

Date: 08/06/2016

FREEDOM OF INFORMATION REQUEST FOI/012789 - Serious incidents

1. How many incidents involving a failure to act upon test results were recorded in your trust in a) 2013/14, b) 2014/15 and c) 2015/16; how many of these were reported as serious incidents; and please provide a breakdown by therapeutic areas in which these failures occurred.

We do not have a specific category for 'failure to act upon test results', our closest category is 'missed abnormal test result', results for which are below:

| Year | Number of Incidents | Serious Incidents |
|-----------|---------------------|-------------------|
| 2013/2014 | 17 | 3 |
| 2014/2015 | 11 | 1 |
| 2015/2016 | 12 | 0 |

| | 2012/2014 | 2014/2015 | 2015/2016 | Tatal |
|---|-----------|-----------|-----------|-------|
| DIIII Annasthasia Taana | 2013/2014 | 2014/2015 | 2015/2016 | Total |
| RHH - Anaesthesia Team | 0 | 1 | 0 | 1 |
| RHH - Sexual Health | 1 | 0 | 0 | 1 |
| RHH - Clincal Measurements Team | 1 | 0 | 0 | 1 |
| RHH - EAU | 1 | 1 | 0 | 2 |
| RHH - Emergency Department | 0 | 0 | 2 | 2 |
| RHH - Labs, Cytology | 1 | 0 | 0 | 1 |
| RHH - Maternity (Community Midwifery) | 1 | 0 | 0 | 1 |
| RHH - Maternity (Obstetric Unit) | 1 | 2 | 0 | 3 |
| RHH - Medical Directorate Team | 0 | 0 | 1 | 1 |
| Corbett - [OP] Gynaecology | 1 | 0 | 0 | 1 |
| RHH - [OP] Gynaecology | 1 | 0 | 0 | 1 |
| RHH - [OP] Maternity (Antenatal) | 0 | 1 | 2 | 3 |
| RHH - [OP] Maternity (Pregnancy Day Assessment Unit) | 1 | 0 | 0 | 1 |
| RHH- [OP] Surgical & Plastics | 0 | 1 | 0 | 1 |
| RHH - Secretaries - Ambulatory Medicine | 1 | 0 | 0 | 1 |
| RHH - Secretaries, Women & Children | 0 | 0 | 1 | 1 |
| RHH Theatres - (Day Case) | 0 | 1 | 0 | 1 |
| RHH - Ward B1 (Orthopaedics) | 1 | 0 | 0 | 1 |
| RHH - Ward B4 (Mixed Colorectal & General Surgery) | 0 | 0 | 1 | 1 |
| RHH - Ward B5 (Female Surgery) | 2 | 0 | 0 | 2 |

| RHH - Ward C2 (Childrens Ward) | 1 | 0 | 2 | 3 |
|-----------------------------------|----|----|----|----|
| RHH - Ward C3 (Elder Care) | 1 | 0 | 0 | 1 |
| RHH - Ward C4 (Oncology ward) | 1 | 0 | 1 | 2 |
| RHH - Ward C5 (Respiratory) | 0 | 0 | 1 | 1 |
| RHH X-Ray/Imaging | 0 | 3 | 1 | 4 |
| RHH Clinical Director - Theartre, | | | | |
| Anaesthestics & Critical Care | 1 | 1 | 0 | 2 |
| Total | 17 | 11 | 12 | 40 |

2. How many incidents involving sub-optimal care of a deteriorating patient were recorded in your trust in a) 2013/14, b) 2014/15 and c) 2015/16; how many of these were reported as serious incidents; and please provide a breakdown by therapeutic areas in which these incidents occurred.

Data is not recorded in this way, we have several 'failure to monitor' categories but nothing specific to 'sub-optimal care of a deteriorating patient'.

3. How many delayed diagnoses were recorded in your trust in a) 2013/14, b) 2014/15 and c) 2015/16; how many of these were reported as serious incidents; and please provide a breakdown by therapeutic areas in which these delayed diagnoses occurred?

| Year | Number of Incidents | Serious Incidents |
|-----------|---------------------|-------------------|
| 2013/2014 | 52 | 1 |
| 2014/2015 | 67 | 0 |
| 2015/2016 | 72 | 2 |

| | 2013/2014 | 2014/2015 | 2015/2016 | Total |
|--------------------------------------|-----------|-----------|-----------|-------|
| RHH - Anticoagulation Team/DVT Suite | 0 | 1 | 0 | 1 |
| RHH - Clincal Measurements Team | 0 | 1 | 0 | 1 |
| RHH - Coronary Care Unit | 1 | 0 | 1 | 2 |
| RHH - EAU | 1 | 1 | 3 | 5 |
| RHH - Emergency Department | 9 | 6 | 6 | 21 |
| RHH - Ward C8 EMU (Elective Medical | | | | |
| Unit) | 3 | 0 | 0 | 3 |
| RHH - Endoscopy | 2 | 1 | 1 | 4 |
| RHH - Labs, Biochemistry | 1 | 0 | 0 | 1 |
| RHH - Labs, Cytology | 0 | 1 | 0 | 1 |
| RHH - Labs, Histopathology | 0 | 2 | 3 | 5 |
| RHH - Labs, Phlebotomy | 1 | 0 | 0 | 1 |
| RHH - Labs, Specimen Reception | 0 | 1 | 0 | 1 |
| RHH - Maternity (Midwifery Led Unit) | 0 | 1 | 0 | 1 |
| RHH - Maternity (Obstetric Unit) | 1 | 0 | 0 | 1 |
| RHH - Medical Directorate Team | 0 | 1 | 2 | 3 |
| RHH - Neo Natal Unit | 1 | 1 | 0 | 2 |
| Corbett - [OP] Gynaecology | 0 | 1 | 0 | 1 |
| RHH - [OP] Children's/Paediatrics | 1 | 0 | 0 | 1 |
| RHH - [OP] Eye Clinic/Ophthalmology | 0 | 1 | 0 | 1 |
| RHH - [OP] Gynaecology | 0 | 1 | 0 | 1 |
| RHH - [OP] Maternity (Antenatal) | 0 | 1 | 1 | 2 |
| RHH - [OP] Surgery | 0 | 1 | 0 | 1 |
| RHH - [OP] Urology | 0 | 0 | 1 | 1 |

| RHH - Renal Unit (Haemodialysis) | 0 | 0 | 1 | 1 |
|---|----|----|----|-----|
| RHH - Surgical Assessment Unit | 1 | 1 | 3 | 5 |
| RHH - Main Theatres | 1 | 1 | 0 | 2 |
| RHH Theatres - (Day Case) | 0 | 0 | 1 | 1 |
| RHH - Ward A3 (Elderly Care) | 1 | 0 | 0 | 1 |
| RHH - Ward A4 (Acute Stroke) | 0 | 2 | 0 | 2 |
| RHH - Ward B1 (Orthopaedics) | 0 | 1 | 0 | 1 |
| RHH - Ward B3 (Mixed Vascular & | | | | |
| General Surgery) | 1 | 2 | 4 | 7 |
| RHH - Ward B5 (Female Surgery) | 1 | 0 | 1 | 2 |
| RHH - Ward C1 (Renal) | 0 | 2 | 0 | 2 |
| RHH - Ward C2 (Childrens Ward) | 0 | 0 | 2 | 2 |
| RHH - Ward C3 (Elder Care) | 2 | 0 | 0 | 2 |
| RHH - Ward C4 (Oncology ward) | 1 | 0 | 0 | 1 |
| RHH - Ward C5 (Respiratory) | 1 | 1 | 0 | 2 |
| RHH - Ward C6 (Urology) | 0 | 0 | 2 | 2 |
| RHH - Ward C7 (GI Medicine) | 2 | 2 | 0 | 4 |
| Corbett X-Ray/Imaging | 0 | 1 | 0 | 1 |
| Guest X-Ray/Imaging - | 0 | 0 | 1 | 1 |
| RHH X-Ray/Imaging | 9 | 22 | 36 | 67 |
| RHH Clinical Director - Diagnostics | 1 | 3 | 0 | 4 |
| RHH Clinical Director - Urgent Care | 1 | 0 | 0 | 1 |
| RHH Clinical Director - Women & Childrens, Maternity, Paeds, Neonatal | 1 | 0 | 0 | 1 |
| RHH Clinical Director - Theartre, Anaesthestics & Critical Care | 0 | 1 | 1 | 2 |
| RHH Clinical Director - Orthopaedics & Specialist Surgery | 1 | 1 | 0 | 2 |
| RHH - Prescribing Team - (Ambulatory Care) | 0 | 1 | 0 | 1 |
| DN, Stourbridge (SH) | 2 | 0 | 0 | 2 |
| Community - Podiatry Team | 1 | 0 | 1 | 2 |
| RHH - Estates (PFI Partners) | 3 | 0 | 0 | 3 |
| RHH - Portering (PFI Partners) | 1 | 3 | 0 | 4 |
| Other | 0 | 1 | 0 | 1 |
| T&O Secretaries | 0 | 0 | 1 | 1 |
| Total | 52 | 67 | 72 | 191 |

4. How many surgical errors were recorded in your trust in a) 2013/14, b) 2014/15 and c) 2015/16; and how many of these were reported as serious incidents?

| Year | Number of Incidents | Serious Incidents |
|-----------|---------------------|-------------------|
| 2013/2014 | 37 | 0 |
| 2014/2015 | 21 | 0 |
| 2015/2016 | 21 | 0 |

- 5. How many incidents involving child abuse within your trust were recorded in a) 2013/14, b) 2014/15 and c) 2015/16; and how many of these were reported as serious incidents?
- 6. How many incidents involving serious injury to a child within your trust were recorded in a) 2013/14, b) 2014/15 and c) 2015/16; and how many of these were reported as serious incidents?

Questions 5 and 6 -

The Trust records incidents of suspected child abuse and concerns over injuries on it's incident reporting tool, however for the years you have requested the information is not recorded in a way that separates if this happened before the child came to hospital or if the incident occurred while the child was in hospital.

From 1/2/16 the Trust's reporting tool was updated so we can now separate this information and from 1/2/16 there were no recorded incidents of a child being abused or being seriously injured while in the Trust.