WRITTEN QUESTION TO THE MINISTER FOR HEALTH AND SOCIAL SERVICES
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QUESTION SUBMITTED ON MONDAY 15th FEBRUARY 2021
ANSWER TO BE TABLED ON MONDAY 22nd FEBRUARY 2021

Question

Will the Minister, in relation to incident reports generated in the Hospital and health service –

(a) advise how many such reports have been generated each year since 2017 to the present date, in each department or category; and

(b) detail the nature of the incidents reported in each of the years in paragraph (a), the frequency in which they occurred, and the lessons learned, and actions taken, in relation to them?

Answer

A safety incident is any unintended or unexpected event which could have led, or did lead, to harm. Incidents are investigated to support learning, which, in turn, helps to keep patients safe; incident reporting is actively encouraged across all health and social care settings locally, nationally and internationally.

A high level of incidents reported reflects an improved reporting culture and should not be interpreted as a decrease in the safety of the organisation. Equally, a decrease cannot be interpreted as an increase in safety.

When incidents or near misses occur in care it is vital they are recorded to ensure learning can take place. This means that people work out if anything has gone wrong and why; this way effective actions can be taken locally to help reduce risk. The intention is to protect patients from harm.

Patient safety related incident reports from NHS Trusts are uploaded from their risk management systems into a central repository, which receives over two million incident reports each year.

It is unlikely that any direct comparison with other organisations can be made in health and social care settings, such as HCS, where there are a broad range of services under one roof – care settings which include acute, mental health, social, learning disability and ambulance services. However, by way of an example, last year the Isle of Wight reported 4,400 incidents and some large acute trusts in the UK can be reporting in the region of over 10,000 incidents per year.

a) A total of 15,212 incidents were reported between January 2017 and December 2020. This number includes various affected parties (patient/client/service users, under 18s, employees, contractors, visitors and the organisation (HCS).

Below are the totals by year from 2017 to 2020. We are constantly looking to increase the reporting of incidents to improve safety through learning.

2017	2018	2019	2020
3796	4035	3613	3768

High levels of incidents reported reflects an improved reporting culture and should not be interpreted as a decrease in the safety of HCS. Equally, a decrease cannot be interpreted as an increase in safety.

b) 93% of all incidents result in low harm or no harm. All patients involved in safety events are advised of the event and the nature of any harm. For example, if the nurse gives the wrong dose of a medication this is escalated to the doctors and pharmacists for discussion and patient reviewed, if required. The patient is informed and an explanation provided as to whether this is a no harm event or has any potential side effects. This is documented in the patient record, including the conversation with the patient regarding the incident. Where possible, individual patients are involved in supporting or identifying learning.

We have over 25 categories of incidents, examples include: patient accident, such as slips, trips and falls; implementation of care and ongoing monitoring/review; medication error; access, admission, transfer, discharge (including missing patient); behaviour - violence and aggression; infection control; devices and equipment.

The categories are further broken down into a range of over 200 subcategories and hundreds of potential subgroups – for example, if the main category is an accident that may/did result in injury, this could include events such as a collision with an object; entrapment; a needle stick injury or a moving and handling accident, plus many more.

The top categories reported across HCS will vary according to the care setting because of differences in care and/or treatment provided – for example, in HCS this may range from acute hospital, maternity, social, safeguarding, mental health and learning disabilities services.

Falls / pressure ulcers / medication errors remain among the top preventable harms within acute NHS organisations and HCS has a similar profile. The economies of scale and the amalgamation of many different services under one health (physical and mental) and social care organisation can make comparisons difficult.

The data on Lessons Learned and Action Taken consists of qualitative data and can contain large amounts of narrative, therefore, due to the nature of the data and the broad date range requested, providing this full account is not practical as it would run to thousands of pages.

However, lessons from individual incidents and themes are shared at ward level and department level, across and between care groups at their monthly Quality & Safety Governance meetings. Presentations related to some incident learning are also delivered at ward/department meetings, leadership/clinical /care speciality meetings and clinical audit days. Individual teams at ward and department level have safety huddles where events are discussed and learning circulated.

The incident management data, including learning and subsequent actions, are presented by each care group at their performance review every five weeks. This data feeds into the HCS Quality & Risk Committee, which reports to the HCS Board. This forms part of our governance assurance structure that is monitored by the Senior Leadership and Ministerial teams.