Serious Incident Annual Report
April 2016 – March 2017

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.

Introduction

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.

1. Putting patient safety first

Commissioning is a tool for ensuring high quality, cost-effective care. Quality is a key thread that underpins the work undertaken by commissioning groups. The mission is to improve the health and wellbeing of people in Nottinghamshire with a specific aim to improve quality by delivering improvements across the three domains of quality:

- Patient Safety
- Patient Experience
- Clinical Effectiveness

Quality is only achieved when all three domains are met. To achieve a good quality service the values and behaviours of those working in the NHS need to remain focussed on patients first.

2. Serious Incident definition and reporting process

The NHS England Serious Incident Framework (March, 2015) describes Serious Incidents as *'acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services'.*

Never Events are '*Serious, largely preventable, patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'.*

Incidents are considered to be Never Events if:

- The incident either resulted in severe harm or death or had the potential to cause severe harm or death.
- There is evidence that the Never Event has occurred in the past and is a known source of risk (for example through reports to the National Reporting and Learning System or other serious incident reporting system).
- There are existing national guidance or safety recommendations, which if followed, would have prevented the incident from occurring.
- Occurrence of the Never Event can be easily identified, defined and measured on an ongoing basis.

In line with the Serious Incident Framework (March, 2015) all SIs must be reported onto the National Strategic Executive Information System (STEIS) within 2 working days with

submission of final report to the Co-ordinating Commissioners 60 days from entry onto STEIS.

SIs are no longer graded but there are three levels of investigation:

- Concise (suited to less complex incidents which can be managed by individuals or a small group)
- Comprehensive (complex issues which should be managed by a multidisciplinary team involving experts and/or specialist investigators)
- Independent (for incidents where the integrity of the internal investigation is likely to be challenged or where it will be difficult for an organisation to conduct an objective investigation internally due to the size of the organisation, or the capacity/capability of the individuals or number of organisation/s).

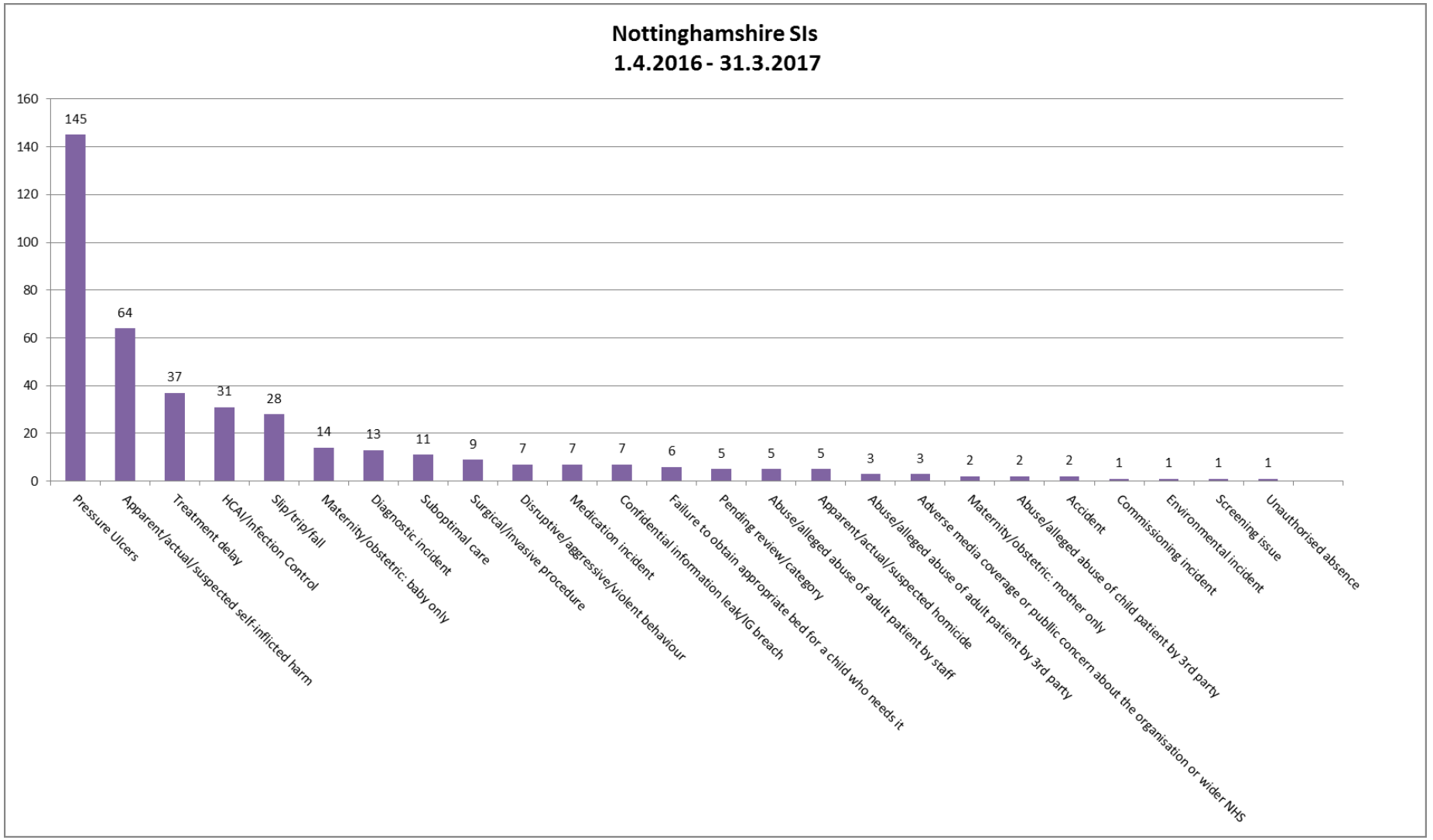
Completed provider Root Cause Analysis (RCA) investigation reports are reviewed by the Quality and Patient Safety Team on behalf of Nottingham North East, Nottingham West and Rushcliffe CCGs. Closure on the national database is only approved once it is clear that there has been a robust investigation and the action plan appropriately addresses the root causes of the incident.

3. Analysis of 2016/17 Serious Incident activity

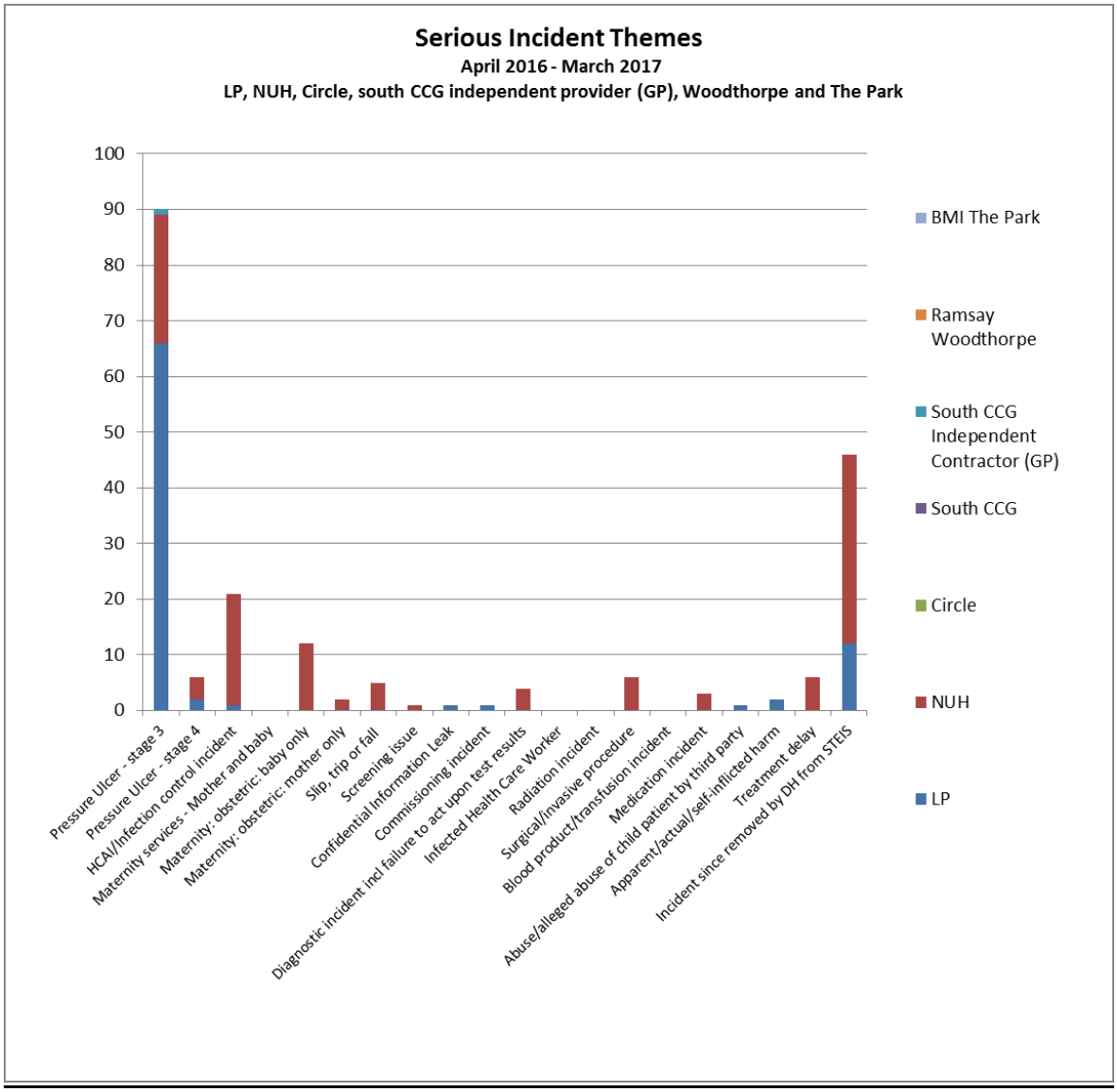
Across Nottinghamshire **410** SIs were reported in 2016/17 (703 in 15/16), of which **161** were attributable to providers where one of the South Nottinghamshire CCGs are co-ordinating commissioner (NUH, LP, CN and Independent Providers). In May 2015 the SI definition altered and in the case of stage 3 and 4 pressure ulcers only 'avoidable' incidents were reportable which partly explains the significant reduction of reported SIs post 2014/15. In addition CCGs had delegated responsibility from NHS England to report Primary Care acquired SIs on STEIS. It should be noted that the South Nottinghamshire CCG Quality Team also have responsibility for quality monitoring, including SI oversight, at BMI The Park Hospital and Ramsay Nottingham Woodthorpe Hospital, however neither provider reported any SIs in 2016/17.

Provider	***Concise*** ***2015/17***	***Comprehensive*** ***2016/17***	***Total***				
			2016/17	***2015/16***	***2014/15***	***2013/14***	***2012/13***
Nottingham University Hospital (NUH)	*59*	*27*	***86***	*106*	*239*	*232*	*286*
Local Partnerships (LP) (covering all Nottinghamshire County community services including Residential Care Homes - north and south)	*72*	*2*	***74***	*89*	*235*	*252*	*226*
Circle Nottingham (TC)	*0*	*0*	***0***	*3*	*5*	*1*	*0*
South CCGs (NNE, NW, Rushcliffe)	*0*	*0*	***0***	*1*	*2*	*1*	*2*
South CCGs (Independent commissioned provider)	*1*	*0*	***1***	*8*	*0*	*1*	*0*
Total	*132*	*29*	***161***	*207*	*481*	*487*	*514*

The following table provides the context of **Nottinghamshire** SI themes using NHS England data:



The following tables focus on SI themes for the South Nottinghamshire CCGs and the providers they are Co-ordinating Commissioner for.

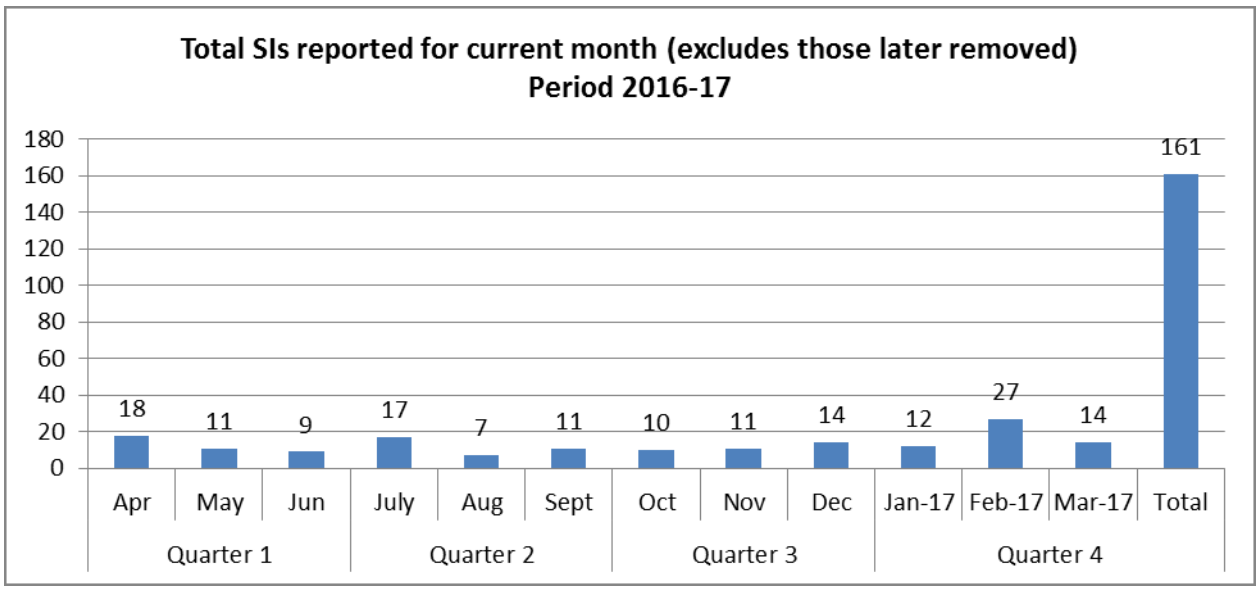


Themes for year 2016/17 *(including those later removed by DoH)*								
Data collected from 1.4.2016 to 31.3.2017	**LP**	**NUH**	**Circle**	**South CCG**	**South CCG Independent Contractor (GP)**	**Ramsay Woodthorpe**	**BMI The Park**	**Total**
Pressure Ulcer - stage 3	66	23			1			**90**
Pressure Ulcer - stage 4	2	4						**6**
HCAI/Infection control incident	1	20						**21**
Maternity services - Mother and baby								**0**
Maternity: obstetric: baby only		12						**12**
Maternity: obstetric: mother only		2						**2**
Slip, trip or fall		5						**5**
Screening issue		1						**1**
Confidential Information Leak	1							**1**
Commissioning incident	1							**1**
Diagnostic incident incl failure to act upon test results		4						**4**
Infected Health Care Worker								**0**
Radiation incident								**0**
Surgical/invasive procedure		6						**6**
Blood product/transfusion incident								**0**
Medication incident		3						**3**
Abuse/alleged abuse of child patient by third party	1							**1**
Apparent/actual/self-inflicted harm	2							**2**
Treatment delay		6						**6**
Incident since removed by DH from STEIS	12	34						**46**
Grand Total	**86**	**120**	**0**	**0**	**1**	**0**	**0**	**207**

During 2016/17, 46 of the 207 incidents initially reported were removed from STEIS. These were mainly pressure ulcers that, following investigation, were found not to meet the SI criteria (i.e. were moisture lesions, stage 2 or found to be unavoidable). This brings the final 2016/17 total to 161.

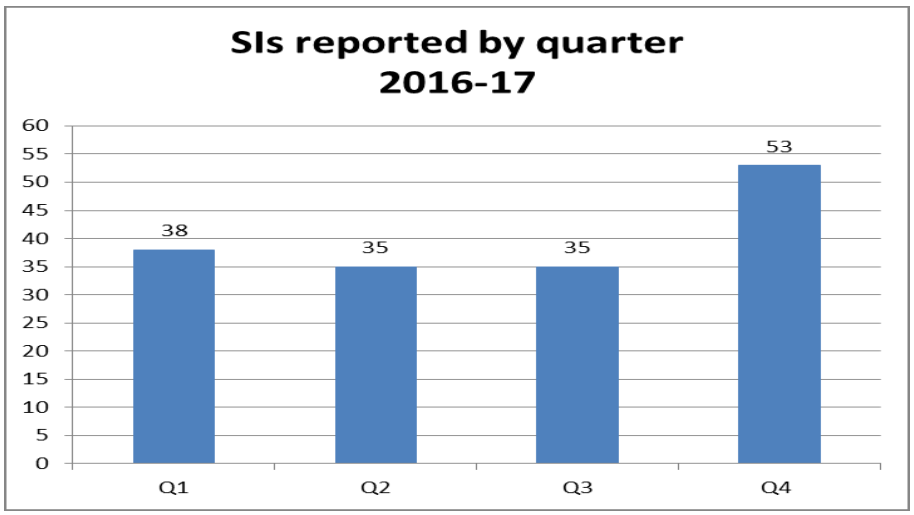
8 of the above SIs were classed as Never Events which are covered in more depth on page 20 of this report.

SI numbers - reported by month – 2016/17



The spike in February/Quarter 4 SIs was due to an increase in maternity reporting (10/27) – further detail is on page 18.

SI numbers – reported by quarter



SIs – reported by month/provider

SIs by provider/month 2016-17	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	March
NUH	9	7	2	3	6	5	5	5	8	7	18	11
Local Partnerships	9	4	7	13	1	5	4	6	9	5	8	3
NNE Primary Care											1	
NW Primary Care												
Rushcliffe Primary Care												
Circle												
Ramsay Woodthorpe												
BMI The Park												
	18	11	9	16	7	10	9	11	17	12	27	14

4. Serious Incident Categories

The most frequently reported SI categories were:

- Pressure Ulcers (only stages 3 and 4 are reportable on STEIS)
- HCAIs
- Maternity
- Never Events
- Falls with harm
- Unclassified serious incidents

Pressure Ulcers (PUs)

Staging is determined by the severity of the pressure damage. Stages 1 and 2 do not meet SI criteria and are not reportable on STEIS. Stages 3 and 4 indicate deeper more invasive tissue damage and are consequently more severe. Patients with a stage 4 wound have a higher risk of developing a life-threatening infection due to their depth.

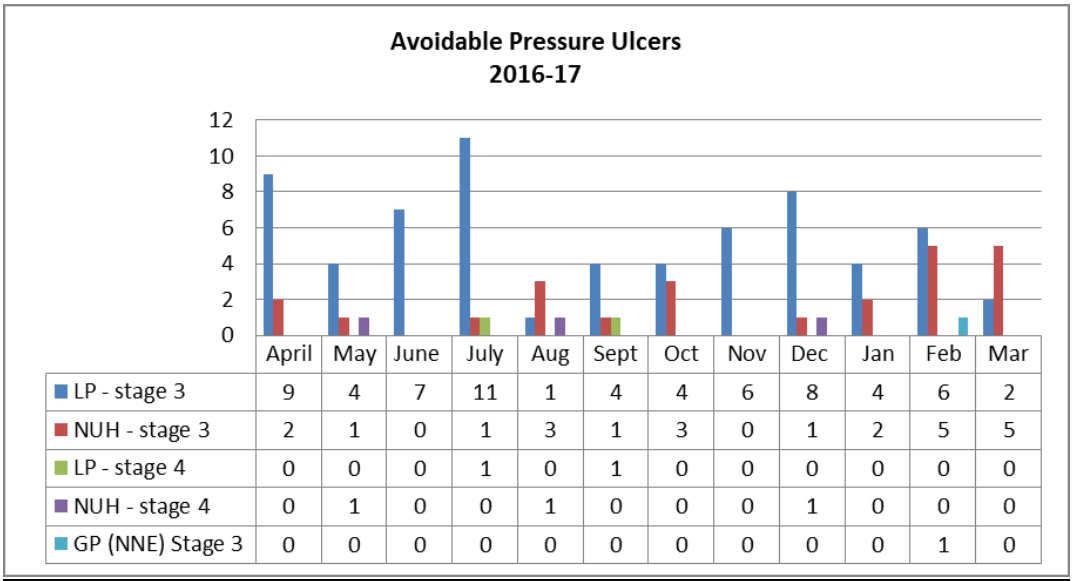
NHS England (North Midlands) data shows that PUs were the highest category of SI reported with **145** PUs reported in Nottinghamshire during 2016-17.

PUs were also the highest category of SIs reported by the providers where one of the South Nottinghamshire CCGs are co-ordinating commissioner with **96** reported in 2016/17, a reduction from 115 in 2015/16.

Total PUs

2016/17 (avoidable only)	2015/16 (avoidable only)	2014/15 (avoidable and unavoidable)	2013/14 (avoidable and unavoidable)	2012/13 (avoidable and unavoidable)
96 *(68 LP, 27 NUH, 1 NNE GP)* ↓	115 *(82 LP, 27 NUH, 6 Primary Care)*	280 *(230 LP, 50 NUH)*	352 *(247 LP, 104 NUH, 1 NW CCG)*	*297 (179 LP, 118 NUH)*

PUs - by provider 2015/16 (stages 3 & 4 combined)



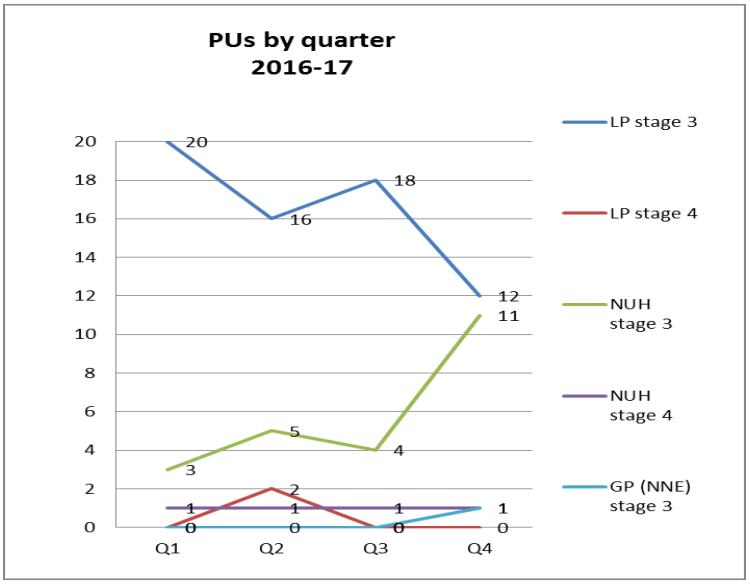
	April	May	June	July	Aug	Sept	Oct	Nov	Dec	Jan	Feb	Mar
LP - stage 3	9	4	7	11	1	4	4	6	8	4	6	2
NUH - stage 3	2	1	0	1	3	1	3	0	1	2	5	5
LP - stage 4	0	0	0	1	0	1	0	0	0	0	0	0
NUH - stage 4	0	1	0	0	1	0	0	0	1	0	0	0
GP (NNE) Stage 3	0	0	0	0	0	0	0	0	0	0	1	0

Stage 3 and 4 Avoidable PU numbers:

Stage 3	**16/17**	15/16	14/15
NUH	**23** ↓	27	30
Local Partnerships	**66** ↓	78	103
Primary Care (GP)	**1** ↓	6	Not recorded at that time
Stage 4	**16/17**	15/16	14/15
NUH	**4** ↑	0	0
Local Partnerships	**2** ↓	4	2
Primary Care (GP)	**0** ↔	0	Not recorded at that time

Overall for the year there is a reduction in avoidable stage 3 PUs from previous years but the following sections give more detail about specific providers.

Pressure Ulcers by Quarter:



NUH

NUH have achieved a 60% reduction with 23 incidents during 2016/17 compared to 70 in 2013/14. The downward trajectory over the last three years is indicative of the significant work that NUH have undertaken to address avoidable PU damage. There has been a reduction in stage 3 damage (23 in 2016/17 compared to 27 in 2015/16).

Overall the combined number of stage 3 and stage 4 PUs for NUH has remained static at 27 for this and the preceding year due to reporting 4 avoidable stage 4 PUs in 2016/17, which is their first since 2013/14. Three of the four patients already had pressure damage on admission to NUH although RCA investigation has indicated that there was learning for the Trust so all four have been deemed avoidable.

Another approach is to correlate PU damage with occupied bed days (OBD) and the next table gives details of this:

Overall NUH Target reduction: Avoidable Pressure Ulcers – Occupied bed days							
	Baseline	Target	Actual	Target	Actual	Target	Actual
Stage	2013/14	2014/15	2014/15	2015/16	2015/16	2016/17	2016/17
Stage 3	0.13	0.10 Avoidable	0.05	0.08 Avoidable	0.04	0.06 Avoidable	0.05
Stage 4	0.00	0.00 Avoidable	0.00	0.00 Avoidable	0.00	0.00 Avoidable	0.01

NUH committed to being in line with the NHS England initiatives 'Sign up to Safety' and 'Saving 6000 Lives' by reducing avoidable harm events by 50% over a three year period and set the aspirational reduction trajectory outlined in the table above. It is evident that

whilst the number of PUs has remained static at 27 from the previous year there has been a slight increase in PU damage at Stages 3 and 4 when considered against occupied bed days.

Additional review of the Q4 spike reveals that PU damage is distributed randomly across wards and the key learning for NUH to focus on during 2017/18 consists of:

- Continuing to support project wards (see below)
- Scope heel protection devices and offloading pressure for heels
- HCA practical training session
- Trial of hybrid mattresses
- Management of moisture lesions
- Ineffective repositioning
- Management of non-concordance
- Wound assessment and staging

NUH feel that there is more stringent challenge of staff and their practice which has increased the classification of avoidable damage. An example is non-concordance – previously staff might use this as a reason for PU damage being unavoidable, whereas now it is expected that the staff have fully explored reasons for non-concordance, including assessment of mental capacity and detailed documentation of discussions with patients around unwise decisions in order for damage to be classified as unavoidable.

Local Improvement Work

NUH have continued their previous year's local CQUIN work which aims to reduce days between PU damage occurring on four specific wards by undertaking a focused improvement programme. A deep dive into Hogarth ward has identified no issues with care delivery (i.e. no avoidable PUs) despite poor achievement against the improvement trajectory.

2014-15 Ward	Pressure ulcer Stage	Average days between events 2013/14	Target	End of Year
E12 Critical Care	2	10	15	**19**
Southwell Respiratory	2	10	12	**15**
C6 Trauma Orthopaedic	2	16	23	**23**
E16 Vascular	3	82	73 due to bed configuration	**200**
2015/16 Ward	**Pressure ulcer Stage**	**Average days between events 2014/15**	**Target**	**End of Year**
Gervis Pearson Oncology	2	17	23	**28**
D58 Acute Medicine	2	16	20	**42**
AICU Critical Care	2	4	7	**7**
F21 Surgical	2	17	30	**29**
2016/17 Ward	**Pressure ulcer Stage**	**Average days between events 2015/16**	**Target**	**End of Year**
CCD Critical Care	2	11	23	**15**
Berman 2 Respiratory	2	19	51	**44**
Hogarth Oncology	2	29	58	**17** *
Edward 2 Elective Orthopaedics	2	28	52	**75**

* **Increase in unavoidable but NO avoidable PU since commencing the project**

NUH have identified a further three new wards (which are the highest reporting areas of PUs) to work closely with this year as well as continuing to support Critical Care Directorate & Hogarth:

2016/17 Ward	Pressure ulcer Stage	Average days between events 2016/17	Target	End of Year
CCD Critical Care	2	15	23*	Continue with shared learning
Hogarth Oncology	2	17	58*	Continue – review differences with Toghill
Toghill Oncology	2	25	27**	New Wards
D8 Spinal /Surgery	2	26	29**	
C51 Medicine	2	41	45**	

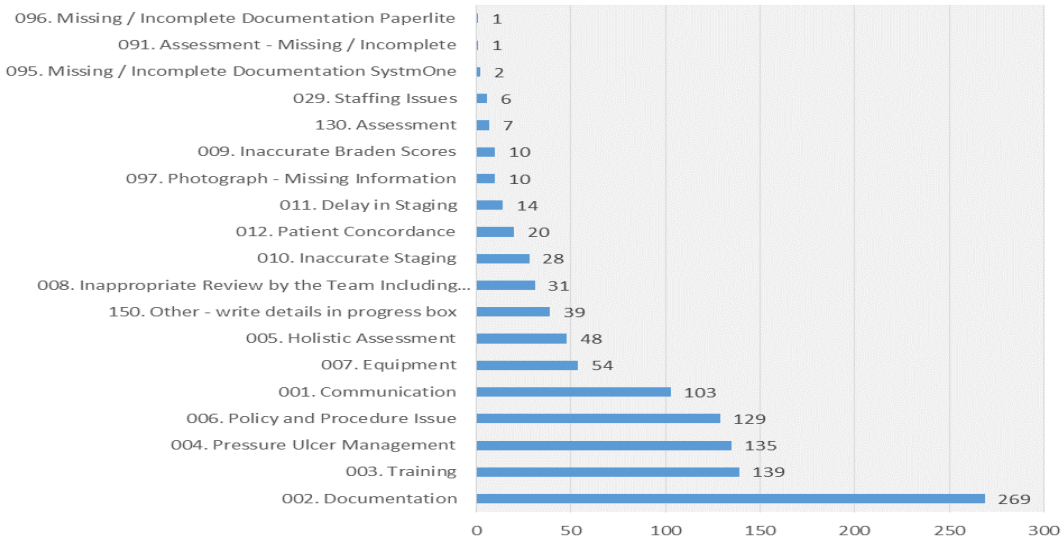
*derived from 2015/16 baseline using the previous 3 year reduction trajectory
**derived from 2016/17 baseline using latest trajectory & wards may also have a 'stretch' target set by the Division

This focused intervention will consist of thematic reviews and 'walk rounds of clinical areas' to establish a baseline assessment and using this information to identify any key areas for improvement. Structured support and education will be offered to the ward teams, assist them to develop Plan, Do, Study, Act cycles and measure their improvement.

LP

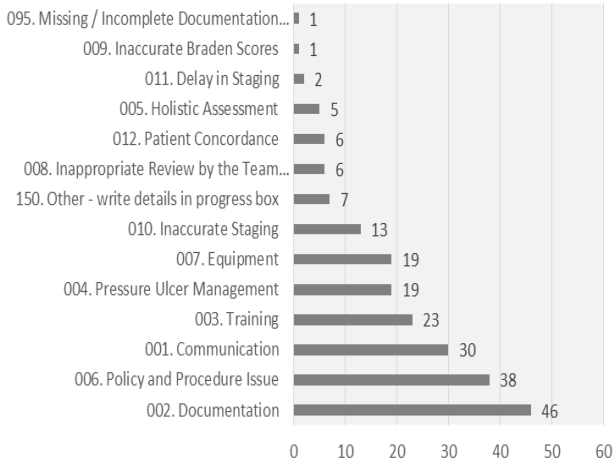
Within LP there has been a reduction from 78 stage 3 avoidable PUs (2015/16) to **66** and from 4 to **2** stage 4 avoidable PUs.

Key RCA pressure ulcer themes: (*Data provided by Amy Barksby, Audit Facilitator, Local Partnerships)*

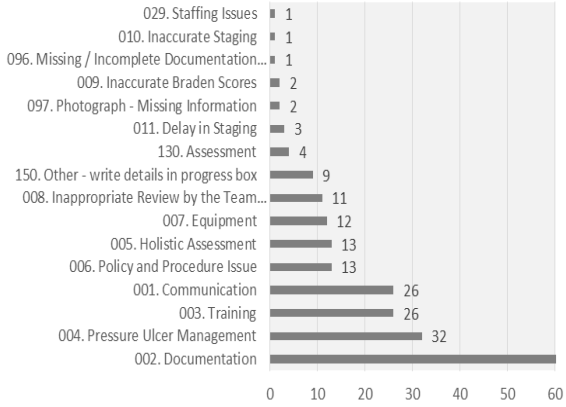


Trends analysis by locality

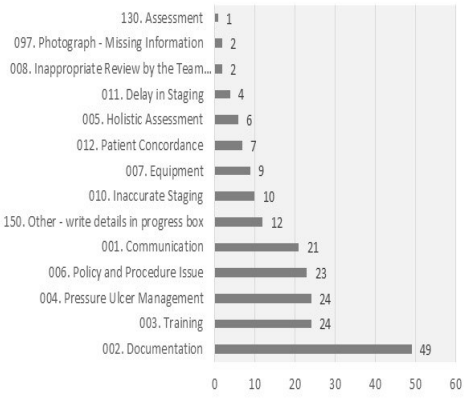
Mansfield and Ashfield



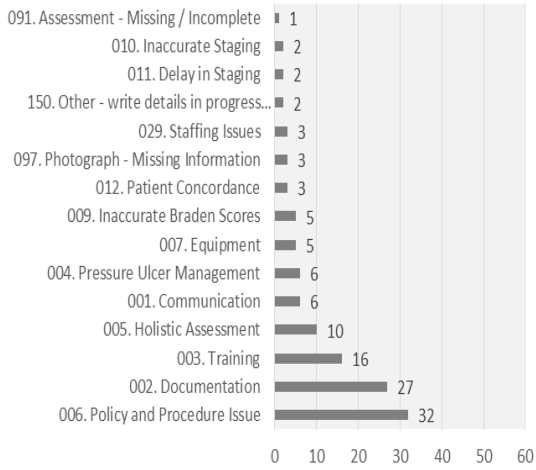
Newark and Sherwood



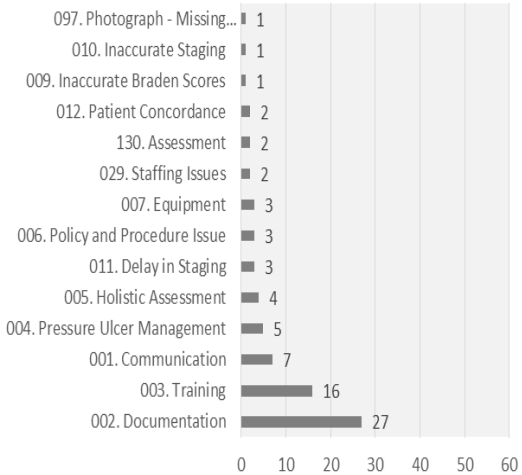
Nottingham North & East



Nottingham West



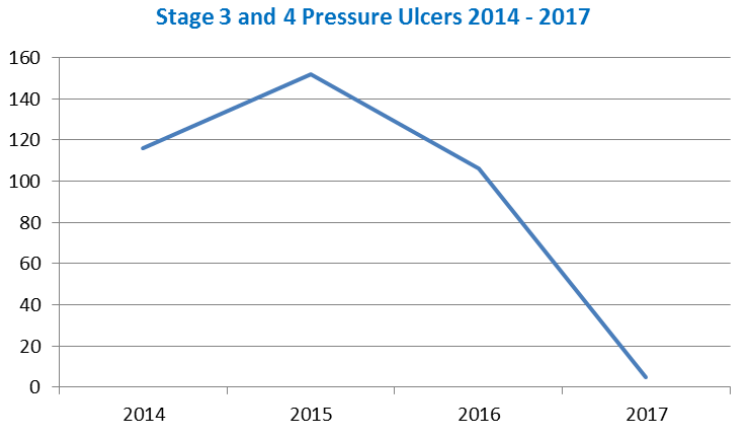
Rushcliffe



LP initiatives:

The NHCFT's Trust 'Sign up to Safety: End of Year 2 Report' identified 6 safety priority workstreams for the Sign Up to Safety campaign, one of which was '*no acquired, avoidable stage 3 & 4 pressure ulcers and a 50% reduction in the number of acquired avoidable stage 1 & 2 (year on year)'.*

From 2014/15 – 2016/17, the number of stage 3 and 4 pressure ulcers reduced by 95.6%.



NHCFT stated that *'The zero ambition for stage 3 and 4 remains challenging in the context of a shifting cohort of service users with more complex needs and those receiving end of life care. We continue to focus on learning from root cause analysis work, seeking to also influence areas not directly in our control'.*

LP have taken a number of actions over a 3 year period to deliver this reduction in avoidable PUs consisting of:

- *Ingenuity Project completed September 2015 (development of a real time shared information system for Action Plan Tracker regarding post incident learning.)*
- *Review of pressure ulcer RCA process commenced following discussion with CCG.*
- *React to Red Training for care homes implemented across participating care homes within LP. Training package offered to all CCGs within the East Midlands via the Academic Health Sciences network*
- *Quality Improvement Matron seconded to the Patient Safety Collaborative to support roll out of training and participate in regional public awareness campaigns*
- *Tissue Viability Nurse seconded one day a week to NHS England North*
- *Conference held in November 2015 and good attendance across Nottinghamshire and positive evaluation from staff attending*
- *Completion of interrogation of patient profile data of stage 3 and 4 acquired avoidable pressure ulcer incidents to identify themes including diagnosis, capacity issues, co-morbidity*
- *Exploration of Human Factors Analysis*
- *Review of SI process for pressure ulcers and RCA process*

<u>Primary Care Acquired Pressure Ulcers</u>

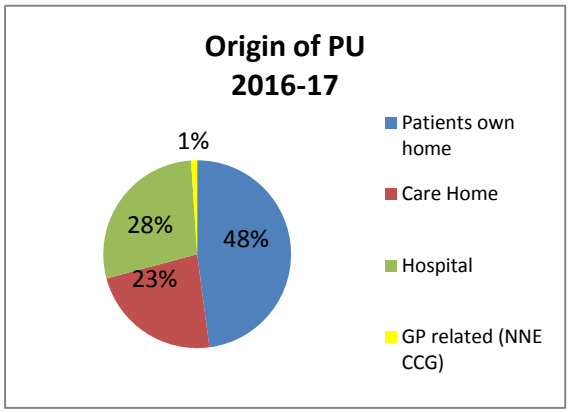
The three south Nottinghamshire CCGs have responsibility for managing serious incidents (SIs) reported by NW, NNE and Rushcliffe Primary Care. Part of this work is around investigating the cause of pressure damage identified when patients are admitted to hospital or when first assessed by community health services. If a patient develops pressure damage when living at home (excluding care homes) and are not under the care of community health services, then pressure damage is defined as 'Primary Care Acquired' and the GP practice is asked to investigate.

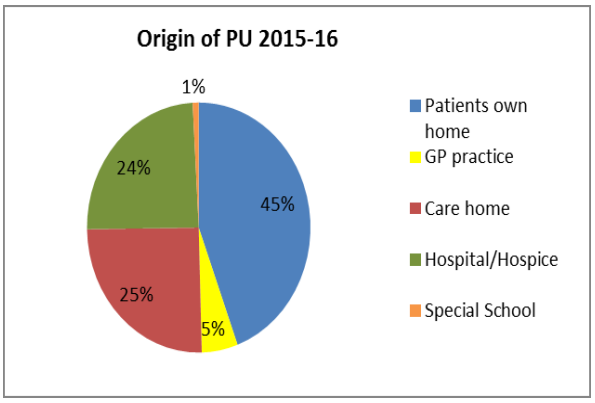
In 2016/17, one stage 3 Pressure Ulcer was found to be avoidable and attributed to an NNE CCG practice. The practice identified learning around considering opportunistic PU assessment/advice in at-risk groups attending the surgery.

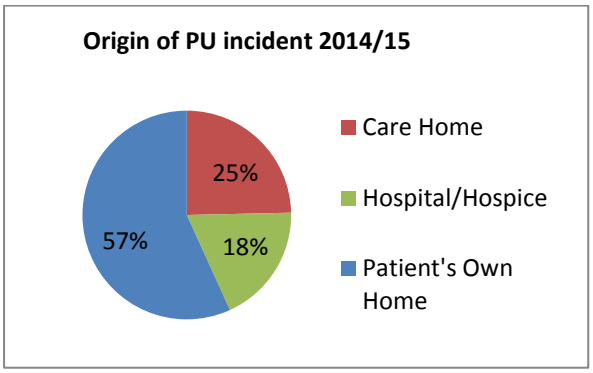
Pressure Ulcer origin 2016/17

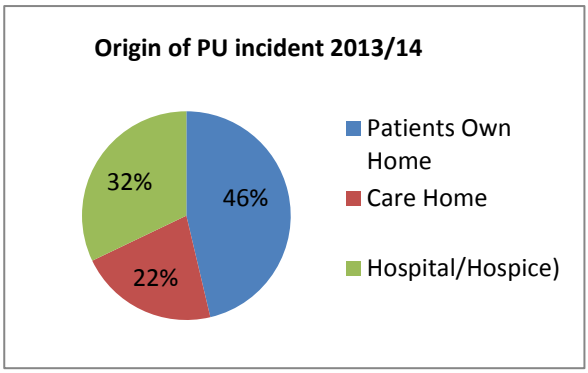
The majority of PUs reported originated in the patient's own home and show a slight increase from 45% in 2015/16 to 48% in 2016/17. The Hospital category shows an increase from 24% in 2015/16 to 28% in 2016/17, the Care Home sector a 2% reduction and a 4% reduction in GP (primary care) acquired.

Of the six 'stage 4' PUs reported, 4 originated at NUH (various wards) and 2 in residential care home settings.









Healthcare Acquired Infections (HCAIs)

NUH HCAI SIs are scrutinised and closed on STEIS on behalf of the three south Nottinghamshire CCGs by the Quality Governance Manager who is hosted by Nottingham City CCG. Countywide community HCAIs are scrutinised and closed on STEIS by the Head of Service, Community Infection Prevention and Control (IPC) Team, hosted by Mansfield and Ashfield CCG on behalf of the five Nottinghamshire CCGs. *A separate IPC Annual Report 2016/17 is available and has been submitted to the South CCGs' Quality and Risk Committee and Governing Bodies.*

NHS England (North Midlands) data shows that **31** HCAI SIs were reported in Nottinghamshire during 2016/17. For providers where one of the South

Nottinghamshire CCGs is co-ordinating commissioner there continues to be a significant reduction in HCAI cases; from 39 in 2015/16 down to **21 in 2016/17**.

South CCG provider - HCAI related SIs reported

All cases of Methicillin Resistant Staphylococcus Aureus bloodstream (MRSAb) *are reported as SIs. Clostridium Difficile (C Diff) cases are only reported if the patient suffers 'moderate or above' harm and lapses in care can be demonstrated following post infection review.*

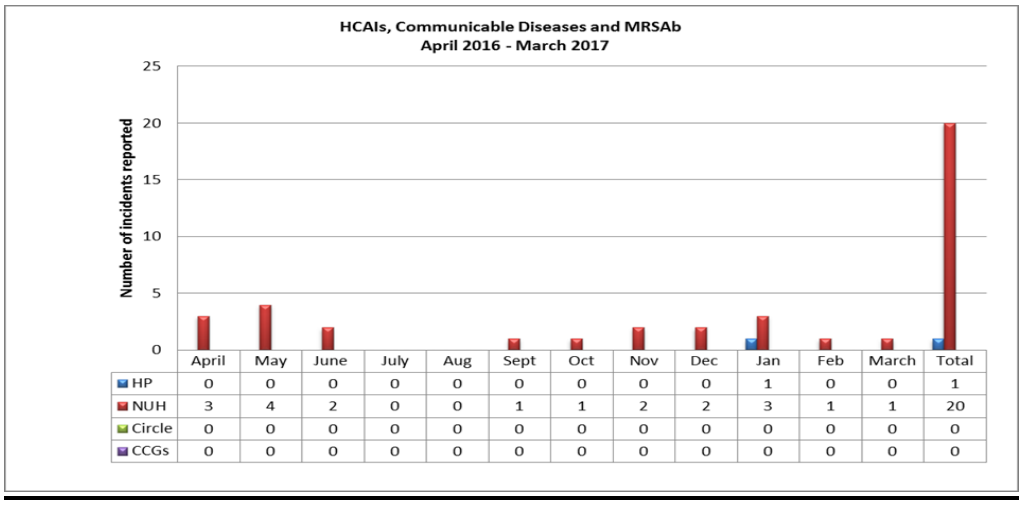
2016/17	2015/16	2014/15	2013/14	2012/13
21 (LP 1, NUH 20) ↓	39 (LP 2, NUH 37)	69 (LP 4, NUH 63, NW 1, NNE 1	35	58

HCAI SIs - by type and provider 2016/17

Note: Community MRSAb and CDiff cases are now registered against the patient's CCG and not LP in terms of numbers. However, following a Post-Infection Review, the outcome can result in the re-assignment to another organisation.

Category	LP	NUH
C Diff		8
MRSA		4
Streptococcus A		3
Influenza A	1 *(Lings Bar Hospital)*	2
Pneumocystis Pneumonia (PCP)		1
Bacillus cereus bacteraemia		1
CRE coliforms		1

HCAI SI numbers - by month 2016/17

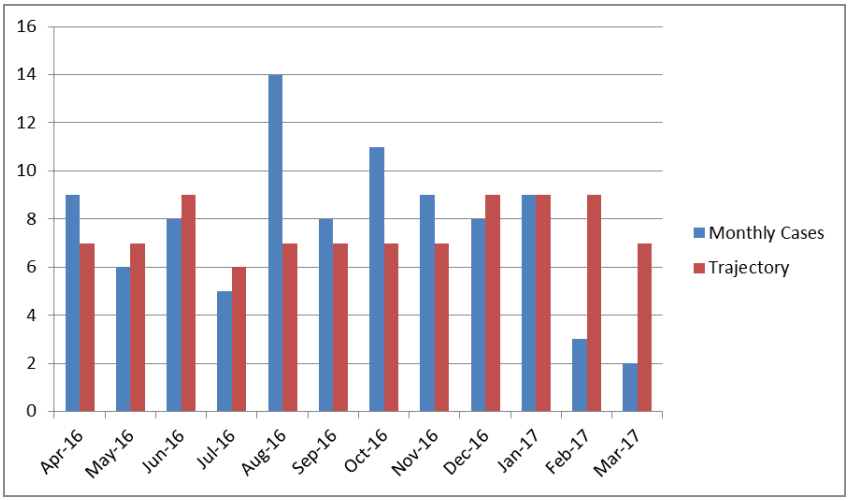


The CCG and NUH have agreed that outbreaks will now be clustered together into one RCA investigation if there are several patients involved to enable better focus on key themes and learning around systems, environments and human factors.

C Diff

NUH have a *C Diff* reduction plan in place which is updated regularly and shared with Commissioners. The Trust breached the *C Diff* Objective (2016-17) with 93 cases reported against a limit of 91. Of these 93, only 8 cases met the SI Framework and were classed as SIs. There were no significant changes in policy or procedure to explain

variance in the number of cases which ranged from 2 - 14 each calendar month. Whilst NUH were over trajectory by 2 cases for 2016/17, when viewed against their comparator organisations their rate of C Diff infections per 1000,000 bed days was the second lowest (as was the case in 2015/16).



Of the 93 cases there were 25 lapses in the quality of care identified (an increase of 10 from 2015/16):

- 6 incidences of cross infection
- 10 incidences of inappropriate antibiotic prescription
- 9 incidences of delayed diagnosis
- 4 incidences of delayed treatment

`Some patients had more than one type of lapse in care. There were no themes or trends to link the increase in cases.

Root Cause Analysis highlighted the learning from the 8 SI cases as:

- Antimicrobial prescribing
- Correct stool sampling
- Timely septic screening and blood cultures
- Environmental cleanliness
- Cleaning of equipment
  Effective isolation

It was decided by the Trust that at the end of the financial year 2016-17 they would return cleaning services to an in-house provider to ensure they could manage and monitor environmental cleanliness; this has now been completed and is being monitored by the CCG.

MRSAb

The NUH MRSAb ambition is zero tolerance; however 4 cases were assigned to NUH.

- One case was not an actual infection but a contaminated sample / colonised line
- Three cases were clinically avoidable with lessons learnt identified from these specific cases
  - Training delivered to the Emergency Department regarding blood culture technique to reduce contamination of samples
  - Trust reiterated to prescribers importance of checking results of antibiotic resistance of sample prior to prescribing antibiotics to reduce inappropriate prescribing

NUH have an MRSA reduction plan in place which is updated regularly and shared with Commissioners and focuses on:

- Sustaining high level compliance with MRSA screening and decolonisation
- Enhancing Trust wide compliance with effective antimicrobial stewardship
- Ensuring all PIR investigations are completed to the required standard within the given timescales

LP

One HCAI SI was reported by LP in 2016/17. This was a case of Influenza A affecting three patients in Lings Bar Hospital. Root Cause Analysis found that the carriage was likely to have come from outside of the hospital via visitors. Learning identified:

- Missed 2nd opportunity when still symptomatic to prescribe Tamiflu.
- Improve communication regarding treatment plans and prescribing between medical staff / ANP and staff.
- Encourage Flu vaccine uptake, to reduce risk to themselves, patients and colleagues

Maternity related incidents (NUH)

From 20 May 2015, STEIS SI categories altered resulting in just 3 maternity categories (baby only; mother and baby; mother only) being applicable. Categories of unexpected admission to NICU, unexpected neonatal death, intrauterine and unplanned admission to ITU were in use on STEIS prior to this and therefore are included in previous years' figures. NUH agreed with the Co-ordinating Commissioner that they would only report incidents as SIs where there was harm or learning in relation to these categories following the change in the national SI framework.

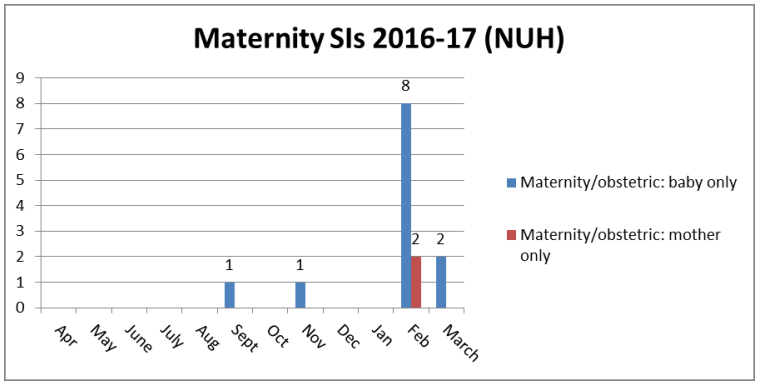
NHS England (North Midlands) data shows that **16** maternity SIs were reported in Nottinghamshire during 2016/17 (14 by NUH and 2 by SFHFT). As the graph on page 19 indicates, there were only 2 SIs entered in the first 3 quarters of 2016/17 for NUH which was such a significant reduction that both NUH and Commissioners felt it required additional scrutiny and analysis. As a consequence a suite of work was undertaken (details given below) which has been shared at the Nottinghamshire and Derbyshire Quality Surveillance Group (QSG). The learning and resulting work has been shared in particular with the SFHFT commissioners, given their maternity SIs are similarly low.

14 maternity serious incidents were reported by NUH for 2016/17 which is an increase from 11 in 2015/16.

The numbers of maternity SIs by year are identified in the table below:

2016/17	2015/16	2014/15	2013/14	2012/13
14 ↑	11	39	38	32

Maternity SIs 2016/17 (by month)



The work undertaken in relation to maternity has consisted of the following:

1. NUH instigated a retrospective review of maternity incidents (December 2015 - December 2016) which led to 12 being entered on STEIS as Serious Incidents (10 x Level 1 concise internal investigation and 2 x Level 2 comprehensive internal investigation).
2. As of January 2017 NUH returned to using a 'trigger list' which automatically classifies certain maternity incident designations as SIs. A new Standard Operating Procedure was developed to strengthen timely escalation of incident review processes and conversion to SI.
3. NUH initiated a review of safety in the maternity service which reviewed outcomes, complaints, previous investigations and a well-led review based on the Care Quality Commission Key Lines of Enquiry.
4. Quarterly CCG confirm and challenge panels which review incidents not deemed to be SIs (including other categories in addition to maternity). For maternity incidents the expertise of the Maternity Clinical network is utilised to provide appropriate scrutiny.
5. City and County CCG representatives continue to meet to clarify and strengthen commissioner processes, not only around safety and quality but also the transformation agenda
6. NUH, NHSE, CCG and LSA colleagues have met and clarified processes and oversight of supervisory investigations.
7. Review of Mothers and Babies Reducing Risk through Audits and Confidential Enquiries (MBRACE) data for perinatal mortality (2014/15) by City CCG and PHE.
8. CCG commissioned external panel review of care delivered and any omissions in care which led to outcome of intrapartum death.
9. Discussion at Derbyshire & Nottinghamshire Quality Surveillance Group (QSG) on 29th March 2017 which led to a multi-agency review of maternity services using a Quality Risk Profiling tool on 13th April 2017.
10. Risk review meeting held on 15th May 2017 which included NUH, Regulators and Commissioners which summarised that actions being taken were comprehensive and appear to be appropriate in addressing the identified concerns and areas for improvement. Whilst areas for further improvement were identified it was concluded, based on the evidence available, that the service is safe.

NUH are undertaking a thematic review of the retrospective SI investigations which is expected to be available to the CCG in Quarter 2 2017/18. One SI reviewed encompasses care across organisations and geographical boundaries so the CCG have agreed to support a multi-organisational review of care delivered across these to share learning and agreed working.

From the perspective of the CCG panel reviews of SI investigations the key themes to date are:

- Communication and triage of women in labour across labour suites and staff at 2 distinct campuses
- Documentation and contemporaneous record keeping
- Care of women in the latent stage of labour
- Adherence to guidelines and clinical decision making/escalation
- Foetal monitoring
- Clinical Leadership and Escalation
- Culture and team working
- Unit closure and diversions

NUH have reviewed and amended their SI processes and refreshed their SI policy so that the category of High Level Incident is replaced by Level 1 and Level 2 investigation classifications, to better reflect the national SI Framework. An overarching maternity action plan has been developed by NUH which holds all the actions related to SIs and reports in one place and this is shared regularly with the CCG at 6 weekly meetings to enable oversight. The Local Maternity System (LMS) will incorporate aspirations to achieve against the CCG Improvement and Assessment Framework in relation to maternity and will include the themes and learning from the actions being taken in relation to NUH maternity services.

NUH has been successful in acquiring funding to support two Human Factors programmes of work in Maternity - NUH TEAMS roll-out and the use of AcciMaps to explore stillbirths. This will support work during 2017/18 to improve Maternity services across NUH.

Top priorities for 2017/18:

- Development of an NUH TEAMS training faculty across Maternity with an initial focus on Labour Suites.
- Workshops to explore the influences on stillbirth events using an AcciMap methodology with support of Loughborough University.

Never Events

Nationally there were **424** Never Events reported in 2016/17 – a continued increase from 345 cases in 2015/16 and 308 in 2014/15. At the time of this report it should be noted that these are provisional figures only and subject to change once sufficient time has elapsed for local incident investigation and national analysis of data to take place.

National Never Events 2016/17 (provisional)

Wrong site surgery	178
Retained foreign object post procedure	109
Wrong implant/prosthesis	49
Wrong route administration of medication	40
Misplaced naso or oro gastric tube	26
Overdose of insulin due to abbreviations or incorrect device	6
Overdose of methotrexate for non-cancer treatment	5
Chest or neck entrapment in bedrails	3

Falls from poorly restricted windows	3
Failure to install collapsible shower or curtain rails	2
Scalding of patients	1
Transfusion or transplantation of ABO incompatible blood components or organs	1
Mis-selection of a strong potassium containing solution	1

Never Events

8 Never Events were reported by providers where one of the South Nottinghamshire CCGs is co-ordinating commissioner (all NUH). This is a slight increase compared to 6 reported in 2015/16 (5 NUH, 1 LP).

STEIS Ref	Provider:	Date reported	Type of incident	Detail	Level of harm
2016/9122	NUH	04/04/16	Surgical/invasive procedure	Wrong implant/prosthesis - hip replacement. Surgeon requested a 32 liner but a 36 liner was selected and implanted in error.	Low
2016/11972	NUH	03/05/16	Diagnostic incident including delay	Misplaced naso gastric tube	Low
2016/19211	NUH	18/0716	Medication Incident	Overdose of insulin due to abbreviation or incorrect device	Low
2016/21127	NUH	08/08/16	Surgical/invasive procedure	Retained foreign object post-procedure (retained vaginal swab)	Moderate
2016/24761	NUH	16/09/16	Surgical/invasive procedure	Wrong site surgery - nerve block	Low
2016/25667	NUH	29/09/16	Medication incident	Wrong route administration of medication (infusions incorrectly reconnected whilst changing patient into theatre gown)	Low
2017/4090	NUH	10/02/17	Medication incident	Wrong route administration of medication (oral vaccine (rotavirus) administered by intramuscular route instead of enterally)	Low
2017/4091	NUH	10/02/17	Surgical/invasive procedure	Retained foreign object post-procedure (retained guidewire)	Moderate

Examples of learning include:

- *Review of the Trust 'epidural prescription and observation chart' in order to provide a section for the documentation of 'post-removal of epidural' 4 hourly observations for 24 hours.*
- *Generation of policy/guidance to ensure that all ICT modelling identifies the need for robust clinical engagement with multiple clinicians to support accurate system design based on 'work as done', rather than 'work as imagined.'*
- *Relaunch to all theatre and anaesthetic colleagues of the "stop before you block" process (SB4YB process), including the use of SB4YB stickers, to be supported by generation of a SB4YB Standard Operating Procedure (SOP) and audit of compliance.*
- *The Obstetric WHO Checklist to be amended to incorporate an additional question at 'sign in', asking the team if there are any swabs in situ from Labour Suite before the case starts.*
- *A review of orientation and induction procedures in all Radiology modalities to strengthen and to ensure that the revised procedures include appropriate processes for induction audit and/or routine review of ultrasound image quality and that these are in line with trust guidance and equipment competencies.*
- *Critical Care to ensure the competency assessment for checking chest x-rays and online teaching module is undertaken by all new doctors within the first month, signed off and documented by a designated supervisor Critical Care consultant.*
- *Gynaecology review of systems for booking invasive procedures, to incorporate clinician involvement in such bookings.*

Slips/Trips/Falls with harm

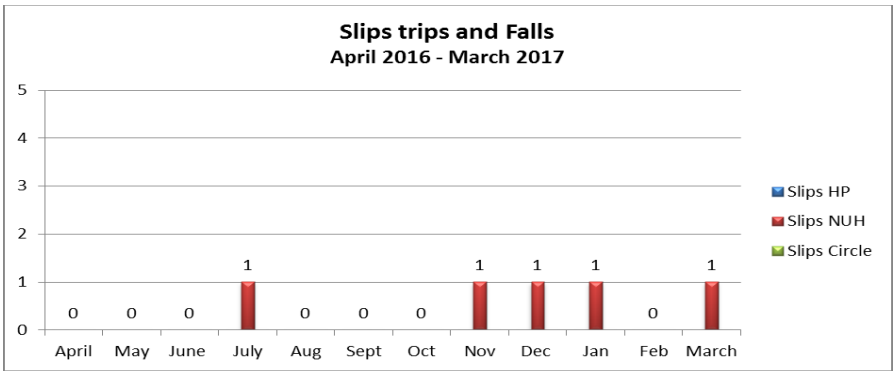
NHS England (North Midlands) data shows that **28** Slips/Trips/Falls (causing severe harm or death) were reported in Nottinghamshire during 2016/17.

Providers where one of the South Nottinghamshire CCGs are co-ordinating commissioners - Slips/trips/falls

2016/17	2015/16	2014/15	2013/14	2012/13
NUH 5 ↓	NUH 16	NUH 75, LP 0, Circle 0	NUH 51, LP 0	NUH 49, LP 0

5 Slips/trips/falls SIs were reported in 2016/17 and attributable to NUH. This is a further decrease on 2015/16 and previous years. Three of the incidents were classed as 'deaths attributed from an inpatient fall' (fractured neck of femur, intracranial haemorrhage and subarachnoid and subdural haemorrhages).

LP has had no fall-related SIs since April 2012. Lings Bar Hospital has a robust patient assessment and monitoring system from admission. One of NHCFT ambitions for 2017/18 is '*no falls causing severe harm or death and a 50% reduction in overall severity of harm'.*



Main categories of injury caused by falls at NUH, 2016-17

2016/17	2015/16	2014/15	2013/14	
3		2	3	Death related falls
	2	18	3	Neck of femur/femur related
		1	1	Fractured Fibula
			1	Fractured tubercle
		2	1	Fractured distal radius
	1	1	1	Fractured elbow
	3	21	18	Fractured hip
		1	2	Fractured humerus
		3	3	Fractured shoulder
		1	1	Fractured thumb/hand
		1		Fractured knee
		2		Fractured ankle
	1	2		Fracture to Pubic ramus/pelvis
		1	3	Fractured ribs
2	8	16	7	Skull//face/head bleed related
		2	4	Fractured wrist
			1	Big toe injury
			2	Periprosthetic fracture
	1	1		Fracture of T11 T12 of spine/lumbar fracture
5	16	75	51	**Total**

NUH Falls *(data provided by NUH)*

NUH target for 2017/18 (as expressed by a rate per 1000 bed days)

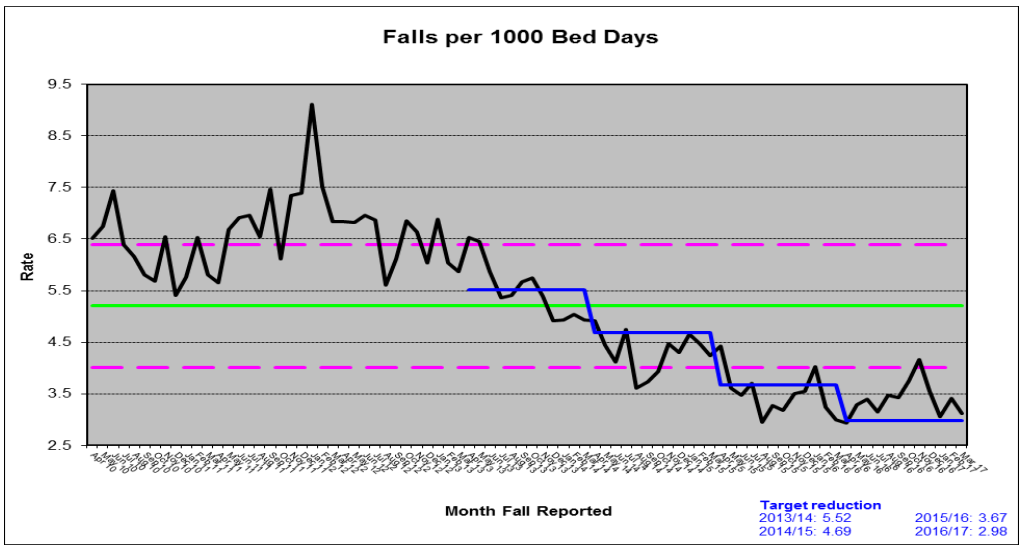
Summary – Performance against targets 2016/2017:

Achievement (vs target) All Falls for 2016/2017	=	3.39 (-3.14%)
Target for 2017/2018	=	2.88 (-15%)
Achievement Average (vs target) Rate Harmful Falls 2016/2017	=	1.06 (-7.8%)
Target for 2017/2018	=	0.90 (-15%)
Achievement Average (vs target) Ratio Falls per Faller for 2016/2017	=	1.23 (-5.4%)
Target for 2017/2018 (Falls/Faller)	=	1.05 (-15%)

NUH contributed to the First National Audit of Falls in Hospitals in March and April 2015. The national average rate of inpatient falls was found to be 6.63/1000 OBDs (NUH rate 2014/15 was 4.42 – one third lower than the national average). Similar rates for falls associated with at least moderate harm were 0.19/1000 OBDs nationally and 0.12/1000 OBDs in NUH (37% lower in NUH). NUH have further reduced the rate of adult inpatient falls however the pace of improvement has slowed in the last 2 years and are reporting improvements below the set targets.

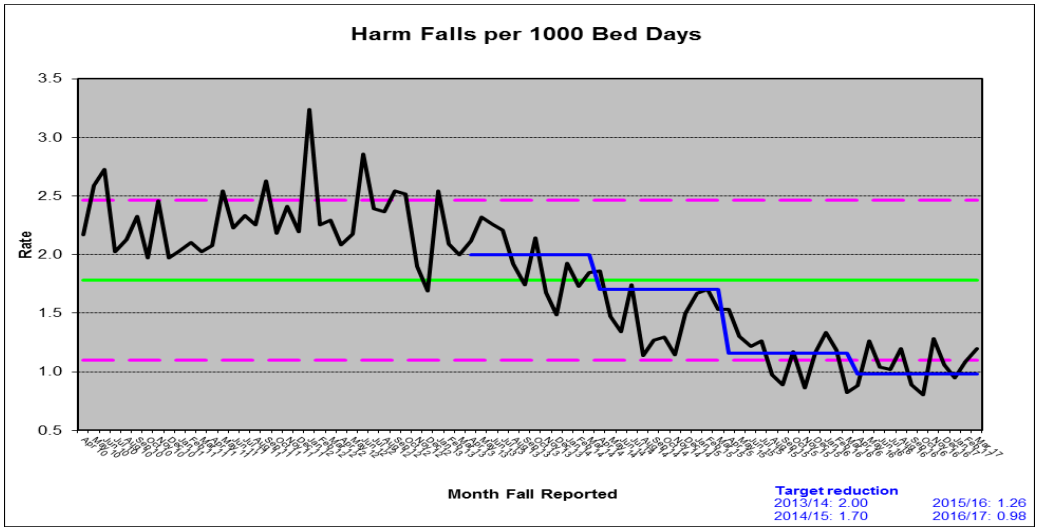
NUH has recorded 93 fewer falls in 2016/17 and 59 fewer falls associated with harm than were documented in 2015/16. There has been no significant reduction in the number of patients incurring severe head injuries and fractures as a result of a fall over the course of the past year. There have been 3 deaths in the first three months of 2017 occurring in association with falls.

Inpatient fall rates per 1000 bed days (April 2001 – March 2017)



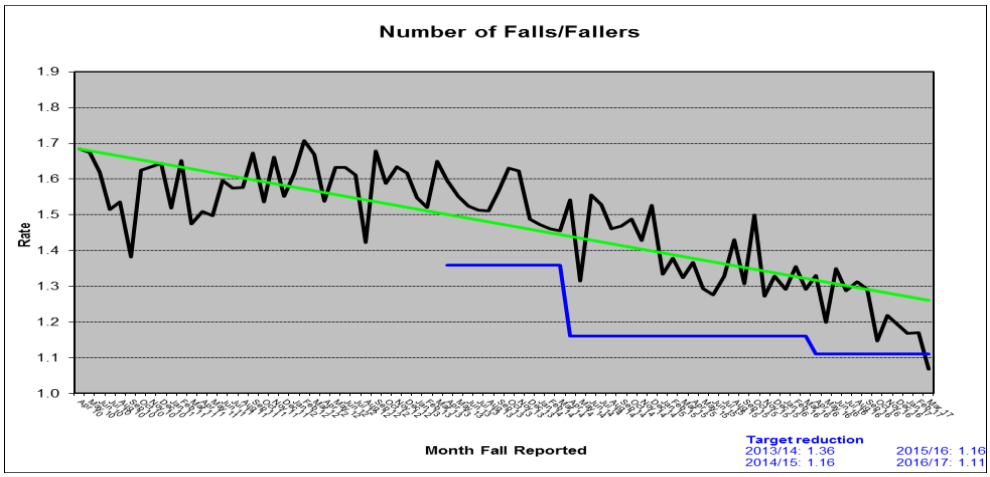
Year on Year Summary: 2010/2011 Average All Falls/1000 OBDs = 6.23 2011/2012 Average All Falls/1000 OBDs = 7.04 2012/2013 Average All Falls /1000 OBDs = 6.46 2013/2014 Average All Falls /1000 OBDs = 5.52 2014/2015 Average All Falls /1000 OBDs = 4.31 2015/2016 Average All Falls /1000 OBDs = 3.50 (-18.8%) 2016/2017 Average All falls/1000 OBDs = 3.39 (-3.14%)	**Target for 2017/2018 = 2.88 (-15%)** **Q1 Apr – Jun 2016 (Average All Falls) = 3.21 (-8.3%)** **Q2 Jul – Sep 2016 (Average All Falls) = 3.37 (-3.7%)** **Q3 Oct – Dec 2016 (Average All Falls = 3.83 (+9.4%)** **Q4 Jan – Mar 17 (Average All Falls) = 3.19 (-8.9%)**

Falls associated with harm – per 1000 bed days (April 2010 – March 2017)



Year on Year Summary 2010/2011 Average Rate Harmful Falls/1000OBDs = 2.21 2011/2012 Average Rate Harmful Falls/1000OBDs = 2.39 2012/2013 Average Rate Harmful Falls/1000OBDs = 2.26 2013/2014 Average Rate Harmful Falls/1000OBDs = 2.00 2014/2015 Average Rate Harmful Falls/1000OBDs = 1.48 2015/2016 Average Rate Harmful Falls/1000OBDs = 1.15 (-22.3%) 2016/2017 Average Rate Harmful Falls/1000OBDs = 1.06 (-7.8%)	**Target for 2016/2017** Average Rate Harmful Falls **= 0.98 (-15%)** **Q1 Apr – Jun 2016 (Average Harm Falls)** /1000OBDs **= 1.05 (-8.7%)** **Q2 Jul – Sep 2016 (Average Harm Falls)** /1000OBDs **= 1.04 (-9.6%)** **Q3 Oct – Dec 2016 (Average Harm Falls)** /1000OBDs **= 1.12 (-2.6%)** **Q4 Jan – Mar 2017 (Average Harm Falls)** /1000OBDs **= 1.08 (-6.1%)**

Repeat fallers - Ratio of Falls to Fallers April 2010 - Mar 2017



Year on Year Summary 2010/2011 Average Ratio Falls per Faller = 1.62 2011/2012 Average Ratio Falls per Faller = 1.56 2012/2013 Average Ratio Falls per Faller = 1.50 2013/2014 Average Ratio Falls per Faller = 1.36 2014/2015 Average Ratio Falls per Faller = 1.38 2015/2016 Average Ratio Falls per Faller = 1.30 (-5.8%) 2016/2017 Average Ratio Falls per Faller = 1.23 (-5.4%)	**Target for 2016/2017 (Falls/Faller) = 1.11 (-15%)** **Q1 Apr – Jun 2016 (Average Ratio Falls per Faller) = 1.24 (-4.6%)** **Q2 Jul – Sep 2016 (Average Ratio Falls per Faller) = 1.30 (-0.0%)** **Q3 Oct – Dec 2016 (Average Ratio Falls per Faller) = 1.16 (-10.8%)** **Q4 Jan – Mar 2017 (Average Ratio Falls per Faller) = 1.14 (-12.3%)**

Key factors which lie at the root cause of injurious inpatient falls

Keyword/Root Cause	% of RCAs citing keyword*
Supervision	44
Delirium	28
Toileting	25
Orthostatic Hypotension	14
Environment	11
Communication	8
Medication	6
Unavoidable	6
Workload	3
Manual handling error	3

*Up to 3 keywords are identified for each incident.

NUH report that '*There is evidence that our provision of enhanced levels of care through cohort nursing and close (arm's length) supervision is waning. There are clear increases in the numbers of unwitnessed falls occurring in areas which should be subject to close observation (i.e. cohort bays and under the provision of 1:1 supervision. The deduction might be that we are not, in fact, delivering better supervision for those patients at highest risk of falling'.*

Learning/key interventions to further reduce falls and repeat falls

- Effective prevention and management of delirium
- Delivery of effective one-to-one or cohort nursing for high-risk patients
- Proactive instigation of toileting regimens where appropriate
- More appropriate use of ultra-low beds
- Effective delivery of RCA action plans at the clinical front line
- Better knowledge management - i.e. database with cross-referencing between characteristics of falls events and actions implemented
- Integration with other safety themes including infection control and pressure ulcer management
- In the coming year (2017/2018) NUH will begin the process of bringing greater detail to the underlying problems leading to repeat falls. They will commission and scrutinise an RCA in all cases of repeat falls. They will refine the Falls Prevention Algorithm and the associated Falls Prevention Care Checklists
- The RCA template/process has been shortened and greater emphasis is now placed upon key themes. The time released will permit the development of "Assurance Assessment Visits". These supportive interventions have worked well in helping to reduce the harm accruing from pressure ulcers. The strategy will be to provide advice and guidance in the better prevention of falls through direct observation of care and the ward environment
- The RCA threshold for head injuries has been refined to encompass only those events associated with evidence of significant brain injury (drop in Glasgow Coma Score and need for CT brain scan).

Key mainstays of the Improvement Strategy:

- Effective management of delirium
- Delivery of effective one-to-one or cohort nursing for patients at highest fall-risk
- Proactive instigation of toileting regimens where appropriate
- Reducing repeat falls

For 2017/18, NUH will focus on the education and training of Falls Champions to act as agents of change within their own clinical teams.

Unclassified Serious Incidents

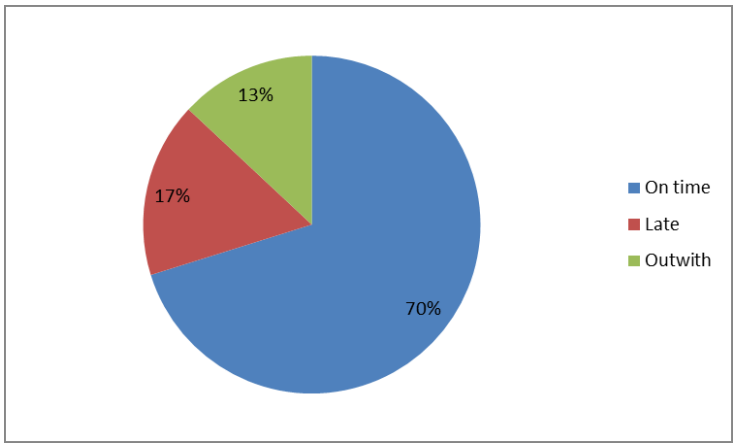
25 unclassified incidents were reported. 8 of these met the criteria for a Never Event (reported on page 20). Of the remaining 17, 12 were attributed to NUH and 5 to LP. The key categories and learning for unclassified SIs were as follows:

- *Failure of follow up/delay in treatment* – learning around administrative/staff processes (human error) and ordering of procedures (electronic systems) in addition to strengthening of communication and safety netting.
- *Patient identity checks*– learning related to strengthening staff checks and use of electronic systems.
- *Failure to rescue/recognise deterioration and escalation* – learning around recognising deterioration, communication between staff/handovers and appropriate escalation and care. Availability of MRI scan.
- *Changes to IT systems* – learning relating to strengthening clinical engagement in IT changes and checking post change for impact.
- *Abuse of a child* – learning around strengthening multi-agency communication and safeguarding supervision
- *Suicide* – learning around holistic and risk assessment of patient and environment
- *Confidential information leak* – learning around use and storage of paper notebooks and electronic information

5. Analysis of CCG monitoring of Serious Incidents

The SI Framework sets a 60 day timescale for providers to submit RCAs to the South Nottinghamshire CCG Quality and Patient Safety team. Where providers are unable to meet this deadline, an extension request must be submitted prior to the due date for approval by the Deputy Director of Nursing and Quality. Extensions are permitted up to a maximum of 20 working days.

A total of **161** RCAs were received from providers:



21 of the RCAs (13.04%) were Healthcare Acquired Infection related. These were reviewed separately by the IPC team, are marked as outwith and therefore not included in the following figures:

140 RCAs (86.95%) were received by the Quality and Patient Safety Team to review:

- There has been a 10% increase in late RCAs compared to 2015/16 – this is mainly due to the increase in maternity SI reporting
- Of the 140 RCAs received, 27 were classed as late as they 'exceeded the original 60 day timescale'.
- Of the 27 received late, 25 had applied for and been approved extensions. The majority of these were maternity-related (13) followed by pressure ulcers (6).
- At the time of this report, 60 RCAs had been subject to further confirm and challenge before CCG closure. 6 of these were Never Events. The main categories for confirm and challenge are PU and maternity related.

Breakdown of extensions requests by provider:

	LP	NUH
Late:	**6**	**21**
With extensions requested	6	19
With no extension requested	0	2

Of the 2 NUH RCAs that were late and no extension requested, the maximum number of days over timescale was 7 days.

Extension reasons:

4	Need to gain further information as part of investigation
10	Case requires further consultant review/MDT or Senior Team involvement
3	Maternity SI escalated to a comprehensive status thus panel needed
2	Delay in process due to national cyber attack
3	Key staff unavailable due to sick leave/annual leave/staff shortage
1	Liaison with East Midland Ambulance Service required
2	Skill mix issue

6. Quality visits

Responsive Quality visits

During 2016/17 there were 6 responsive quality visits to providers as a consequence of concerns raised or to follow up on actions related to learning from SIs. The table below indicates any responsive visits which were undertaken (excluding other routine planned visits which have taken place during the year).

CIRCLE, NOTTINGHAM			
Date	**Area**	**Reason for Visit**	**Outcome**
29.06.16	IPC - Unannounced	Seek assurance on IPC standards.	Staff welcoming and helpful. Very positive visit, assurance of IPC standards provided.
HEALTH PARTNERSHIPS			
Date	**Area**	**Reason for Visit**	**Outcome**
03.05.16	Safeguarding	To understand safeguarding arrangements due to soft intelligence and CQC verbal feedback in relation to capacity within the safeguarding team	Team appeared to have high level of knowledge and skills however had been stretched to capacity over recent years. Issues with newly qualified staff for children's services not receiving 1-1 and group supervision. Concern that safeguarding

			audits and quality monitoring systems may not be effectively identifying gaps. Further clarity of the Safeguarding Link role is required and how this will be embedded. Recommendations given.
22.09.2016	Newark Health Centre	A quality visit undertaken in March 2016 highlighted concerns relating to staffing levels, clinical leadership, and staff morale. This was a follow up visit to enable the provider to share with the CCG's the changes that have been made to address the concerns previously identified.	Evidence of a hardworking and committed workforce that was embracing the recent additions to the clinical leadership of the team following an extended period with insufficient senior clinical staff (qualified District Nurses). Senior managers agreed the existing caseloads remain too large and requires further cleansing.
NOTTINGHAM UNIVERSITY HOSPITALS			
Date	**Area**	**Reason for Visit**	**Outcome**
19.5.2016	E15, A23, E12 Kitchen - QMC	Unannounced visit to follow up on environmental cleanliness concerns	Good assurance of sustained actions to ensure environmental cleanliness and IPC practice.
13.06.2016	Seacole, Newell, Winifred 2 wards – City	Announced visit to follow up on environmental cleanliness concerns.	Joint visit by NHSI and CCG which indicated lack of sustained improvements in environmental cleanliness and IPC practice. Poor assurance and NUH providing response. For ongoing monitoring.
20.9.2016	QMC and City Hospitals	NHSI, PH England and the CCG visited both the QMC and City Hospital on 20 September 2016 to follow up on environmental cleanliness concerns'. Findings were mixed:- • Excellent examples of how ward staff had taken on board the findings from previous visits • Concerns remained regarding cleanliness, waste and linen which are the responsibility of estates and facilities • Assured the Board were addressing the issues identified.	Trust had implemented a daily afternoon walk round on each ward an input standards of cleanliness against a 15 point checklist for cleaning via an app on a smart phone / tablet. This is a short term measure. A fully qualified external assessor will be in place by November 2016 and will lead on reporting to Trust Board. Regular communications to all staff regarding the situation, also celebrate the good. Try to keep staff positive and engaged as well as aware of the importance.

7. Reporting and sharing the learning

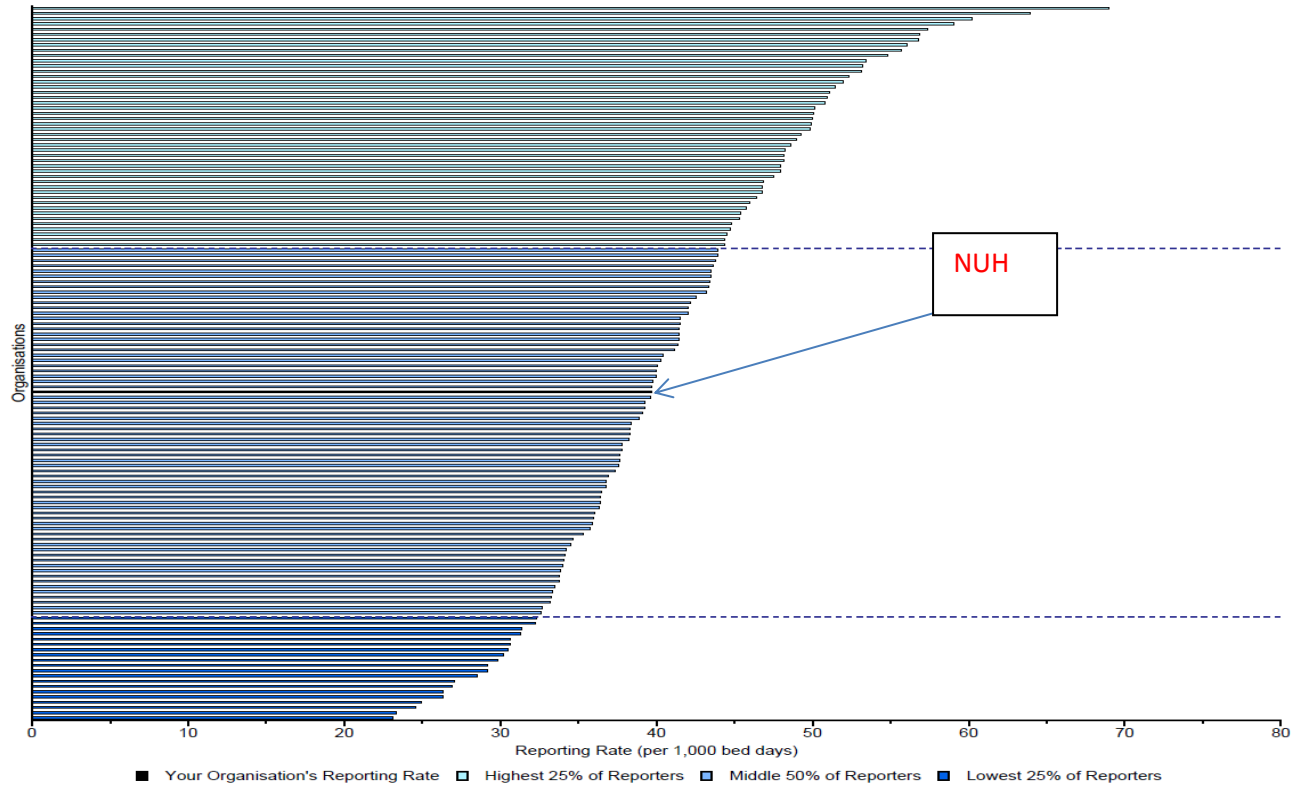
National Reporting and Learning System data highlights:

The comparative reporting rate summary provides an overview of incidents reported by NHS organisations to the National Reporting and Learning System (NRLS) occurring between 1 October 2016 and 31 March 2017. NUH reported 10,199 incidents (rate of 39.66 per 1000 bed days) during this period. This indicates that NUH have a relatively healthy mature reporting culture.

Organisational Safety Report 1/10/2016 – 31/3/2017 (NRLS)

The comparative reporting rate summary shown below provides an overview of incidents reported by NHS organisations to the National Reporting and Learning System (NRLS) occurring between 1st October 2016 and 31st March 2017. Your organisation reported 10,199 incidents (rate of 39.66) during this period.

Figure 1: Comparative reporting rate, per 1,000 bed days, for 136 Acute (non-specialist) organisations.



The median reporting rate for this cluster is 40.14 incidents per 1,000 bed days.

Sharing the learning

The three south Nottinghamshire CCGs continue to strive for a reduction in patient harm through the sharing of key learning and recommendations with associate commissioners and other NHS organisations via:

- Quality Scrutiny Groups for LP/NUH/Circle/Nottingham Woodthorpe and BMI The Park hospitals
- Quality Surveillance Group/NHS England (North Midlands)
- NHS England Serious Incident Network
- Patient Safety Collaborative (East Midlands Academic Health Science Network)
- Quality visit reports
- Quality dashboards
- Quality and Risk Committee
- Commissioning for Quality and Innovation (CQUIN) review meetings

- Nottinghamshire-wide HCAI group
- Quality monitoring visits/information sharing with Nottinghamshire Adult Safeguarding Leads/ South CCG Care Home Subgroup
- Nottinghamshire Nursing Cabinet
- The Quality and Patient Safety 'Quality Counts' Newsletter
- The South Nottinghamshire CCGs' quarterly Quality report
- Primary Care Quality Groups in each South Nottinghamshire CCG
- Protected Learning Time Events

8. Commissioner aims and objectives for Patient Safety and Quality for 2017/18

- Continue developing collaborative approaches to sharing learning from SIs across CCGs, Regulators and providers.
- Maintain Commissioner oversight of quality and safety of providers, during a period of change for CCGs, regulators and providers.
- Sustain oversight of and continue to develop measures for primary care around quality assurance
- Strengthen the process for serious incident reporting and investigation for Care Homes and Home Care

9. Conclusion

Robust incident reporting and investigation processes allied with an open, honest and mature learning culture remain an important component of delivering safe health care and improving outcomes. Commissioners play a vital role in ensuring that organisations have these processes in place and that learning as a result of adverse incidents is identified and embedded in practice.

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.

10. Recommendation

The Quality and Risk Committee is asked to review and take assurance from the Serious Incident Annual Report 2016/17.

Liz Gundel
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Quality and Patient Safety Team - NNE, NW and Rushcliffe CCGs
October 2017