Never Events Report to Governing Body

1. Introduction

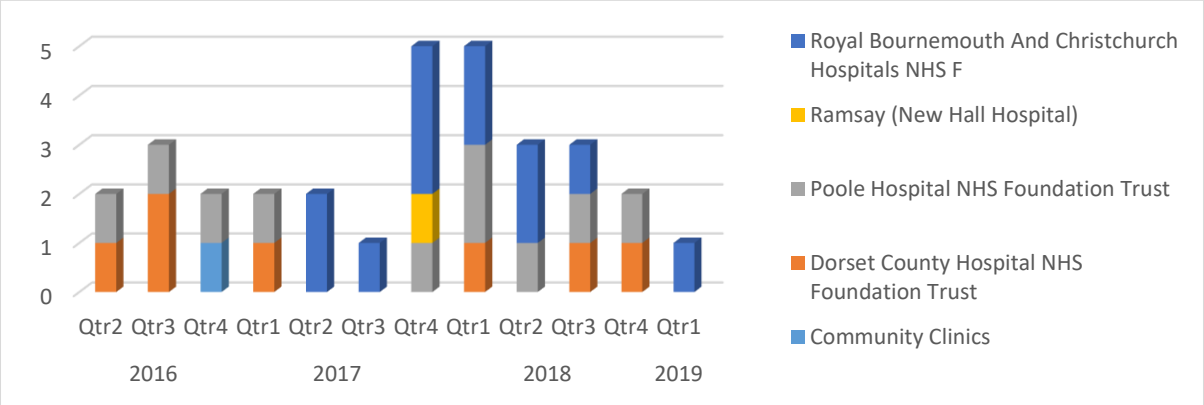
1.1 The purpose of this paper is to provide the Governing Body an update on the work to improve the standard of investigation of Never Events (NEs) that occur within the Dorset system, the aim of which is to embed learning from the incidents to prevent recurrence.

1.2 NEs are reported and investigated in line with the NHS Serious Incident Framework (2015) which is currently under review and due to be updated in Spring 2019. Each incident is subject to a comprehensive investigation using root cause analysis (RCA).

1.3 Being open and honest with those affected in an incident is an integral part of the investigation process and all NHS providers are required to comply with CQC Regulation 20 in relation to duty of candour.

2. Background

2.1 The table below represents the pattern of reporting of NEs by provider for the period April 2016 – March 2019.

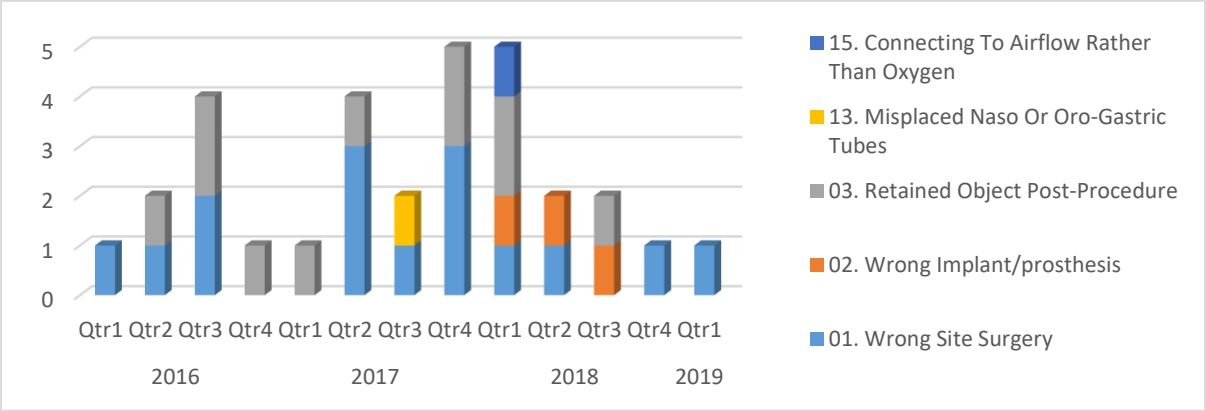


** Please note the CCG Risk database uses calendar quarters e.g. Qtr 1 is January to March*.

2.2 Statistically the number of reported incidents has been consistent over the period although this is impacted by the spike of 10 incidents in 2017/18. A report was provided to Governing Body in July 2018 to compare reporting rates with the national benchmarking data and to give assurance regarding the quality improvement work undertaken in RBCH as a response to the 8 reported NEs in the previous year.

2.3 There has been a steady decline in numbers from January 2018 to date with no reported NEs since January 2019.

2.4 The table below represents the type of NE reported to the CCG in the period April 2016 – March 2019.



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2.5 The most frequently reported NEs are, in order; Wrong Site Surgery, Retained Object Post Procedure and Wrong Implant/Prosthesis which reflects the reporting picture nationally. It is also worth noting that the South West Quality Network has recently identified a potential emerging trend in Wrong Site reporting from the specialties of Dermatology and Ophthalmology. Of the 15 reported incidents of this type in Dorset four have been in Dermatology and two in Ophthalmology.

3. Report

Quality of Investigation Reports

3.1 As reported to Governing Body in July 2018 the process of evaluating the investigation of Never Events in Dorset was changed, with the intention of ensuring that there is further openness and sharing of learning in order to prevent repetition of incidents. The following actions were implemented;

- All providers now attend CCG NE panels;
- All learning and action plans are therefore shared across providers;
- NE 72 hour reports are shared between providers;
- The scrutiny process for investigations has focussed on the content of the investigation and the thoroughness of the evaluation of the incident, with CCG representative attending internal incident review panels for NEs.

3.2 At this stage it was decided not to move to a standard reporting template as providers were in the cycle of preparing for and responding to CQC inspections.

3.3 There is some evidence that learning has prevented recurrence in the following examples;

- Cluster of retained guidewire incidents at RBCH has not recurred;
- Trend in dermatology incidents across providers has stopped since the introduction of use of photography as part of improved documentation;
- Cluster of retained swab incidents at PHT has not recurred.

3.4 At the request of the Director of Nursing in one Dorset provider, NHS Improvement undertook a review of 6 NE reports and provided their findings in January 2019. The high level themes from this feedback was broadly similar to that found by the CCG in relation to all provider reports and these were shared with Patient Safety Leads at our meeting in March 2019.

3.5 Directors of Nursing have agreed to introduce a standard template for NEs to further improve the quality of the reports and ensure they are accessible for patients and families in 2019. Any new template will need to incorporate the expectations of the revised Serious Incident Framework due for publication. In addition, the Patient Safety Leads have suggested to work towards standard content of all Serious Incident (SI) comprehensive reports with a toolkit developed to support implementation.

Investigation Training

3.6 Competency of investigating officers (IO) i.e. those staff who are responsible for undertaking RCA is an important factor in the quality of reports produced. In order to maintain competency, each IO would need to undertake a minimum number of RCAs following initial training and receive refresher updates**.** The NHS SI Framework states the RCA investigation 'must be undertaken by those with appropriate skills, training and capacity'.

3.7 There is a variation across Dorset providers, both in the approach to RCA investigation and in the provision of training to staff involved. One trust has a dedicated team of IOs for comprehensive SI investigation whilst others rely on the involvement of the clinical team where the incident has occurred supported by risk management officers. There is an argument that learning is best embedded when the clinical team are fully involved. As a minimum RCA training is available to all staff in the trusts however it is not clear how often this updated. RCA training does not automatically include the advanced communication skills required to support and engage patients and families in the process.

3.8 As a Dorset system there is an opportunity to agree a standard approach to investigation and consider the training needs for staff. This will be reviewed in line with the new SI framework when it is published.

Duty of Candour

3.9 The CCG requires assurance from providers that CQC Regulation 20 in relation to duty of candour is appropriately applied as part of the NHS Standard Contract. In summary the requirements are;

- patients, carers and or family are informed of the incident;
- this contact is in person and includes a verbal apology;
- the contact and the apology is documented in the patient record;
- this is followed up in writing to the patient and or family at the conclusion of the investigation.

3.10 There is inconsistent compliance with the above evidenced in the NE reports provided to the CCG which is corroborated by the findings of NHS Improvement (Appendix 1). CCG representatives attending internal trust panels have received assurance that good practice in relation to duty of candour is undertaken by staff and that the wishes of individuals are respected, however this is not always fully recorded in the final reports.

3.11 The CCG has conducted deep dives into the duty of candour in provider trusts with the focus on evidence from its application in moderate harm incidents. The methodology of these deep dives will be revised to include a specific focus on serious incidents in 2019. This will include a check that documentation is available in the trust to support the statements recorded on the RCA reports.

4. Conclusion

4.1 As part of the CCG Nursing and Quality Directorate objectives 2019/20 actions have been identified to continue the improvement in quality of NE reports;

- introduce a standard template for NE reports in Dorset;
- review training requirements for IO and consider a standard approach to investigation across the system;
- revise the methodology for the duty of candour deep dives in trusts.

4.2 The CCG Patient Safety Team remains committed to working collaboratively with provider teams to improve the quality of reporting and ensuring learning is embedded to prevent recurrence of SIs and NEs in Dorset.

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