INTEGRATED QUALITY AND SAFETY REPORT

Annual Review
May 2016 – May 2017

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Chief Nurse

TAKING PRIDE IN OUR CARE

Barking, Havering and Redbridge University Hospitals NHS Trust

WHAT IS AN INCIDENT?

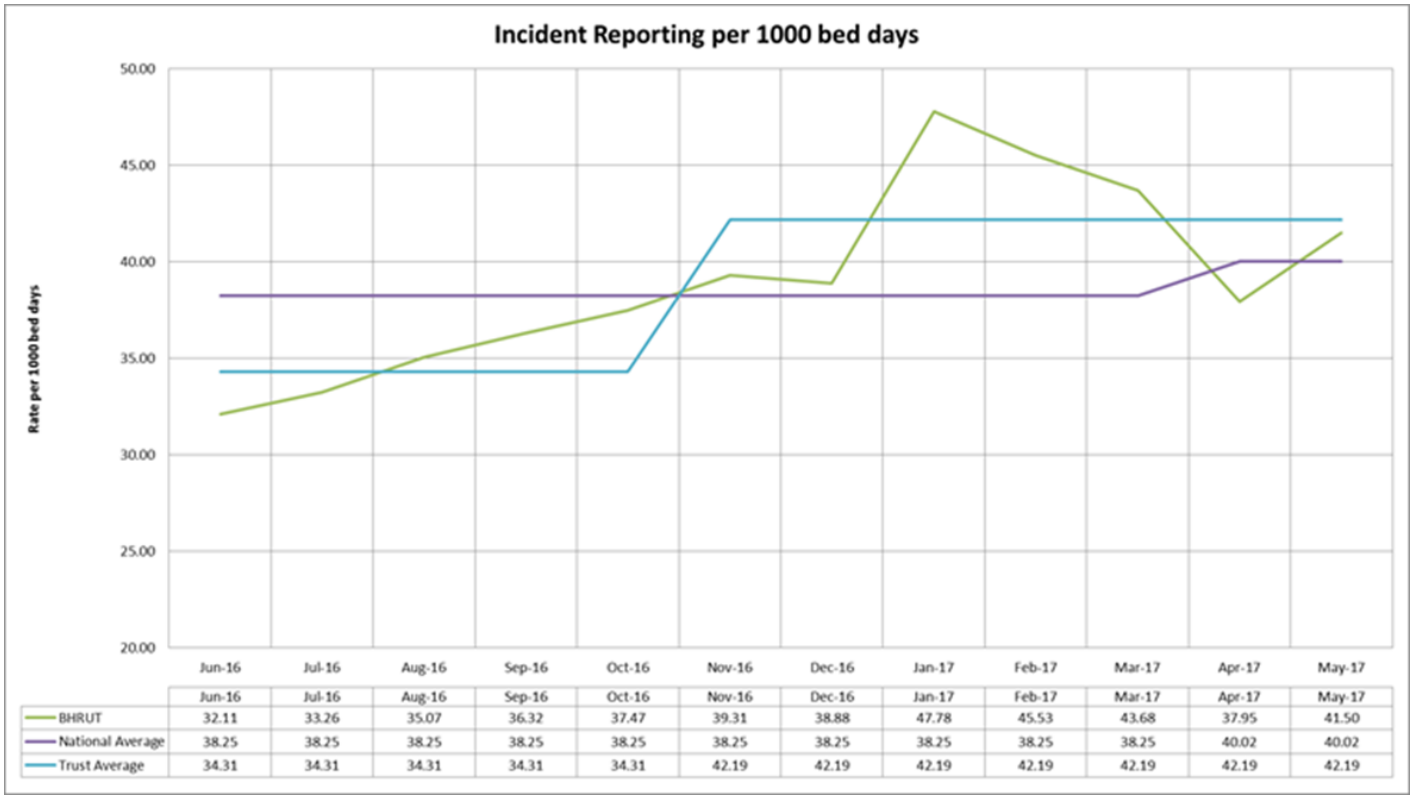
'An incident is any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving NHS care' ***National Patient Safety Agency***

Examples of incidents could include:

- An expired drug being administered
- Failure to act on test results
- Equipment breaking down
- Hospital acquired pressure ulcers
- Not recognising a deteriorating patient
- Slips, trips or falls

INCIDENT REPORTING

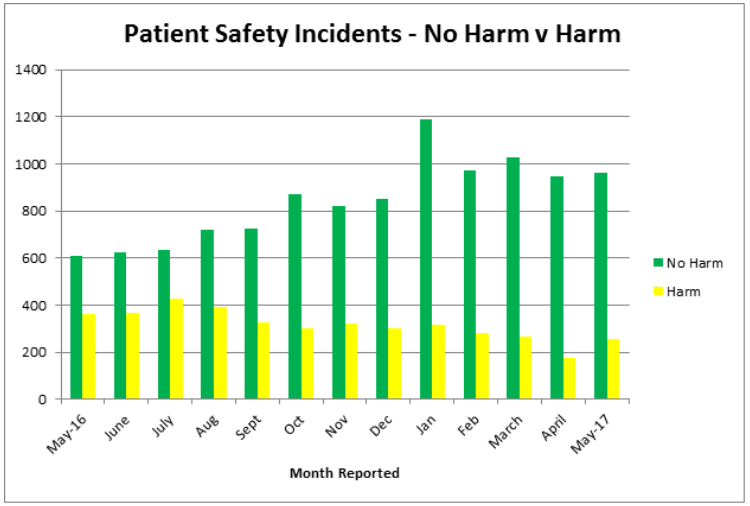
High incident reporting rates point towards an organisation with a good safety culture where staff feel confident to report concerns in order to improve patient safety through learning from incidents. At Barking, Havering and Redbridge University Hospitals (BHRUT) we actively encourage staff to report not only incidents which have occurred, but also concerns relating to potential 'near misses' which allow us to identify potential for harm before harm occurs.



	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16	Jan-17	Feb-17	Mar-17	Apr-17	May-17
BHRUT	32.11	33.26	35.07	36.32	37.47	39.31	38.88	47.78	45.53	43.68	37.95	41.50
National Average	38.25	38.25	38.25	38.25	38.25	38.25	38.25	38.25	38.25	38.25	40.02	40.02
Trust Average	34.31	34.31	34.31	34.31	34.31	42.19	42.19	42.19	42.19	42.19	42.19	42.19

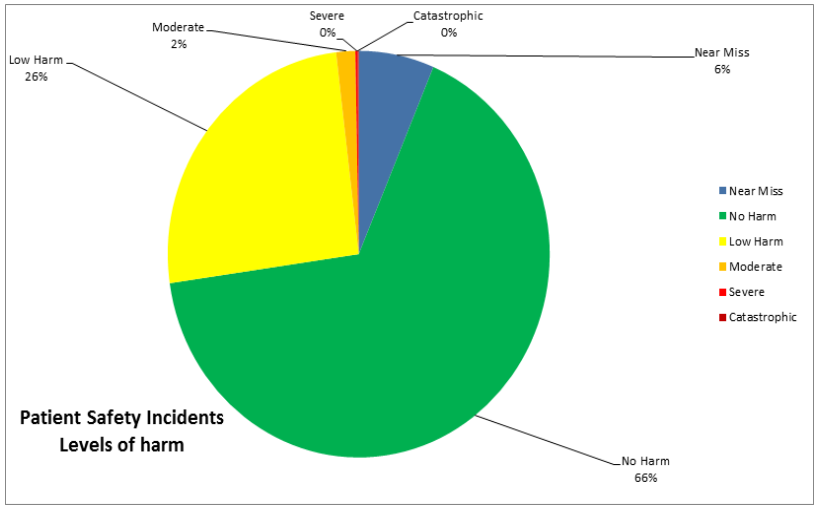
Over the past year our incident reporting figures have been on an upwards trajectory and we have achieved figures above the national average every month since November 2016 except for a slight dip in April 2017.

PROVIDING ASSURANCE OF IMPROVING PATIENT SAFETY



No harm	Incidents where no harm has been caused to the patient, including near misses where an incident is reported with the potential to harm patient but no harm has occurred
Harm	Incidents where the patient has sustained harm (low – catastrophic harm groups)

	Near Miss	Potential to cause harm
	No Harm	No injury caused
	Low Harm	Minor injury requiring minor intervention
	Moderate	Injury requiring professional intervention over a short term period
	Severe	Major injury leading to long term injury
	Catastrophic	Leading to death



TOP FIVE INCIDENT GROUPS

Of the 22,564 incidents were reported in the past year, 15,003 were related to patients' safety and were reported to the National Reporting and Learning Service. The remaining 7,561 incidents were non-patient related incidents e.g. staff accidents.

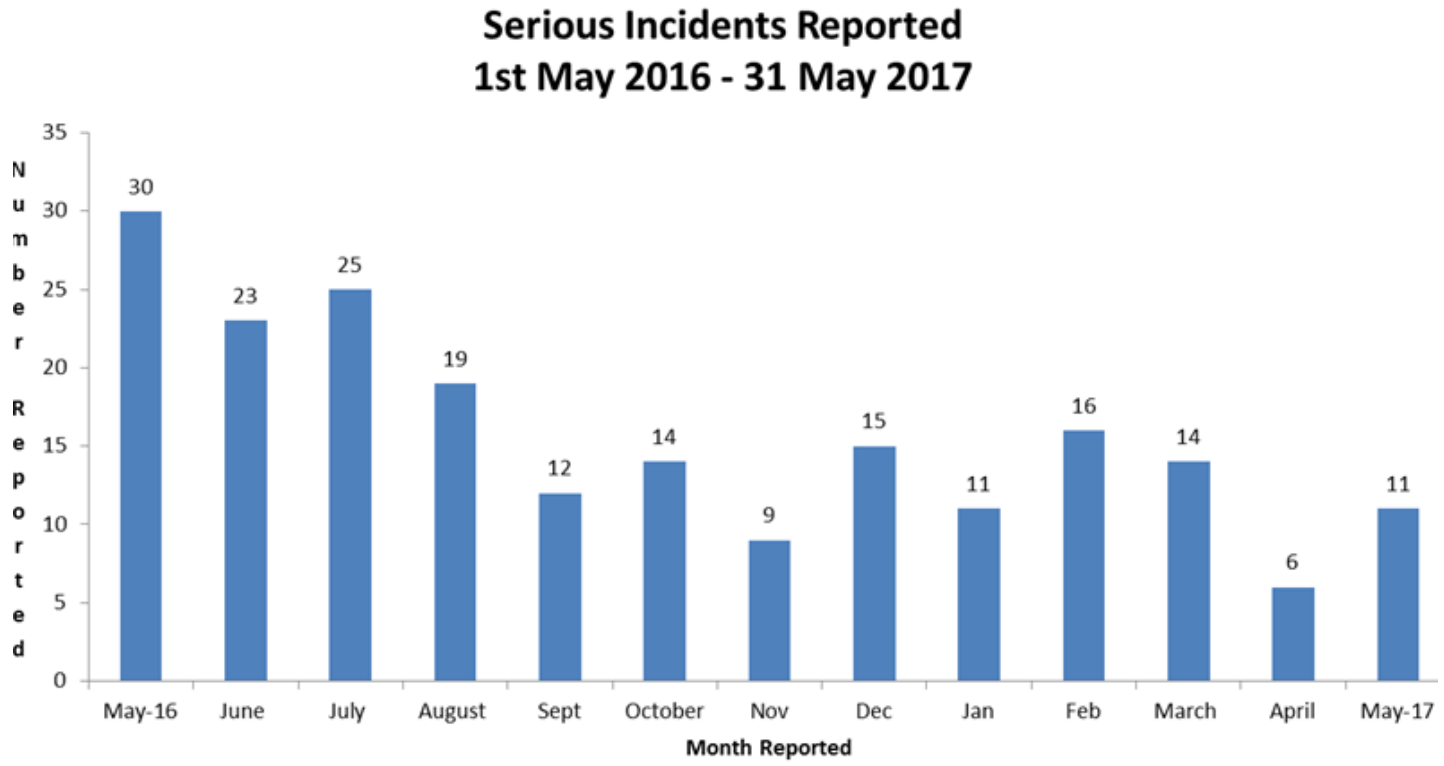
Incidents are grouped in order to identify areas of concern, allowing the trust to consider additional strategies to tackle areas where improvement may be required.

1. **Inherited pressure ulcers**. Staff complete an incident report for any patient who attends our hospitals with a pressure ulcer. These incidents are notified immediately to the Tissue Viability Team who endeavour to assess the patient whilst in our care.
2. **Treatment failure and delay.** The majority of incidents within this category relate to surgical delays or cancellations. These can include minor delays such as late running of theatre lists due to clinical complications or requirement to cancel surgery for a variety of reasons
3. **Slips, Trips and Falls.** We have seen a decrease in the numbers of falls overall, both without and with harm. For the financial year of 2016-2017 72% of all falls resulted in no physical harm.
4. **Medication.** Medication incidents can include supply, administration and prescription errors with various levels of harm: 85% of these incidents fall into the 'near miss' or 'no harm' categories.
5. **Obstetrics.** Our Maternity team deliver around 8,000 babies per year. This category can include incidents relating to ante natal care, unexpected complications during delivery requiring transfer to Labour Ward from the Birthing Centre, and unexpected admissions to neonatal intensive care unit.

REDUCING SERIOUS INCIDENTS

Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified. *NHS England Serious Incident Framework (2015)*

Over the past twelve months we have noted a reduction in the number of incidents per month which have met the criteria as a Serious Incident, largely as a result of ongoing learning.

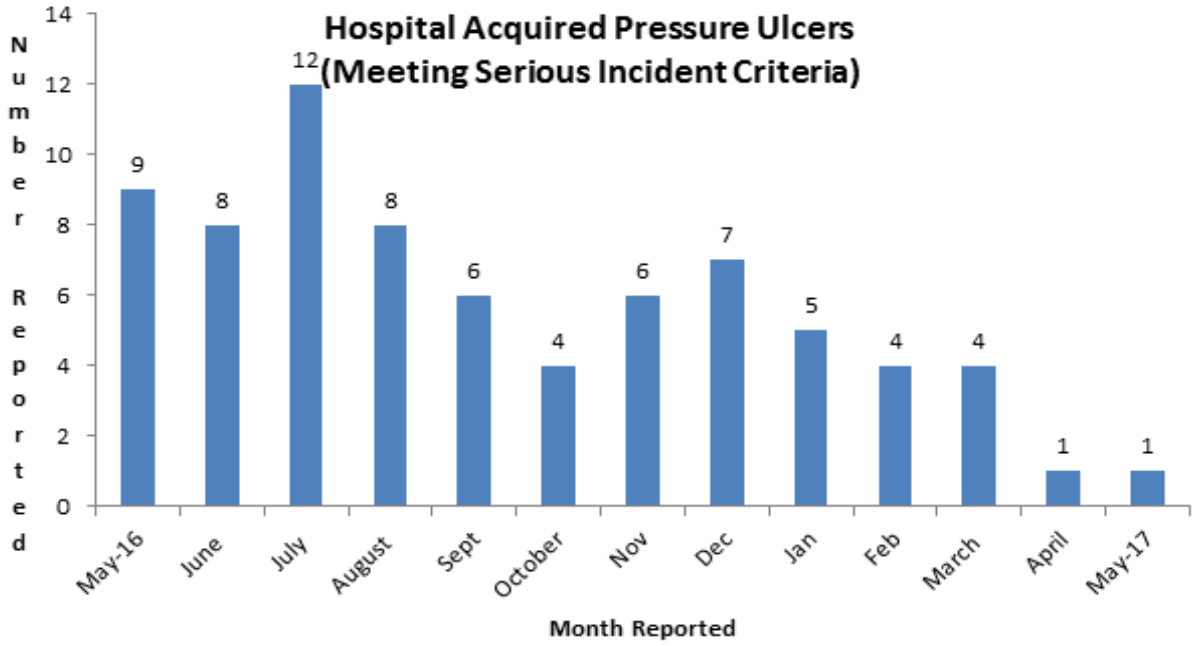


LEARNING FROM SERIOUS INCIDENTS

Over the past year the incidence of hospital-acquired pressure ulcers reportable as serious incidents has steadily reduced, indicating great progress with identification of pressure damage and early intervention to reduce the potential for skin breakdown.

The Trust is actively working to reduce these wounds, holding monthly review panels for all hospital-acquired wounds that explore how they occur and identify issues to be addressed. These panels have been instrumental in reducing the number of wounds reported and the Trust is now reporting the lowest numbers since May 2015.

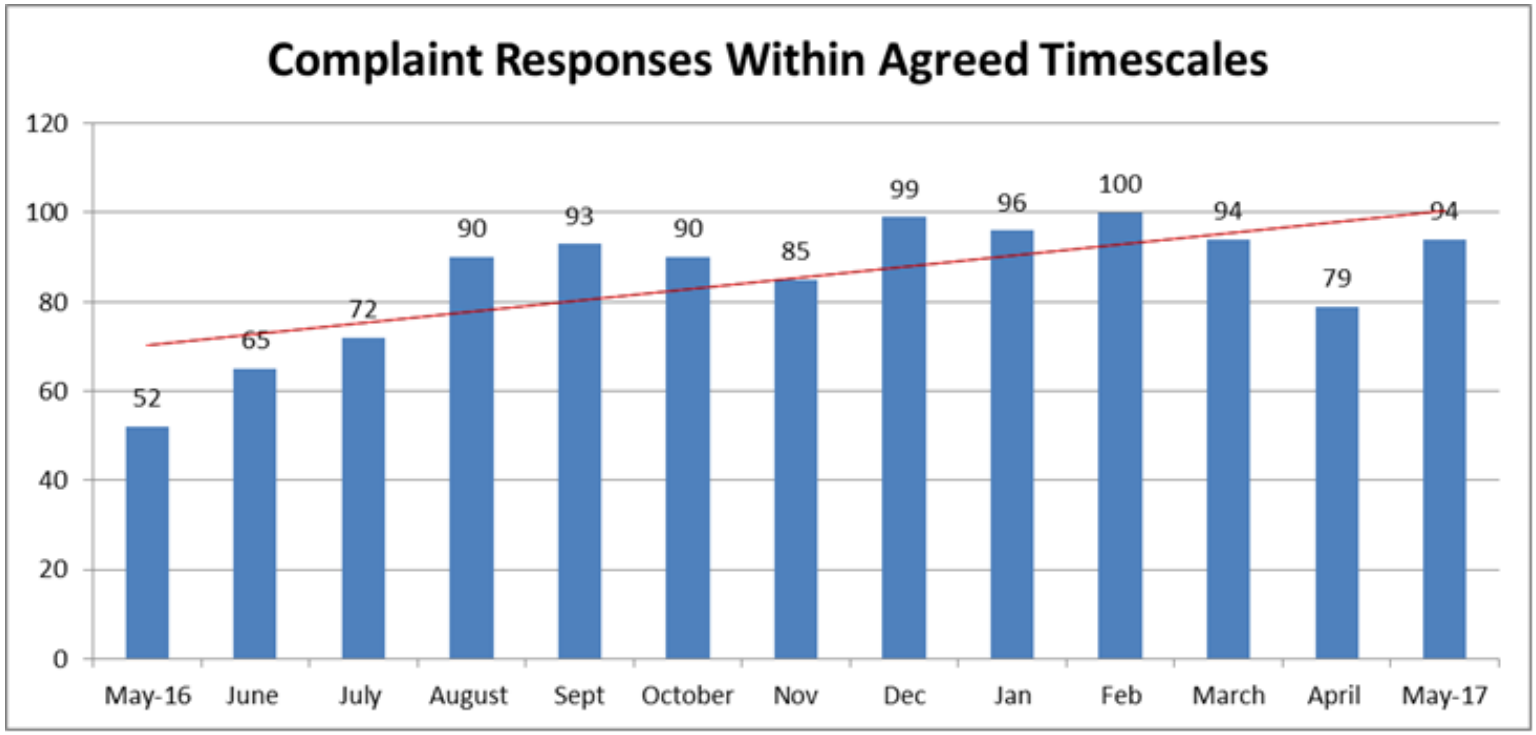
A trend was identified earlier in the year that showed that heel damage was problematic area. To address these issues mirrors were distributed to the ward staff to use to help check the heels more easily. Additional education was provided to ward staff to help them find alternatives to heel protectors when this equipment is not viable.



COMPLAINTS

We value all feedback from service users as an indicator of the quality of care we provide. Complaints are a vital part of this feedback and we aim to provide a robust response to concerns which have been raised.

We have a target of acknowledging formal complaints received within three working days and a 85% target of responding to complaints within the agreed timescales. Complaint responses within agreed timescales have improved dramatically from 52% in May 2016 to 94% in May 2017.



LITIGATION AND CLAIMS

Our legal department provided assistance in 87 inquests between May 2016 and May 2017. During this period we received one Regulation 28 report advising on required changes to practice.

Regulation 28

During March the first regulation 28 Report in 18 months was issued against the Trust in relation to a case where a patient died following a liver biopsy on 8 June 2016.

Action taken in response to the Regulation 28 is that the Trust has created a new care and has developed a standard operating procedure (SOP) for the clinical area. There has been an increase in staffing within radiology to ensure that a patient has a nurse in attendance until such time as they are returned to the ward and consideration of a dedicated recovery area within Radiology is in the planning stages.