Kingston Hospital NHS
NHS Foundation Trust

Annual Review of PALS, Complaints, Claims and Incidents Annual Report 2015-16

Trust Board	**Item: 14e**
Date: 27 July 2016	**Enclosure: J5**
Purpose of the Report: • Provide the annual review of the, Patient Advice and Liaison Service (PALS) contacts, complaints, compliments, claims, inquests and incidents (including serious incidents (SIs) that occurred during 2015-16. • Identify any themes and trends across these areas and over time.	
For: Information x **Assurance** x	
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Risk Implications – Link to Assurance Framework or Corporate Risk Register:	Corporate Quality and safety risks are recorded on the risk register
Legal / Regulatory / Reputation Implications:	CQC Outcomes
Link to Relevant CQC Domain: **Safe** x **Effective** x **Caring** ☐ **Responsive** ☐ **Well Led** x	
Link to Relevant Corporate Objective:	Strategic Objective 1: to deliver quality, patient centred healthcare services with and an excellent reputation.
Document Previously Considered By:	
Recommendations: The Trust Board is asked to **note** the annual report.	

Annual Review of PALS, Complaints, Claims and Incidents Annual Report 2015-16

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Summary

This Annual report provides an overview of the, Patient Advice and Liaison Service (PALS) contacts, complaints, compliments, claims, inquests and incidents (including serious incidents (SIs) that occurred during 2015-16.

Headlines from 2015-16

- 1579 PALS contacts logged
- 465 complaints which is modest 1% decrease on the previous year.
- The response to complaints within 25 working was met in approximately 82% of complaints. A significant improvement on the previous year.
- 85 new claims (71 clinical and 14 non-clinical).
- No Prevention of Future Death' reports (PFD) issued from the coroner.
- Compliments are being collated and reported to the Patient Experience Committee.
- In total 6929 incidents were reported, a 6% rise.
- There was a reduction in serious incidents with 40 in 2015-16 and 57 in 2014-15.
- Only 2.4% of patient safety incidents involved more than minor harm which is below the national average of 3.2%.
- There has been a significant decline in hospital acquired pressure ulcers.
- There was an increase in the number of reported falls with 774 in 2015-16 when compared with 730 in 2014-15 but the actual rate per bed days reduced.
- Common themes from issues staff and patients are reporting are: Communication, appointments, care/treatment and medication.

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1 Introduction

The Trust has well established systems and processes in place for (PALS) contacts, complaints, compliments, claims, inquests and incidents. The purpose of this report is to summarise activity for the period 2015-16 and identify any themes and trends across these areas and over time. By looking at activity and trends in these areas the Trust can take an informed approach to further developing and improving patient safety and patient experience.

Governance and Assurance

The Quality Assurance Committee (QAC) receives information on all areas of concern, and assurance on the actions that are being taken to address quality of care which falls below expected standards. To strengthen this triangulation, complaint reporting is also feeding into QAC rather than have a separate complaints committee. In addition, information on incidents is also discussed at the Clinical Quality Improvement Committee and Mediation Safety Committee. Complaints and Compliments are also shared with the Patient Experience Committee. The Trust has a weekly serious incident Group. The Quality Assurance Committee receives annual claims reports.

During this period there has been:

- Active programmes as part of Sign up to Safety to reduce pressure ulcers, respond to sepsis and reduce misinterpretation of fetal monitoring
- Further work to embed the WHO checklist including regular audit
- Improvement in cancer targets (including diagnosis and treatment)
- During 2014-15 a number of improvements to the governance processes as well as the introduction of a new reporting system that have now had time to settle and become embedded during 2015-16.
- In particular the Serious Incident Group has brought a focus to reviewing and learning from SI's.
- There have been more frequent and in depth incident reports to the services.
- There has been a sustained focus from the complaints team to support services to reduce complaint response times.

2 Patient Advice and Liaison Services (PALS)

PALS provide information and help to resolve concerns that a patient or their family/carer may have. The team aims to resolve problems and concerns quickly in order to prevent them escalating into a complaint. The team works hard to ensure that investigations are thorough, and that the outcomes reflect the seriousness of the issues that patients and their relatives or carers have raised. Concerns received from, or on behalf of, patients in no way prejudice how they are treated, and are seen as valuable information to help improve services for patients and carers. The overwhelming majority of concerns investigated through PALS are resolved without escalation to the formal complaints process.

The PALS service remained busy with 1579 contacts logged in 2015-16 (there were 1920 contacts in 2014/15). Staffing limitations during part of the year necessitated a streamlining of the data entry from PALS contacts so comparisons of numbers of concerns year on year are not possible. The PALS data does, nonetheless, provide useful data about themes and trends throughout the year. The sites that feature most prominently are Dermatology and Plastics, General Surgery and the Royal Eye Unit, followed by Radiology and car parking concerns.

2.1 Types of PALS concerns

The table below shows the top two subjects of concerns within the top ten areas:

Department and Subject	n	Department and Subject	n
Office - Dermatology & Plastics	**117**	**Anti-Coagulant Service**	**54**
Appointments	101	Communication (Incl. Consent)/info	43
Communication (Incl. Consent)/info	16	Appointments	11
Office - General Surgery	**87**	**Office - Gastroenterology**	**44**
Appointments	66	Appointments	30
Communication (Incl. Consent)/info	21	Communication (Incl. Consent)/info	14
Office - REU	**75**	**Office - ENT**	**44**
Appointments	64	Appointments	39
Communication (Incl. Consent)/info	11	Communication (Incl. Consent)/info	5
Radiology	**69**	**OPD - Phlebotomy**	**39**
Appointments	52	Communication (Incl. Consent)/info	21
Communication (Incl. Consent)/info	17	Appointments	18
Car Park	**55**	**Accident & Emergency**	**37**
Estates/support Services/environment	53	Care & Treatment	23
		Communication (Incl. Consent)/info	14

The predominant issues for 2015/16 are around appointment administration concerns and communication, as for the previous year. The most frequent communication concern is patients being unable to contact a particular service. Concerns about the attitude of staff and general poor communication with the patient, relative or carer were also received.

Trust administration staff were the most frequently cited staff group followed by, and to a lesser degree, nursing then medical staff. The departments with the most communication issues are the Anti-Coagulant Clinic, Phlebotomy, General Surgery, Radiology, and Dermatology and Oral Surgery offices. This is a change from the previous year when the top five were Radiology, Ophthalmology, Oral Surgery, Dermatology and Cardiology.

The most frequent appointment related concern is patients being unable to contact the relevant department about their appointment. Concerns about appointment cancellations and patients being unhappy with the appointment bookings were also received in 2015/16.The specific service lines most commonly referred to were Dermatology and Plastics, General Surgery, the Royal Eye Unit and Radiology. This remains the same as the previous year apart from radiology replacing rheumatology in the top five.

This table shows a breakdown of the areas experiencing the most concerns about appointments and communication (the top two concerns raised through PALS).

Subject of Concerns	Total for Top Departments
Appointments	**406**
Office - Dermatology & Plastics	101
Office - General Surgery	66
Office - REU	64
Radiology	52
Office - ENT	39
Office - Gastroenterology	30
Office - Orthopaedics	28
Office - Rheumatology	26
Communication (Incl. Consent)/information	**161**
Anti-Coagulant Service	43
Office - General Surgery	21
OPD - Phlebotomy	21
Radiology	17
Office - Dermatology & Plastics	16
Office - Oral Surgery	15
Accident & Emergency	14
Office - Gastroenterology	14

As can be seen from the table below the number of concerns regarding appointments has reduced by a third.

Top five concerns by category

2015-16		2014-15	
Category Type for concern	**n**	**Category Type for concern**	**n**
Appointments	727	Appointments	1115
Communication (Incl. Consent)/information	399	Communication (Incl. Consent)/information	314
Care & Treatment	154	Care & Treatment	144
Tests / Investigations	70	Estates/support Services/environment	127
Estates/support Services/environment	68	Tests / Investigations	61

2.2 Actions in response to PALS concerns

Most concerns raised with PALS are resolved quickly and locally for the patient. However where there are wider issues then Trustwide actions are undertaken. To address the PALS concerns around administration there is an administration improvement programme in place and a number of actions have been undertaken to bring about a significant reduction in PALS concerns:

- Embedding the Patient Pathway Coordinator role in service lines
- A new telephony system (netcall) was also introduced to make it easier for patients to get in contact with us. This has led to significant improvement in the number of calls answered and the time to answer (from 80% in 2014 to 89% in May 2016 with 5 seconds shaved off the average response time which was 21.88 in May 2016)
- Main Outpatient Department redesign will make it easier for patients to leave with a follow up appointment.
- Significant improvement % of letters post outpatient appointment sent out in 10 working days from 54% in 2014 to 85% in May 2016.

There are also examples of more local quick fixes when concerns are raised.

- Palliative Care updated the opening times of the restaurant on the back of their leaflet after a PALS complaint.
- Clarification of the Trust website information relating to Radiology and Blood Testing.

3 Complaints

The Trust is committed to learning from any complaint received, and considerable focus is placed on this aspect of the complaints process. The Complaints team ensure that all complaints are robustly investigated and that, where action is needed to improve the care or service a patient receives, this is reflected in the complaint response.

Every reasonable effort is made to resolve complaints at a local level (i.e. within the Trust) and this involves correspondence and meetings with complainants. In 2015/16, the Trust received 465 formal complaints of which 19 related to car parking following the installation of the new system.

Separating out the car parking complaints (as was done in 2014/15), 446 formal complaints were received which represents an increase of less than 4% compared with the 430 received in 2014/2015. Including the car parking complaints and comparing the total complaints (including the car parking ones) for 2014/5, there is a decrease in complaints of 1%.

The Trust endeavours to respond within 25 working days to all complaints. During 2015/16, this deadline was met in 82% of complaints, which is an improving trend compared to 75% in 2014/15. Work is ongoing to further improve this response rate. Nationally, it is recognised that complaints have become more complex as services have expanded and there is more cross over with other local healthcare providers.

The Complaints Committee, chaired by a Non-Executive Director, met every quarter and received detailed information about current complaints and changes being made to improve services. This includes evidence from the service lines that a robust system is in place to ensure all actions arising from complaints are completed and monitored. Improvements have been made to the complaints process further to discussions at the Complaints Committee and these include refining the tone of the complaint responses, and service line managers calling complainants on receipt of the complaint to provide a more personalised service to complainants. This scrutiny of complaints by the Board will now be undertaken by the Quality Assurance Committee as this meeting provides more opportunity to triangulate the data with other quality and safety issues and data.

Complaints may highlight a need to change a practice or improve a service in an individual area. When identified, a change in practice will be implemented to avoid recurrence. Individual complaints (in an anonymised format) are used in training at all levels and for all staff. They are also shared at service line meetings and in other committees such as the Learning Disability Forum. Complainants' stories are shared with the Trust Board at every meeting.

3.1 Types of Complaints

The most commonly complained about issues are communication, appointments, care and treatment and concerns around diagnoses. The areas that attracted the highest level of complaints in 2015/16 are reflected in the table below.

Top 10 Departments	2014-15	2015-16	Performance
Accident & Emergency	70	67	↓
REU	30	27	↓
Dermatology & Plastics	12	26	↑
Orthopaedics	24	20	↓
Car Park	42	19	↓
Radiology	6	13	↑
Anti-Coagulant Service	1	11	↑
Maternity Assessment Triage	5	8	↑
Transport	6	8	↑
OPD - Paediatrics	2	6	↑

When comparing 2014/15 to 2015/16, complaints received by Accident & Emergency have decreased by 4%, REU by 10%, Orthopaedics by 17% and car parking by 55%.

Dermatology and Plastics, the Anticoagulation Clinic and Radiology have seen the highest increase in complaints (>100%). Paediatrics OPD has also seen an increase although the numbers of complaints received is small. Maternity Assessment Triage has seen an increase and transport related complaint have also increased.

Dermatology and Plastics complaints are predominately appointments related (n=17). Radiology has received a number of communication and tests/investigation related complaints. The majority of the Anticoagulation Service complaints related to communication.

From a ward perspective, the wards that attracted the most complaints in 2015/16 were the Acute Assessment Unit (n=18, largely care and treatment and communication concerns), Hamble Ward (n=11, care and treatment and admission/discharge), Blyth Ward (n=10, largely care and treatment concerns), and Hardy Ward (n=8, mainly admission/discharge and communication concerns) It is noted that not all wards are comparable in terms of bed numbers and/or activity.

Top ten areas by subject of complaints

Department and Top Subject	No of complaints	Department and Top Subject	No of complaints
Accident & Emergency	**21**	**Radiology**	**5**
Communication (Incl. Consent)/information	21	Communication (Incl. Consent)/information	5
Car Park	**19**	**Maternity Assessment Triage**	**4**
Estates/support Services/environment	19	Communication (Incl. Consent)/information	4
Office - REU	**15**	**OPD - Paediatrics**	**4**
Appointments	15	Tests / Investigations	2
Office - Dermatology & Plastics	**11**	Appointments	2
Appointments	11	**Office - Orthopaedics**	**4**
Anti-Coagulation Service	**6**	Appointments	4
Communication (Incl. Consent)/information	6	**OPD - Orthopaedics**	**3**
Transport	**6**	Appointments	3
Transfer (Incl. Transport)	6	**Royal Eye Unit - A&E**	**3**
OPD - Dermatology & Plastics	**6**	Appointments	1
Appointments	6	Diagnosis (Incl. Failed Or Wrong)	1
Royal Eye Unit - OPD	**5**	Communication (Incl. Consent)/information	1
Appointments	5	**Royal Eye Unit - Theatres**	**2**
		Procedure (Incl. Surg/endo/anaesth Etc)	2

General trends of complaint subjects when comparing 2014/15 with 2015/16 show an improvement in care and treatment and diagnosis related complaints. Communication and test/investigations related complaints have shown an increase; however, appointment related complaints have remained stable. The table below shows the main complaints subjects

Subject	2014/15	2015/16	
Communication (Incl. Consent)/information	69	101	↑
Appointments	80	80	→
Care & Treatment	114	79	↓
Diagnosis (Incl. Failed Or Wrong)	40	36	↓
Tests / Investigations	15	32	↑

3.2 Actions in Response to Complaints

- Orthopaedics have implemented an additional check for the administrative staff to carry out on a weekly basis to identify any patients who may not have made their follow up appointment. These patients will then be contacted to ensure they do not experience a delay in being seen.
- Gynaecology doctors check each result and assure themselves that they are for the correct patient and administrative staff will tick the three identifiers on each result as they check them to ensure that patients' results are not mixed up.
- The Anti-coagulation Service ensures that they have an accurate clinic list on the day of clinic to refer to when calling/seeing patients on the day, as well as introducing the new telephone phone system.
- The ED have revised procedures for the assessment of patients who arrive by ambulance to ensure documentation provided by the ambulance crews is kept together with the patient's records and is available to the assessing doctor.

Close links with the Risk team ensures incidents are investigated as soon as they come to light through a complaint, and that the complaints and risk processes are dovetailed where appropriate.

3.3 Next Stage of Complaints

If local resolution has been exhausted, complainants can refer any outstanding concerns to the Parliamentary Health Service Ombudsman, where an assessor will review the subject of the complaint and the complaint investigation. Nationally, there has been a significant increase in the number of cases that the Ombudsman is investigating, with a significantly lower threshold to investigate now in place. In 2015/16, seven complaints were taken to the Ombudsman by complainants. Three were not upheld and the remaining are pending responses from the Ombudsman. This is a positive endorsement of our complaints process.

4 Claims

4.1 Claims Process

Claims are managed via specific Ministry of Justice protocols concerning the disclosure and timeframes relating to the administration of each particular type of case. The Claims Department follows a strict programme of identifying disclosable data utilising Health Records, CRS, Winpath, Ulysses, Radiology, Complaints, clinicians' comments, SI/RCA reports and archived information pertinent to each case. Claims are then managed in collaboration with the NHSLA and, if required, panel solicitors.

4.2 Outcomes and Themes

In relation to the management of claims, the Trust is performing with better than average timeframes with a notification to resolution period of 3.91 years (average timeframe is 4.25 years) and a level of cases closed without damages of 60%. The time from notification to resolution is affected by the specific type of claim; for example Obstetric claims take considerably longer to complete than claims relating to other specialties.

There are currently 289 open claims. Over the financial year period, the Trust received 85 new cases (71 clinical and 14 non-clinical) and has closed 64 cases received over previous years.
Of the 64 cases closed in 2015/16, 33 were settled, 14 challenged and withdrawn, 5 defended and 12 simply withdrawn without challenge. A robust stance is maintained in relation to closing cases where possible. Closing cases as quickly as possible (where there is lack of merit or weak allegations) significantly reduces claimant solicitors' costs which are second only to damages, in relation to NHSLA expenditure. This process helps to protect the Trust against a rapid rise in contributions.

Specialities
The specialities receiving the most new clinical claims in 2015/16 were: Obstetrics with 13 cases, Accident and Emergency with 12 cases, Orthopaedics with 9 cases and General Medicine with 7 cases.

This list generally reflects the previous financial period in that the top three specialities are in virtually the same positions. Within A&E, the most common theme is treatment/procedure inappropriate. Within General Medicine, there are currently no common subject themes. Surgical complications and diagnostic issues are the basis of the majority of the Orthopaedic claims received. Obstetrics cases comprise of allegations mainly concerning CTG monitoring, use of Syntocinon, delay in Senior Obstetric input and infection.

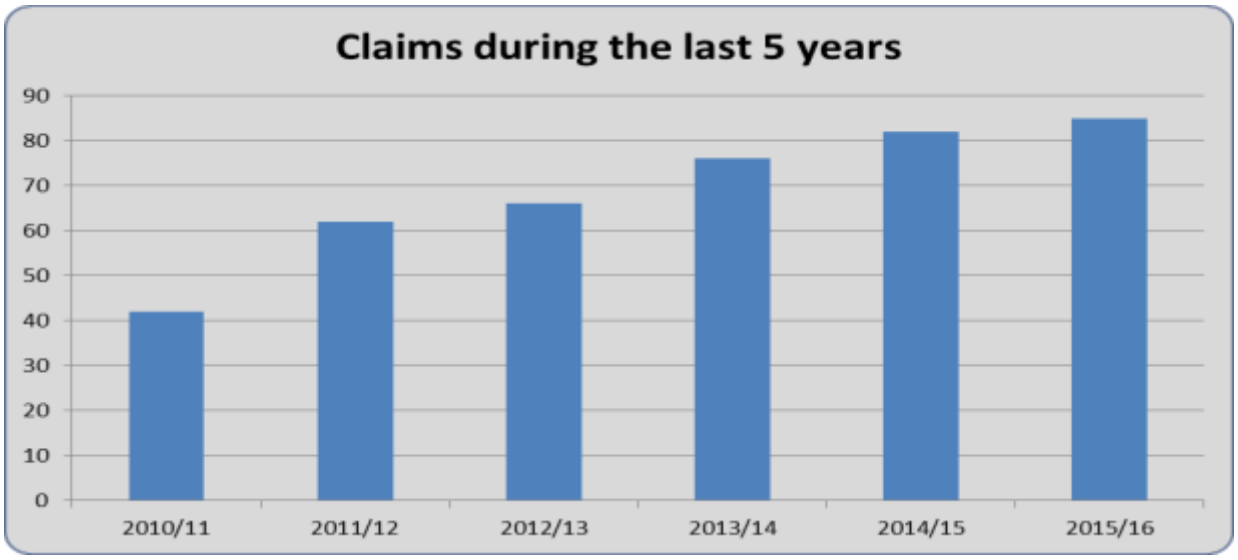
Themes
The top subjects for cases within this period are:

1. Treatment/procedure inappropriate in 26 cases
2. Failure to act on adverse symptoms in 8 cases
3. Failure in referral process in 7 cases
4. Diagnosis missed on first presentation in 6 cases
5. Delay in treatment in 5 cases

NB – There can be more than one subject theme in a case. At present there is no NHSLA Benchmarking relating to themes.

4.3 NHSLA predictions for 2015/16 and our Trust

The NHSLA predicted a 15% national increase in claims nationally for this financial period. Our current figures generally reflect the NHSLA statistics. The number of claims which the Trust has been receiving over the last five years has been steadily increasing. This reflects the increasing trend towards litigation and expectations of financial compensation for unexpected clinical outcomes.



4.4 Benchmarking

In order to benchmark the NHSLA groups Trusts into 'member types' by similar size and demographics. However there is very limited benchmarking data.

NHSLA Contributions
Every year, the Trust makes a payment to the NHSLA calculated to maintain clinical negligence scheme cover. This cover protects the Trust in relation to all damages and the majority of costs pertaining to clinical cases. The general basis for calculating this contribution takes into account the number of clinical staff employed, number of patient episodes, historical claims data and claims risk by speciality. From information provided by the NHSLA the Trust's contributions for CNST cover during this financial period was £6,360,194. This is an increase of approximately 7% over 2014/15. The NHS average rise in contributions is 17% which has been calculated on the previous financial period.

4.5 Actions following Claims

A crucial part of the claims process is the action taken in relation to the learning from claims. This helps to mitigate risk and reduce future harm to patients. Historically, recommendations of actions were provided independently from panel solicitors or the NHSLA on cases which presented a high risk. This no longer happens, and Trusts are now expected to monitor their own recommendations and evidence the actions taken.

Usually, action will have been taken at around the time of the incident leading to the claim; particularly, when the incident has been the subject of a risk investigation. The claims process provides a further opportunity to consider whether additional action needs to be taken when the incident is reviewed during the claims process.

The Quality Assurance Committee receives annual claims reports.

5 Inquests

The volume of inquest related work continues to grow significantly in line with the national trend. There is a better awareness of which cases doctors need to report to the Coroner, and an increased public awareness of the coronial process.

Hospital staff are commonly called to inquests where they are either asked to provide collateral information about a patient's condition following an accident or a fall, or where there are concerns that the care of a patient may have more than minimally contributed to a patient's death. The Trust supports staff who are called as witnesses to inquests to ensure they are properly informed about the process to enable them to give good and effective evidence to the coroner.

Inquests are also increasingly complex, focusing in great detail on the care given to patients, the risk investigation process and the learning from an incident. The Coroner takes his/her duty to make risk management recommendations very seriously, and the actions taken following a Serious Incident investigation are discussed with the Coroner at the hearing and assurance is sought from the Coroner that these have been undertaken. Where the Coroner feels that an organisation has not addressed deficiencies that might adversely affect another patient, s/he will issue a 'Prevention of Future Death' report (PFD). This instructs the Trust to take action, where action has been found wanting. It is sent to the CQC, and the Chief Coroner who publishes such reports on the Courts and Tribunals Judiciary website. We have rarely been issued with a PFD reports and none were issued during this 2015-16. The Trust continues to work to ensure robust actions are taken at the time of a Serious Incident investigation and can be evidenced at Inquest hearings.

6 Compliments

Although Trust staff receive many compliments, these are not always recorded and shared. In the past 12 months there has been a more formal approach to capturing and feeding back compliments. Compliments reports are shared at the Patient Experience Committee.

6.1 How are compliments received and managed?

The Trust receives compliments via a number of channels. These include:

- Thank you letters received via the Chief Executive's Office
- Thank you letters received directly through clinical departments
- Compliments gathered via the Friends and Family Test
- Compliments via Care Connect on NHS Choices
- Compliments received via Twitter
- Compliments via other websites such as I Want Great Care.
- Compliments received via other routes such as emails to the PALS Department
- Verbal compliments
- Small gifts such as chocolates to wards

Compliments from different sources are pulled together on a quarterly basis and reported Patient Experience Committee

6.2 Compliments - key themes

The Trust received several thank you letters and emails via the Chief Executive's Office.
More are received directly to the relevant services. Themes of the letters include:

- Superb care
- Understanding
- Sympathetic
- Respectful
- Courteous
- Friendly
- Polite
- Caring
- Kindness
- Patient

Compliments gathered via the Friends and Family Test
The Trust asks its patients to complete the Friends and Family Test (FFT) across all of the services that it provides. The test asks people whether or not they would recommend a particular service to friends and family and also asks for reasons for their rating. This enables the Trust to have an overview of both positive and negative patient experience and to make changes in a timely fashion. Here are some of the adjectives used to describe the staff:

- Excellent
- Efficient
- Professional
- Attentive
- Friendly
- Lovely
- Helpful
- Kind
- Caring

Online Ratings:

Compliments received via Care Connect on NHS Choices
The Trust has been a pilot site for Care Connect since 30 July 2013. The website enables people to leave reviews and raise issues and concerns. It is hosted on the NHS Choices Website. The Trust overall rating is 3.5 stars.

Compliments received via I Want Great Care
Patients can post comments on the I Want Great Care website and these are available for public view. Approximately 200 reviews have been left for the Trust giving it an overall 5 star rating with many positive comments.

Compliments received via Patient Opinion
The Patient Opinion website has continued to grow in more activity. The majority of the reviews on the website presently appear to be copied over from other sites such as NHS Care Connect and I Want Great Care, but the Trust is now also monitoring this site for additional feedback on a regular basis. There are over 400 stories related to the hospital with many positive mentions.

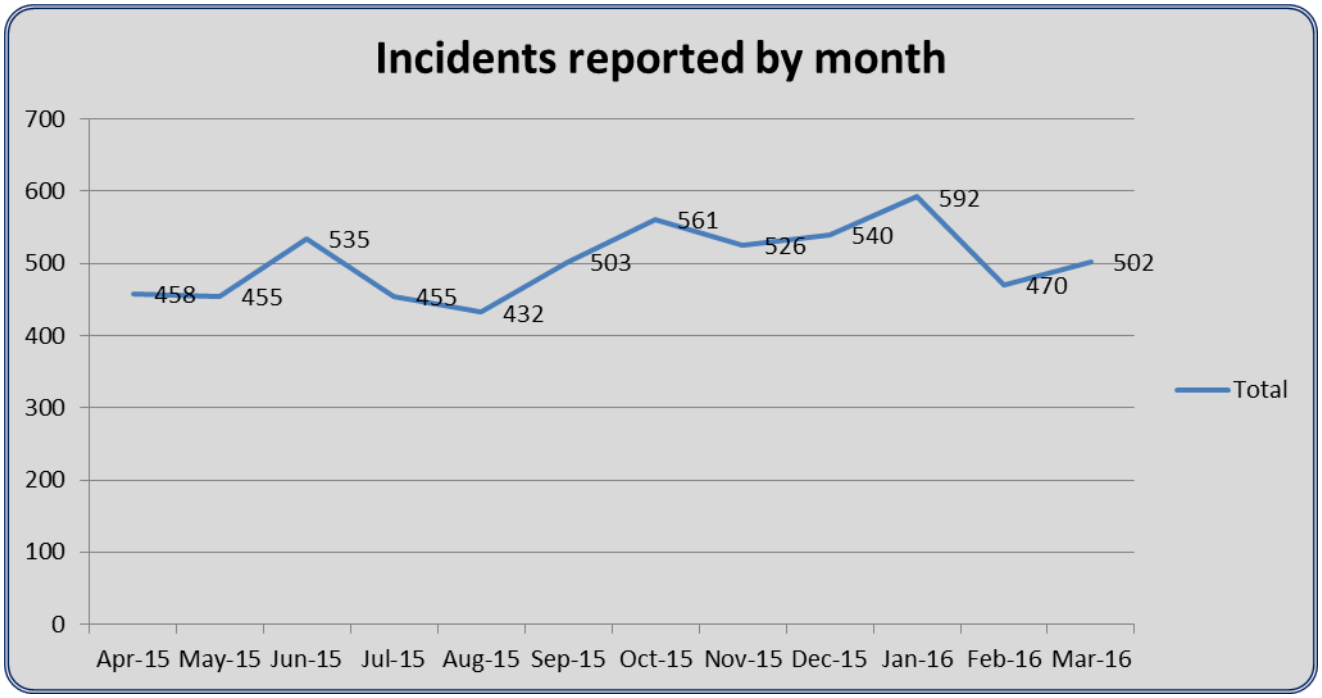
Pictorial representation of feedback given to Kingston Hospital:

7 Incidents

An incident is an event or circumstance arising in the course of providing or supporting the provision of health care services that could have or, did, lead to unintended or unexpected harm, loss or damage to a patient, member of staff, visitor, the Trust and its property or environment. Staff report incidents on the Trust intranet using a system called Ulysses,
The Trust reports incidents for several reasons: to ensure it complies with its statutory obligations such as meeting the requirements of the Care Quality Commission (CQC), the NRLS (National Reporting & Learning System), the Management of Health & Safety at Work Regulations and Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR). The Trust also reports incidents to ensure that they are investigated to identify learning points and influence change to practice where necessary, to prevent reoccurrence. Incident reporting is key to staff and patient safety and improving the patient experience. High levels of incident reporting, with low harm, are a sign of a Trust with an open culture for learning from incidents and near-misses.

7.1 Incident reporting

- There were 6029 incidents during 2015-16. This is an increase from the previous year when there were 5669 incidents reported in 2014-15
- There was a notable increase in incident reporting levels between September 2015 and January 2016.
- Nurses are top reporters of incidents. However, it should be noted they are the largest workforce which makes pharmacists, administrators, laboratory staff and radiographers good reporters relative to the total numbers that work in the hospital.
- There was an overall increase in reporting in the second half of the year



7.2 NRLS Benchmarking

The Trust makes regular uploads to the National Learning and Reporting System which is DOH requirement. The figures are then collated and benchmarked with other Acute Trusts across the country. Nationally reporting rates increased, the reporting rate for the Trust slightly reduced during this period. The Trust report 2,413 incidents to NRLS during April – September 2015 which is a median reporting rate of 32.55, significantly lower than the median or the cluster at 38.25. There may be a number of factors influencing this. The NRLS report only covers the first part of the year 15-16 and is based on one third of the total incidents reported last year. For the last 2 years is the Trust has shown a decline in the incident reporting rate when compared to national reporting rates which have risen over time. There is currently a drive to increase incident reporting across the Trust. There has been increased training, sharing of key safety messages and learning from incidents. The Trust is also undertaking a safety culture survey of all staff during July and August 2016 to better understand safety culture in teams across the hospital.

April to September	Cluster median	KHFT median
2014	35.1	33.8
2015	38.25	32.55

7.3 Incident Types

- There were 4765 incidents affecting patients
- The numbers of reported community incidents include 380 community acquired pressure ulcers. The community acquired pressure ulcer reporting rate remained the same as the previous year at 7.7.
- The was a slight decrease in patient safety incident reporting (3%) and a slight increase in non-patient safety incidents
- Only 2.5% of all incidents (patients and staff) involved more than minor harm.
- Only 2.4% of patient safety incidents involved more than minor harm which is below the national average of 3.2%.
- The levels of harm during 2015-16 have remained relatively static when compared with the previous year.
- High levels of incident reporting, with low harm, are a sign of a Trust with an open culture for learning from incidents and near-misses.

Incident Reporting by Affected Party 2015-16	Number of Incidents	% of Total 2015-16	% of Total 2014-15
Patient	4765	79.0%	82.1%
Staff	578	9.6%	7.8%
Community	463	7.7%	7.7%
Buildings & Infrastructure	198	3.3%	2.2%
Visitor/Relative/Contractor	28	0.5%	0.2%

Harm levels for incidents:

Harm levels for all incidents	2014-15	% 2014-15	2015-16	%2015-14	% Change
1 - No Harm	3822	67%	3866	64%	3.4%
2 - Minor, Non Permanent Harm (Upto 1 M)	1548	27%	1828	30%	-2.7%
3 - Moderate, Semi Permanant Harm (Upto 1 M)	147	2.6%	101	2%	0.6%
4 - Major, Major Permanant Harm	19	0.3%	18	0.3%	0.0%
5 – Catastrophic/Death	6	0.1%	6	0.1%	0.0%
6 - Near Miss	124	2.2%	182	3%	-0.8%
7 – Not recorded	7	0.10%	28	0.5%	-0.4%

7.4 Patient Safety incidents: Trends and Areas of Concern

As would be expected Emergency Services division and A&E, AAU and Maternity services reported the most incidents due to nature of the work done in those areas and the high volume of patients.

There were 4960 patient safety incidents (PSI's) as defined by the NRLS definitions. Only 2.4% of Patient Safety incidents involved more than minor harm. (The most recent national average available was from NRLS for Patient Safety incidents and the average was 3.2%)

As would be expected given the high risk nature of their work, the maternity service most frequently reported patient incidents. Post-partum haemorrhages (234 incidents), unexpected admission to NNU (68 incidents), Post-natal re-admission (73 incidents) and third degree tear (50 incidents) were four of the most frequently reported incident types.

- 349 failure to monitor or escalate incidents were reported during 2015-16 a deteriorating patient. Pressure ulcers are also reported under this category, and account for 216 patient incidents.

- Delays in patients receiving treatment are also is one of the most commonly reported incident types (178 incidents) reported as care and treatment issue.

- Documentation issues ranged from missing notes, mislabelled information to delayed clinics or appointments because notes failed at arrive at the clinic.

Falls

Preventing patient falls remains a high priority for the Trust. Falls are reported in the Trust Quality report and score card. There was an increase in the number of reported falls with 774 in 2015-16 when compared with 730 in 2014-15 but the actual rate per bed days reduced.

Falls	2014-15	2015-16
Number of Patient Safety Incident (PSI) Falls	730	774
Number of Patient Safety Incident Falls where moderate or severe harm occurred	19	18
Number of Patient Safety Incident Falls per 1000 G&A beddays	5.6	5.5

Medication

Medication incidents remain a focus and continue to be monitored at the bi-monthly Medicine Safety Group. All Trusts are now obliged to have a designated Medical Safety Officer to oversee reporting of medication incidents to the NRLS, and these officers are tasked with monitoring the quality of data reported.

The number of reported patient medication incidents increased slightly. This could be due to the embedding of e-prescribing and CRS leading to an increase in errors, or increased reporting and awareness. The medication incident rate peaked in Quarter 3 and has now reduced.

Medication Incidents	2014-15	2015-16
Medication Incidents	701	718
% of Medication Incidents Where Moderate Occurred	0.5%	0.12%

Pressure Ulcers

- There has been a significant decline in hospital acquired grade 2 pressure ulcers. Grade 3 and 5 pressure ulcers are discussed in the serious incident section of the report.

Pressure Ulcers	2014-15	2015-16
Number of patients with hospital acquired pressure ulcers (Grade 2)	**67**	**36**
Number of patients with hospital acquired pressure ulcers (Grade 2) per 1000 beddays	**0.40**	**0.26**

7.5 Duty of Candour

In March 2015 the CQC published Regulation 20: Duty of candour. The aim of the regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf), in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology.

The Trust takes its responsibilities under the Duty of Candour seriously. The Duty of Candour applies to all incidents that result in moderate harm and above. To deliver the duty, the incident should be acknowledged to the patient and/or their family as soon as practically possible and the affected person(s) offered an apology.

When a Serious or a moderate harm Incident occurs the patient and/or family are informed that a Root Cause Analysis investigation will be completed and the findings of the investigation shared with them on completion. The patient and/or the family affected by the incident are provided with the necessary support, and all discussions are followed up in writing.

Once the Serious incident investigation has been completed and the report approved by SIG, the patient and/or family are sent a copy of the report, along with a letter and offered the opportunity of a face to face meeting to discuss the investigation findings.

In March 2016 an internal audit was completed by KPMG to review the Trust's compliance with the Duty. Several key recommendations were identified following the identification of some inconsistencies within the process. All incidents that result in moderate harm and above must be accurately and promptly identified with a record of the evidence maintained when the duty has been delivered within the incident form on Ulysses.

7.6 Staff Incidents

There were 578 staff incidents during 2015-16 which is significant increase on the previous period.

Staff Incidents & Associated Harm Levels	2014-15	2015-16
Total Incidents Reported	**435**	**578**

The top five types of staff incidents are shown below. There has been an increase in staff report incidents around tests and investigations and medications.

Type of staff incident	2014-15	2015-16
Accidents (Incl. Falls/sharps/manual Handling)	175	149
Security	111	131
Tests / Investigations	2	71
Medication	38	63
Communication (Incl. Consent)/Information	25	39

7.7 Post incident actions

Following each incident, Managers are responsible for reviewing and investigating the incident and ensuring that suitable actions are put in place to prevent a similar incident in a similar situation recurring. The following provides examples of such actions:

Pressure Ulcers:

All grade 2 pressure ulcer incidents across all wards are reviewed in the Pressure Ulcer Management Panel (PUMP) on a monthly basis. The Tissue Viability Nurse and respective matrons maintain close surveillance of the patients involved to prevent further deterioration. There was a new Pressure Ulcer Strategy launched during 2015.

Falls

- There is a new Quality improvement project in place to increase in the proportion of patients who received assessment/intervention for the 7 key NICE recommendations regarding care to avoid falls.
- Magnets to identify high risk patients who are also discussed at the RAG board.

8 Serious Incidents

Serious incidents are described as incidents that occur during NHS funded healthcare (including in the community), which result in one or more of the following;

- unexpected or avoidable death or severe harm of one or more patients, staff or members of the public;
- a never event - all never events are defined as Serious Incidents although not all never events necessarily result in severe harm or death;
- a scenario that prevents, or threatens to prevent, an organisation's ability to continue to deliver healthcare services, including data loss, property damage or incidents in population programmes like screening and immunisation where harm potentially may extend to a large population;
- allegations, or incidents, of physical abuse and sexual assault or abuse; and/or
- loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation.

The impact of serious incidents on patients, relatives and staff, can be significant and often are a result of failures in care or of service delivery. It is essential that all serious incidents are robustly investigated so that weaknesses in systems and individual practice are understood and addressed and that lessons learned from investigations are shared and mitigating actions put in place.

There were 40 serious incidents declared by Kingston Hospital NHS Foundation Trust from 1st April 2015 to 31st March 2016. This section will provide an overview of those incidents and the lessons learnt and actions taken in order to prevent the recurrence.

8.1 Serious Incident Management process

The overarching Trust document associated with the management of Serious Incidents is the 'Procedure for the Identification and Management of Serious Incidents'. This document is based on National (NHS England) Serious Incident Framework (March 2015). The Serious Incident Framework explains the responsibilities and actions for dealing with serious incidents and the tools available. It outlines the process and procedures to ensure that serious incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again.

All Serious Incident investigation reports are, once completed, and agreed by the relevant Service Line. This process enables the Service Line to review and agree that the action plan that has been developed will address the report's recommendations, as well as learn from the incident. The Service Line is responsible for ensuring that all Serious Incident action plans are effectively delivered.

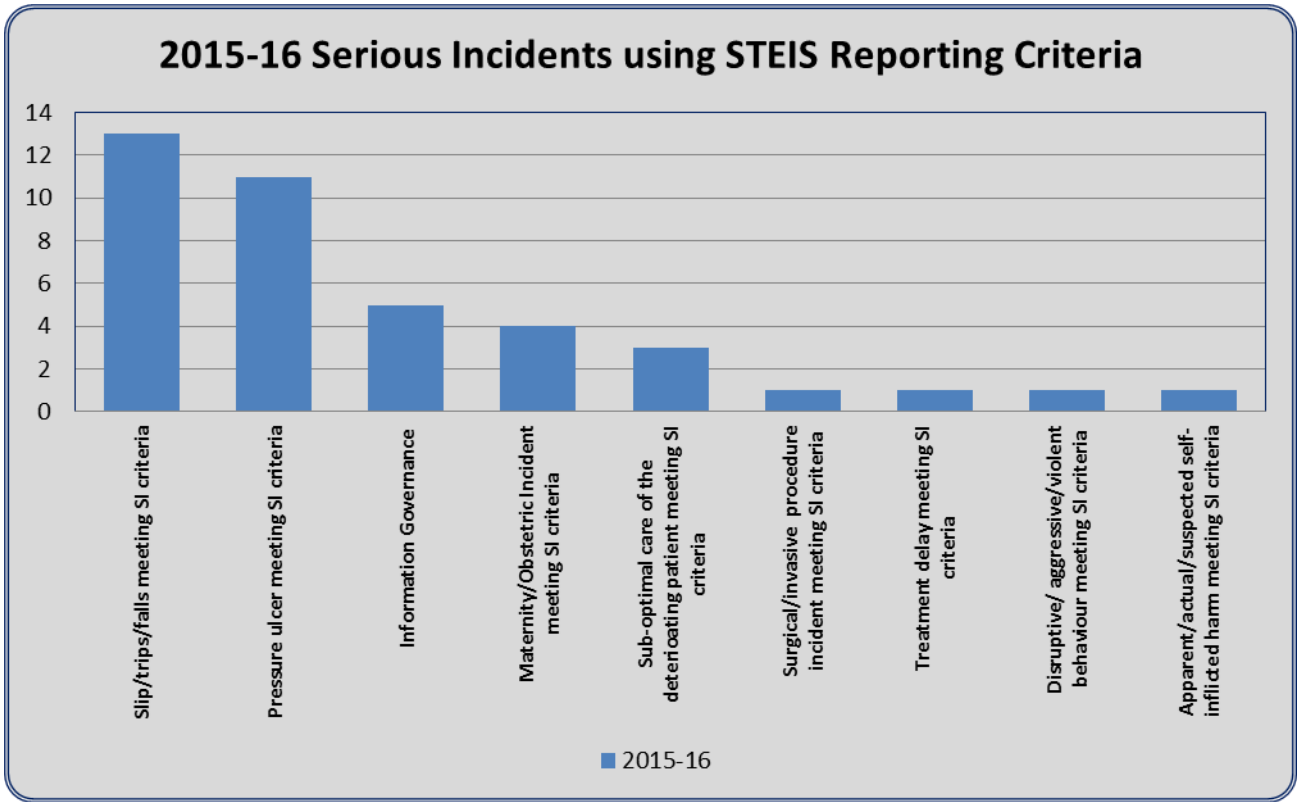
The Trust's Serious Incident (SIG) Group meets weekly. The SIG is responsible for ensuring that comprehensive serious incident investigations take place, and that appropriate recommendations and robust actions are identified and delivered. Thus ensuring learning from incidents and improving both the quality and safety of patient care. The SIG is chaired by the Medical Director, and membership includes the Director of Nursing and Patient Experience, Divisional Directors, Quality Improvement Leads for Patient Safety and the Quality Manager from Kingston Clinical Commissioning Group. Serious Incident reports are presented to SIG by either the Lead Investigator and/or the relevant Clinical Director. Once reports have been approved by the SIG they are submitted to Kingston Clinical Commissioning Group (CCG). All Never Event reports are subject to further scrutiny by a Scrutiny Panel chaired by Non-Executive Director and subsequently the full Trust Board.

Tracking of Action Plans
All actions arising from Serious Incidents and Never Events Incidents are tracked using the SI action plan tracker. This tracker enables both Service Lines and the Serious Incident Group (SIG) to monitor the delivery of actions and to identify any issues that may be preventing the delivery of the action plan. The Serious Incident Group reviews the full SI action trackers of each Division every month. The Trust Board has responsibility for monitoring the Never Events Incidents action plans. These are also presented to the CCG for assurance on progress with delivering the actions.

Investigation Training
In order to deliver a robust SI investigation staff need support and training. The Quality Improvement Leads for Patient Safety support all SI investigation panels. They provide both group and or one to one investigation training. In May 2016 a 'Root Cause Analysis Workshop' was offered to all service lines. A total of 14 staff attended and the next RCA training workshop will be in July 2016 and thereafter bi-monthly. The training aims to deliver improvements in the Trust SI RCA investigation process and to share learning from previous investigations.

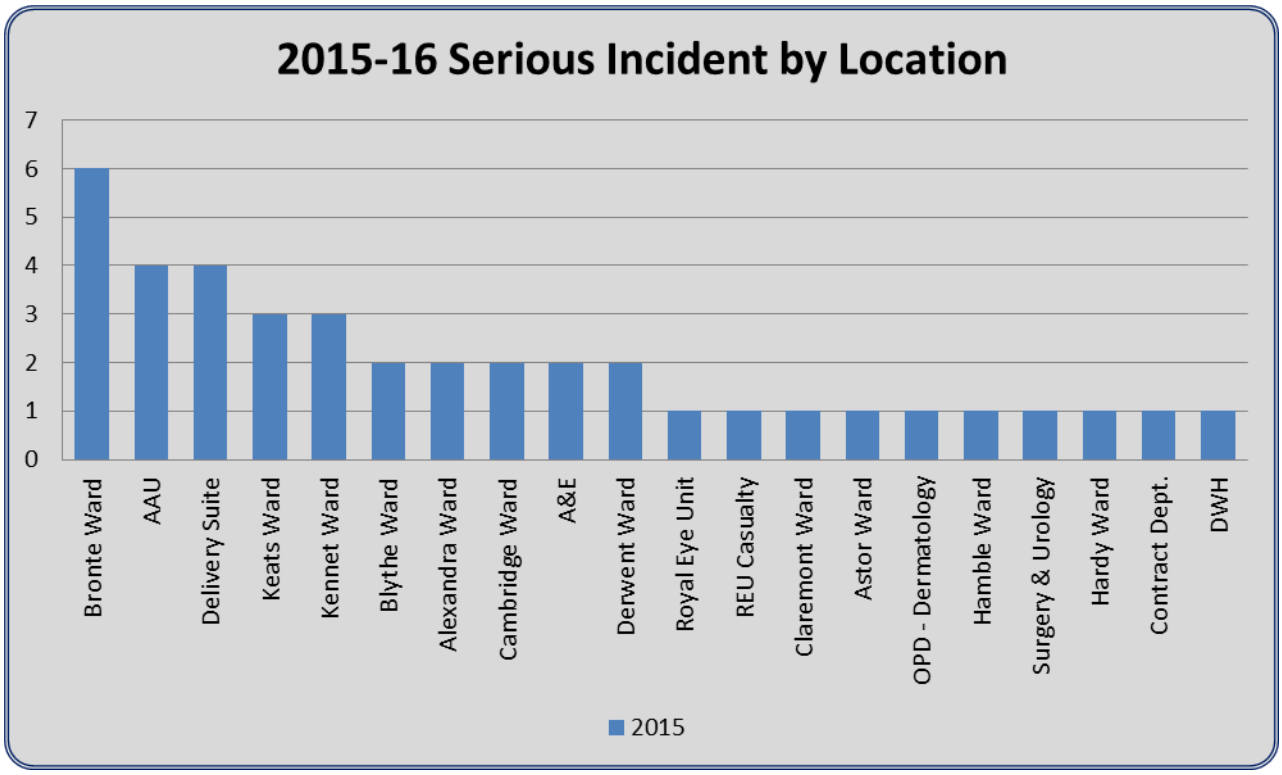
8.2 Number and category of Serious ~Incidents in 2015-16

Between 1 April 2015 and 31 March 2016 (the period covered by this report) the Trust has declared 40 Serious Incidents (SI) and no Never Events within 9 categories.



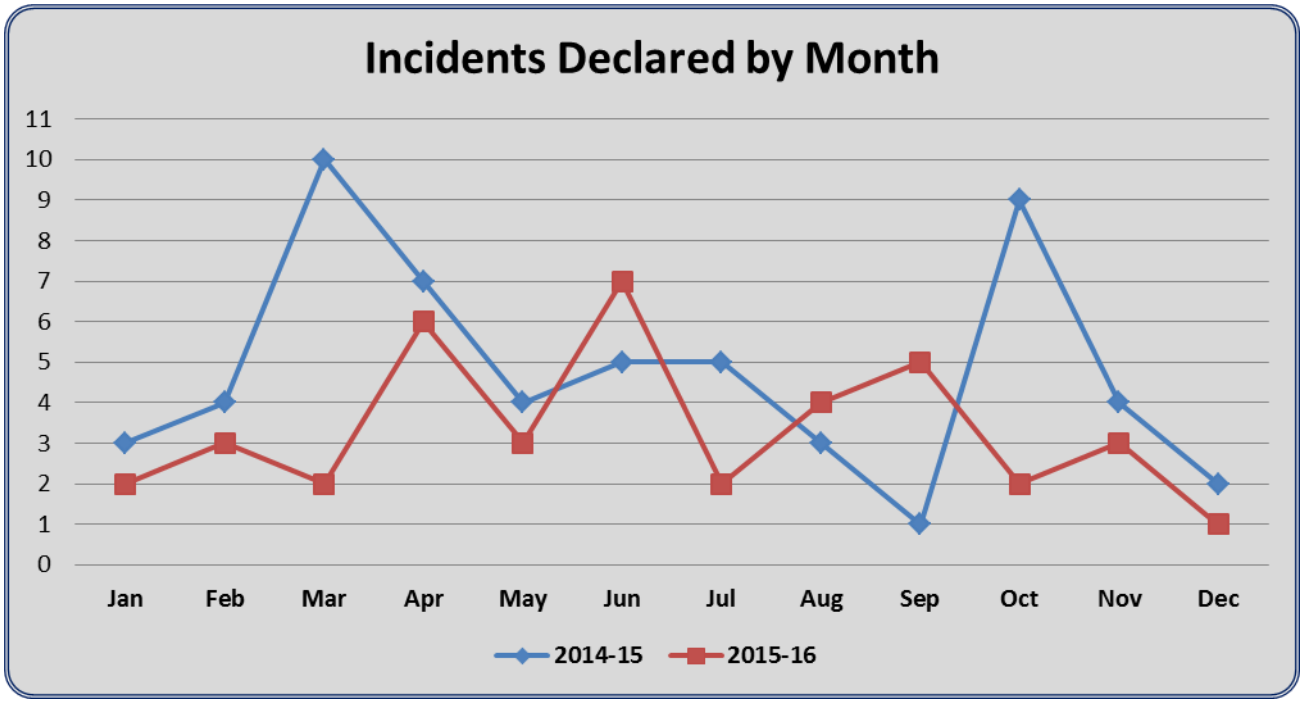
The area with the single most SI's reported during this period in 2015-16 was Bronte ward, a 30 bedded Cardiology and Haematology ward. The type of Serious Incidents reported by the ward during 2015-16 period included 3 Pressure Ulcers, 2 Falls and 1 Self Harm.

When all three Elderly care wards are combined (including the escalation ward, then this speciality reported 11 incidents during this period, which included 5 falls, 4 Pressure Ulcers, 1 Sub- optimal care of a deteriorating patient and 1 Disruptive/aggressive/violent behaviour.



8.3 SI Themes and trends analysis

- There were less SIs reported last winter than in the previous winter period.



- There has been a fall in Pressure Ulcers meeting SI criteria, maternity incidents and surgical and diagnostic incidents.

Reporting Criteria	2014-15	2015-16
Pressure ulcer meeting SI criteria	17	11
Slip/trips/falls meeting SI criteria	13	13
Confidential information leak/Confidential information leak/information governance breach meeting SI criteria breach meeting SI criteria	6	5
Maternity/Obstetric Incident meeting SI criteria	7	4
Sub-optimal care of the deteriorating patient meeting SI criteria	4	3
Surgical/invasive procedure incident meeting SI criteria	4	1
Diagnostic incident including delay meeting SI criteria (inc. failure to act on test results)	4	
Apparent/actual/suspected self-inflicted harm meeting SI criteria		1
Disruptive/ aggressive/violent behaviour meeting SI criteria		1
Treatment delay meeting SI criteria	1	1
Unauthorised absence meeting SI criteria	1	
Grand Total	57	40

- Of the 13 falls incidents reported in 2015-16 the five themes identified included:
- Four incidents identified the failure to implement an individualised care plan for the patient, which would have provided the appropriate falls prevention care.
- Four incidents identified the failure to accurately assess and to identify the patient's risk of falls so that the appropriate falls prevention care could be implemented and a safe environment maintained.
- Three incidents identified the frail condition of the patient which for both incidents staff where present and both falls were witnessed but could not have been prevented.
- One incident identified the failure to provide falls prevention equipment.
- Three incidents identified the lack of supervision for patients known and identified as high risk of falls, one incident occurred during a cardiac arrest elsewhere on the ward, and the other incidents occurred during toileting the patient and staff did not want to breach the privacy and dignity of the patient.

Cross cutting themes:

- Communication in teams
- Documentation either lacking or absent
- Not recognising clinical risk
- Not acting on observations i.e. failing to respond to/or prioritise deterioration
- Clinical interpretation
- Escalation to senior colleagues
- Human error – distraction and lowered vigilance when staff are busy
- Human factors – situational awareness and task focus.

During this period there has been:

- Active programmes as part of Sign up to Safety to reduce pressure ulcers, respond to sepsis and reduce misinterpretation of fetal monitoring
- Further work to embed the WHO checklist including regular audit
- Improvement in cancer targets (including diagnosis and treatment)
- Introduction of vital signs monitoring. Regular NEWS audits.

8.4 Never Events

Never events are a sub-set of Serious Incidents and are defined as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'. In 2015/16 there were no never events at the Trust.

8.5 Actions taken as a result of SI investigations:

There is a CTG education programme and also Sepsis improvement project as part of the hospital's Sign up to Safety Improvement projects. The Trust has an active Pressure Ulcer Management Panel and Falls Group. Both of these groups are focused on learning from and reducing incidents. Falls and Sepsis will be 2016-17 Quality Account Quality Priorities for the Trust. The Falls work will focus on addressing the 7 recommendations from NICE and the national inpatient audit of falls on ensuring assessment and management of:

- Dementia and Delirium
- Blood pressure
- Medication Review
- Mobility aids
- Continence Care plan
- Call Bells
- Visual impairment

Examples of actions taken to prevent reoccurrence of incidents

- Sepsis - Web page now available to staff on Sepsis to promote awareness.
- Maternity - There is new guidance on measuring fundal height from 24 weeks gestation which was sent to GPs
- Falls - Use of high risk falls magnets to identify those patients at high risk of falls, prompting an MDT approach/discussion to falls risk management
- Pressure ulcers - Learning was shared at the Sisters forum to ensure other wards are reminded about best practice in preventing pressure ulcers when using masks
- Information Governance - Daily bulletin reminders for staff on IG good practice. Sophos software has been altered to now block data containing the letters MRN (whether capitals, lower or mixed case).
- Elderly Care - Patients identified as having complex unpredictable/aggressive needs are now identified at the AAU board round so that they can be placed in the most appropriate ward.

9 Triangulation

The tables below shows the top 10 categories during 2015-16 for all patient safety incidents, complaints and PALS queries.

- As would be expected there is more alignment between complaints and PALs areas.
- A&E and maternity feature across incidents and complaints but do not feature in the top 10 of PALS queries.
- OPD feature strongly in PALS and REU features across incidents, PALS and complaints.
- AAU feature strongly in incidents but not in complaints or PALS.
- Communication, appointments, medication and care/treatment feature in PALS, incidents and complaints.
- Medication also features for complaints and incidents as does tests and investigations.

PALS

Top 10 PALS Concerns by category	No of Concerns
Appointments	727
Communication (Incl. Consent)/information	399
Care & Treatment	154
Tests / Investigations	70
Estates/support Services/environment	68
Procedure (Incl. Surgery/endoscopy/anaesthesia Etc)	36
Admission/discharge	35
Transfer (Incl. Transport)	24
Medication (Incl. Blood Products)	16
Information Governance	16

Complaints

Top 10 Complaints by category	Count of Case Number
Communication (Incl. Consent)/information	101
Appointments	80
Care & Treatment	79
Diagnosis (Incl. Failed Or Wrong)	36
Tests / Investigations	32
Procedure (Incl. Surgery/endoscopy/anaesthesia Etc)	26
Admission/discharge	23
Estates/support Services/environment	22
Infrastructure & Resources	11
Medication (Incl. Blood Products)	11

Incidents

Top 10 Patient Safety incidents by category	Total
Accidents (Incl. Falls/sharps/manual Handling)	855
Maternity	788
Medication (Incl. Blood Products)	642
Care & Treatment	436
Tests / Investigations	409
Failure To Monitor / Escalate (Including PUs)	349
Documentation (Incl. Patient Records)	241
Infrastructure & Resources	197
Appointments	186
Communication (Incl. Consent)/information	156

10 Conclusion

In 2014-15 there were a number of new processes and systems implemented such as the Ulysses reporting system and the introduction of the Serious Incident Group. During 2015-16 these systems became embedded.

The number of complaints has dropped slightly and there has been a decrease in PALS contacts. Issues regarding appointments, although still a consistent theme have fallen when compared with the previous year. Claims in line with national trends have risen. Benchmarking data is not readily available. However, in relation to the timely management of claims, the Trust is performing better than the national average

The number of incidents reported has risen and the level of harm is lower than the national average. A good safety culture is indicated by high levels of reporting with low levels of harm. The NRLS report shows that the Trust needs to continue to push incident reporting and further increase reporting so that we stay in line with national reporting rates. There has been a focus on training and feedback from incidents to improve reporting, this will continue in 2016-17.

As would be expected the Emergency Services division and A&E, AAU and Maternity services reported the most incidents. There has been a reduction in hospital acquired pressure ulcers and this is reflected also in lower numbers of SIs, as there have been fewer grade 3 & 4 pressure ulcers meeting SI criteria.

The Out Patient Departments feature strongly in PALS and complaints due to issues around appointments. Communication, appointments, medication and care/treatment are common themes featuring across PALS, incidents and complaints.

There have been active improvements to address themes from incidents including Trust wide initiatives such as Sign up to Safety.

Inevitably when looking at learning from incidents and complaints there is an understandable focus on when things go wrong. The vast majority of care interactions at the Trust are positive experiences for patients, carers and staff. It is also important to note the compliments received from visitors, carers and patients. The compliments during this period showed staff to be caring, respectful, helpful and kind.

By looking at what we do best and what we could do better the Trust is taking an informed approach to further developing and improving patient safety and patient experience.

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