NHS
Nottingham North and East
Clinical Commissioning Group

Meeting Title	NHS Nottingham North and East CCG Governing Body			**Date:** 21 November 2017				
Paper Title	Serious Incident Annual Report – 2016-17			**Agenda Item:** NNE/GB 17189				
Lead Director Report Author	Nichola Bramhall, Director of Nursing and Quality Rebecca Stone, Deputy Director of Nursing and Quality Liz Gundel, Quality Support Officer							
Purpose (tick one only)	Approval	☐	Acknowledge/ Note	☒	Review	☐	For Information	☐
Executive Summary	This report provides an analysis of Serious Incidents (SIs) reported by Nottingham University Hospitals NHS Trust (NUH), Local Partnerships – General Health (LP) (the community services division of Nottinghamshire Healthcare Foundation Trust), Circle Nottingham (CN), Nottingham West (NW), Nottingham North and East (NNE) and Rushcliffe (RCCG) Clinical Commissioning Groups (CCGs) and Independent Providers (GP practices) via the Department of Health Strategic Executive Information System (STEIS) during the period 1 April 2016 to 31 March 2017. It aims to provide assurance of a robust system of scrutiny, challenge and shared learning undertaken by the Quality and Patient Safety Team on behalf of Nottingham North East, Nottingham West and Rushcliffe CCGs and associate commissioners. There has been an overall decrease in the total number of SIs reported from the previous year in that **410** were reported across Nottinghamshire in 2016/17 compared to **703** in 2015/16. Similarly, the numbers of SIs reported by providers where one of the South Nottinghamshire CCGs is co-ordinating commissioner dropped to **161** in 2016/17 compared to **207** in 2015/16 (481 in 2014/15, 487 in 2013/14 and 514 in 2012/13). This decrease is partly due to refreshed guidance on the national SI framework being issued in March 2015 which altered the threshold for SI reporting, re-defined the categories and ceased to grade SIs. As a consequence, whilst this report includes SI activity pre- March 2015 it makes exact comparisons for some categories of SI unreliable. The main categories of SIs reported in 2016/17 were Stage 3 and 4 avoidable Pressure Ulcers (PUs), Healthcare Associated Infections (HCAIs) and maternity incidents. This is consistent with the reporting patterns in the previous year (and compared to NHS England data for Nottinghamshire for 2016/17); with the exception of falls (severe harm/death) which have significantly reduced. • **Pressure Ulcers** There has been an overall reduction in pressure ulcers from **115** in 2015/16 to **96** in 2016/17. It should be noted that pre-2015/16 figures included avoidable and unavoidable cases, whereas from 2015/16 only avoidable cases required reporting as an SI which indicates an improving picture of reducing avoidable harm from pressure damage. • **Healthcare Associated infections (HCAIs)** HCAIs SIs have significantly reduced from **39** in 2015/16 to **21** for 2016/17. The number of Methicillin Resistant Staphylococcus Aureus bloodstream (MRSAb) cases has slightly reduced from **7** in 2015/16 to **6** in 2016/17. • **Maternity** There has been a slight increase in maternity incidents from **11** in 2015/16 to **14**							

	in 2016/17. • **Never Events** There were **8** Never Events reported by providers where one of the South Nottinghamshire CCGs is co-ordinating commissioner (all NUH). This is a further increase compared to **6** in 2015/16 and **5** in 2014/15). There are similar cases compared to 2015/16: Wrong implant, misplaced naso-gastric tube, retained foreign object and wrong route administration of medication. • **Falls** There has been a significant reduction in falls that meet the SI criteria (resulting in moderate harm or above) from **16** in 2015/16 to **5** in 2016/17. The criteria for reporting falls SIs has not changed as a result of the revised guidance. The number of falls that do not meet SI criteria has also fallen in addition to the ratio of repeat fallers. The Quality and Patient Safety Team continue to work with providers to ensure that incidents are reported and robustly investigated with appropriate action plans developed to prevent recurrence and enhance learning related to systems, processes and human factors. The Quality and Patient Safety Team will continue to work with providers to support continual improvement through the analysis of themes and trends and sharing of learning and best practice.

If paper is for approval, have the following impact assessments been completed?

Quality Impact Assessment	Yes ☐ No ☐ N/A ☒	Equality Impact Assessment	Yes ☐ No ☐ N/A ☒	Privacy Impact Assessment	Yes ☐ No ☐ N/A ☒

Conflicts of Interest - Recommended action to be agreed by the Chair at the beginning of the item.

☒ No conflict identified
☐ Conflict noted, conflicted party can participate in discussion but not decision
☐ Conflict noted, conflicted party can remain but not participate
☐ Conflicted party is excluded from discussion

Implications: *(please tick where relevant)*

Integration	☐	Patient Choice	☐
Reducing inequality	☐	Patient & Public Involvement	☒
Constitution	☐	Quality of Services	☒
Governance	☒	QIPP	☐
Innovation	☐	Research	☐
Learning and Development	☒	Sustainability	☐

Finance checked by:	**N/A**

Appendices	
Report History	This is an annual report
Patient and Public Involvement	N/A

Recommendation	The Governing Body is asked to: **NOTE** The Serious Incident Annual Report 2016-17