COMPLAINTS, LITIGATION, INCIDENTS, PALS (CLIP)

EXECUTIVE SUMMARY

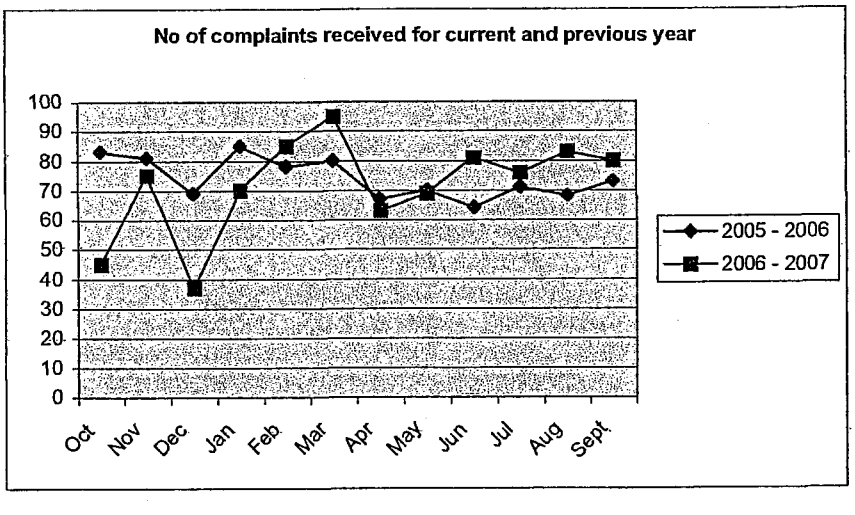
This is the executive summary relating to the ninth Complaints, Litigation, Incidents and PALS (CLIP) report to Trust Board. Whilst the CLIP report relates to the quarter July to September 2007 and where possible, comparative information on previous quarters has also been provided, this summary also provides a full year comparison for each main element of the report.

Highlights of this report will also be presented to the Trust's Governance & Quality Committee in January 2008, so that the Divisional Clinical Governance Leads can ensure discussion at the Divisional Clinical Governance Team meetings.

COMPLAINTS

- For the quarter July to September 2007, the Trust received 239 complaints compared to 212 in the corresponding quarter last year: an increase of 13%.
- For the quarter July to September, the average response within the 25 working day target was 80% compared to 84% in the corresponding quarter last year.

Complaints analysis – by quarter								
	Oct – Dec 06		Jan – Mar 07		Apr – Jun 07		Jul – Sept 07	
	No	%	No	%	No	%	No	%
Complaints received	157		250		213		239	
Total Closed within 20 working days	114	73	195	78	175	82	192	80



The number of complaints received ranges from 37 per month to 95, with an average of 71 per month for the reporting year 2006/07 compared to 74 per month for the year 2005/06

Note:

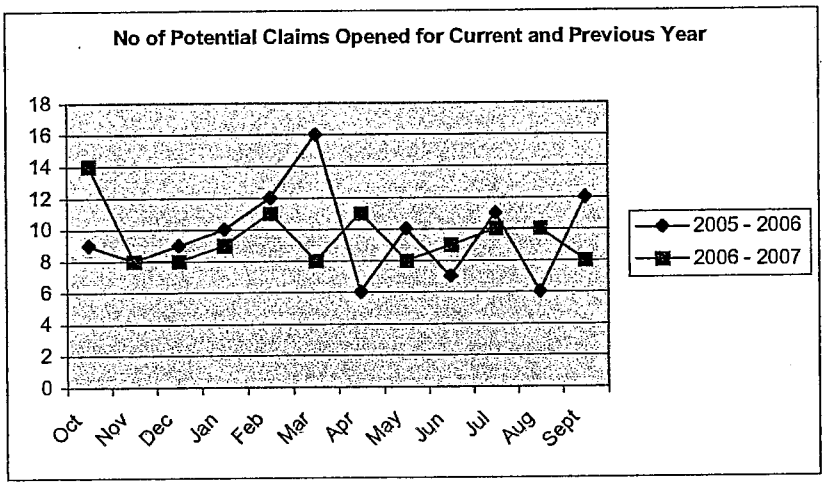
- 25% (60 in number) of the complaints received this quarter concerned poor communication
- There has been an increase in the number of complaints triaged green (simple): this is attributable to an improvement in the complaints handling process by which all complaints are now forwarded to the complaints office
- There has been change in process with regard to complaints referred to the Ombudsman's office: such complaints are referred back to the Trust via the Healthcare Commission and will be recorded as such.

LITIGATION

- For the quarter July to September 2007, the number of potential clinical negligence claims was 28 compared to 29 in the corresponding quarter last year: a 3% decrease
- For the quarter July to September, the number of Coroner's requests for reports was 43 compared to 33 in the corresponding quarter last year

Claims analysis – by quarter				
	Oct – Dec 06	Jan – Mar 07	Apr – Jun 07	Jul – Sept 07
	No	No	No	No
Potential Clinical Negligence claims	30	28	26	28
Number of Coroner's requests for reports	43	42	51	43

It should be remembered that not all claims proceed to litigation (successful or otherwise) and for the level of Trust activity, the number of claims received compares favourably with similar organisations

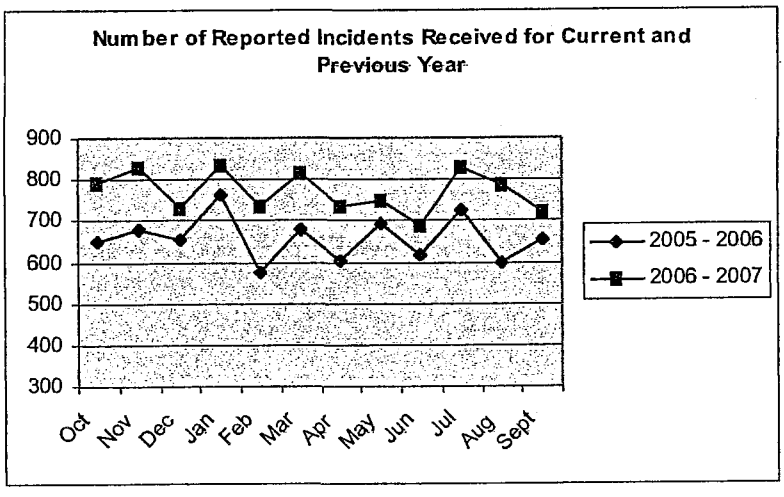


As with complaints, the number of potential claims received fluctuates throughout the year(s) but the total for the year 2006/07 was 114 compared to 116 for the previous year.

INCIDENTS

- For the quarter July to September 2007 the total number of reported incidents was 2334 compared to 1937 in the corresponding quarter last year: an increase of 17%. Slips/trips/falls and medication incidents remain two of the three most reported incidents.

Incident analysis – by quarter				
	Oct – Dec 06	Jan – Mar 07	Apr – Jun 07	Jul - Sept
	No	No	No	No
Total Number of Reported Incidents	2316	2239	2153	2334
Total Number of Serious (red) Incidents	23	42	27	18



As with complaints and potential claims the number of reported incidents fluctuates throughout the year(s). However, there has been a 15% increase on the number reported in 2006/07 (9239) compared to the previous year (7888)

- For the quarter July to September 2007, 18 serious (red) incidents were reported compared to 14 in the corresponding quarter last year. Of these 18 red incidents 8 were specifically related to MRSA; the remaining 10 were:
  - Problem with PEG feeding
  - SCAST invoking operational directive
  - Medication error
  - Allegation of sexual assault
  - Pt died shortly after transfer to DCCQ
  - Death of patient post-colonoscopy
  - Pt received wrong unit of blood: unharmed
  - Pt died post-surgery: developed renal failure
  - Inappropriate admission to gynae: pt died

Recently reported serious (red) incidents	
Oct 07	**Nov 07**
• 7 x MRSA	• 2 x MRSA
• Pt on long-term steroids missed 4 doses -> hypotensive crisis • Pt with chest pain reviewed x6 by medics. No ECG overnight. ECG following morning indicated ST elevation MI. Pt died • Community pharmacist reported that 4 pts had presented with problems concerning new paperwork provided for warfarin pts: 2 pts were on wrong dose	• Inappropriate outlier on DSU. Condition deteriorated; no I/V fluids available + no ECG. Now on RHCU • Pt being assessed on G2M by Resp SpR. Meanwhile pt from ED took available RHCU bed: considered that pt moved from ED to prevent breach rather than clinical need • 1 trained nurse on duty. HCSW required help with distressed pt. S/N unable to leave pt she was attending. Distressed pt arrested and died • Medication error – notified to us by coroner

PATIENT ADVICE AND LIASION SERVICES (PALS)

- For the quarter July to September 2007 a total of 362 concerns were brought to the attention of PALS compared to 392 in the corresponding quarter last year: a decrease of 8%.

PALS **analysis – by quarter**				
	Oct – Dec 06	**Jan – Mar 07**	**Apr – Jun 07**	**Jul – Sept 07**
	No	No	No	No
Total Number of Reported Concerns	392	392	279	362

PLAUDITS

The inclusion of plaudits in the full report continues to provide the Board with a more balanced representation of patient opinion on the services provided and it is clear from those collected that positive comments from service users continues to far outweigh the number of complaints received.

A detailed breakdown of the plaudits collected is on page 15 of the *full* report but for the quarter July to September 2007 they number 1,929: over eight times as many as the number of complaints received

ORGANISATIONAL LEARNING

An overview of changes made or recommended following complaints, incidents can be found on page 16 of the full report and demonstrates that the Trust takes action, further develops practice and is working to ensure cross-organisational learning following feedback received through the complaints and incidents.