NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

Trust Board

Agenda Item	11a.	**Date: 27 September 2017**	
Title of Report	Patient Safety Annual Report		
Purpose of the report and the key issues for consideration/decision	For the Board to receive for approval. The report has been reviewed at the Quality & Safety Committee.		
Prepared by: Name & Title	Patient Safety team		
Presented by:	Pauline Law, Director of Nursing		
Action Required (please X)	**Approve** x **Adopt** **Receive for information**		
Strategic/Corporate Objective(s) supported by this paper	BAF Objective: To deliver safe, high quality, effective, evidence-based patient care		
Is this on the Trust's risk register?	**No** On the BAF **Yes** **If Yes, Score**		

Which Standards apply to this report?	
CQC	x
NHSLA	x
BAF Objectives	x
WWL Wheel	x

Have all implications related to this report been considered?

	Yes/No/NA	Any Action Required		Yes/ No/NA	Any Action Required
Finance Revenue & Capital	Na	Na	Equality & Diversity	Na	Na
National Policy/Legislation	Y		Patient Experience	Y	
NHS Contract	Y		Governance & Risk Management	Y	
Human Resources	Na	Na	Terms of Authorisation	Y	
Consultation/Communication	Na	Na	Human Rights	Na	Na
Other:	Na	Na	Carbon Reduction	Na	Na
If action required please state:					

Previous Meetings

Please insert the date the paper was presented next to the relevant group

ECC	Audit Committee	Quality & Safety Committee	Finance & Investment Committee	Management Board	Strategy Committee	Workforce Committee	NED	Other
Na	Na	13.09.17	Na	Na	Na	Na	Na	Na

NHS
Wrightington, Wigan and Leigh
NHS Foundation Trust

Patient Safety

Annual Report 2016/17

Pat O'Brien
Patient Safety Manager
August 2017

Your hospitals, your health, our priority

INTRODUCTION

Incident reporting has been a requirement within the NHS since the removal of NHS Crown Immunity in 1991. Initially incident reporting had a 'health and safety' focus in view of the requirements of the Health and Safety at Work Act 1974), it was more of an 'accident' reporting process.

At the time, things that went wrong in relation to patient care weren't immediately recognised as requiring reporting, they weren't 'accidents' and therefore there wasn't immediate recognition that this was an equally important requirement for patient safety.

Thankfully, 35 years on, with some difficult lessons and experiences, the NHS recognises understands and utilises incident reporting for its primary function and purpose which is to:

"Identify if systems, processes and practices in place are effective and fit for purpose in protecting the safety and well-being of patients, staff, visitors to the organisation and the organisation's ability to provide and maintain safe, effective patient care and services".

This is certainly the case within the Trust with its ever developing effective and pro-active incident reporting and safety culture, in which incident reporting is recognised, established and used as an invaluable means of:

- Alerting the Trust when things are not supporting the provision of safe, effective patient care and services
- Understanding why and how things have or may go wrong
- Learning and improving

The Patient Safety Team annual report normally provides an annual overview of the work of the Patient Safety Team and the incident reporting culture across the organisation with a particular focus on trends, themes and lessons learnt from those incidents affecting patient safety, including serious incidents and Never Events.

This year's annual report is a little different because whilst 2016/17 was yet again a hectic and challenging year for incident reporting and the Patient Safety Team it has also been an exciting year of celebration and change. 2016/17 has been the year in which we have really been able to see how far we have come since the introduction of the Datix Web Incident Reporting System on 16 April 2010.

This year's report therefore begins with the Highlights and Lowlights. The main body of the report will focus on our incident reporting and patient safety culture and the journey and progress made from 2010 to date.

1. PATIENT SAFETY TEAM and INCIDENT REPORTING HIGHLIGHTS AND LOW LIGHTS 2016/2017

Highlights

- Finalists for the Trust Recognising Excellence Awards in 2016
- Finalists for the Health Service Journal Patient Safety Awards in November 2016
- Shortlisted for two categories in the HSJ 2017 Patient Safety Awards:
    - Best Organisation
    - Clinical Governance and Risk Management in Patient Safety
- 9% increase in incident reporting rates for the second year running exceeding the target of a sustained 5% year on year increase
- Positive improvement in compliance with incident reporting to investigation completion times across all divisions
- Further improvement and achievement in upload of eligible patient safety incidents to the National Reporting and Learning System (NRLS). The Trust's confirmed benchmarked position is 14th out of 136 Trusts (last year 26th out of 136) with the Trust now in the top 10% of best performing trusts nationally
- Incidents meeting the definition of a Near Miss are more widely understood and reported by staff.
- Significant increase in the number of reported 'Near Miss by Intervention' incidents
- Staff Survey Results: The Trust is in the 'highest 20% 'staff confidence and security in reporting unsafe clinical practice' – supports Just Culture
- Work completed in relation to reporting behaviours by staff groups removing perception of Datix as a punitive negative tool.
- Questionnaire to promote incident reporting and supportive 'Just Culture' developed and will be piloted in August 2017 with a view to further trust-wide roll out
- Securing and delivering slots on the doctors in training protected teaching time sessions
- Working with the Health and Safety Team and Violence and Aggression Working Party to completely revise the categories and subcategories relating to violence and aggression incidents including recognition of health-related incidents and equality and diversity related incidents
- Themed approach being taken to SIRI (Serious Incidents Requiring Investigation) meetings with the Commissioners and 2 Trust Governors as members. SIRI Panel is discussed in more detail in the report section covering Serious Incidents.
- A recent comment from one governor SIRI Panel representative that the meeting demonstrated strong and effective mechanisms to support and demonstrate learning.
- Development and delivery of a two day 'Significant Event Lead Investigator' training programme in conjunction with the Head of Quality Improvement, Staff Engagement, and Project Management Team
- Revised Rapid Review, Concise and Comprehensive Investigation report templates and tools
- Duty of Candour look back exercise completed to support the drive to fully implement and evidence compliance has supported development of a plan for monitoring and feeding back to divisions on application of Duty of Candour
- Suite of Patient Safety Team 'How to ……. 'screen shots completed and added to the intranet providing to provide further support and guidance to staff on reporting, investigating and now final approval following investigation of all incidents reported via Datix Web

- Improved reporting against 2015/16 performance, under Nursing 'Red Flags' linked to nurse staffing and patient care
- Midwifery 'Red Flags' linked to midwifery staffing and care set up ready for introduction July 2017
- No CAS alert breaches

Lowlights

- The number of StEIS reportable Serious Incidents reported in 2016/17 was 31, which is an increase against 2015/16 (22)
- One Never Event during 2016/17 – Bed rail entrapment
- One Serious Incident Investigation KPI breach for late report submission, under the Serious Incident Framework which came into being on 1 April 2015 - although the Trust continues to benchmark extremely positively in relation to KPIs
- Some staff still feeling they do not receive feedback despite improvements to the system
- Areas of under and inconsistent incident reporting remain
- Similar emerging themes and trends to 2015/16 present throughout all 4 reporting quarters of 2016/17
- Partial assurance that Duty of Candour is being fully and appropriately applied. Actions are underway to achieve full compliance.
- Partial assurance of progress with the development of NatSSIPs and LocSIPPs. Significant progress has been made in theatres with further actions required for procedures undertaken outside theatres that meet the definition of Interventional Procedures.

2. TRUST - WIDE INCIDENT REPORTING 1 APRIL 2002 TO 31 MARCH 2017

a. Summary of Progressive and Improving Annual Reporting Trends and Numbers

The Trust first introduced the Datix Incident Reporting System as the way to report and manage its incidents in April 2002, the system was paper based at that time with staff completing forms which were then inputted on to the system by the then Patient and Staff Safety Team. From 1 April 2002 to 31 March 2010 there were 39,580 incidents reported over 8 financial years. The paper based system was flawed with delayed submission, inputting and follow up problems and so in April 2010 the Trust moved to Web based incident reporting to enable earlier if not always immediate submission of incidents.

Except for 2010/11, there has been a year on year increase in the number of incidents reported. The slight reduction during 2010/11 was predicted and expected and as experienced by almost all trusts in the first year that the web based system was introduced.

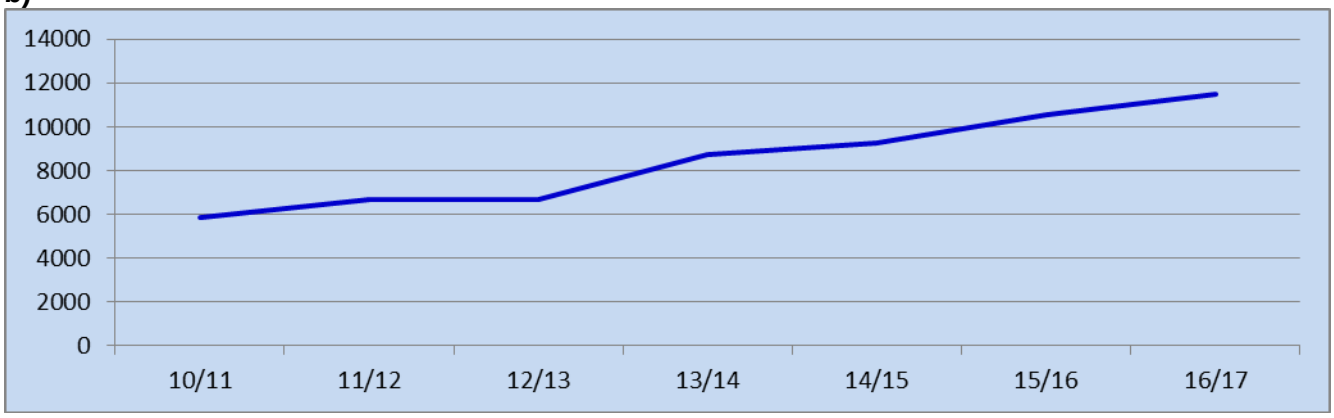
From 2011 onwards though there has been a sustained and positive trend of increased reporting continued and in total from 1 April 2010 to 31 March 2017, staff have submitted 59,237 incidents via Datix web over 7 financial years.

Charts a) and b) below provide a summarised analysis of the year on year upward trend of incident reporting and a run chart to add visual context to the sustainability and level of progress made.

a)

	2010/11	2011/12	2012/13	2013/14	2014/15	2015/16	2016/16	Total
Incidents reported by financial year	**5,858**	**6,650**	**6,691**	**8,740**	**9,255**	**10,546**	**11,497**	**59,277**
Increase in reporting rate against previous financial year	**N/A Baseline**	**↑ 792 14% increase**	**↑ 41 <1% increase**	**↑ 2,049 23% increase**	**↑ 515 6% increase**	**↑ 1291 14% increase**	**↑ 951 9% increase**	

b)



During 2016/17 the trend has continued with 11,497 incidents being reported which was an increase of 951 compared to 2016/17.

Since the introduction of Datix web our staff have reported 19,657 more incidents during 7 financial years than they did via the paper based system over 8 financial years.

The 2016/17 aim was to sustain a minimum 5% increase in reporting rates year on year. For the second successive year we have exceeded that with a 9% increase in 2016/17 reporting rates achieved.

All staff throughout the organisation should be made aware of, thanked, congratulated and be proud of their contribution to this significant progress and achievement by the Trust

From 1 April 2016 to 31 March 2017 a total of 11,497 incidents were reported via the Trust's Datix web incident reporting system, 532 were rejected by the Datix System Administrators as duplicate or inappropriate submissions (e.g. non WWLFT incident, same incident, same details different reporter).

Whilst this is a higher number than 2015/16 (334) this is not to be viewed as a negative, many of these incidents were duplicates as more than one staff member and in many cases staff groups reported the same incident but from a different perspective. This is therefore a positive development as more staff and more staff groups understand the purpose and importance of incident reporting and rather than assume that someone else will report the incident they do it. After identifying the report providing the most information and most factually accurate the duplicate incidents were merged, referenced in the retained record and remain safely stored on the system supported by a secure audit trail.

b) Reported Incidents Totals and Severity of Harm - All incidents - 2010 to 2017

Another indicative feature of an improving incident reporting and safety culture within an organisation is the actual severity of harm resulting from an incident.

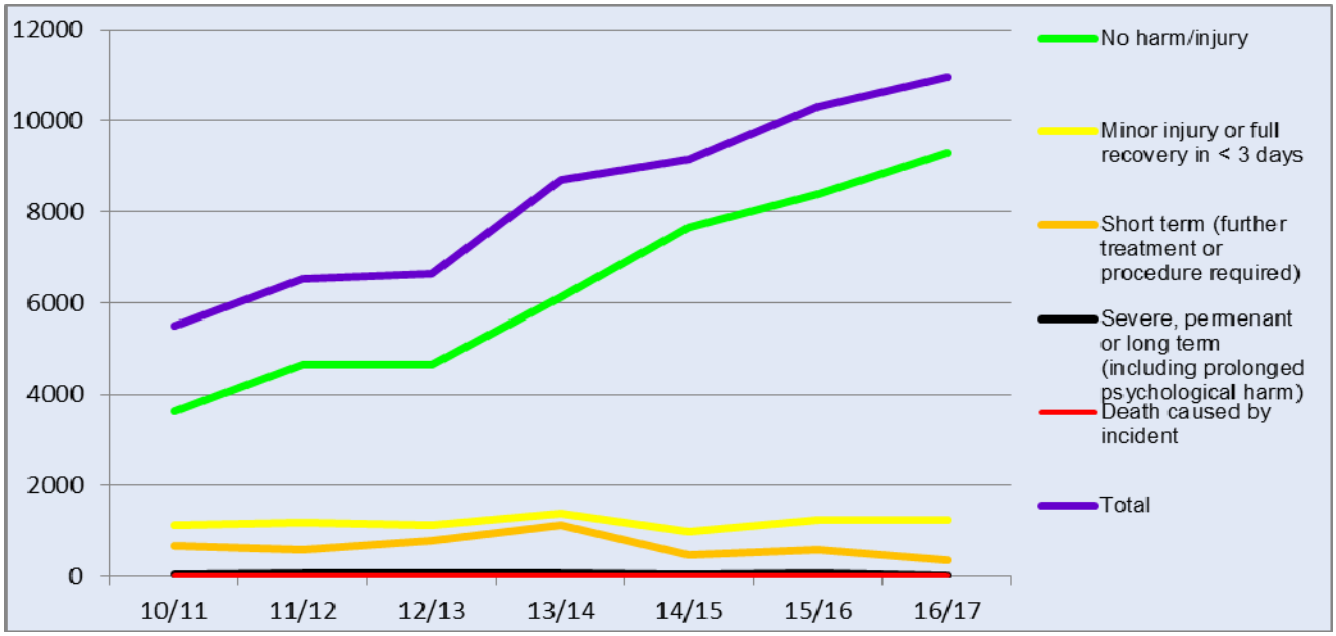
However, to be a credible benchmark, this statement and any analysis must be balanced against the attention drawn by the NRLS to all Trusts that:

"*Recognising and reporting incidents resulting in severe harm or death, is an important sign of an organisation's reporting culture. If the numbers of incidents reported as severe harm or death are low compared with peers you, should check that your reports reflect all incidents you are aware of through sources such as mortality review, inquests, litigation or complaints*

The Trust, based on the most recent annual and monthly data available via the NRLS, benchmarks well against similar organisations both locally and nationally. The Trust reports within the range of 0.3 to 0.5% of incidents as resulting in severe or catastrophic harm. This is comparable to other GM Trusts and the NRLS identifies that nationally just under 1% of incidents (0.8%) are reported as resulting in severe harm or death.

Not only have we seen a sustained increase in the number of reported 'no harm' incidents but we are also now recording a sustained year on year decrease in moderate harm incidents with no increase in severe and catastrophic harm incidents.

The chart below clearly illustrates the improvement and progress made in respect of this.



1.2 Divisional Incident Reporting Trends

Review Work undertaken by the Patient Safety Manager has identified that:

- Medicine Division continue to report the highest number of incidents with Q4 recording the highest number of reported incidents over the last 24 months and also the second significant increase in reporting during 2016/17. This is correct even taking account of the higher than normal number of duplicate and rejected incidents submitted during Q4.

- Surgery Division has registered an increase in reporting during Q4, having taken into account the higher than normal number of duplicate and rejected incidents during Q4. Therefore the need for continued monitoring still applies because of the previously and repeatedly registered apparent inconsistency in numbers reported; with a variance of plus or minus 50-100 incidents recorded each quarter.

- Specialist Services Division (inclusive of Shared Services) remains the lowest reporter amongst the clinical divisions. Specialist Services (exclusive of Shared Services) have continued their recovery in reporting incidents, following a dip in incident numbers in Q1 of 2016/17. Q4 has seen an increase in reporting for the third successive quarter with Q4 recording the highest number of reported incidents of 2016/17 and over the last 24 months. This is correct even having taken into account the higher than normal number of duplicate and rejected incidents during Q4.

- A marginal increase in reporting rates is seen within Estates and Facilities who have recorded their highest incident reporting rate for 24 months (88); when excluding Sterile Services incidents (142).

- Reporting rates amongst the remaining divisions remain low overall with Information Management and Technology registering a 30% reduction in reporting rates during Q4, but back to previous levels pre-HIS.

Previous reports have recommended that those divisions identified as low reporters or with repeatedly inconsistent reporting patterns should undertake work to establish if they actually had a low incident occurrence rate or if/why staff were failing to recognise or lacked the confidence to report.

A variety of work has been undertaken and will be continued, undertaken, recommended or supported by the Patient Safety Manager to improve reporting rates amongst staff within the divisions.

It is pleasing to note that Specialist Services, Medicine and Estates and Facilities sustained the increase in the numbers of reported incidents across their divisions and that Surgery in Q4 appears to have built on progress made since Q2.

The divisional reporting rates are summarised in the chart below which includes a comparison of 2015/16

ALL REPORTED INCIDENTS BY REPORTING QUARTER 2016/17 AND 2015/2016 FOR COMPARISON BY DIVISION OR DIRECTORATE	15/16 Q1	15/16 Q2	15/16 Q3	15/16 Q4	16/17 Q1	16/17 Q2	16/17 Q3	16/17 Q4
Corporate Support Services Division	5	10	11	6	5	9	7	10
Estates & Facilities Division	54	40	49	44	51	63	202	230
Finance	2	1	2	0	1	1	4	1
Human Resources (HR)	2	2	2	3	1	3	1	6
Information Management and Technology	15	14	12	10	10	21	20	14
Medicine Division	1054	1246	1439	1394	1378	1355	1469	1629
Shared Services (Radiology & Pathology Services)	91	251	226	212	195	169	74	83
Specialist Services	486	361	328	360	323	378	418	551
Surgery Division	624	719	800	667	751	632	688	764
Totals	**2333**	**2644**	**2869**	**2696**	**2715**	**2631**	**2883**	**3288**

There are a number of significant changes seen in the divisional reporting rates during 2016/17 Q3 within Estates and Facilities and Shared Services which have been highlighted in red above for ease of reference. This reflects changes in reporting arrangements; SSDU has been moved from Shared Services to Estates and Facilities.

3. NRLS UPLOAD PERFORMANCE 2015/16

There are two National Reporting and Learning System (NRLS) reporting periods:

- 1 April to 30 September
- 1 October to 31 March

The Trust was for some years an outlier in terms of performance linked to NRLS reporting and was one of the worst performing Trusts nationally in 2012/13.

The Trust had achieved some improvement during 2014/15.

During 2015/16 not only had the Trust sustained previous progress made, it recorded its most significantly improved performance.

The plan for 2016/17 was simply to maintain that position, but that was not to be. The Trust's exact progress, performance and position by April 2017 is detailed below:

September 2014 137th out of 140 acute non-specialist trusts and **one of the worst reporters** nationally

April 2015 71st out of 140 acute non-specialist trusts **and amongst average 50%**

September 2015 37th out of 137 acute non-specialist trusts **and** just outside **top 25%**

April 2016 26th out of 136 acute non-specialist trusts and in the **top 25%**

 **September 2016 13th out of 136** acute non-specialist trusts and in the **top 10%**

 **March 2017 14th out of 136** acute non-specialist trusts and still in the **top 10%** with a further increased reporting rate against September 2016

The work of the Divisional Governance Leads and their Divisional colleagues should be commended for the improved management and investigation of reported incidents which has contributed to this continued progress and achievement.

4. DATIX

4.1 Datix Developments 2016/17

System development and snagging work continues in response to ongoing divisional, service and staff restructuring and relocation and requests for additional staff to be added as investigators. Changes have been made to the identified 'Divisions' for the purpose of registering Incidents, Complaints, Claims and Risks on the Datix Web and Risk Management Systems. This will enhance further the identification and monitoring of trends, themes and risks within these specific areas that have potential for organisational as well as local impact and learning. It will also better support the work to set up of automatically generated monthly and quarterly reports.

A Datix Quality Improvement Group has been established. Early work and meetings have identified the key priorities for 2017/18 and regular monthly meetings are scheduled to take place throughout the coming year.

The first areas of focused work relate to the Risk register and Incident Reporting modules.

4.2 Daily Datix Teleconference

The Datix Daily Teleconference continues to promote and result in early identification, escalation and investigation of potential and actual serious incidents and Never Events, with most serious incidents having been reported via Datix web and raised at teleconference within 24 hours of being reported.

From April 2016, all Ward Managers also began to receive the daily teleconference log and it was hoped this this would assist will assist divisions to better meet investigation timescales, improve feedback to staff and support shared organisational learning.

Mid 2016 Band 6's were added to the distribution list.

Junior Doctors in training also now receive the teleconference log each Friday.

The daily teleconference now includes each Friday, updates on incidents and investigations received by the Executive Scrutiny Committee or the Serious Incidents Requiring Investigation (SIRI) Panel. In addition, the Friday teleconference log also includes the Executive Scrutiny Committee Pledge: *'Learning From Experience and Learning From Excellence'*.

These additions are positive progress to promote and support sharing and understanding of learning and across the organisation. In addition they provide staff with re-assurance that reported incidents are reviewed, investigated and responded to.

4.3 Looking at Reporting Behaviours of Staff Groups - Identified High and Low Reporters

In 2016/17 an identified challenge was to improve the reporting rates amongst staff groups identified as low reporters. Two of the key focus areas were staff's misunderstanding that only managers can report incidents and lack of feedback to staff on incidents they have reported.

There has been further modification to Datix to make reporting simpler and to make feedback swifter.

Some staff remained reluctant to report or be involved in reporting because of the behaviour and attitude to incident reporting exhibited by colleagues and this was raised as a concern to the Patient Safety Manager. In response to this the Patient Safety Manager undertook random review of a number of 'rejected' incident forms to consider approaches and communication between staff relating to the reason, context and manner in which incidents are reported which confirmed that in some instances, Datix incident was being used in a negative way.

The issue was therefore covered as the 'Headline of the Day' on a Daily Teleconference log distribution email. This type of behaviour is much less frequently seen since this time.

In terms of the staff groups who report incidents review work undertaken by the Patient Safety Manager has identified that: in comparison to 2015/16:

- Nursing and midwifery staff continue to report the highest number of incidents,
- Pharmacy and therapy staff also report well and this is an ongoing improvement
- Senior Medical staff are now starting to report more frequently themselves but still often ask nursing or junior medical staff to report on their behalf
- Junior medical staff report well and this is an ongoing improvement
- Within the remaining staff groups there is no clear pattern to under reporting - it appears to be dependent on specialty or service and also the type of incident and where the incident is identified.

4.4 Just Culture

- The drive to embed 'Just Culture' is continuing and is a key focus area alongside 'Human Factors' within the 'Lead Investigator Training' now being delivered by and within the Trust. Embedding these principles not only into our policies but into our daily practice and approaches to incident reporting and management will help all staff feel able to report incidents and appropriately supported when they do so.

- The continuing increase in reporting rates is indicative that the principles of 'Just Culture' continue to become more widely recognised, understood and applied and that this in turn is contributing to an enhanced safety and incident reporting culture.

- Staff Survey Results demonstrate that the Trust remains in the 'highest 20% for 'staff confidence and security in reporting unsafe clinical practice' – supports evidence of an improving 'Just Culture'.

- Questionnaire to promote incident reporting and supportive 'Just Culture' developed and will be piloted in August 2017 with a view to further trust-wide roll out

4.5 Feedback to Reporters of Incidents

Following the modifications to Datix to enable earlier feedback to staff, as reported in 2015/16 further work has been undertaken to ensure that those staff who want feedback from reported incidents receive it:-

- The Patient Safety Team have begun a rolling programme of correspondence to staff who enter incorrect email addresses (personal as opposed to their WWLFT email), thus preventing them receiving feedback
- Correspondence details exactly what they need to do for future reporting and provides them with their correct email address for future reference
- The Divisional Heads of Governance are copied in to the correspondence to provide further support at local level if staff require this
- Register established of staff having difficulties and frequency support required.
- Datix contact details and incident forms being corrected to enable feedback to be provided.

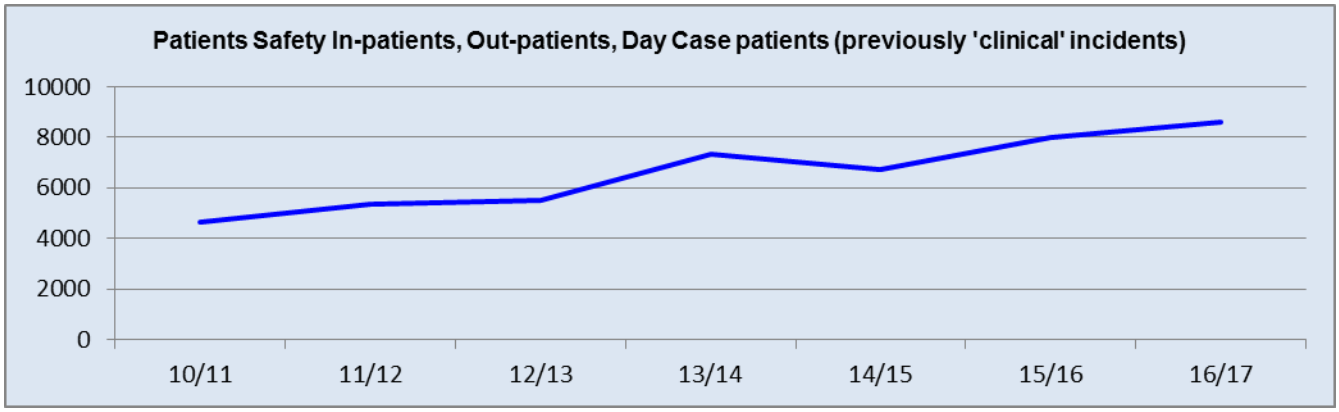
5. CLINICAL/PATIENT SAFTY INCIDENT REPORTING

5.1 Clinical/Patient Safety Incidents: Reporting Trends and Themes

The total number of incidents reported during 2016/17 affecting patients and excluding all rejected incidents was 8,607 which accounts for 75% of all reported incidents.

There is an increase in reported clinical/patient safety incidents of 603 which is a 7% increase against 2015/16 reporting rates, a 22% increase against 2014/15 and 46% since the introduction of Datix web in 2010.

The charts below detail the reporting trends from 1 April 2010 to 31 March 2017 in tabular and run chart format:



Patients Safety Incidents (previously 'clinical' incidents) In-patients, Out-patients, Day Case patients	2010/ 11	2011/ 12	2012/ 13	2013/ 14	2014/ 15	2015/ 16	2016/ 17	Total
	4646	5355	5491	7347	6712	8004	8607	**46162**

5.2 Top 5 Identified Incident Reporting Themes

The 2015/16 report made a recommendation that the Divisional DQECs should review the top 5 'Emerging Themes' and take action to reduce the risk of reoccurrence, this recommendation is still pertinent to the 2016/17 annual reporting period.

It can be seen from the table below that there has been some changes to the top 5 emerging themes This is as a result of a focused piece of work by the Patient Safety Manager and Head of Governance, for Specialist Services to reallocate categories more appropriate to the reported incident details. As a consequence of this diagnosis and investigations incidents now appear in the top 5, having significantly increased during 2016/17 Q4 in particular.

	15/16 Q1	15/16 Q2	15/16 Q3	15/16 Q4	16/17 Q1	16/17 Q2	16/17 Q3	16/17 Q4	Increase/ Decrease this quarter with last
Direct Care (Patient Safety Incident)	225	297	331	298	355	290	377	**351**	↓
Medicines administration/supply	129	203	204	153	130	107	93	**113**	↑
Documentation and Records	119	112	148	151	172	116	126	**129**	↔
Communication, Confidentiality and Consent	115	80	96	114	92	133	131	**125**	↔
Diagnosis (and investigations)	95	96	116	106	108	115	113	**185**	↑
Medicines prescribing	56	101	101	76	82	78	95	**80**	↓

A themed SIRI is planned for April 2017 looking at diagnostic incidents.

5.3 Emerging Themes

Of note is that:-

- Direct Care incidents remain a theme seen across all clinical divisions and are the most frequently reported incidents.
- Incidents relating to diagnosis are a common theme within two out of the three clinical divisions.

The key themes emerging are re-iterated again as the same as in previous quarters and years.

Further analysis has identified that common threads relating to all the 'Top 5'Incidents incidents, including, less obviously medicines administration and prescribing incidents, continue to be:

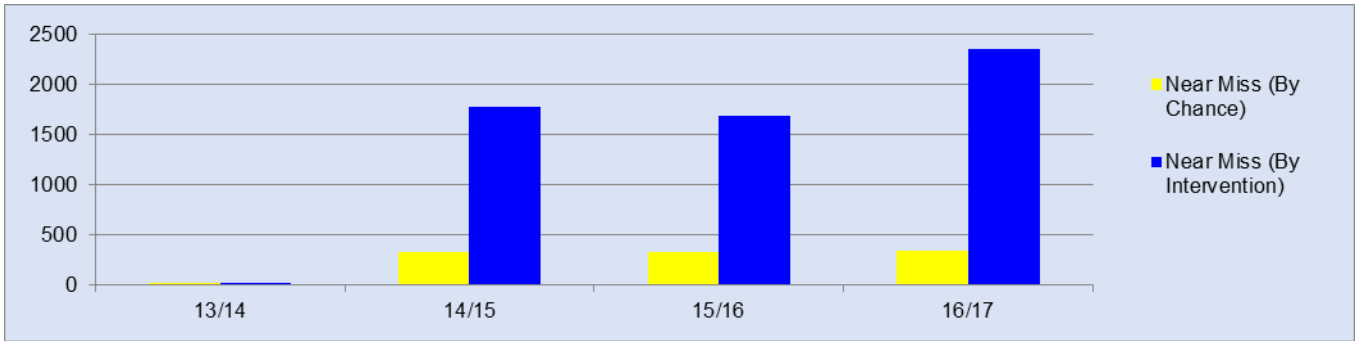
- Documentation standards not met - frequency, accuracy, dating and timing, and instrument returns to SSDU following procedures/surgery.
- MEWs scoring and escalation reflecting the same themes as general documentation above.
- Escalation and review in response to changes in condition.
- Patient identification linked to documentation, medication administration, documentation accuracy and check procedures.
- Communication between wards, clinics, departments and within actual teams including both verbal and written communications.

5.4 Near Miss Incident Reporting Trends

An increase in Near Miss reporting is a clear indication of an organisation with a positive and improving safety, incident reporting and learning culture. There has been a drive through various work streams and training programmes to raise awareness and understanding of

Near Miss reporting and its value in learning and improving safety. The importance of Near Miss reporting was discussed at the Quality and Safety Committee in April 2016.

Analysis of progress relating to this aspect of incident reporting can be seen in the chart below, which details the trends in Near Miss reporting from 2013/14 to 2016/17.



Last year's Annual Report identified that, except for the final reporting quarter, there was evidence of increased Near Miss reporting since 2013/14. However, given the reduction seen by 2015/16 Quarter 4 it was recognised that there was a very clear challenge for further work to improve staff recognition and understanding of the value of Near Miss reporting.

The chart above below details the number of reported Near Miss incidents by year from 2013/14.

	2013/14	2014/15	2015/16	2016/17	Total
Near Miss (By Chance)	12	321	326	345	1004
Near Miss (By Intervention)	4	1771	1688	2358	5821
Totals:	16	2092	2014	2703	6825

There are two key points to note:

- There are more reported 'Near Miss by intervention' than 'Near Miss by chance' incidents which demonstrates staff are taking positive steps to intervene and prevent harm.
- All of the above support other indications that the Trust has a positive and improving safety,
  incident reporting and learning culture.

All staff throughout the organisation should be made aware of, thanked, congratulated and be proud of their contribution to this significant progress and achievement by the Trust

6. SERIOUS INCIDENT REPORTING, INVESTIGATION AND LEARNING

6.1 Serious Incidents submitted to StEIS

The revised NHS England Serious Incidents Framework became effective from 1 April 2015.

The number of StEIS reportable Serious Incidents reported in 2016/17 was 31, which is an increase against 2015/16, however this must be balanced against the attention drawn by the NRLS to all Trusts that:

"*Recognising and reporting incidents resulting in severe harm or death, is an important sign of an organisation's reporting culture. If the numbers of incidents reported as severe harm or death are low compared with peers you, should check that your reports reflect all incidents you are aware of through sources such as mortality review, inquests, litigation or complaints*

The Trust has during 2016/17 submitted to StEIS, for the first time, serious incidents identified directly via routes other than incident reporting and these have included via mortality reviews, inquests and complaints.

In order to monitor Trust compliance with the revised NHS England Serious Incidents Framework a number of Key Performance Indicators (KPIs) have been created by the Trust for close monitoring of key milestones and these are monitored via the StEIS Log and regularly reported to the Quality & Safety Committee and Commissioners.

The identified KPIs are:-

- Submission to StEIS of all Serious Incidents within 48 hours of their confirmation as an incident meeting the StEIS Serious Incident reporting criteria.
- Submission to WBCCG of an incident Rapid Review Report within 48 hours of the incident being submitted to StEIS.
- Submission to CCG of all Serious Incident Investigation Reports that include Action Plans within 60 working days of the Serious Incident being submitted to StEIS.

The Trust has achieved 100% compliance against the first 2 KPIs; however, one comprehensive level 1 investigation report was late due to the complexity of the investigation.

6.2 Never Events

During 2016/17 there was one serious incident meeting the Never Events reporting criteria for bedrail entrapment.

The first review of progress on implementation of the MDT, trust-wide action plan developed following the investigation of the reported Never Event involving bed rails was provided to the January 2017 SIRI Panel by the Health and Safety Manager and Advanced Nurse Practitioner, Child Health.

The Trust secured de-escalation of an incident which when submitted to StEIS was believed to meet the Never Events reporting criteria of 'Misplaced naso-gastric tube' and was therefore submitted to StEIS as this until the investigation was completed. Following its own review of the investigation report findings, the Trust submitted a request for de-escalation which was granted following further review by Wigan Borough CCG and NHS England.

6.3 SIRI (Serious Incidents Requiring Investigation) Panel Meeting

SIRI Panel has a 'Calendar of Returns' the purpose of this is to keep recalling those implementing action plans (not report authors) to present and re-present until all actions are completed and demonstrated to be effective. SIRI reviews the calendar every quarter and re-plans for any returns. SIRI may also recall if there is any change to national guidance which may compromise or impact in any way on previously 'Closed' actions.

The monthly SIRI Panel continues with CCG and governor representation. During 2016/17 there was one themed SIRI interactive SIRI panel held focusing on Mortality in February 2017.

During 2016/17 Q4, following review of a reported serious incident the Executive Scrutiny Committee determined that the SIRI Panel of 27th April 2017 should also be a themed interactive panel focusing on diagnostic requests and follow up and in particular radiological investigation requests.

An Internal Patient Safety Notice (IPSN) was issued on behalf of the Medical Director to provide direction to the divisions in providing an overview of concerns, suggestions and proposed actions to better enhance patient safety. This is to provide the focus for presentations and interactive session led by the Medical Director. The 2017/18 Q1 SEC report will include a summary of this event including identified themes, learning and agreed priorities for action and development.

6.4 Awards and Sharing Learning

The Patient Safety Team was delighted to be shortlisted for a number of awards during 2016/17:

- Finalists for the Trust Recognising Excellence Awards in 2016
- Finalists for the Health Service Journal Patient Safety Awards in November 2016
- Shortlisted for two categories in the HSJ 2017 Patient Safety Awards:
    - Best Organisation
    - Clinical Governance and Risk Management in Patient Safety

Sadly we did not win, however, we are proud to have made it as finalists and more importantly proud and motivated by what has been achieved since 2010 to date, submitting our entries and presenting to the judges brought significant realisation of exactly what has been achieved by the Trust and the contribution the Patient Safety Team have made and will continue to make to the Trust's Patient Safety Journey so far.

The weekly pledges from ESC for Q4 are issued for highlight the Trust-wide Learning from Excellence and Learning from Experience via the Friday Daily Teleconference log and via the weekly news brief.

Plans for 2017/18 include establishing an appropriate forum and means to share both learning and experience from reported serious incidents with our neighbouring providers at Bridgewater Community Health Care NHS Foundation Trust and North West Boroughs Partnership NHS Foundation Trust. A sharing event is planned for May 2017.

7. PATIENT SAFETY - 2017/18

The long-standing Patient Safety Manager will be taking flexible retirement in August 2017 and a new work plan for the team will be developed by the incoming post holder.

From the autumn of 2017/18, a Datix Administrator will be in post for 2 days per week, with a key priority being reviewing and updating how the Datix is configured.