Health and Social Care Board

Public Health Agency

Learning Report

Serious Adverse Incidents

October 2011 – March 2012

March 2012

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SECTION 1

1.0 INTRODUCTION

An adverse incident is defined as, any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation,[1] arising during the course of the business of an HSC organisation / Special Agency or commissioned service. Appendix A of this report sets out the criteria of a Serious Adverse Incident (SAI).

These incidents occur in all health systems and can be the result of system failures, human error, intentional damaging act, rare complications or other causes.

An organisation with a culture of safety will not only report these incidents but will have a process in place by which learning from these incidents is shared both locally and regionally.

This report identifies key regional learning, action taken and proposed arising from SAI's reported during the period up to March 2012.

The aim is to improve the care and treatment of patients and clients, to improve safety and ensure respectful management of the incident.

2.0 BACKGROUND

Responsibility for management of SAI reporting transferred from the DHSSPS (Department) to the Health and Social Care Board (HSCB) working in partnership with the Public Health Agency (PHA), with effect from 1 May 2010.

In April 2010, following consultation with key stakeholders, the HSCB issued the procedure for the 'Reporting and Follow up of Serious Adverse Incidents' for full implementation on 1 May 2010. The procedure sets out the arrangements for reporting, managing, investigating and reviewing of all SAIs occurring during the course of business of an HSC organisation, Special Agency or commissioned service. It also sets out the arrangements of how SAI's are managed within Primary Care Services in conjunction with the adverse incident system in place within the HSCB Integrated Care Directorate.

The procedure details arrangements for internal management of SAI's by HSCB and PHA staff, supported by an additional internal protocol in relation to the nomination and role of a HSCB/PHA Designated Review Officer (DRO).

[1] Source: DHSSPS How to classify adverse incidents and risk guidance 2006
www.dhsspsni.gov.uk/ph_how_to_classify_adverse_incidents_and_risk_-_guidance.pdf

3.0 MANAGING SERIOUS ADVERSE INCIDENTS REPORTED

The arrangements for managing SAIs reported to the HSCB/PHA include:

- Regional reporting system to the HSCB for all SAIs.
- The nomination of a DRO to review and scrutinise reports.
- Regional SAI Group meeting held on a bi-monthly basis to consider reports, identify learning and agree actions.
- Escalation if required in respect of:
  - timescales for receipt of SAI and Investigation reports
  - assurances for action being taken forward by reporting organisations following the investigation.

In addition, the HSCB Senior Management Team receives and considers all SAI's on a weekly basis.

4.0 SAIS REPORTED DURING PERIOD OCTOBER 2011 – MARCH 2012

During the period 1 October 2011 to 31 March 2012, the HSCB received 144 SAIs. This represents a decrease on the previous six months (April - September 2011) when 145 SAIs were reported to HSCB. A breakdown of these SAI's by reporting organisation and programme of care is detailed at Appendix B.

4.1. PROGRAMMES OF CARE

SAI's are categorised by Programmes of Care as follows:

- Mental Health
- Acute Services
- Family and Child Care
- Learning Disability
- Corporate Business / other
- Maternity and Child Health
- Primary Health and Adult Community (Including General Practice)
- Elderly
- Physical Disability and Sensory Impairment
- Health Promotion and Disease Prevention

5.0 DE-ESCALATION OF A SAI

HSC organisations/Special Agencies or Commissioned Service Providers are encouraged to report SAI's, however, it is recognised that SAI reports can be based on limited information at the time of reporting and on further investigation the situation may change.

This can result in the incident no longer meeting the criteria of an SAI. In such instances a request can be submitted by the reporting organisation to de-escalate the

SAI. The decision to approve de-Escalation of a SAI is made by the HSCB/PHA Designated Review Officer

During the reporting period fourteen (14) SAI notifications received were de-escalated.

SECTION 2

1.0 LEARNING FROM SERIOUS ADVERSE INCIDENTS

The purpose of any adverse incident reporting system is to improve patient safety. A key aim of the SAI reporting and learning process is to reduce the risk of recurrence, both within the reporting organisation and across the HSC as a whole. The dissemination of learning following a SAI is core to achieving this and to ensure these lessons are embedded in practice and the quality of care provided.

The Regional SAI Group has a role in meaningful analysis, identifying learning across organisations, making recommendations for change and informing the development of solutions.

Learning opportunities can be identified in a number of ways:

- Through individual investigations and Root Cause Analysis (RCA)
- Aggregation of similar incidents over time identifying common themes and trends.
- Systematic reviews of areas of concern.

When learning is identified, both providers and the Regional SAI Group have a role in identifying actions which will make changes to practice through, for example, prioritisation, training or dissemination of information and in implementing and sustaining these changes in practice.

The Regional Group may also decide to commission specific thematic reviews of Serious Incidents to identify trends and patterns across commissioned provider organisations and ensure wider implications and key learning points are disseminated across the HSC.

In taking forward this work, the Regional SAI Group recognises that there are many barriers to learning as identified in 'An Organisation with a Memory'.[2]

- An undue focus on the immediate event rather than on the root cause of problems
- A tendency towards scapegoating and finding individuals to blame rather than acknowledging and addressing deep rooted organisational problems
- Lack of corporate responsibility
- Organisational culture

In meeting its objectives the Regional SAI Group will be exploring new methods of learning to maximise the impact on patient safety.

[2] An Organisation with a memory (2000) Department of Health England.

2.0 DISSEMINATION OF LEARNING INITIATIVES

These current initiatives were identified as part of the SAI review process and relate to both learning from trends, reviews and individuals cases. Some of these initiatives may relate to learning identified and reported in the previous report as part of ongoing work.

2.1. PHYSIOLOGICAL EARLY WARNING SCORES

Physiological Early Warning Scores (PEWS) is a guide used mainly by nursing and medical staff to quickly determine the degree of illness of a patient. Early identification of clinical deterioration is important in preventing subsequent cardiopulmonary arrest and to reduce mortality.

An analysis of SAIs reported to the HSCB/PHA identified that a number of incidents were, as a result of deterioration, not recognised or acted upon. In particular the analysis confirmed that consistently and effectively detecting and acting upon patient deterioration is a complex issue. A series of points where the PEWS process can fail were identified, including not taking and recording observations, not recognising early signs of deterioration, not communicating observations of concern and not responding appropriately.

To address these issues the PHA in partnership with DHSSPS held a multidisciplinary learning event (held on 28 March 2012). The objective of the workshop was to examine the variation in PEWS charts and calculations throughout the Region, and to work collectively to develop a structured system that will endeavour to reduce variances, support reliable scoring and improve structured escalation.

The event was attended by the Chief Medical Officer, Trust Chief Executives, Directors and Senior Nursing and Medical staff throughout the region. A number of expert speakers were invited to lead the event and work with participants to agree a plan of action to address design and implementation issues from a Regional perspective. A Regional action plan and its implementation will be led by the lead Nurse (Safety and Quality) within the Public Health Agency and includes Senior Clinical professionals from the five HSC Trusts and CCANI. A steering group comprising PHA leads, DHSSPS, GAIN and CCANI will oversee the action plans and monitor progress against agreed timescales.

2.2. CHEST DRAINS INSERTION

Following receipt of a SAI relating to risks associated to chest drain insertion, the Safety Alerts Team, chaired by Director of Public Health through the Chief Executive, HSCB requested all Trusts to provide up to date positions regarding implementation of the National Patient Safety Agency (NPSA) Alert – Rapid Response Report 3: Risks of Chest Drain Insertion (DHSSPS Circular ref: HSC (SQSD) 44/2008.

The circular was issued in 2008, by the DHSSPS in response to a number of incidents notified to the NPSA.

The HSC Policy Collaborative is leading specific work aimed at harmonising individual Trust guidelines in respect of chest drain insertion. The work is due to be completed in June 2012.

In May 2012, all Trusts submitted progress reports in response to the Chief Executives letter. In summary Trusts are making good progress with implementing the recommendations outlined in the Rapid Response Report and re-stated in the Chief Executives correspondence.

The recommendations include:

- Chest drains to be inserted by staff with relevant competencies and adequate supervision:
- Ultrasound guidance is strongly advised when inserting a drain for fluid
- Clinical guidelines to be followed and staff made aware of risk;
- A lead to be identified for training of all staff involved in chest drain insertion;
- Written evidence of consent to be obtained from patients before procedure, wherever possible
- Local incident data relating to chest drains to be reviewed and staff encouraged to report further incidents

Trusts responded providing up to date positions in respect of each of the recommendations and included copies of their respective polices/procedures and protocols where available. Where Trusts indicated that recommendations were not implemented in full, details of issues preventing full implementation and the process in place/timescales for resolving these issues were obtained.

All responses and supporting documentation was reviewed by the Regional Safety Alerts Team.

2.3. ADMINISTRATION OF CONTROLLED DRUGS

As a result of SAIs reported in relation to the safe storage and administration of Controlled drugs (CDs) within secondary care, the Regional SAI Group requested RQIA to give consideration to including the "management of controlled drugs" into their planned three year review programme for the period 2012-2015.

2.4. ADVERSE INCIDENTS IN MATERNITY SERVICES

Following the occurrence of a SAI in maternity services, Trusts were issued with a learning letter from the Director of Public Health and Acting Director of Nursing. Trusts were advised to put systems and processes in place to ensure:

- The implementation of antenatal Early Warning Scores in maternity inpatient and day obstetric units/fetal assessment unit settings. A regional approach to developing an antenatal Early Warning Scoring system is being taken forward by the HSC Safety Forum in partnership with the 5 Trusts.

- Local clinical guidelines are updated when new evidence emerges, e.g. from NICE

- Medical duty rotas for Consultants and trainee doctors re cross-referenced to ensure adequate level of expertise is available at all times, and that locum doctors who are unfamiliar with the unit are not rostered on both duty rotas during the same period.

- All day obstetric units/fetal assessment units have guidance on the appropriate management/referral pathway for women who present with neurological symptoms and that all staff working in the day Obstetric units/fetal assessment units are trained on the application of the guidelines.

2.5. PATIENTS ENROLLED IN A CLINICAL TRIAL

The occurrence of a SAI relating to a patient enrolled in a clinical trial was brought to the attention of all HSC Trusts. The SAI occurred when a patient enrolled in a Randomised Clinical Trial (RCT) suffered a fatal subdural haematoma having taken an accidental overdose of Warfarin. A joint letter from the Director of Public Health and Director of Integrated Care set out learning in the three main areas:

- Trial design and implementation of safeguards for patients
- The need to ensure adherence to Trust's policy on Warfarin reversal.
- The need to identify promptly patients who may have inadvertently taken significant overdoses of Warfarin where more aggressive reversal therapy would be indicated.

The letter highlighted specific actions required of Trusts participating in Clinical trials of any drug. These are as follows:

2.5.1. Action for Trusts: Trial planning

- Trusts should take action to ensure that information on Clinical Trials underway within the Trust is readily available for healthcare professionals assessing trial patients if they present as an emergency. This should include the name and details of the Clinical Trial and where to obtain Senior Clinical advice if necessary. This may be done by use of the Trust's intranet. The feasibility of developing methods to highlight individual patients enrolled on Clinical Trials should also be explored, such as through alerts on the PAS and NIRAES patient tracking systems.

- When agreeing to participate in a Clinical Trial, even if packaging and labelling have been approved by other regional or national bodies such as the MHRA, Trust staff should review same. Particular care is needed if the doses or presentation of drugs differ significantly from regimes in standard use in Northern Ireland. If it is thought that packaging and labelling could cause patient confusion, this should be brought to the attention of the approving body and the clinical trial sponsors who may approve amendments.

- When agreeing to participate in a Clinical Trial, Trusts should consider whether there is a need to develop a protocol to include the emergency management of patients on that trial who may be admitted to Hospital. This protocol should be readily available to medical staff who may be asked to assess the patient.

- Arrangements should be in place to have 24/7 advice from senior medical staff who are aware of, and able to provide advice on, the emergency management of patients enrolled in any Clinical Trial undertaken by the Trust.

- Trials which involve outpatients must set out clear expectations and communication mechanisms with regard to any tests or reviews of patients by their GP and how the GP should respond to any complications which may arise.

- Clinical trial staff should participate in any Trust training and education programs relevant to the medicines within a clinical trial. Where a clinical trial protocol includes strengths of non-investigational medicines that have been withdrawn from use in Northern Ireland for safety reasons, these strengths must not be used in clinical trials.

2.5.2. Action for trial investigators in Trusts

- Trial investigators must ensure education and information is provided to patients on dosing of clinical trial medication and check patients' understanding.

- Where a clinical trial protocol involves a variable dose, a written record of dosing information, checked by Medical Staff, should be issued to each individual patient which is reviewed and updated with any dose changes. A copy should be kept in the patient's records, signed by the member of staff.

- Where a clinical trial protocol involves different strengths of a medication, the verbal explanation of doses should include explicit instruction on the tablets required to make up the required dose and highlight different strengths where these are required by patients. Patient understanding of dosage regime should be confirmed and the confirmation recorded in the patient's notes. This is especially important where regimes are complicated.

- If there is an unscheduled admission of a patient enrolled on a clinical trial, which is thought to be linked to the Trial medication, their trial medication should be reconciled urgently by the relevant Research Department/Team.

2.5.3. Action for Trusts: for cascade to medical and other healthcare staff

- Medical Staff and other Healthcare Professionals asked to assess a patient in a clinical trial should actively seek information from the patient

and/or relatives about details of the trial. Trusts should also have information available with contact details for trial investigators.

- If a patient has presented at a hospital other than that running the trial, staff should contact the hospital where the trial is being run to access information and make contact with the trial team.

2.6. HEPARIN SODIUM

Measures have been put in place to monitor prescribing of heparin in primary care. Regional Guidelines for Care of Central Access Devices in children from GAIN are in final draft and will be available to Trusts to inform local policy soon.

The Regional Primary Care IT Change Advisory Group have completed work to ensure that GP clinical system suppliers are aware of the factors that contributed to this incident and that changes by suppliers are checked. A learning letter to Trusts will be issued to share the learning in relation to the following:

- Discharge planning includes timely communication with all who will contribute to the patient's ongoing care;
- Compliance with discharge medication supplies;
- Removal of brand names from policies and guidelines.

2.7. FIRE INCIDENT

RQIA Estates Team has developed a draft protocol for discussion regarding the learning from two fire related SAI incidents. Following approval this will be shared with other relevant statutory bodies such as NIFRS, HSENI and Local Councils with a view to gaining their agreement.

2.8. PSEUDOMONAS OUTBREAK

During December 2011 and January 2012, outbreaks of *Pseudomonas aeruginosa* affecting babies in the neonatal units (NNUs) of two hospitals in Northern Ireland were reported to the Public Health Agency.

On 31 January 2012 the Minister commissioned an independent review of the circumstances contributing to the occurrences of Pseudomonas infection within neonatal units across Northern Ireland led by Professor Pat Troop and an interim report was published March 2012.

This interim report made 15 recommendations and HSCB/PHA have a joint process in place to implement the recommendations relevant to HSCB/PHA. The final report of the review will be presented to the Minister in late May 2012 and will include a particular emphasis on the experiences of the families and communication between organisations.

2.9. REPORTED SUICIDES

During this period, a total of 51 SAIs were reported in relation to completed suicides. A detailed examination of these incidents was completed, particularly focusing on those SAIs where individual was known to mental health services. The data relating to Northern Ireland was compared with the data available across the U.K.

The purpose of this work, which was completed in February 2012 by the lead mental health commissioning nurse, was to identify the number of individuals who were in contact with Mental Health Services in Northern Ireland who died by suicide and compare those numbers with recorded deaths by completed suicide in the general population. The information was compared with similar data from England, Scotland and Wales.

The report examined those SAIs reported during the period April 2011 – January 2012 (10 SAIs). Some of key findings arising from this examination include:

- 13% of patients were in contact with services 24 hours before death
- 21% of patients were non compliant with medication in the month before death
- 10% of patients were psychiatric inpatients at the time of death
- 30% of patients died within three months of discharge from inpatient care

The key difference between the patient profile in Northern Ireland and other UK countries was in relation to those individuals under 25 years. Whilst Northern Ireland data indicates that a lower percentage of individuals were known to mental health services (15%) than in other UK countries, a higher percentage were misusing drugs and other substances (65%) or alcohol misuse (70%) and had previously completed acts of self harm (75%)

The report findings are due to be presented to the relevant Bamford Subgroup. The data has been shared with Trusts and will form part of the action plan being taken forward from the previous mental health learning event. The Regional SAI Group believe it is essential to continually review and analyse SAIs reported in relation to completed suicides.

SECTION 3

NEXT STEPS

1.0 REVIEW OF SAIS REPORTED IN RELATION TO CARE AND TREATMENT OF OLDER PEOPLE

Following discussions at the Regional SAI Group and subsequently with the chair of the Regional Complaints Group, it has been agreed to conduct an analysis of SAIs and complaints relating to care and treatment of older people.

A group has been established within the PHA/HSCB to examine SAI's and Complaints reported within the period April 2011 – March 2012, examine any themes, patterns and trends and roll out any learning arising from the in depth analysis

The data will be compared to the findings arising from Patient Client Experience Standards work. A workshop, for all key stakeholders will be held in late 2012 to examine the learning identified and agree the next steps required to implement the learning which will improve the Safety and Quality of Care for patients within Northern Ireland. The outcomes of this work will be reported on in subsequent learning reports.

2.0 REVIEW OF THE PROCEDURE FOR REPORTING AND FOLLOW UP OF SAIS

A series of events and meetings have taken place over the past six months as part of the review of 2010 Procedure for Reporting and Follow up of SAIs. In November 2011 a workshop was held to review the current arrangements for how Designated Review Officers (DRO) from both the HSCB and PHA undertake their role; to identify any opportunities to provide further support and guidance to DROs and as a result improve the management of SAIs. In addition, a number of meetings have been held with HSC Trusts in order to identify and resolve issues which have proved problematic in relation to the current procedure.

A group of HSCB/PHA staff involved in the SAI process are currently taking forward the outcome of the above work and will prepare a draft report for circulation to the HSC for consultation within the next couple of months; with formal issue and implementation anticipated in autumn 2012.

3.0 REGIONAL ADVERSE INCIDENT AND LEARNING (RAIL) SYSTEM

The PHA working closely with the HSCB and all other HSC organisations has a responsibility to ensure the Regional Adverse Incident Learning System is successfully designed and implemented and evaluated. The aim of the project is to implement agreed proposals for an integrated system that will support a culture of learning from adverse incidents and the effective implementation of that learning across the HSC and Primary Care services.

The RAIL team is continuing to develop the Outline Business Case, due for submission in June 2012.

4.0 SAFETY ALERTS TEAM ESTABLISHED –STANDARDS AND GUIDELINES

The HSCB/PHA has recently established a Safety Quality Alerts Team who will regionally manage arrangements for the implementation and assurance of Safety Alerts and equivalent correspondence that requires a high level of assurance.

5.0 PROGRESS WITH IMPLEMENTING MENTAL HEALTH REVIEW RECOMMENDATIONS

Following a commissioned review of all SAIs relating to suicide a Workshop was held in October 2011 to agree actions in response to the regional learning identified. This Workshop was attended by lead clinicians and managers of mental health services across Northern Ireland. Expert speakers from across the UK as well as other agencies interfacing with mental health services led the discussions and action planning.

The outcome of this workshop is an action plan for improvements to services. A number of key areas of work were identified to improve systems, and processes and the quality of service to clients and their families. These include:

A Place of Safety: Identification and Clarification

It was agreed that work was required to ensure an agreed definition of a place of safety is established and its purpose understood. Appropriate provision of safe, quiet places in Emergency Departments is required. A working group has been established to take this work forward including Trusts and the PSNI so that appropriate protocols and provision are developed. Newly published GAIN Guidelines on use of Mental Health (Northern Ireland) order will be utilised.

Engaging hard to reach vulnerable high risk individuals

A scoping exercise is underway to establish the outreach practice in each Trust and identify best practice in this area. The issue of those who do not attend appointments was identified as an area for improvement. A review of Integrated Elective Assessment Protocol (IEAP) appointment systems in mental health has just been completed, and recommendations on improvement are awaited.

Telephone access for individuals who are in a crisis

A number of SAI investigations identified that clients who attempted to make contact with services by telephone received a voicemail message and later completed suicide. The mental health nursing team have developed an audit tool to assess the use and response to messages across mental health services. A pilot has just concluded and the questionnaire has been refined.

The audit has been circulated to Trust's and is to be returned by end of May 2012. The purpose of this audit is to determine the current policies and procedures in place in relation to the management of telephone answering machine messages left by service users. The plan would be to ensure the most effective practice for managing messages and ensuring prompt access for those in crisis.

GP Involvement in the SAI review process

Learning from a review of SAIs in suicide recognised the value of input from the clients' GP. It was agreed that their participation in the review process should be encouraged by accommodating their attendance at meetings. A report will be requested if they are unable to participate. This learning has been communicated regionally. It was also acknowledged that GPs will be advised and appraised on SAIs and their findings. The Bamford working group will take this forward within their care pathway work.

Single point referral for mental ill health patients

The Bamford working group will include this learning in their work on Crisis Response Home Treatment (CRHT) Care Pathway

SECTION 4

CONCLUSION

Within this reporting period, a number of learning letters were issued and learning events held. The six HSC Trusts are positively responding to the interim arrangements for disseminating and implementing change as a result of learning from SAI's. Until agreement is reached on a Regional learning system, the current arrangements enable and support regional learning arising from SAI investigations. Furthermore the arrangements facilitate engagement with HSC Trusts on SAI data analysis, and provide opportunities to collectively agree solutions to improve reporting and dissemination of lessons learned.

Over the next six months action will be taken forward to implement and develop reporting systems to further enhance safety and quality processes. Learning outcomes as a result of specific reviews will be disseminated locally, regionally and where appropriate nationally, in order to improve both safety and quality and ultimately the care and treatment of patients and clients.

APPENDIX A

DEFINITION OF AN ADVERSE INCIDENT AND SAI CRITERIA

'Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation, [3] arising during the course of the business of an HSC organisation / Special Agency or commissioned service.

The following criteria will determine whether or not an adverse incident constitutes a SAI.

SAI CRITERIA

- serious injury to, or the unexpected/unexplained death (*including suspected suicides and serious self harm*) of :
  - A service user
  - A service user known to Mental Health services (including Child and Adolescent Mental Health Services (CAMHS) or Learning Disability (LD) within the last two [4] years)
  - A staff member in the course of their work
  - A member of the public whilst visiting an HSC facility.

- Unexpected serious risk to a service user and/or staff member and/or
  - member of the public

- Unexpected or significant threat to provide service and/or maintain business
  - continuity

- Serious assault (*including homicide and sexual assaults*) by a service user
  - on other service users,
  - on staff or
  - on members of the public

  Occurring within a healthcare facility or in the community (where the service user is known to mental health services including CAMHS or LD within the last two years).

- Serious incidents of public interest or concern involving theft, fraud, information breaches or data losses.

[3] Source: DHSSPS How to classify adverse incidents and risk guidance 2006
www.dhsspsni.gov.uk/ph_how_to_classify_adverse_incidents_and_risk_-_guidance.pdf

[4] Mental Health Commission 2007 UTEC Committee Guidance

APPENDIX B

ANALYSIS OF SAI ACTIVITY OCTOBER 2011 – MARCH 2012

The HSCB has **received 144 SAIs** from across Health and Social Care (HSC) for the above period. The information[5] below has been aggregated into summary tables with commentary to prevent the identification of individuals.

Table 1 below provides an overview of all SAIs reported by organisation and includes **year on year comparison** of activity for the same **reporting period 1 October to 31 March**.

TOTAL SAI ACTIVITY	2010-11	2011-12
BHSCT	26	41
BSO	0	2
HSCB	2	1
INDEP	0	1
NHSCT	30	24
NIAS	1	0
PCARE	1	18
SEHSCT	19	15
SHSCT	31	25
WHSCT	20	17
Totals:	**130**	**144**

SAI DE-ESCALATION

SAI reports submitted can be based on limited information at the time of reporting. If on further investigation the incident does not meet the criteria of an SAI, a request can be submitted by the reporting organisation to de-escalate.

In line with the HSCB Procedure for the reporting and follow up of SAIs the reporting organisation provides information on why the incident does not warrant further investigation under the SAI process. This information is considered by the HSCB/PHA Designated Review Officer prior to approving any de-escalation. During the reporting period **14 SAI notifications** received were subsequently **de-escalated**.

TOTAL DE-ESCALATED	2010-11	2011-12
BHSCT	1	1
NHSCT	3	2
PCARE	1	8
SEHSCT	3	1
SHSCT	0	2
WHSCT	1	0
Totals:	**9**	**14**

[5] Source- HSCB DATIX Information System

SAI ANALYSIS BY PROGRAMME OF CARE

De-escalated SAI notifications have been **excluded** from the analysis in the remainder of this report.

ACUTE SERVICES

ORGANISATION	2010-11	2011-12
BHSCT	6	16
NHSCT	4	3
NIAS	1	0
SEHSCT	0	0
SHSCT	1	6
WHSCT	5	1
Totals:	17	26

Current period: Twenty-six (26) incidents relating to Acute Services were reported relating to the following categories, with less than 5 incidents being reported in any one category.

- **Categories:**
  - Slips, trips and falls
  - Diagnosis
  - Equipment failure
  - Treatment / Procedure
  - Failure to act / monitor
  - Cardiac arrest
  - Unintended injury / exposure
  - Healthcare acquired infection
  - Physical abuse, assault or violence
  - User error
  - Other

There were no major themes emerging from the SAIs. The largest group (n=4) associated with the category was 'Treatment procedure inappropriate / wrong.'

MATERNITY & CHILD HEALTH

ORGANISATION	2010-11	2011-12
BHSCT	2	1
SHSCT	1	2
WHSCT	0	2
Totals:	3	5

Current period: Five (5) SAIs relating to maternity and child health were reported.

FAMILY & CHILD CARE

ORGANISATION	2010-11	2011-12
BHSCT	2	2
NHSCT	5	3
SEHSCT	0	1
SHSCT	4	1
Totals:	11	7

Current period: Seven (7) SAIs relating to family and childcare were reported relating to the following categories, with less than 5 incidents being reported in any one category.

- **Categories:**
  - Access, admission, transfer, discharge other
  - Breach of Confidentiality
  - Absconder / missing patient
  - Physical abuse, assault or violence
  - Sexual
  - Cardiac Arrest

OLDER PEOPLE SERVICES

ORGANISATION	2010-11	2011-12
NHSCT	4	3
SHSCT	1	0
WHSCT	1	3
Totals:	6	6

Current period: Six (6) SAIs relating to older people services were reported relating to the following categories, with less than five incidents being reported in any one category.

- **Categories:**
  - Alleged abuse/assault
  - Delay / failure to monitor
  - Medication

MENTAL HEALTH

ORGANISATION	2010-11	2011-12
BHSCT	14	16
INDEP	0	1
NHSCT	12	11
SEHSCT	15	12
SHSCT	16	11
WHSCT	11	9
Totals:	**68**	**60**

Current period: Sixty (60) SAIs relating to mental health were reported.

- 51 related to suspected/attempted suicides* or unexpected deaths

The remaining nine (9) reported related to the following categories, with less than five incidents being reported in any one category.

- **Categories:**
  - Self harm
  - Violence / aggression
  - Sexual / physical abuse
  - Missing patient
  - Access, admission, transfer, discharge to/from service

**Suspected suicide – suicide (completed) whether suspected or proven. It should be noted that in the absence of knowledge of the inquest verdict, all of these cases have been classified as "suspected suicides" regardless of the circumstances in which the individual was reported to have been found.*

LEARNING DISABILITY SERVICES

ORGANISATION	2010-11	2011-12
NHSCT	1	0
SEHSCT	1	0
SHSCT	5	1
WHSCT	1	0
Totals:	**8**	**1**

Current period: One (1) SAI relating to learning disability service was reported.

PHYSICAL DISABILITY AND SENSORY IMPAIRMENT

ORGANISATION	2010-11	2011-12
SHSCT	1	0
Totals:	**1**	**0**

Current period: No reported incidents

PRIMARY HEALTH AND ADULT COMMUNITY (INCLUDING GENERAL PRACTICE)

ORGANISATION	2010-11	2011-12
BHSCT	1	0
HSCB	2	0
NHSCT	1	0
PCARE	0	10
WHSCT	0	1
Totals:	4	11

Current period: Eleven (11) SAIs relating to Primary Health and Adult Community were reported with less than five incidents being reported in any one category.

- **Categories:**
  - Controlled drugs missing / unaccounted
  - Financial Loss
  - Records missing, believed lost, damaged or stolen
  - Mismatch between patient and medicine
  - Communication failure - outside of immediate team
  - Assessment
  - Other
  - Proven, alleged or suspected theft
  - Wrong drug / medicine

CORPORATE BUSINESS

Table 7 - Corporate Business

ORGANISATION	2010-11	2011-12
BHSCT	0	3
BSO	0	2
HSCB	0	1
NHSCT	0	2
SEHSCT	0	1
SHSCT	0	1
WHSCT	1	1
Totals:	1	11

Current period: Eleven (11) SAIs relating to Corporate Business were reported with less than five incidents being reported in any one category.

- Information Governance
- Failure or overload of IT or telecommunications system
- Fire - Accidental
- Other

HEALTH PROMOTION AND DISEASE PREVENTION

ORGANISATION	2010-11	2011-12
BHSCT	0	1
SHSCT	2	1
Totals:	**2**	**2**

Current period: Two (2) SAIs relating to Health Promotion and Disease Prevention were reported.

- **Categories:**
  - Medication incorrectly stored
  - Failure to act on adverse test results or images