NHS Improvement

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By email

Dear

Request under the Freedom of Information Act 2000 (the "FOI Act")

I refer to your email of 19 December 2016 in which you requested information under the FOI Act from NHS Improvement. Since 1 April 2016, the Patient Safety functions under section 13R of the NHS Act 2006 have been exercised by the NHS Trust Development Authority, as part of the integrated organisation known as NHS Improvement.

Your request

You made the following request:

In your Reporting and Learning System for Patient Safety how many Documentation incidents were recorded in each of the last three financial years (2013/14), (2014/15) and (2015/16) where the degree of harm was recorded as "death".

I would be grateful if you could provide me with a table , giving a brief three or four sentence summary of each documentation incident that was recorded in the last two financial years (2014/15) and (2015/16).

Decision

NHS Improvement holds the information that you have requested.

The information we hold is from the National Reporting and Learning System (NRLS). By way of background, some information about the NRLS may be helpful. The primary purpose of the NRLS is to enable learning from patient safety incidents occurring in the NHS. The NRLS was established in late 2003 as a largely voluntary scheme for reporting patient safety incidents, and therefore it does not provide the definitive number of patient safety incidents occurring in the NHS.

All NHS organisations in England and Wales have been able to report to the system since 2005. In April 2010, it became mandatory for NHS organisations to report all patient safety incidents which result in severe harm or death. All patient safety incident reports submitted to the NRLS categorised as resulting in severe harm or death are individually reviewed by clinicians to make sure that we learn as much as we can from these incidents, and, if appropriate, take action at a national level.

The NRLS is a dynamic reporting system, and the number of incidents reported as occurring at any point in time may increase as more incidents are reported. Experience in other industries has shown that as an organisation's reporting culture matures, staff become more

likely to report incidents. Therefore, an increase in incident reporting should not be taken as an indication of worsening of patient safety, but rather as an increasing level of awareness of safety issues amongst healthcare professionals and a more open and transparent culture across the organisation.

In total 27 patient safety incidents were reported to the NRLS, where the incident was categorised as 'Documentation' and the outcome was reported as death by the original reporter; and occurring between 1 April 2013 and 31 March 2016 (based on the date the incident was reported to have occurred) and uploaded to the NRLS by 22 December 2016.

Table 1. Breakdown of the 27 incidents categorised as 'Documentation', by financial year of date of incident, where outcome was reported as death.

April 2013 – March 2014	April 2014 - March 2015	April 2015 - March 2016	Total
11	8	8	27

In response to part 2 of your request, Annex 1 below provides a summary of the 16 patient safety incidents reported as occurring between April 2014 and March 2016. The incident description provided is verbatim and has been redacted where this was required to ensure that no information can potentially identify those involved with the incident. Redactions are indicated by square brackets.

Review rights

If you consider that your request for information has not been properly handled or if you are otherwise dissatisfied with the outcome of your request, you can try to resolve this informally with the person who dealt with your request. If you remain dissatisfied, you may seek an internal review within NHS Improvement of the issue or the decision. A senior member of NHS Improvement's staff, who has not previously been involved with your request, will undertake that review.

If you are dissatisfied with the outcome of any internal review, you may complain to the Information Commissioner for a decision on whether your request for information has been dealt with in accordance with the FOI Act.

A request for an internal review should be submitted in writing to FOI Request Reviews, NHS Improvement, Wellington House, 133-155 Waterloo Road, London SE1 8UG or by email to nhsi.foi@nhs.net.

Publication

Please note that this letter and the attached information will shortly be published on our website. This is because information disclosed in accordance with the FOI Act is disclosed to the public at large. We will, of course, remove your personal information (e.g. your name and contact details) from the version of the letter published on our website to protect your personal information from general disclosure.

Yours sincerely,

NHS Improvement

Annex 1

This is a summary of patient safety incidents reported by the original reporter, where the incident was reported to the NRLS between April 2014 and March 2016. The incident description provided is verbatim and has been redacted to ensure that no information can potentially identify those involved with the incident. Please note any spelling errors or abbreviations are those used by the original reporter.

Incident no.	Financial Year	Description of incident type categorised as "Documentation"
1	2014/15	Doctor failed to complete documentation following review of patient when acutely unwell . Patient suffered cardiac arrest at 8am and no documentation of treatment and clinical examination for arrest team
2	2014/15	On doing my medicine and observation round , patient found unresponsive with absent breath and heart sounds , arrest call put out , CPR commenced but unsuccessful . On checking previous observations , the morning observations taken at 07:20 the oxygen saturation level was reduced at 88% , previous sats being 93%-98% , all over observations were stable . The observations taken at 16:30 by the afternoon nurse , oxygen saturation was of 80% and no BP recorded and on call doctor was not notified . .
3	2014/15	Patient brought over from A&E with no obsevations or assesments such as BM completed . When patient assesed in AMU news score of 8 , BM of 1.8 , patient SOB and looked unwell , patient arrested and eventually died .
4	2014/15	Patient admitted to ICCU with a massive pulmonary embolus . Patient originally presented with a left middle cerebral artery infarction . Family history of PE [relative]. Unable to locate VTE risk assessment . No enoxaparin given . (The omission of enoxaparin was probably on the basis of haemorrhagic risk in the context of acute stroke) . .
5	2014/15	Bleeped by SN from [ward name] to inform me that one of her patient had passed away . upon questioning soon realised that there was no DNAR form in place . immediately asked for a cardiac arrest call to be put out and both [job title] headed to the ward . On the way , a RED NEWS call was put out by the ward , called [ward name] to instruct for a cardiac arrest to be put out instead .
6	2014/15	Patient admitted with central chest pain radiating to the back and hypotensive . Had CT aorta which was reported as no dissection . however in view of high degree of suspicion , a repeat CT aorta was requested which was refused . Patient had a cardiac arrest and dies after 48 hours . Post mortem confirms aortic dissection . .
7	2014/15	Patient nursed in resus 1 did not have a DNAR . ITU Consultant found patient to be asytolic and did not commence CPR . Informed staff that patient was not breathing and was asytolic . .
8	2014/15	Patient had been admitted for Incision and Drainage procedure of abdominal wall . On [date] . Platelet count reduced , blood film showed pancytopenia and referred to Haem SpR - no malignant cells seen , no evidence of microangiopathic haemolytic anaemia

		noted . Blood film report suggested clinical team to discuss further investigations with haem SpR . Patient discharged and readmitted with symptoms of abdominal wall complications . Repeat blood film showed abnormal blood cells on [date plus 6 days] (also worsening Platelet count) film not referred to haem SpR . Patient died after massive cerebral bleed [time and date plus 8 days]. Blood film review requested on [date plus 8 days] - showed possible leukaemia as cause of bleed . .
9	2015/16	A referral from the patients GP was received on [date] 2014 and an appointment was offered to patient to attend the [name] Clinic for a Flexible Cystoscopy , Ultrasound Scan and Urine Microscopy . Patient was contacted by telephone on [date plus 3 days] to book this appointment however ; patient declined the appointment stating that [patient] did not want the procedure . [Patient] attended a routine urology clinic on [date plus two months] and was seen by Registrar to Professor [Staff Name] unfortunately at this appointment patient did not voice any complaints about haematuria and was discharged back to his GP . At this appointment , there was no record in the paper record or on the [name] system that the patient had declined an appointment to attend the [name] Clinic in May 2014 . The management of patient would have been very different and it is possible that the patients bladder cancer may have been detected and treatment started earlier . .
10	2015/16	I reviewed the patient on the [date] after he self - discharged from Dr care (who clearly informed him about the possible consequences) . [Patient] had a history of shortness of breath and a small troponin rise . [Patient] investigations showed a severe distal left main disease and moderate to severe aortic stenosis . [Patient] had no major comorbidities apart from [patient's] chronic obstructive pulmonary disease (heavy smoker / >20 cigarettes a day for more than 35 years) . [Patient] was quite fit , walking on the flat and on a hill without major limitations for at least 200 yards. I offered [patient] surgical aortic valve replacement plus coronary artery bypass quite urgently with a time scale of 2-4 / 52 . At that time [patient] digested a bit more [patient's] clinical situation and the fact that [patient] needed cardiac operation. I flagged it up to the waiting list office to have an expedite surgery . Unfortunately several cancellations affected , the following months , the regular list of urgent / elective patients . The scheduled patients have been repetitively changed and delayed due to the cancellations and I did not have further up - date . On [date plus three months] I received an email from the general ICU Consultant who gently informed me that the patient sadly died on the ICU at [hospital name] after [patient] collapsed at home with a VF (cardiac arrest) [Patient] underwent PCI to his LMS disease but [patient] went into cardiogenic shock and died .
11	2015/16	Patient attended for elective Total Parathyroidectomy (Renal patient) . Cardiac arrest on induction of anaesthetic and died . .
12	2015/16	Myself and colleague went to visit a client and couldn't gain access and was informed by neighbour that [neighbour] had not seen [person] for a few days . Noticed the curtains were drawn , then checked at the post office where [person] usually collects

		[person's] money . They hadn't seen [person] , we then asked our admin team to check if [person] had been admitted to hospital which [person] hadn't . Phoned the police who attended the address . They police gained access by force and my colleague and the policeman access the flat and found the client deceased in the bathroom .
13	2015/16	Patient had excision of malignant melanoma on [date] . Arrangements made for follow up appointment to discuss diagnosis and need for further treatment . Histology (Pathology) confirmed a 1.6 mm Breslow depth malignant melanoma surrounded by in situ disease and incompletely excised . Seen for first time after surgery by consultant a delay of over ten months . On questioning the patient revealed that several out patient appointments had been cancelled by the hospital e searcher confirmed 6 appointments had been cancelled by the hospital , five times in 2015 and once in 2016 . As a result this patient has not been offered timely treatment of a confirmed incompletely excised potentially lethal disease . .
14	2015/16	This patient had been seen by Mr [initials] in clinic for a stricture of the transverse colon . He organised a CT pneumocolon , which was performed (? exactly where) on [date] . The scan was reported 2 days later on [date plus 2 days] as a tight obstructing lesion of the transverse colon . ~ [time and date plus 3 days] Patient developed severe abdominal pain and was seen in ED resus ~[time] . Patient was profoundly septic with a rigid upper abdomen . CT revealed a perforated transverse colon proximal to the stricture . With IV antibiotics and fluid resuscitation , the patient was transferred to the acute theatre and an Ext right hemicolectomy + stoma and mucous fistula performed . There was extensive contamination and the patient deteriorated rapidly with profound sepsis . They died in recovery . .
15	2015/16	Took over from on call nurse in th 1 as patient was waiting for an ITU bed . Anaesthetist ask me to check patient pulse in the foot . Took a doppler and check patient pulses , could not find any informed the anaesthetist and call the vascular surgeon . Vascular surgeon came and decided to re open the patient . Prepare the instrument for re opening . Patient arrested on the table , one of the staff called 2222 . Resuscitate patient . Patient arrested on the table several times and chest compressions was done while operation was on going (surgeon had to stop and cover the surgical site to allow for the chest compressions) . .
16	2015/16	pt poorly handed over . NEWS score stated on handover 0 . When looking at documents actually a 4 . Obs done on transfer pt NEWS 6 . Pt previously been tracking 6 + 7 . No documentation of any previous sepsis bundle screening completed . Sepsis bundle commenced when NEWS score of 6 identified .