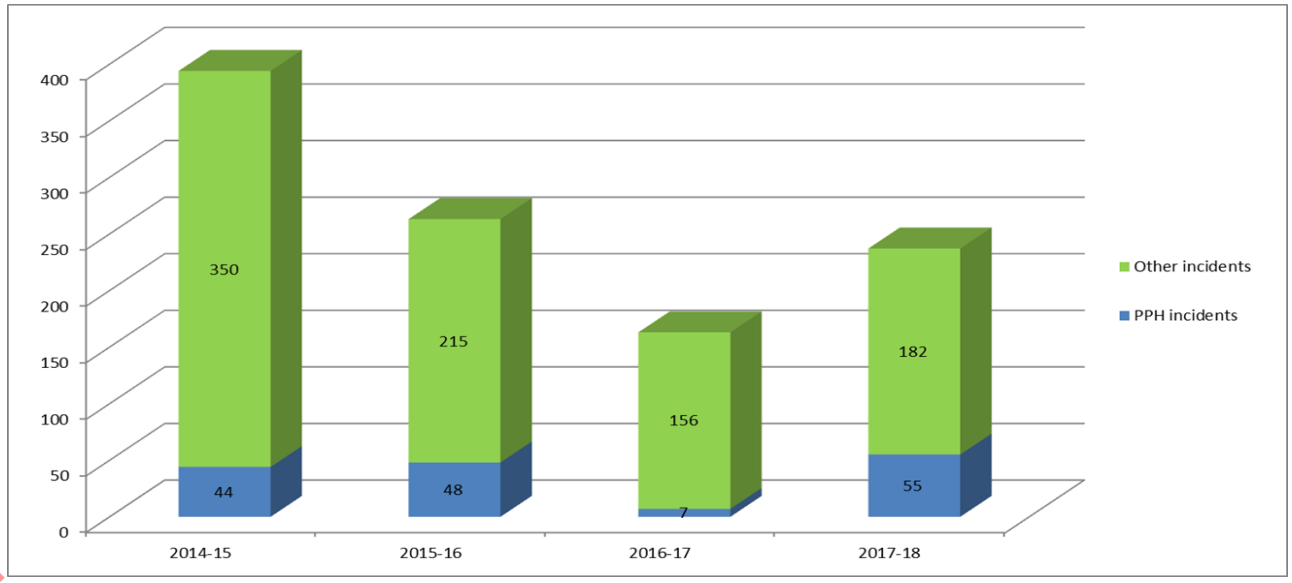
Never Events are serious, largely preventable, patient safety incidents that should not occur if the available, preventative measures have been implemented by healthcare providers.

In 2017/18 **Eight** Never Events were escalated for the Trust – this is double the number that was escalated in 2016/17.

Never Event Type	Lessons learned
Wrong route administration of medication	The new ISO 80369-6 epidural connector will be incompatible with intravenous devices. Drugs drawn up into syringes for epidural use will not be able to inject into intravenous ports, and vice versa.
Retention of a guide wire	All guidewires brought to the trolley throughout the procedure are accounted for and safely disposed of. All guidelines, policies and procedures are to be followed and adhered to.
Misplaced NG tube	Protocol for the management of a patient in an out of hospital cardiac arrest including administration of DAPT will be developed and implemented The Insertion and Management of NG Tubes in Adults policy is to be reviewed, ensuring that the safety checklist for NG insertion interfaces with the policy.
Wrong patient surgery	Review of local Safety Standard for Invasive Procedure (LocSIPP) Review of storage facilities for medical records in dermatology for the 2WW Pathway. Process mapping to be undertaken for admin, consent and the 2WW processes. Risk assessment of working environment for administration and records purposes
Retention of a guide wire	Ensure lines are always inserted using two person process and LOCSIPP completed and audit the use of LocSIPP.
Retained glove	The policy for the Management of Surgical Swabs, Instruments, Needles and Accountable Items to be reviewed and updated. Review standardisation of equipment for the maintenance of the pneumoperitonuem
Patient put on Medical air and not Oxygen	Medical air flowmeters must be removed from terminal units and stored in an allocated place when not in active use.
Retained throat swab	Standardisation of swab counts when mouth gags are used will be reviewed as a result of this Never Event.

Reducing avoidable harm to patients 2017/18

From the 2017/18 moderate plus harms data UHL is not seeing a significant increase in actual harm as the numbers suggests as the main reason for the increase in harm is due to way in which specific incidents (Post-Partum Haemorrhage) have been graded this year in comparison to last year. They were previously graded this way in 2014/15 and 2015/16. Without these incidents included we would have seen an 8.4% increase rather than the 33% evident in the graph for 2017/18.



Learning from Patient Safety Incidents

Corporate Risk Management

Effective risk management awareness and practice at all levels is an integral success factor for UHL. At its simplest, risk management is good management practice. Application of the risk management framework will ensure the organisation's management understands the risks to which it is exposed and deals with them in an informed, proactive manner.

Board Assurance Framework

The Board Assurance Framework (BAF) has been closely monitored during the year by the Trust Board and includes a description about the principal risks which may adversely affect the achievement of our strategic objectives. Through regular review of the BAF the Trust Board receive assurance that the highest rated risks and areas of concern are being effectively managed and additional assurance commissioned where a gap is identified.

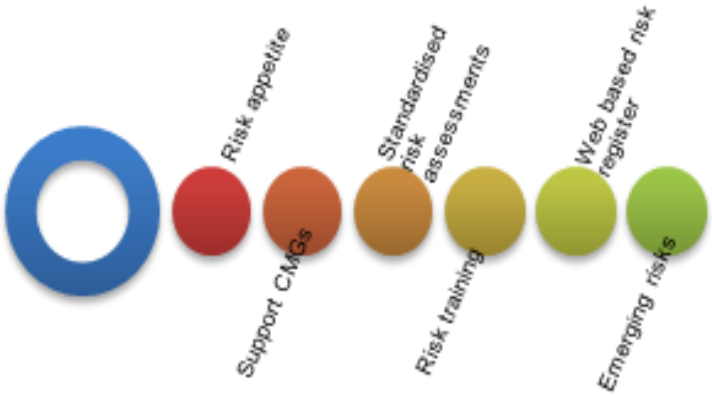
This highest rated principal risks on the BAF are as follows:

- workforce shortages,
- demand & capacity capability,
- financial sustainability.

Risk Register

Risk management assessments are undertaken by clinical and corporate services to consider amongst other things potential for harm and adverse reputation. Following endorsement by senior management, the risks are recorded on the Trust risk register and provide UHL's risk profile. This process demonstrates a 'ward to Board' risk reporting framework. Analysis of the risk register has identified the two main risk causation themes as workforce shortages and ability to meet increasing demand pressures, which correlates to the principal risks on the BAF and to national trends. Financial pressures, including external funding and internal performance are recognised as enablers to support the delivery of the Trust's objectives. Other causation themes identified on the risk register, include adherence to national and local processes and procedures; limitations with technology equipment and infrastructure; and availability of clinical equipment/devices.

The Road Ahead 18/19



2017/18 Central Alerting System

National patient safety alerts, MHRA medical device alerts, important public health messages and other critical safety information and guidance are issued to NHS Trusts via the national Central Alerting System (CAS). This is a web-based system that provides a mechanism for healthcare organisations to confirm that actions to comply with national alerts have been taken within specified timescales. At UHL we consistently achieve a high level of compliance with deadlines and from 1st April 2017 to 31st March 2018 we received a total of 109 national alerts, with no deadlines for compliance breached.

Patient Safety Alerts

Within Leicester's Hospitals there is a robust accountability structure to manage PSAs. Heads of Nursing take an active role in the local management of alerts and broadcasts are reported through established governance arrangements to the executive team and Board for corporate oversight of compliance. During 2017/18 we received 6 patient safety alerts and no alerts breached their due date.

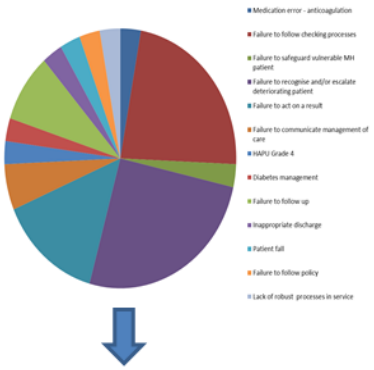
Following an appraisal of the Trust's process to manage alerts, a new panel consisting of the Director of Safety and Risk, Medical Directors & Chief Nurses teams, Risk Manager and Patient Safety Manager will scrutinise the effectiveness of the proposed action plans.

Alert Titles
NHS/PSA/RE/2017/002 - Resources alert to support the safety of girls and women who are being treated with valproate
NHS/PSA/W/2017/003 – Warning alert about risk of death and severe harm from ingestion of superabsorbent polymer gel granules
NHS/PSA/RE/2017/004 – Resource alert to support safe transition from the Luer connector to NRFit™ for intrathecal and epidural procedures, and delivery of regional blocks
NHS/PSA/W/2017/005 – Warning alert about risk of severe harm and death from infusing total parenteral nutrition too rapidly in babies
NHS/PSA/D/2017/006 – Directive alert confirming removal or flushing of lines and cannulae after procedures
NHS/PSA/W/2018/001 – Warning alert about risk of death and severe harm from failure to obtain and continue flow from oxygen cylinders

MHRA Alerts

During the year the corporate risk management team have carried out an internal review of processes for managing safety alert broadcasts at local levels. Findings from the review support that robust and effective governance is in place to manage compliance with alerts at management and operational level and a small number of recommendations, to strengthen the level of assurance, have been identified and will be applied during 2018/19.

Themes from Serious Incidents in 2017/18



8 Never Events

1 Misplaced nasogastric tube
2 retained foreign objects – guide wires
1 wrong route administration of medication
1 wrong site surgery – wrong patient
2 retained foreign objects – swab/glove
1 unintentional connection of patient requiring oxygen to an air flow meter

Anticoagulation Committee

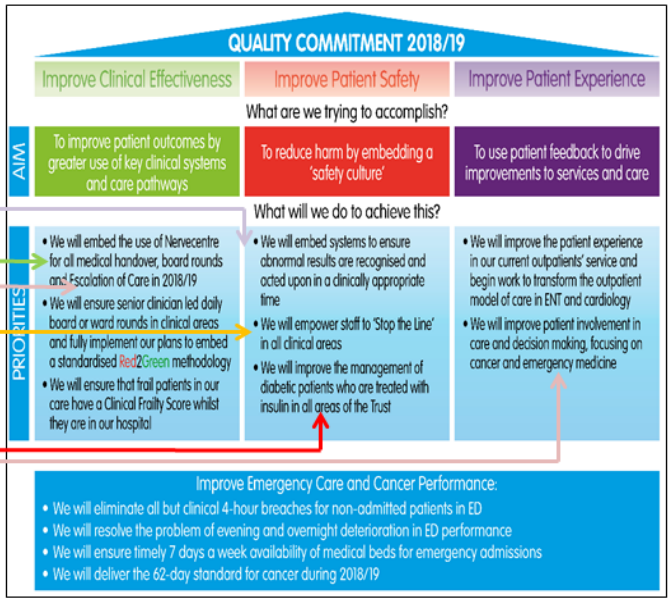
Safer Surgery/Stop the Line work programme, NatSSIPS/LocSSIPS work

Deteriorating Patient Board work programme

ICE Programme Board work programme

Medical handover work stream
Improve communication

Insulin safety work plan



PATIENT SAFETY AND QUALITY IMPROVEMENT

Patient safety and quality improvement are the central objectives of the trust and remain our highest priority. We recognise that patient safety is a fundamental component of high quality care and in 2018/19 we aim to build upon a strong performance of harm reduction and improvement initiatives. NHS Improvement guidance, Health Foundation and IHI quality improvement models as well as HSIB and CHFG recommendations continue to inform our approach to safety and improvement. Our ambition is to drive down to zero preventable harm. To achieve this we seek to learn from the best, to become devoted to continuous learning and improvement, to develop effective and sustainable solutions and to work with system partners to support system-wide patient safety.

The central planks of our safety programme are:-

- **Safety Leadership and Culture**
- **Safety Process**