

Annual Report on Management of Serious Untoward Incidents 2009/10

Wendy Lefort, Clinical & Practice Governance Manager, April 2010

1. Introduction

Healthcare organisations strive to be as safe as possible for patients, staff and the public. Unfortunately, incidents do occur that impact on safety. It is important that these are reviewed to reduce the chance of something similar happening again. We also need to spread learning from incidents so that healthcare organisations can put systems in place to stop the same problems occurring.

There are certain more serious incidents that need very robust investigation to find out why they happened. These are defined nationally as Serious Untoward Incidents (SUIs). These include unexpected or avoidable death, or serious harm to patients, staff or the public.

As part of its role in safeguarding and improving the health of its population, NHS Cambridgeshire (NHSC) requires the organisations it commissions to report details of all SUIs. This requirement is included in all contracts. NHSC monitors these provider organisations to ensure the SUIs are investigated appropriately and that learning from the investigation is shared across the health economy.

This report summarises the SUIs reported to NHSC during 2009/10, giving comparison with the previous year where appropriate.

2. Summary of SUI activity

Number of SUIs reported

The number of SUIs reported to NHSC between 1 April 2009 to 31 March 2010 is given below.

Status	2009/10	2008/09
SUIs open at 1 April	70	45
SUIs reported during period	89	104
SUI investigations completed during period	120	79
SUIs open at 31 March	39	70

NOTE: SUI figures for 2008/09 throughout this report have changed slightly from the 2008/09 annual report due to reclassification and changes in definitions.

There were several SUIs with reports outstanding at 31st March 2009, and provider organisations have worked hard in 2009/10 to finalise older reports and reduce the number of SUIs open at the year end.

SUI levels and categories

All SUIs are given a level from 1 (least) to 3 (most) dependent on the severity of the incident. The number of SUIs for each level for 2008/09 and 2009/10 was:

Level	2009/10	2008/09
1	40	41
2	14	21
3	35	42

The number of level 1 SUIs was consistent for each year, but higher level SUIs have fallen. This is partly due to a reduction in infection control incidents reported. No other trends for higher level SUIs were apparent.

Each SUIs is classified under an NPSA category. The table below shows the categories where 5 or more SUIs were reported in 2009/10.

Level	2009/10	Level 1	Level 2	Level 3	2008/09
Infection Control	17	0	0	17	31
Suicide / Possible suicide	16	13	1	2	16
Patient Care	11	6	4	1	8
Clinical Assessment & Treatment	10	1	1	8	7
Information	10	5	4	1	6

In addition to NPSA categories, certain types of SUIs were flagged in 2009/10 to highlight areas of importance, for example cases relating to safeguarding children (3 SUIs) or where there has been media interest (11 SUIs).

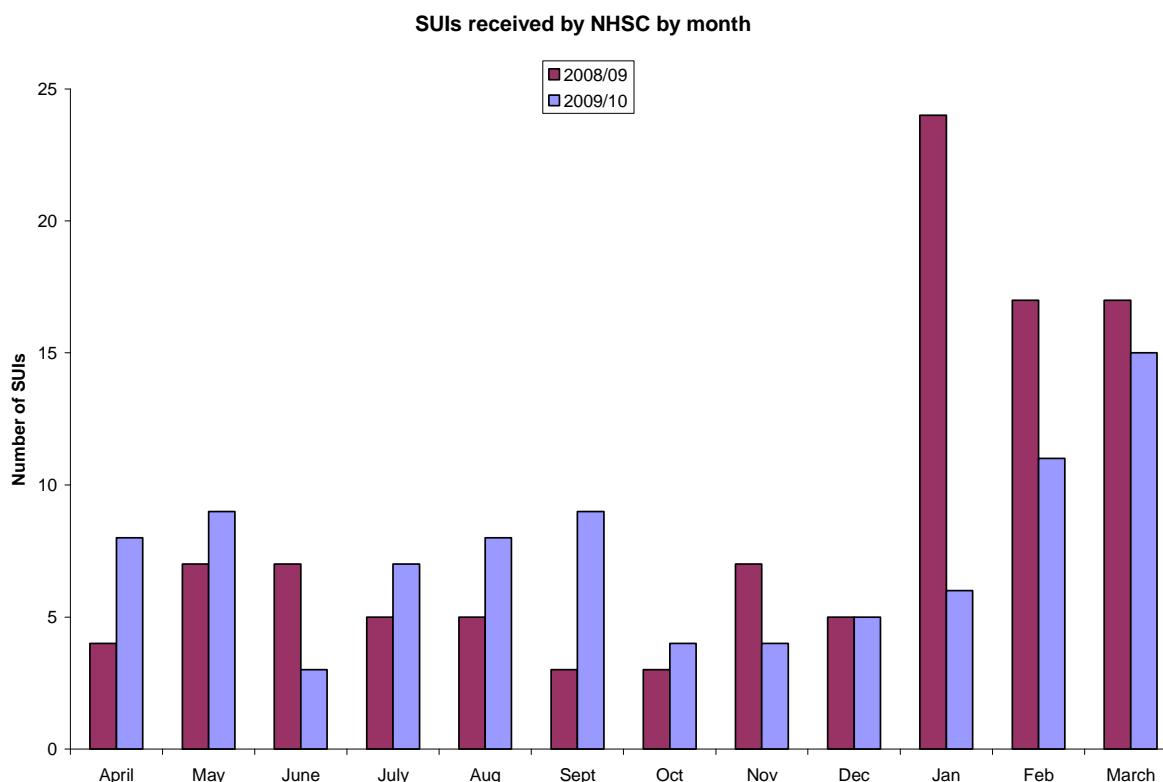
Source of SUIs

There are four main providers reporting SUIs to NHSC. These include two acute trusts, Cambridge University Hospital Foundation Trust (CUHFT) and Hinchingsbrooke Hospital (HHCT), one mental health trust, Cambridgeshire & Peterborough Foundation Trust (CPFT) and one community service, Cambridge Community Services (CCS). In addition, there are two prisons in the region and they are required to report SUIs. The EoE Ambulance trust reports SUIs that relate to NHSC patients or services. Some SUIs that relate to independent contractors, or involve multiple agencies, are reported and investigated by NHSC. The number of SUIs by reporting organisation for 1 April 09 to 31 Mar 10 is given below:

	CCS	CPFT	CUHFT	EoE Ambulance	HHCT	NHSC	Prisons
SUIs open at 1 April 2009	3	26	18	5	6	8	4
SUIs reported during period	7	29	23	3	15	9	3
SUIs closed during period	9	43	29	5	15	14	5
SUIs open at 31 March 2010	1	12	12	3	6	3	2

Month of reporting

The month of reporting is shown in the graph below. The increase in January and February 2009 reflects a change in requirements regarding infection control SUIs. In both years there was an unexplained increase in reporting in March.



Time taken for SUI investigation

The time taken to investigate a SUI varies significantly depending on the type of incident. The outcome of an investigation may be delayed by police involvement, the need for an inquest, or difficulty accessing all relevant stakeholders. Organisations are required to give regular updates to ensure investigations do not stall or get overlooked. The table below gives statistics for the length of investigations for SUIs closed in 2009/10.

Weeks between date of incident and final report	2009/10		2008/09	
	No.	(%) of SUIs	No.	(%) of SUIs
9 or less weeks	16	13%	8	10%
10 – 19	19	16%	9	11%
20 – 29	25	21%	16	19%
30 – 39	14	12%	17	20%
40 – 49	16	13%	9	11%
50 – 59	16	13%	11	14%
More than 59	14	12%	11	14%

	2009/10			2008/09
	All	Level 1	Level 2/3	All
Median (number of weeks)	30	26	36	34
Maximum (number of weeks)	138	130	138	110

The time for completion of the SUI final report has improved during 2009/10 but further progress is required. The target time to complete and report on a SUI investigation is 9 weeks for level 1 SUIs. NHSC will be working with trusts to reduce the time taken for SUI investigation for 2010/11. Prompt investigation will ensure stakeholders have good recall of the events around the SUI and will ensure improvements happen as soon as possible and learning is available for dissemination in a timely fashion.

Review of final reports and action plans

NHSC reviews all final reports to ensure all relevant aspects of the SUI have been investigated and recommendations follow from the investigation findings. The root causes of SUIs are coded to make further thematic analysis easier. In the first three months of 2010, 46 reports were received. The root causes identified from these reports are shown below. (SUIs can have more than one root cause).

Lack of policy or procedure	21	Lack of training	10
Inadequate communication	9	Poor record keeping	8
Poor record keeping	8	No risk assessment	8
Accountability of staff	8	Pathway problems	4
Lack of engagement of staff	3	Lack of clinical engagement	3
Poor cross boundary working	2	Staffing levels	2

The main root causes identified include issues with documentation and training issues which can be addressed quickly. The problems with inadequate communication and accountability of staff may need more holistic solutions and change management.

3. Learning from SUIs

A final report is required for each SUI covering the investigation findings, recommendations and action plan. During 2009/10, there has been an increased focus on ensuring that recommendations for SUIs are carried out and action plans completed. NHSC has started formal review of action plans at Clinical Quality Reviews (CQRs) held between NHSC and provider organisations. Providers are required to demonstrate progress against action plans and the SUIs are not closed until the action plan has been completed, or steps taken towards completion in the case of major changes being required.

Where there is learning that may be useful outside the reporting organisation, this is disseminated in a variety of methods including CQRs, newsletters and e-mail.

NHSC have completed thematic reviews of SUIs relating to Information Governance, Infection Control and Vulnerable Adults. An assessment of progress against the recommendations of the 2008/09 mental health thematic review is currently in progress. NHSC also reviewed the investigation of a multi-agency SUI relating to a care home. This was to determine how the investigation was managed across agencies and to highlight any areas for improvement.

The learning from the thematic reviews highlighted the importance of:

- Involving the patient and patient's family or carers in the investigation, in line with the 'Being Open' guidance
- Ensuring there is senior clinician involvement where appropriate
- Having a trust-wide approach to tackling communication problems
- Sharing investigation with other organisations where the incident relates to several parts of the patient's pathway

NHSC are to hold a SUI learning event in June 2010 to discuss learning from both individual incidents and thematic learning. Providers have been asked to present learning from an incident of their choice. Further events will be planned following evaluation.

4. New serious incident process for 2010/11

The NPSA National Framework for Reporting and Learning from Serious Incidents Requiring Investigation came into force on 1st April 2010. Commissioned services are now to use this framework for reporting serious incidents together with the NHSC procedure which gives local requirements.

The framework has not changed existing processes significantly but has made these more robust. The timescales for reporting incidents have been clarified and, as stated previously, NHSC will be ensuring providers carry out investigation so learning is available in a timely manner. The grading of incidents has changed together with the notation for an incident with SIs (serious incidents) now used instead of SUIs.

The framework covers all NHS organisations including independent contractors. NHSC will be working with independent contractors in 2010/11 to promote reporting and learning from serious incidents.

5. Summary

- NHS Cambridgeshire receives information about all serious untoward incident (SUIs) reported from commissioned services and independent contractors.
- Reporting organisations are required to give regular updates and final reports of the investigation into the SUI, and to follow up recommendations and carry out action plans.
- NHSC monitors the reporting and investigation of SUIs and the actions taken. Thematic learning is carried out based on local or national concerns. The trust has a major role in disseminating learning from SUI investigations and this was carried out using discussion, newsletters and .e-mails.
- The number of SUIs reported to the PCT fell during 2009/10 from the previous year, with higher level SUIs decreasing. Timescales for completing SUI investigations improved slightly but are still well above the targets set by the NPSA.
- The root causes of SUIs cover a wide range of areas, with lack of documentation or training highlighted as a problem in over 50% of SUIs.
- Thematic review highlighted the importance of involving patients, ensuring senior clinician involvement, having a trust-wide approach to communication problems and sharing investigation where the incident covers patient pathway issues.
- The new NPSA Serious Incident framework has being used from 1st April 2010, and this has clarified roles and responsibilities, and procedures for serious incident management.

Glossary

Being Open	Open communication of patient safety incidents that result in harm or the death of a patient while receiving healthcare.
Carers	Family, friends or those who care for the patient. The patient has consented to their being informed of their confidential information and to their involvement in any decisions about their care.
Clinical Governance	A framework through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish.
Commissioning organisation	An organisation with responsibility for buying services from service providers in either the public, private or voluntary sectors.
Health economy	All stakeholders that contribute to healthcare in a specified region.
Incident	An event or circumstance which could have resulted, or did result in unnecessary damage, loss or harm such as physical or mental injury to a patient, staff, visitors or members of the public.
Independent contractors	GPs, dentist, optometrists and community pharmacists that provide services as independent businesses contracted with the commissioner.
Infection control	Processes, policies and procedures used to minimize the risk of spreading infections, especially in healthcare facilities.
Information Governance	The structures, policies, procedures, processes and controls implemented to manage information in such a way that it supports the organisations regulatory, legal, risk, environmental and operational requirements.
Level of incident	A number given to an incident to reflect how serious it is. Levels for SUIs range from 1 to 3. The level of the incident determines the reporting timescales and commissioner involvement.
Never Events	Patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare provider.
NHS-Funded Healthcare	Healthcare that is partially or fully funded by the NHS, regardless of the location.
NPSA	National Patient Safety Agency. An organisation that leads and contributes to improved, safe patient care by informing, supporting and influencing the health sector.
Patient pathway	The care and treatment received by the patient as seen from the patient's perspective rather than that given by individual health care organisations
Provider organisations	Organisations that NHSC commissions to provide healthcare to its population. These organisations provide a wide range of healthcare including acute, primary medical and dental, ambulance, community and mental health services

Root cause	A cause which leads to an outcome or effect of interest. Commonly, root cause is used to describe the depth in the causal chain where an intervention could reasonably be implemented to change performance and prevent an undesirable outcome.
Safeguarding children and vulnerable adults	Ensuring that people live free from harm, abuse and neglect and, in doing so, protecting their health, wellbeing and human rights. Children, and adults in vulnerable situations, need to be safeguarded. For children, safeguarding work focuses more on care and development; for adults, on empowerment, independence and choice.
Safety	A state in which risk has been reduced to an acceptable level.
Severe Harm	A patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.
SUI / SI	<p>Serious Untoward Incident / Serious Incident - An incident that meets the definition set out by the NPSA:</p> <p>A serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care resulting in:</p> <ul style="list-style-type: none"> • Unexpected or avoidable death of one or more patients, staff, visitors or members of the public; • Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy, or result in prolonged pain or psychological harm (this includes incidents graded under the NPSA definition of severe harm); • A scenario that prevents or threatens to prevent a provider organisation's ability to continue to deliver health care services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment, or IT failure; • Allegations of abuse; • Adverse media coverage or public concern for the organisation or the wider NHS; • One of the core set of 'Never Events' as updated on an annual basis
Thematic review	A review of related incidents to determine if there are common root causes that should be addressed to prevent re-occurrence of similar incidents.
Unexpected Death	Where natural causes are not suspected. Local organisations should investigate these to determine if the incident contributed to the unexpected death