REPORT OF THE VICE-CHAIRMAN OF JOINT CITY AND COUNTY HEALTH SCRUTINY COMMITTEE

NEVER EVENTS AND SERIOUS INCIDENTS

Purpose of the Report

1. To allow Members the opportunity to consider information regarding the occurrence of Never Events and other serious incidents in the following organisations: East Midlands Ambulance Service, Nottingham University Hospitals NHS Trust and Nottinghamshire Healthcare Trust.

Information and Advice

2. Never Events are defined as serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. To be a ‘Never Event’, an incident must fulfil the following criteria:

- The incident has clear potential for or has caused severe harm/death.
- There is evidence of occurrence in the past (i.e. it is a known source of risk).
- There is existing national guidance and/or national safety recommendations on how the event can be prevented and support for implementation.
- The event is largely preventable if the guidance is implemented.
- Occurrence can be easily defined, identified and continually measured

3. Never Events include: retained foreign object post operation, misplaced gastric tubes, wrong implant or prosthesis, wrong site surgery, wrongly prepared high risk injectable medication, maladministration of potassium containing solutions, and many others. A complete list of Never Events for 2012/13 is attached as an appendix to this report.

4. Since nationally defined Never Events tend to focus on the work of acute hospital trusts, some organisations agree local Never Events (or other serious incidents) with their commissioners.

5. While Never Events and Serious Incidents, by their nature are likely to be extremely rare the Joint Health Committee may expect to see that robust plans are in place to learn from the incidents which do occur and mitigate their effect, where possible. Members may wish to explore what learning has taken place and whether or not the locally defined events or incidents appear to be the right ones.

6. Members will be aware that the Joint Health Committee exercises its prerogative to comment on provider Trusts’ draft Quality Accounts. Outcomes from this engagement with
Trusts regarding Never Events and Serious Incidents are potentially something that the committee might wish to comment on within the published Quality Account.

7. Representatives of East Midlands Ambulance Service, Nottingham University Hospitals and Nottinghamshire Healthcare Trust will attend the meeting to brief Members and answer questions as necessary.

8. Briefings from the relevant organisations on the occurrence of Never Events and other serious incidents are attached as further appendices to this report.

RECOMMENDATION

That the Joint City and County Health Scrutiny Committee:-

1) receive the briefing and ask questions as necessary

2) determine if further information on Never Events and other serious incidents is required

Councillor Parry Tsimbirdis
Vice-Chairman of Joint City and County Health Scrutiny Committee

For any enquiries about this report please contact: Martin Gately – 0115 9772826

Background Papers

Department of Health – The “never events” list 2012/13

Electoral Division(s) and Member(s) Affected

All
List of Never Events

1. Wrong site surgery
2. Wrong implant/prosthesis
3. Retained foreign object post-operation
4. Wrongly prepared high-risk injectable medication
5. Maladministration of potassium-containing solutions
6. Wrong route administration of chemotherapy
7. Wrong route administration of oral/enteral treatment
8. Intravenous administration of epidural medication
9. Maladministration of Insulin
10. Overdose of midazolam during conscious sedation
11. Opioid overdose of an opioid-naïve patient
12. Inappropriate administration of daily oral methotrexate
13. Suicide using non-collapsible rails
14. Escape of a transferred prisoner
15. Falls from unrestricted windows
16. Entrapment in bedrails
17. Transfusion of ABO-incompatible blood components
18. Transplantation of ABO incompatible organs as a result of error
19. Misplaced naso- or oro-gastric tubes
20. Wrong gas administered
21. Failure to monitor and respond to oxygen saturation
22. Air embolism
23. Misidentification of patients
24. Severe scalding of patients
25. Maternal death due to post partum haemorrhage after elective Caesarean section
Overview of Trust Process

This report provides a brief overview of the approach Nottinghamshire Healthcare has taken to be assured on the systems and processes in place to prevent Never Events as defined in the Department of Health Never Events Framework from occurring.

The Trust has three clinical divisions; Local Services, Forensic Services and Health Partnerships. Each division has undertaken a review of their systems and processes and where gaps were identified, developed plans to address these. The outcome of these assessments were considered by the Trust’s Patient Safety and Effectiveness Committee in April 2013 and collated into a single overview document.

Each division has their own governance systems in which they monitor compliance. This overview document was reviewed by the Patient Safety and Effectiveness Committee again in September 2013.

This document is attached to provide assurance to the JHSC on the current level of compliance and ongoing actions required.

A further update will be reviewed by the Committee in April 2014. This Committee which is chaired by the Executive Director of Nursing, Quality and Patient Experience reports to the Quality and Risk Committed (QRC). The QRC is a Board committee chaired by a Non-Executive Director. This process ensures that the Trust Board is provided with assurance on the effectiveness of the Trusts systems and processes.

Occurrence of Never Events

Never Events are a key performance indicator (KPI) on the Trusts Quality and Performance Report which is submitted to the Trust Board each month. There has only been one occurrence of a Never Event in May 2012. This was an inappropriate administration of the drug methotrexate and no harm was caused to the patient.

Fiona Illingsworth
Head of Integrated Governance and Performance
November 2013
# NEVER EVENTS Overview of Compliance (v September 2013)

<table>
<thead>
<tr>
<th>NEVER EVENT</th>
<th>APPLICABLE TO TRUST</th>
<th>FORENSIC COMPLIANCE</th>
<th>LOCAL SERVICES COMPLIANCE</th>
<th>HEALTH PARTNERSHIP COMPLIANCE</th>
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</thead>
<tbody>
<tr>
<td><strong>SURGICAL</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1) Wrong site surgery</td>
<td>✓</td>
<td>*</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2) Wrong implant/prosthesis</td>
<td>✓</td>
<td>N/A</td>
<td>N/A</td>
<td></td>
</tr>
<tr>
<td>3) Retained foreign object post-operation</td>
<td>✓</td>
<td>N/A</td>
<td>N/A</td>
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<tr>
<td><strong>MEDICATION</strong></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>4) Wrongly prepared high risk injectable medication</td>
<td>✓</td>
<td></td>
<td></td>
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<tr>
<td>5) Maladministration of potassium-containing solutions</td>
<td>✓</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>6) Wrong route administration of chemotherapy</td>
<td>✓</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>7) Wrong route administration of oral/enteral treatment</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>8) Intravenous administration of epidural medication</td>
<td>x</td>
<td>N/A</td>
<td>N/A</td>
<td>N/A</td>
</tr>
<tr>
<td>9) Maladministration of Insulin</td>
<td>✓</td>
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<td></td>
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<tr>
<td>10) Overdose of midazolam during conscious sedation</td>
<td>✓</td>
<td></td>
<td></td>
<td>N/A</td>
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<tr>
<td>11) Opioid overdose of an opioid-naïve patient</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>12) Inappropriate administration of daily oral methotrexate</td>
<td>✓</td>
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<tr>
<td><strong>MENTAL HEALTH</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13) Suicide using non-collapsible rails</td>
<td>✓</td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>14) Escape of a transferred prisoner</td>
<td>✓</td>
<td></td>
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<td>N/A</td>
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<tr>
<td><strong>GENERAL HEALTHCARE</strong></td>
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<tr>
<td>15) Falls from unrestricted windows</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>16) Entrapment in bedrails</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>17) Transfusion of ABO-incompatible blood components</td>
<td>✓</td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>18) Transplantation of ABO or HLA-incompatible organs</td>
<td>x</td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>19) Misplaced naso- or oro-gastric tubes</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>20) Wrong gas administered</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>21) Failure to monitor and respond to oxygen saturation</td>
<td>✓</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>22) Air embolism</td>
<td>✓</td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>23) Misidentification of patients</td>
<td>✓</td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
<tr>
<td>24) Severe scalding of patients</td>
<td>✓</td>
<td></td>
<td></td>
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<tr>
<td><strong>MATERNITY</strong></td>
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<tr>
<td>25) Maternal death due to post-partum haemorrhage after elective caesarean section</td>
<td>x</td>
<td></td>
<td></td>
<td>N/A</td>
</tr>
</tbody>
</table>

- There is an expectation that the attached exception report will be populated to correspond with all amber coded compliance scores.

Never Events Overview of Compliance v August 2013
<table>
<thead>
<tr>
<th>Never Event</th>
<th>Action Required</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>7) Wrong route administration of oral/enteral treatment</strong></td>
<td>18.04.13: Re-visiting the guidelines and old Safety Alerts has highlighted an area that requires additional assurance. Action required is to make sure stocks of oral/enteral syringes are available in all clinical areas that may need to measure and administer oral liquid medicines in a syringe. This action will apply across all Forensic Directorates. 28.08.13 Heads of Healthcare in Offender Health have been contacted by the Chief Pharmacist. Assurances now received that this is being complied with in the prisons and all secure hospitals.</td>
</tr>
<tr>
<td><strong>13) Suicide using non-collapsible rails</strong></td>
<td>18.04.13: Collapsible curtain and shower rails to be installed in Prospect House. Money has been set aside for this to happen and it has been built into the facilities programme. 28.08.13 Collapsible rails installed and risk will be removed from the risk register.</td>
</tr>
<tr>
<td><strong>15) Falls from unrestricted windows</strong></td>
<td>18.04.13: A New Safety Alert has been issued requiring a review of all fitted window restrictors to ensure they are fit for purpose. A survey is being carried out by Facilities to assess the issue before work commences to rectify where required. 22.04.13: Estates has been compiling a set of plans and schedules with a view to providing a survey of the patient areas for the following Notts HC forensic sites: Rampton Hospital Arnold Lodge Wathwood Hospital Wells Road Centre (WRC) Westminster House (Offender Health) Prospect House (Porchester Road) It is not considered appropriate to complete a window-by-window condition survey in this instance but a record of the window type present in each patient area, noting the window opening restrictor which is currently in operation and assessing whether it complies with the requirements documented in HTM 55 (Windows) will be carried out. The project is ongoing and facilities are working to the SAB timescale so this will be complete by the end of May 2013. 28.08.13 The Safeguard system was updated on 8/7/13 listing that all surveys are now completed and documented. A full set of drawings for all Forensic Sites (including WRC) which details window specs and window restrictors are now in place and the survey was completed. The outcome of the survey highlights that there is no further work required – any remedial works were addressed during the survey, which were only required at the WRC.</td>
</tr>
<tr>
<td><strong>Exception Report: Local Services</strong></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Never Event</th>
<th>Action Required</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4) Wrongly prepared high-risk injectable medication</strong></td>
<td>Ø Confirmation from the Physical Healthcare Team (June 2013) that Intramuscular administration training is currently available via the Learning and Development Department. Ø Guidelines for staff to learn lessons from medication errors / near misses in at consultation stage; and are anticipated to be ratified by end August 2013. The Trust-wide Injectable Medicines Policy 19.09 has been reviewed by Pharmacy; and was ratified July 2013. Ø Divisional assurance was provided to the Director for Nursing, Q and PE by the Divisional Associate Director for Nursing, Q and PE; and Divisional Head of Governance, Q and PE (June 2013), that all directorates will ensure a second registered nurse checks CDs at night (in line with Medicines Code). Where units have only one registered nurse on a shift, the unit manager / nurse in charge must ensure provision is made for two registered nurses to check CDs. This risk is detailed on the Divisional Risk Register (score 4 / low) with recommendations for staff in managing this risk. All directorates were emailed 07/06/2013 to confirm this compliance requirement, with request to provide assurance to LSIGG July 2013 meeting.</td>
</tr>
</tbody>
</table>

| **9) Maladministration of insulin** | Ø 22/08/2013 - There is considerable assurance in respect of this item. LS Division and Forensic Division Physical HC Teams have worked together to agree required changes to the Trust’s e-learning package to support the safe use of insulin (July 2013). Laura Hodgson (Physical Healthcare Facilitator, LS Division) has confirmed changes required with Dominic Manfred, IT Department (August 2013); and it is understood that the updated e-learning Trust package should be available by 31/12/2013. In the interim the NHS Diabetes package continues to be available for staff; and there is a link to this via the Trust e-learning package (which has also been cascaded via the Physical Healthcare Team’s monthly Divisional newsletter). Ø 04/06/2013 - Second registered nurse checking of preparations at night can be challenging to achieve (in line with Medicines Code). Ø Ensuring adequate nurse cover at night will be a requirement in the Trust’s revised Medicines Code.Ø 19.09 - Injectable Medicines Policy reviewed and ratified July 2013. Ø 07/06/2013 - All directorates confirmed compliance with second nurse checking of CD at night. Ø 07/06/2013 - All directorates provided assurance to LSIGG July 2013 meeting. |
with Medicines Code) on some units due to registered nurse staffing levels. However, assurance has been provided by directorates to the Division that registered nurses will work to the Medicines Code at all times; and ensure required cover is available to meet administration requirements. This risk is detailed on the Divisional Risk Register (score 4 / low) with recommendations for staff in managing this risk.

11) Opioid overdose of an opioid-naïve patient

- 04/06/2013 - Second registered nurse checking of CDs at night can be challenging to achieve (in line with Medicines Code) on some units due to registered nurse staffing levels. However, assurance has been provided by directorates to the Division that registered nurses will work to the Medicines Code at all times; and ensure required cover is available to meet administration requirements. This risk is detailed on the Divisional Risk Register (score 4 / low) with recommendations for staff in managing this risk.

15) Falls from unrestricted windows

- 18.04.13 - A New Safety Alert has been issued requiring a review of all fitted window restrictors to ensure they are fit for purpose. A survey is being carried out by Facilities to assess the issue before work commences to rectify where required.

19) Misplaced naso-gastric tubes

- 11/06/2013 - Divisional Physical HC Team met with CAMHS and supported review of the CAMHS protocol. The Trust-wide Policy states that, other than CAMHS, naso-gastric tubes should not be inserted by Nottinghamshire Healthcare NHS Trust staff; and patients are required to be transferred to an acute hospital for naso-gastric tube management. There is, therefore, no requirement for further work on this Never Event at this time.

20) Wrong gas administered

- 11/06/2013 - Update from Physical Healthcare Team to report that it is stated in the Resuscitation Policy (number 1.20) that emergency oxygen training is covered within both basic and hospital life support training, including how to ensure appropriate documentation for people with conditions such as COPD. LS Division and Forensic Division follow this guidance.

23) Misidentification of patients

- 07/06/2013 - Full compliance with photographic ID on prescription charts is confirmed within MHSOP and SS Directorates. Non-compliance is reported by AMH, breaching the Trust-wide directive. 21/08/2013 – AMH are due to provide assurance of compliance by end of August 2013.

**Exception Report: Health Partnerships**

<table>
<thead>
<tr>
<th>Never Event</th>
<th>Action Required</th>
</tr>
</thead>
</table>
| 9) Maladministration of insulin | Work continues around:  
A. All registered staff to complete training via e learning - All new staff to complete training within 3 months of their start date  
B. Leadership for diabetes link roles to be formalised  
C. SystmOne forward planning of insulin patients (3 weeks visits always planned) in progress.  
The HP Action Plan Tracker is in place to monitor RCA Action Plans and reports are presented to the HP Medicines Management Group on a quarterly basis. |
| **11) Opioid overdose of an opioid-naive patient** | Update 03/09/13  
Lead: Jane Swan – Senior Medicines Management Advisor  
Work continues around:  
A. Outside of control of HP organisation  
B. Outside of control of HP organisation  
C. Leadership of palliative care link roles to be formalised.  
D. New policy version will have section tailored to the needs of Health Partnerships services. |
| **12) Inappropriate administration of daily oral methotrexate** | Update 03/09/13  
Lead: Jane Swan – Senior Medicines Management Advisor  
The risk assessment is on-going to establish if this is an actual risk to HP. |
| **15) Falls from unrestricted windows** | Update 03/09/13  
Lead: Jane Swan – Senior Medicines Management Advisor  
The EFA Alert related to window restrictors was circulated previously via CAS System.  
On-going estate maintenance etc including estate related incidents with NHS Notts County. |
| **19) Misplaced naso- or oro-gastric tubes** | Update 03/09/13  
Lead: Clive Gunn – Health, Safety and Risk Facilitator  
This procedure is mainly in use at the Childrens Development Centre and within community nursing services for adults and children. For adults a Home Nursing service provides tube passes in the community and work to their own policies and procedures. For other services a local procedure needs to be developed in line with RM Guidelines. |
| **21) Failure to monitor and respond to oxygen saturation** | Update 03/09/13  
Lead: Vanessa Briscoe – Specialist Services General Manager  
With regards to dental services the monitoring of intra operative oxygen saturation levels are not undertaken. However the only operations undertaken where this is an issue take place within QMC. These operations are performed with a QMC anaesthetist in attendance working to QMC policy and procedures. A risk assessment will be undertaken to ensure this is satisfactory. |
| **23) Misidentification of patients** | Update 03/09/13  
Lead: Gill Goodwin – Mansfield and Ashfield General Manager  
The majority of care homes utilise photographic id for patients; however work is on-going to ensure a consistent approach across all of the homes into HP provide care. |
Learning from Serious Incidents and Never Events

1.0 Introduction

A Serious Incident (SI) is defined as an incident that occurred in relation to NHS-funded services which resulted in (or could have resulted in) one of the following:

- Unexpected or avoidable death to one or more patients, staff or members of the public
- Serious and or permanent harm to one or more patients, staff or members of the public where the outcome requires life-saving intervention, major surgical/medical intervention or will shorten life expectancy or result in prolonged pain or psychological harm
- The actions of staff providing NHS funded care that are likely to cause significant public concern i.e. serious instances of abuse (physical/sexual/mental).
- An event that prevents or significantly threatens EMAS’s ability to deliver healthcare services.
- One of a core set of ‘Never Events’ (NEs) as defined and updated annually by the National Patient Safety Agency (NPSA)
- One of a set of ‘Local Never Events’ as agreed by EMAS and the Lead Commissioners

‘Never events’ are defined as *serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers*. To be a ‘never event’, an incident must fulfill the following criteria:

- The incident has clear potential for or has caused severe harm/death.
- There is evidence of occurrence in the past (i.e. it is a known source of risk).
- There is existing national guidance and/or national safety recommendations on how the event can be prevented and support for implementation.
- The event is largely preventable if the guidance is implemented.
- Occurrence can be easily defined, identified and continually measured

The list of National Never Events is reviewed and updated annually. The majority of the current National Never Events are not applicable to the ambulance service focusing more on acute hospital care e.g. jumping from a window, wrong site surgery and retained instruments. The Director of Nursing and Medical Director have therefore agreed the following Local Never Events for contractual inclusion in line with other ambulance services in the Midlands and East region.

- Patient falling or jumping from moving vehicle
- Patient falling from an ambulance trolley
- Ambulance involved in a blameworthy fatal collision (either pedestrian or other vehicle occupant)
EMAS has not had any nationally prescribed or locally agreed Never Events year to date.

2.0 Process

In line with the Regional SI Policy all SIs must be reported onto the national Strategic Executive Information System (STEIS) within 2 working days with submission of final reports to the Lead Commissioners (Erewash Clinical Commissioning Group (CCG) 45 days from entry on to STEIS for Grade 1 and 60 days for Grade 2 SIs.

Once an incident has been reported onto STEIS the Commissioner and EMAS will agree the severity of the incident and it will be allocated a grading; 0, 1 or 2 as follows:

**Grade 0**: Incident where it is initially unclear whether or not the incident qualifies as a serious incident at this early stage. If within three working days it is found not to meet the criteria for a serious incident, it can be downgraded with agreement from the Trust's commissioner. If within that time the incident is found to be a serious incident it will be re-graded as a grade 1 or 2 incident.

**Grade 1**: This level of incident will require a Comprehensive Root Cause Analysis (RCA level 2 Investigation), as defined by the NPSA National Framework for Reporting and Learning from Serious Incidents Requiring Investigation. Incidents would include; Healthcare Acquired Infections (HCAI) outbreaks, avoidable/unexplained deaths, ambulance service missing target for arrival resulting in death or severe harm to a patient.

**Grade 2**: Incidents considered as high risk. This level of investigation will require a Comprehensive RCA (RCA level 2 Investigation) or an Independent Investigation (RCA level 3), as defined by the NPSA National Framework for Reporting and Learning from Serious Incidents Requiring Investigation. Incidents would include; maternal deaths, child protection significant data loss and information security (DH Criteria Level 3-5), Never Events, accusation of physical misconduct or harm.

All SIs are subject to a thorough investigation which includes establishing the facts, highlighting any areas of good practice, identifying any service delivery problems, care delivery problems, contributory factors, root cause(s), any learning points and actions required to minimize the risk of recurrence. The NPSA Incident Decision Tree flowchart is used to enable investigators to determine if the incident is as a result of individual failings or system failures. This helps to identify if the actions that need to be taken to prevent recurrence should be localized or Trust wide and ensures appropriate use of human resource procedures.

On completion of the investigation, the report is submitted to either the Director of Nursing and Compliance or the Medical Director for review and approval prior to submission to the CCG for closure. Any recommendations made within the report are incorporated into an action plan, which is agreed with all identified leads. The action plan is then entered onto a central spreadsheet and monitored by the Clinical and Operational Governance Groups. ‘Open’ SI investigations are detailed and discussed at the Clinical Governance Group and Quality and Governance Committee. EMAS adopts a ‘being open’ policy providing any patient involved in a serious incident (or their loved ones) a full apology and an explanation of what happened. On conclusion of the investigation the findings are shared with the patient involved or their representatives and details of actions being taken to prevent recurrence are explained. Closed SI investigations and any associated learning is also presented to the Public Trust Board at every meeting in the interests of ‘Being Open’. (Being Open Framework, NPSA, 2009).
Where themes are identified, common root causes are explored and if indicated a comprehensive ‘deep dive’ analysis is undertaken. Learning is shared via Learning Review Groups at Divisional and Strategic levels. A central ‘Learning and Improvement Log’ is maintained and learning is disseminated to staff via local and corporate communications. Education and training programmes are also informed by learning from SIs/NEs.

3.0 Data

The table below shows a summary of SI and NE activity year to date during 2013/14 and the for the full year 2012/13. All SIs reported year to date have been reported as Level 1 SIs. Numbers in brackets indicate near misses. This also shows the number originally reported as SIs but subsequently downgraded once the investigation identified no failings on the part of EMAS.

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<thead>
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</thead>
<tbody>
<tr>
<td>Total Numbers of SIs reported (including near misses and NEs)</td>
<td>5 (2)</td>
<td>8</td>
<td>7</td>
<td>13</td>
<td>3</td>
<td>9 (3)</td>
<td>3 (1)</td>
<td>3</td>
<td>2</td>
<td>4(1)</td>
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<td>1</td>
<td>8</td>
<td>7</td>
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<tr>
<td>National (Local) Never Events</td>
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<td>0</td>
<td>0 (1)</td>
<td>0 (1)</td>
<td>0</td>
<td>0</td>
<td>0</td>
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<td>0</td>
<td>0</td>
<td>0</td>
<td>0(3)</td>
</tr>
</tbody>
</table>

The table below shows activity by County for 2013/14 year to date (numbers in brackets indicate near misses):

<table>
<thead>
<tr>
<th></th>
<th>Derbyshire</th>
<th>Emergency Operations Centre (EOC)</th>
<th>Leicestershire &amp; Rutland</th>
<th>Lincolnshire</th>
<th>Northants</th>
<th>Nottinghamshire</th>
<th>Other e.g. Trust/HART</th>
<th>YTD Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Number SI</td>
<td>6(1)</td>
<td>3(1)</td>
<td>9(1)</td>
<td>5</td>
<td>3(1)</td>
<td>2</td>
<td>3</td>
<td>31 (4)</td>
</tr>
<tr>
<td>reported (including near misses &amp;NEs)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Reported as SI</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>0</td>
<td>2</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>then downgraded</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>National (Local)</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Never Events</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
3.1 Nottinghamshire SIs

To date during 2013/14 Nottinghamshire have reported 2 SIs. One related to a delayed response to a patient who had fallen who went on to develop chest pains and the second related to inadequate assessment of a patient who had suffered a stroke who was not transported to hospital by the first crew who attended them. Both investigations are currently underway so it is not possible to identify the root causes, contributory factors or learning/ action as a result of the incidents at the time of preparing this report.

3.2 Analysis of September and October Increase in SIs

If there has been an increase in SIs reported (as there was in September (7) and October(11)) a review of these SIs is undertaken to identify if there are any outliers in terms of area, common themes, clinicians or root causes, this enables the Trust to ensure that appropriate measures are being taken to prevent recurrence. Findings from the review of the increased cases in September and October are shown below.

**Themes:** The 18 SI reported in September and October 2013 were categorised as follows:

<table>
<thead>
<tr>
<th></th>
<th>Delayed Response</th>
<th>Care Management</th>
<th>Breach of Confidentiality</th>
<th>Incorrect code/ Delayed treatment</th>
<th>Sustained poor performance Trust wide</th>
<th>Missing Drugs</th>
<th>Allegation against staff</th>
<th>Data irregularity</th>
<th>Safeguarding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sept 13</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Oct 13</td>
<td>1</td>
<td>6</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td>1</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Incident Dates:** The table below shows the dates the incidents occurred (as opposed to the date reported). Delays in reporting are sometimes incurred for example if the clinician has not recognized that a serious incident has occurred or the Trust is unaware of an adverse patient outcome until notified by a third party e.g. acute hospital, other healthcare provider or via a complaint.

<table>
<thead>
<tr>
<th>Apr 13</th>
<th>Jun 13</th>
<th>Jul 13</th>
<th>Aug 13</th>
<th>Sep 13</th>
<th>Oct 13</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>7</td>
<td>4</td>
</tr>
</tbody>
</table>

**Care Management:** Care Management SIs reported in September & October (date of incident is shown in brackets) are as follows:

- 1 x inappropriate non-conveyance (September 13)
- 1 x conveyance of a patient with chest pain in a car who suffered a cardiac arrest on route. (September 13)
- 5 x missed fractures: 4 x spinal (July, August, September and October 13), 1 x hip (September 13)
These incidents are currently under investigation so it is not possible to identify the root causes, contributory factors or learning/ action as a result of the incidents at the time of preparing this report.

**Divisional breakdown:** The breakdown for the 18 SI reported in September and October is as follows:

<table>
<thead>
<tr>
<th></th>
<th>Notts</th>
<th>Derbys</th>
<th>Leics</th>
<th>Northants</th>
<th>Lincs</th>
<th>EOC</th>
<th>Trust</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>4</td>
<td>4</td>
<td>0</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
</tbody>
</table>

**Common clinicians:** All SIs have been reviewed year to date to determine if there are any common clinicians. One clinician was involved in 2 of the SIs (missed spinal fractures). An HR investigation is running alongside the SI investigation.

Early learning points (delay in reporting, inadequate assessment/ documentation/ safety netting/ missed fractures) have been shared with Divisional Directors and Consultant Paramedics. They have been asked to share with staff through local communications e.g. listening events, Quality Visits and Clinical Team Mentor supervision sessions.

The Consultant Paramedics are presenting a further review of missed spinal injury SIs at November 2013 Clinical Governance Group with a proposed action plan for addressing this recurring theme. In addition representatives from EMAS are meeting with Erewash Clinical Commissioning Group in November/ December to undertake a further detailed review of C spine SIs to determine if any additional actions are required to further mitigate this risk.

**4.0 Immediate Actions**

When a serious incident has been reported, a number of immediate actions are taken to safeguard patients and staff. Actions will differ depending on the nature of the incident but may include:

- Where care management failure is suspected, clinical staff are removed from patient-facing duties until such time that competence can be assured e.g. by retraining, assessment or supervision.
- Welfare checks for staff and patients/ public
- Re-education of staff
- Quarantining equipment
- Issuing immediate communications to raise Trust wide awareness
- Reporting to external agencies as appropriate e.g. Information Commissioner, MHRA, HSE, CQC, local authority and the police
5.0 Trust Themes

The following table and graph show themes for the previous 12 months. Numbers in brackets indicate near misses.

<table>
<thead>
<tr>
<th>THEMES 2012/13</th>
<th>Sept</th>
<th>Oct</th>
<th>Nov</th>
<th>Dec</th>
<th>Jan</th>
<th>Feb</th>
<th>Mar</th>
<th>Apr</th>
<th>May</th>
<th>June</th>
<th>July</th>
<th>Aug</th>
<th>Sep</th>
<th>Oct</th>
<th>13/14</th>
<th>12/13 Full Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allegation against HCP</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 (1)</td>
<td>2 (1)</td>
</tr>
<tr>
<td>Breach of Confidentiality</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>3</td>
</tr>
<tr>
<td>Care Management</td>
<td>2</td>
<td>3</td>
<td>3*</td>
<td>3</td>
<td>6</td>
<td>2(1)</td>
<td>2</td>
<td>1</td>
<td>4(1)</td>
<td>1</td>
<td>6</td>
<td></td>
<td>16 (2)</td>
<td></td>
<td></td>
<td>20**(2)</td>
</tr>
<tr>
<td>Data Irregularity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Delayed Response</td>
<td>1</td>
<td>1</td>
<td>3</td>
<td>2</td>
<td>2</td>
<td></td>
<td></td>
<td></td>
<td>2(1)</td>
<td>1</td>
<td></td>
<td>3(1)</td>
<td></td>
<td></td>
<td>14 (2)</td>
<td></td>
</tr>
<tr>
<td>Sustained poor performance</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Incorrect code/Delayed Treatment</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>4</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1 (1)</td>
<td>3</td>
<td>11</td>
</tr>
<tr>
<td>Drug Management/Loss</td>
<td>3</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
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<td>1</td>
<td>4</td>
</tr>
<tr>
<td>RTC</td>
<td></td>
<td>1</td>
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<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>3* (1)</td>
</tr>
<tr>
<td>Safeguarding</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Service Failure</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1(1)</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>1 (1)</td>
</tr>
<tr>
<td>Vehicle Incident</td>
<td>1</td>
<td>1</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>3 (1)</td>
</tr>
<tr>
<td>Patient/staff accidental injury</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Patient Abscond</td>
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<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td>1</td>
</tr>
<tr>
<td>Grand Total (Near Miss)</td>
<td>3</td>
<td>5</td>
<td>8</td>
<td>7</td>
<td>13</td>
<td>3</td>
<td>9 (3)</td>
<td>3</td>
<td>3</td>
<td>2</td>
<td>4(1)</td>
<td>1</td>
<td>7(2)</td>
<td>11</td>
<td>31 (4)</td>
<td>62 (7)</td>
</tr>
<tr>
<td>Downgraded SIs</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>4</td>
<td>0</td>
<td>2</td>
<td>8</td>
<td></td>
<td></td>
<td>2</td>
<td></td>
<td></td>
<td>7</td>
</tr>
<tr>
<td>Locally Agreed Never Events</td>
<td>1</td>
<td>1</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
<td></td>
<td></td>
<td>1</td>
<td>3</td>
<td></td>
</tr>
</tbody>
</table>

*Shows locally agreed never event
6.0 Harm Rates

It should be noted that the level of harm cannot necessarily be attributed to acts or omissions by EMAS staff. Other factors may prevail e.g. patients' pre-existing condition.

<table>
<thead>
<tr>
<th></th>
<th>No harm/ near miss</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Minor harm- requires minor treatment/ remains independent</td>
</tr>
<tr>
<td>2</td>
<td>Moderate harm- requires hospital treatment/ no permanent harm</td>
</tr>
<tr>
<td>3</td>
<td>Severe harm- permanent injury/ requires help with activities of daily living</td>
</tr>
<tr>
<td>4</td>
<td>Death</td>
</tr>
</tbody>
</table>

The chart below shows the level of harm (where known) for all patient safety incidents (PSIs) including SIs since 1st April 2013. This shows that 84% of all PSIs reported year to date resulted in low or no harm which indicates a healthy reporting culture.

One indicator used by some organisations as a safety measure is the number of SIs as a percentage of the total PSIs reported. The table below shows the comparison between 2011/12, 2012/13 and the current year to date. There has been a reduction in the number of SIs as a percentage
of the total PSIs compared to previous years which could indicate that the campaign to increase the rate of no (near miss) and low harm incident reporting which commenced in 2012/13 and has continued this year is having a positive impact on the reporting culture.

<table>
<thead>
<tr>
<th></th>
<th>2011/12</th>
<th>2012/13</th>
<th>2013/14 to date 31/10/13</th>
</tr>
</thead>
<tbody>
<tr>
<td>PSI total</td>
<td>150</td>
<td>148</td>
<td>178</td>
</tr>
<tr>
<td>SI Total</td>
<td>50</td>
<td>62</td>
<td>31</td>
</tr>
<tr>
<td>SIs as percentage of PSIs</td>
<td>33%</td>
<td>42%</td>
<td>17.4%</td>
</tr>
</tbody>
</table>

7.0 Key Learning and/or Service Improvements

Actions taken in response to learning from serious incident themes are detailed below.

Delayed Response

- “Being the Best” consultation being implemented to reconfigure EMAS estate and redesign service delivery model to improve response to all call categories
- Emergency Operations Centre Strategy in development for presentation to Trust Board in January 2014
- Independent Review undertaken to provide clear evidence base for workforce profile required (Process Evolution)
- Increase in Community First Responder Schemes and Public Access Defibrillators
- Use of Third Party Private Providers
- Development of Resource Management Centre to optimise resource utilisation including use of third party providers to support timely response
- Proactive sickness absence management and recruitment of clinical staff to support ‘safe staffing’
- Guidance issued to frontline staff to support non-conveyance and reduce on-scene time where clinically indicated
- Ongoing work with Acute Trusts and Commissioners to address hospital turnaround delays.
- Review and ongoing implementation of the Performance Improvement Plan by Chief Operating Officer
- Welfare checks have been introduced for green call delays and where no contact can be made these calls are automatically upgraded as a safeguard
- Process for monitoring the completion of welfare calls and determining the patient outcomes for those patients experiencing significant delayed response being developed by the Distribution Director/ Medical Director
- Capacity Management Plan revised September 2013 to include Divisional triggers and enhance patient safety

Care Management

- Review of the Clinical Assessment Team Framework undertaken
- Review of stand down/ suspension guidelines to ensure patients are safeguarded and staff are treated fairly
- Healthcare Decisions panel considered for all registered clinicians involved in care management SIs
• Revision of the Safe Carriage Standard Operating Procedure (SOP) to make staff responsibilities with regard to safely securing patients clear and clarify action to be taken if patients cannot be adequately secured. In response to the local never events (2012/13), EMAS has undertaken an inspection of every Trust vehicle to ensure stretchers were fitted with appropriate harnesses.

• More robust process for monitoring the quality of Third Party Providers

• Scoop stretchers and head blocks rolled out Trust wide to facilitate appropriate immobilization of patients

• C spine- appropriate assessment and management of potential spinal injuries reiterated in CEO bulletin and clinical update, introduction of a C Spine assessment and management training video podcast and flowchart, spinal injury assessment and management delivered face to face in Essential Education from 1 July 2013

• Maternity- update as part of Essential Education (EE) from 1 July 2013, development of Maternity SOP and red flags for use by call takers, Maternity Case Studies issued to Organisational Learning Team for use in training

• Bulletin issued reinforcing the completion of the Safer Ambulance Vehicle Checklist

• Equipment- SOP developed to enable the safe retention, conveyance and registration of faulty equipment on Station

• Issue of new kit bags November 2013 to ensure minimum standard of equipment taken to scene

• Request for education submitted for 2014/15 EE to cover human factors in healthcare aimed at addressing the recurring themes in care management SIs e.g. ‘framing’ of incidents

**RTC**

• Re-categorisation of RTCs where the nature of the patient injury is unknown to ensure high priority response given

• Process for ensuring driver reassessments following RTCs strengthened

**Drug-related incident**

• Deep dive review of all drug related SIs has been undertaken by the Head of Clinical Audit, Governance & Research (Accountable Officer for Controlled Drugs), the associated action plan is monitored at Clinical Governance Group

• Reminder of responsibilities relating to medicines management included in Clinical Update

• Observers no longer allowed to be involved in pre shift checking procedures

• Emergency drugs now provided in pre packed rolls and replacement programme implemented September 2013

**Breach of confidentiality**

• Deep dive review of all information governance related SIs undertaken by the Information Governance Manager)and the associated action plan is monitored at Clinical Governance Group

• Communications in CEO bulletin and Clinical Update to reinforce crew responsibilities in relation to information governance

• Stretch targets set by Division for electronic patient records usage

• Information Governance incident case study produced for use in managers investigation training from May 2013

• Strengthened process for communication between control and third party providers
Head of Information Governance has delivered bespoke IG training to control staff and is currently scoping the requirement for training for other departments/teams.

**Incorrect coding**
- Reviewing call takers performance on a monthly basis (particularly around call coding) to ensure high standards are maintained
- Call Review Session Meetings to identify and share lessons learned led by the Deputy Medical Director
- A deep dive into call handling/incorrect coding serious incidents has been undertaken

**ICT Outage**
- Improved understanding of resilience of systems and processes
- Strengthened Business Continuity training programme for key staff including the need to train non-essential service staff

**8.0 National Benchmarking**

SI benchmarking data was collated for the Quality, Governance and Risk Directors National Ambulance Group. Nine Ambulance Trusts submitted data on the total number of SIs reported during 2012/13.

The number of the SIs classified as near misses was not collected. A number of the Trusts failed to provide a breakdown of the categories of SIs and one Trust provided incomplete information.

The average number of SIs reported was 54 with a range of 17-111. EMAS reported 62.

Although information regarding activity levels was requested (and submitted by EMAS) not all Trusts submitted this data so this was not provided in the reports. It is therefore difficult to make any meaningful comparison of the data. This is also made difficult by the absence of recording of near miss SIs as it is difficult to determine the varying approaches to reporting.

It is possible that some Trusts with lower than average reporting rates do not report near misses but this is purely speculation. Excluding the high number of SIs relating to hospital handover delays (reported in the main by only one Trust) the top three themes are Care Management, Delayed Response and Incorrect Coding/Delayed Treatment. This is consistent with the themes reported by EMAS.

**9.0 Conclusion**

EMAS is committed to minimizing the risk of serious incidents occurring and responding appropriately when they do. This includes being open and honest about what has happened, offering an apology and providing information about the results of investigations and action taken to prevent recurrence. EMAS uses every serious incident as an opportunity to learn and improve the services provided to the public.
JOINT HEALTH SCRUTINY COMMITTEE
December 2013

Serious Incidents at NUH
Introduction

It is increasingly recognised in healthcare that incident reporting is an important factor in improving patient safety. Organisational learning from incidents (even if no-harm or low-harm) and near misses can help prevent harm. The safest hospitals are generally those with the high rates of incident reporting. In such hospitals the pattern of incident severity changes over time, with a greater proportion of incidents being no or low harm, and fewer serious incidents.

Incident reporting is a key element of our Patient Safety Programme. NUH staff are encouraged and supported to report all incidents and near misses so that they are investigated and timely action can be taken to reduce the likelihood of recurrence (and/or the degree of harm should the event recur).

We have a robust system in place for managing serious incidents. Each is investigated by a team led by a senior clinician who is a member of our governance faculty of consultants, nurses and members of the allied health professions. The faculty is fully trained (with input from our solicitors) in investigation and root cause analysis.

In the most serious incidents, the chair of the investigation team will meet with the patient and/or family at the start of the investigation to get their recollections of events and understand the questions they want answered.

The investigation report is submitted to our clinical risk committee (CRC) where there is robust scrutiny and challenge. The CRC carefully monitors the associated action plan to completion.

The full Report is shared with the patient and/or family, and the chair of the investigation team meets with them to explain the findings and the recommendations. Typically a letter of apology from our Chief Executive follows.

The full report is shared with our commissioners, who also review a selection of our action plans to gain assurance on our systems and processes.

An incident may be classified as serious even though it results in no or low harm to the patient: the seriousness is not determined solely by the severity of harm actually caused, but also by its potential for harm and its preventability.

Recently the Department of Health described that all incidents in specific categories should be classified as serious:

- Patient fall resulting in fracture
- Pressure ulcer
- Maternity-related incidents
- Infection-related incidents

This has resulted in an increase in the number of incidents classified as serious.

We have designed bespoke templates to help staff undertake analysis and identify the root causes of incidents in each of these categories. These are subject to rigorous review by the appropriate committee.
We share learning from our incidents in a variety of ways: our monthly Patient Safety Newsletter for all staff, local training and governance fora, at training events, and (where appropriate) at induction. We share learning externally via the East Midlands Safety Collaborative.

**NUH Serious Incidents in the 12 months to October 2013**

<table>
<thead>
<tr>
<th>Never Events</th>
<th>Patient Harm</th>
</tr>
</thead>
<tbody>
<tr>
<td>Incorrect procedure performed (corrected mid-procedure)</td>
<td>Low</td>
</tr>
<tr>
<td>Inadvertently retained foreign object post procedure (guide plate for screws)</td>
<td>Moderate</td>
</tr>
<tr>
<td>Chest drain inserted on the wrong side (bilateral fluid)</td>
<td>Moderate</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Serious Incidents : general</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Failure to follow NUH antibiotic guidelines in the post-operative period for a</td>
<td>Patient died</td>
</tr>
<tr>
<td>patient with severe infection</td>
<td></td>
</tr>
<tr>
<td>Patient’s medication inadvertently placed in wrong “take-home” bag</td>
<td>None</td>
</tr>
<tr>
<td>Incorrect intraocular lens inserted requiring further surgery</td>
<td>Moderate</td>
</tr>
<tr>
<td>Patient taken into wrong anaesthetic room (not operated on)</td>
<td>None</td>
</tr>
<tr>
<td>Failure to act on abnormal observations and test results</td>
<td>Severe</td>
</tr>
<tr>
<td>Prescribed medication not administered resulting in admission to intensive care</td>
<td>Moderate</td>
</tr>
<tr>
<td>4 patients being treated for chronic back pain received anaesthetic injections at (probably) the incorrect anatomical level of the spine.</td>
<td>Low</td>
</tr>
<tr>
<td>Insertion of intra-aortic balloon pump on opposite side to that requested</td>
<td>Low</td>
</tr>
<tr>
<td>A swab routinely used during tonsillectomy was inadvertently (and briefly)</td>
<td>None</td>
</tr>
<tr>
<td>retained in the patient’s throat (coughed out as she was waking up from anaesthesia)</td>
<td></td>
</tr>
</tbody>
</table>

**Serious incidents : specific categories**

<table>
<thead>
<tr>
<th>Number</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Patient fall resulting in fracture</td>
<td>61</td>
</tr>
<tr>
<td>Pressure ulcer</td>
<td>147</td>
</tr>
<tr>
<td>Maternity related incidents</td>
<td>28</td>
</tr>
<tr>
<td>Infection related incidents</td>
<td>41</td>
</tr>
</tbody>
</table>

**NUH Comparative rate of patient safety incidents (including serious incidents) and patient harm in incidents**

NUH reports a relatively high number of incidents (per 100 admissions), and this has been increasing (April - September 2011: 7.3, April - September 2012: 8.9, October 12 to March 13: 9.3). NUH reports more patient safety incidents than similar trusts.

The distribution of severity and type of incident is similar to that seen in peer hospitals (Appendix A)

**Media Reports of November 2013**

In November 2013 the media alleged that NUH has a high number of deaths due to incidents in 2012/13 (based on NRLS data). This seems to have been based on data for April 12 to September 12 (the full year's data has not yet been validated and released by
NRLS). Furthermore, NRLS itself comments “not all organisations apply the national coding of degree of harm in a consistent way, which can make comparison of harm profiles of organisations difficult”. The media report was based on numbers of incidents in patients who died.

However (1) consideration is more helpfully of the rate of incidents per admission (since hospitals are of such varying size [see above]), and (2) the report does not acknowledge that the death may be unrelated to the reported incident. Examination of the 44 NUH patients mentioned in the media by NUH (and notably independently by the Care Quality Commission) suggests that in only eight was the incident a significant factor in the patient’s death.

Examples of action taken / improvements made

Production of NUH Safer Surgery DVD and booklet focussing on a uniform approach to the 5 key steps to safer surgery

Recruitment of Falls Prevention team (enabling additional staff to be deployed to the areas of need on a daily basis)

We have updated our Falls Prevention toolkit and developed a toolkit to support patients with delirium

“React to Red” trust wide campaign raising awareness and helping staff to reduce the incidence of pressure ulcers

Monthly Medical Director’s newsletter published for all staff with key learning points from incident investigations and actions required

Hand hygiene improvement workshop held to refresh and strengthen our approach to sustained improvements in hand hygiene

Dr Stephen Fowlie, Medical Director

Appendix A
Organisation Patient Safety Incident Report

Reported incidents to the National Reporting & Learning System between 01 October 2012 to 31 March 2013
Are you actively encouraging reporting of incidents?

The comparative reporting rate summary shown below provides an overview of incidents reported by your organisation to the National Reporting and Learning System (NRLOS) between 01 October 2012 and 31 March 2013. 9,194 (rate of 5.3) incidents were reported by this organisation during this period.

**Figure 1: Comparative reporting rate per 100 admissions for 29 ACUTE TEACHING organisations.**

The median reporting rate for this cluster is 7.5 reporting rate per 100 admissions.

Organisations that report more incidents usually have a better and more effective safety culture. You can't learn and improve if you don't know what the problems are.

How regularly do you report?

Your organisation reported incidents to the National Reporting and Learning System (NRLOS) in 6 of the 6 months between 01 October 2012 and 31 March 2013.

**Report regularly:** Incident reports should be submitted to the NRLOS at least monthly.

Fifty percent of all incidents were submitted to the NRLOS more than 30 days after the incident occurred. In your organisation, 50% of incidents were submitted in more than 30 days after the incident occurred.

Report serious incidents quickly: it is vital that staff report serious safety risks promptly both locally and to the NRLOS, so that lessons can be learned and action taken to prevent harm to others.
Organisation Patient Safety
Incident Report

National Reporting and Learning System

Reported incidents between 01 October 2012 to 31 March 2013

NOTTINGHAM UNIVERSITY HOSPITALS NHS TRUST
Organisation type: Acute teaching

What type of incidents are reported in your organisation?

![Bar chart showing top 10 incident types]

If your reporting profile looks different from similar organisations, this could reflect differences in reporting culture, the type of services provided or patients cared for. It could also be pointing you to high risk areas. The response system is more important than the reporting system.

![Bar chart showing incidents reported by degree of harm for acute teaching organisations]

Do you understand harm?

Nationally, 68 per cent of incidents are reported as no harm, and just under 1 per cent as severe harm or death.

However, not all organisations apply the national coding of degree of harm in a consistent way, which can make comparison of harm profiles of organisations difficult.

Organisations should record actual harm to patients rather than potential degree of harm.

Further information

The NRAS helps the NHS to understand why, what and how patient safety incidents happen, learn from these experiences and take action to prevent future harm to patients. National data can be found at: