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8 April 2013

HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL – AGENDA SUPPLEMENT

Thursday 11 April 2013
2pm
Council House (Next to the Civic Centre), Plymouth

Members:
Councillor Mrs Aspinall, Chair
Councillor Monahan, Vice Chair
Councillors Mrs Bowyer, Fox, Gordon, James, Dr. Mahony, Mrs Nicholson, Parker, Jon Taylor and Tuffin.

Members are invited to attend the above meeting to consider the items of business overleaf.

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Chief Executive

HEALTH AND ADULT SOCIAL CARE OVERVIEW AND SCRUTINY PANEL

9. NEVER EVENTS - PLYMOUTH HOSPITALS NHS TRUST (Pages 1 - 4)

The panel will consider a report on recent 'Never Events' occurring at Derriford Hospital.

Summary Report	
Devon Health and Adults Overview and Scrutiny Committee	
Subject	**Update on Surgical Never Events**
Prepared by	Patient Safety & Effectiveness Manager
Approved by	Director of Nursing
Presented by	

Purpose

To provide the Health and Adults Overview and Scrutiny Committee with an overview of the recently reported Never Events related to surgical safety. The Trust takes these incidents extremely seriously and is taking appropriate action to improve patient safety.

Background

1 In January 2011 significant concerns were raised regarding surgical safety at Plymouth Hospitals NHS Trust due to the reporting of 6 surgical never events over a 10 month period. At that the Trust was issued with a CQC Warning Notice and a stringent improvement programme was implemented. The majority of those incidents related to inadequate intraoperative count processes resulting in retained foreign objects.

2 The Overview and Scrutiny Committee has received several updates since that time on progress with surgical safety improvement and assurance has been provided to demonstrate that the Trust has implemented the learning identified during the investigation of those incidents.

3 Over the past 2 years (April 2011 to March 2013) the Trust has reported a further 8 never events related to surgical safety. These incidents are summarised below:

- July 2011 – Retained foreign object
- July 2012 – Wrong site surgery
- September 2012 – Retained foreign object
- November 2012 – Wrong site surgery
- January 2013 – Wrong site interventional radiology
- March 2013 – Wrong site surgery
- March 2013 – Wrong site radiology
- March 2013 – Wrong implant

Of these incidents, the two retained foreign object never events (July 2011 and September 2012) both related to cases where the national guidelines were followed but were not adequate to protect patients against the specific circumstances of these incidents. This learning has now been incorporated into our standard process at the Trust and the learning shared externally.

The remaining 6 incidents all relate to wrong site procedure/surgery and have occurred over a period of 9 months with a cluster of 3 never events being reported in March 2013.

4 The Trust has a robust process in place to ensure that each never event is dealt with appropriately and promptly. This process includes the following:

- Incident recognised, reported and escalated immediately to the Senior Management Team.
- Patient and/or relative immediately informed of the incident. Corrective action implemented if appropriate. A full apology is issued at that time and this is followed up in writing. The patient and/or relative is invited to contribute and participate in the formal investigation.
- Incident immediately escalated externally to the Commissioners, Strategic Health Authority and Care Quality Commission.
- Full Root Cause Analysis Investigation commenced and overseen by the Medical Director and Chief Nurse.
- All Never Events are reported publicly via the Trust Board meetings which include papers that are circulated to the Overview and Scrutiny Committees and the media.

5 Each of the Never Events reported by the Trust has been communicated as per the process described above. Due to the recent occurrence of a number of the incidents the investigations remain in progress at this time and will be subjected to a thematic review on completion.

6 The Trust has implemented a number of immediate actions to safeguard patients pending the outcome of the formal investigations. These actions are summarised below:

- Trust-wide communication distributed informing all staff of the occurrence of the incidents and the key learning identified during preliminary investigation. This communication included specific requirements for all staff to ensure that the Trust's 'Policy for Preventing Wrong Site, Wrong Procedure and Wrong Person Surgery' is being fully adhered to for all interventional and surgical procedures.
- A number of immediate changes to practice have been implemented where specific process failures have been identified.
- A detailed Surgical Safety Improvement Programme has been implemented. The programme is led by the Director of Nursing, Assistant Medical Director and Theatre Matron and addresses cultural and behavioural issues alongside systems and processes. The programme has been approved by the Trust Development Authority and Commissioners who will continue to monitor the implementation of the programme until completion. The programme includes improvement activity within the following domains:
    - Governance arrangements
    - Never Event investigations
    - Safety culture and team behaviours

  - Clinical processes including team brief and the surgical safety checklist
  - Operational processes including theatre scheduling
  - Education and team training
  - Communication strategy

- The Trust's Safety & Quality Committee will be completing the internal monitoring of the implementation of the programme and will provide assurance to the Trust Board on the subject.

Conclusion

The Trust is committed to the continued open and transparent reporting of all incidents affecting patient safety. It is important to note that the recently reported never events differ in type and context from those reported previously and that the Trust has robust oversight mechanisms in place to ensure that the implementation of learning is effectively enacted and monitored.

In healthcare, an organisation that encourages staff to report incidents and works to create a learning culture is actually working towards better patient safety. The recently published Francis Report talked extensively about the importance of ensuring an open NHS culture.

We want to continue to promote an open culture with regards to adverse incidents and actively encourage all of our staff and patients to report areas of concern because all of these will provide learning. This is a practice that must be continued, supported and encouraged.

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