Blackwater Law

Report into Serious Incidents at NHS Trusts and Health Boards

England & Wales

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Contents

About this report

This report looks at the recorded number of Serious Incidents at NHS trusts and Welsh health boards in England and Wales. The figures were obtained through Freedom of Information Requests that were responded to by 235 of the 242 trusts and health boards. The data sets-out the number of Serious Incidents that have occurred in the years 2015-2016 and 2016-2017 and also analyses the data by type of trust or health board – namely mental health, acute health and ambulance trusts – as well as by region and type of incident most commonly recorded.

Introduction to Blackwater Law

Blackwater Law is a specialist team of expert medical negligence solicitors that represents individuals and families across England and Wales in medical negligence litigation claims.

Blackwater Law aims to provide clients with access to justice and the compensation they require to support them in dealing with their injury or illness now and into the future, as well as any potential loss of earnings where the individual's ability to work (at the same level or at all) has been affected.

The team at Blackwater Law represents clients in many serious, complex and high value cases and is recognised by The Legal 500 – an independent directory of the UK's leading law firms – as a leading medical negligence law firm acting on behalf of individuals or their families.

Responses from 235 NHS trusts and health boards

The people behind this report

Jason Brady
Partner

Jason Brady is a Partner and Head of the team of medical negligence solicitors at Blackwater Law. Jason has been practicing law in the field of medical negligence and serious injury litigation for 19 years and deals with a wide range of cases where acts or omissions on the part of healthcare providers have caused serious or life-limiting injuries or illness, and in the most serious cases, death. Jason is also a Senior Litigator Member of the Association of Personal Injury Lawyers and is recognised as a leader in his field.

"It is truly concerning to learn that the number of Serious Incidents being recorded by NHS Trusts across England and Wales stands at such a significant figure. It is crucial to remember that these are not just statistics. Each of these incidents is a patient and a family that may be suffering, potentially unnecessarily, with possible long-term implications for their future and quality of life."

To contact Jason Brady, call 0800 083 5500.

Dominic Graham
Senior Solicitor

Dominic Graham is a Senior Solicitor in the Blackwater Law team and has been practising in the field of serious injury and medical negligence for 14 years. Dominic specialises in dealing with the most complex of medical negligence cases, advising clients and their families in cases involving referral delays causing life-limiting injury and disability, misdiagnosis, negligent performance of surgical procedures and birth injuries to mothers and babies.

"From my experience advising patients and families that have suffered as a result of a Serious Incident, I know the implications for the future quality of life of the affected individual can be severe. It is therefore extremely concerning to see, for what might be the first-time, this almost complete picture of the number and type of Serious Incidents being recorded by NHS trusts across England and Wales."

To contact Dominic Graham, call 0800 083 5500.

Reasons for the research and this report

This research was undertaken to gain a better picture of the recording of Serious Incidents across NHS trusts and Welsh health boards in England and Wales.

Blackwater Law is advising an increasing number of clients and families where they have suffered serious injury, illness, disability and, in the worst cases, death, following a Serious Incident being reported during the course of their care. This trend is concerning and the team at Blackwater Law wished to gain a full picture of the number of Serious Incidents being recorded at trusts and health boards across England and Wales.

It became clear that there is no source providing a complete, or even close to complete, picture of the frequency with which Serious Incidents are being recorded at trusts and health boards across England and Wales. To gain this insight therefore, Blackwater Law had to undertake its own research. To the best knowledge of Blackwater Law this is the first time an almost complete picture of the recording of Serious Incidents at NHS trusts and Welsh health boards across England and Wales has been made publicly available in an accessible format.

A number of items have become apparent through the process.

In many instances the data from each NHS trust was produced and provided in unique form, meaning that it was a complex and time-consuming exercise to collate and garner useful information. Where an NHS trust had provided categorisation/description of the Serious Incidents it had recorded, this was often provided in different terminology and formats. It is acknowledged that a definitive list of Serious Incidents would be challenging to create given the incredibly varied circumstances that a Serious Incident may arise from and the wide range of injury and suffering such an incident may lead to. However, greater consistency in reporting amongst the NHS trusts could provide for improved learning across NHS organisations.

It is currently not known by Blackwater Law whether a complete picture of the number of Serious Incidents being recorded by NHS trusts and Welsh health boards in England and Wales is held by any NHS organisation. If it is, Blackwater Law was not able to discover this. Those interested in the research that has been undertaken and presented here may argue that it should not require a private company and many hours to collate and analyse such data and that this should be more transparently published, perhaps by an organisation such as NHS Improvement.

If such a set of data does exist, Blackwater Law believes that the public would benefit from this data being made available via a central source and in an accessible format as is the case with Patient Safety Incidents and Never Events data via the NHS Improvement website.

242 FOI requests sent

What is a Serious Incident?

Serious Incidents were previously known as Serious Untoward Incidents and are sometimes referred to by NHS trusts as Serious Incidents Requiring Investigation.

There is no specific definition of a Serious Incident or list of what comprises a Serious Incident; however NHS England's Serious Incident Framework describes Serious Incidents as set out in the excerpts below.

"Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for leaning is so great, that a heightened level of response is justified…

"Serious Incidents include 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." [1]

"Serious Incidents can be isolated, single events or multiple linked or unlinked events signalling systematic failures within a commissioning or health system." [2]

Serious Incidents requiring recording and investigation extend beyond those Serious Incidents directly impacting patients to those that indirectly impact patient safety and also include incidents impacting an organisation's ability to deliver ongoing healthcare or the public perception of an organisation's ability to deliver ongoing healthcare.

Include unexpected or avoidable harm, injury & death

1 NHS England Patient Safety Domain (27 March, 2015); *Serious Incident Framework: Supporting learning to prevent reoccurrence*, pages 7. Accessible online via: https://improvement.nhs.uk/uploads/documents/serious-incidnt-framwrk.pdf (accessed on 29th January 2018).

2 NHS England Patient Safety Domain (27 March, 2015); *Serious Incident Framework: Supporting learning to prevent reoccurrence*, pages 12. Accessible online via: https://improvement.nhs.uk/uploads/documents/serious-incidnt-framwrk.pdf (accessed on 29th January 2018).

Serious Incidents data

A picture of the Serious Incidents recorded across 228 NHS trusts & 7 Welsh health boards in England and Wales[3]

The data obtained from 235 NHS trusts and Welsh health boards in England and Wales reveals that 40,668 Serious Incidents have been recorded in the two financial years from 1st April 2015 through to 31st March 2017.

Data was unavailable for six NHS trusts for the financial year 2015/2016 and therefore has not been included within the totals shown below. Data for these NHS trusts was available for the year 2016/2017 and therefore has been included in the total for the year 2016/2017.

20,235
Serious Incidents
2015/2016

20,433
Serious Incidents
2016/2017

The number of Serious Incidents recorded by the NHS trusts and Welsh health boards is broadly similar for both periods. It is expected there would not be a material impact on the difference between the two periods were data for the six missing NHS trusts and Welsh health boards available for inclusion in the 2015/2016 data set, based on the data provided by these organisations for the 2016/2017 period.

40,668 Serious Incidents recorded

3 Any analysis of data within this report has not been endorsed by any of the NHS trusts or Welsh health boards.

Number of Serious Incidents by region

Each NHS trust and health board has been assigned to their relevant region, determined by their main location listed on the NHS Choices website[4]. It is acknowledged that a number of NHS trusts will have more than one site, which may in some instances span two regions, or have services which span multiple regions. In these instances, each NHS trust has been listed against the corresponding region based on their main address alone, as published by NHS Choices, as opposed to appearing in multiple regions.

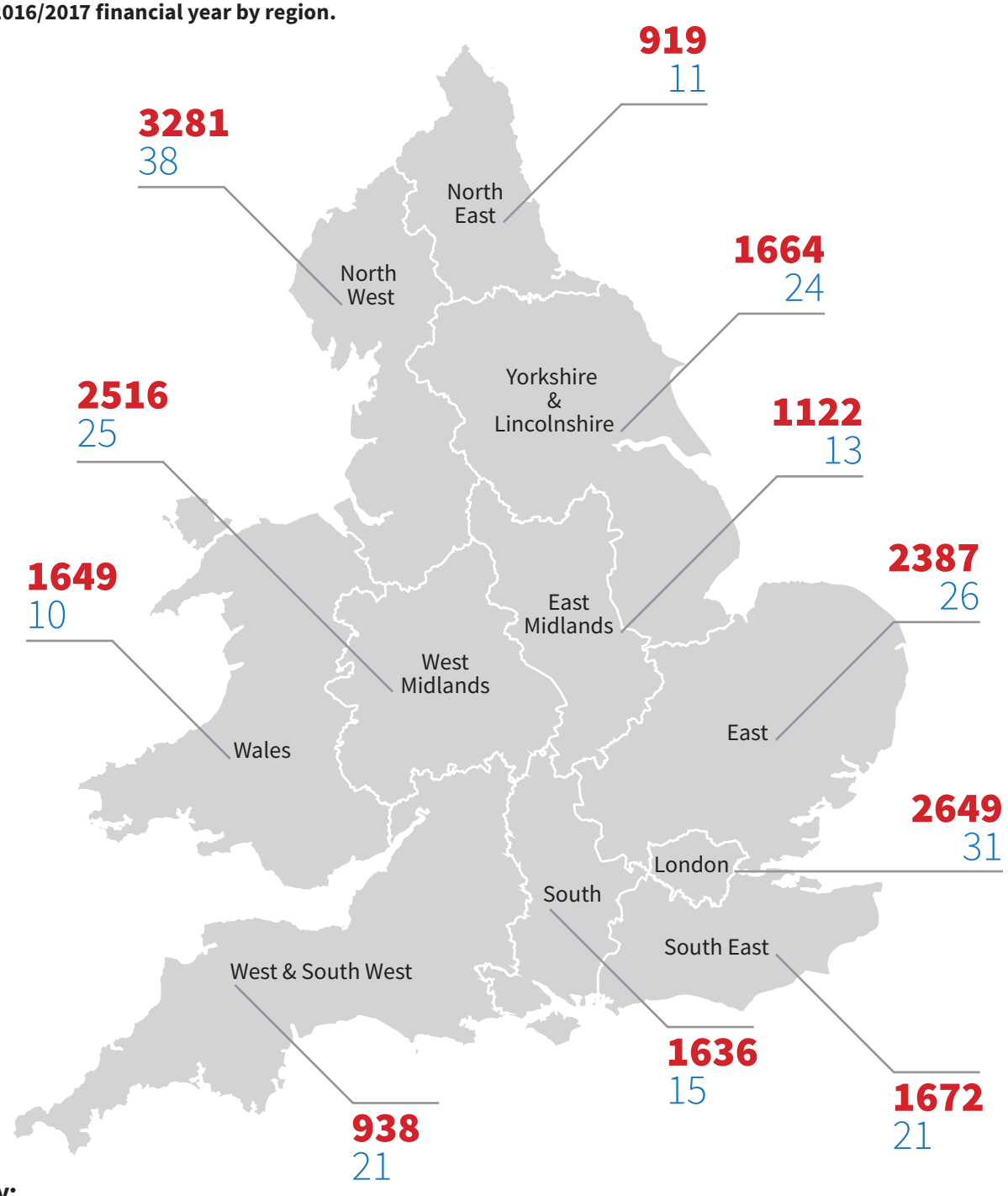
The number of trusts and health boards within each of the 11 regions ranges from 10 in Wales through to 38 in the North West[5]. Given the varying number of NHS trusts and health boards within each region, with significant differences in patient numbers and number of patient contacts, there is a vast difference in the number of Serious Incidents recorded by NHS trusts within each region. Whilst identifying the number of Serious Incidents being recorded within each region, this data alone cannot be used to determine difference in the quality of health care being delivered across regions.

Data across 11 regions

4 NHS Choices.
Accessible online via: https://www.nhs.uk/pages/home.aspx (accessed on 13th November 2017).

5 38 trusts in the North West, although two separate sets of figures and incident data have been provided by Central Manchester University Hospitals NHS Foundation Trust and University Hospital of South Manchester NHS Foundation Trust which merged on 1st October 2017 to become Manchester University Foundation Trust.

Map 1: Serious Incidents recorded by all NHS trusts and Welsh health boards in 2016/2017 financial year by region.



Key:

■ **Number of Serious Incidents recorded in 2016/2017**

■ Total number of NHS trusts and health boards in region

Blackwater Law

Data reflects the 228 NHS trusts and 7 Welsh health boards. 38 Trusts in North West region although separate data was provided for Central Manchester University Hospitals NHS Foundation Trust and University Hospital of South Manchester NHS Foundation Trust although both trusts merged on 1st October 2017 to become Manchester University NHS Foundation Trust. 26 Trusts in East region although separate data was provided by North Essex Partnership University NHS Foundation Trust and South Essex Partnership University NHS Foundation Trust which has since merged on 1st April 2017 to become Essex Partnership University NHS Foundation Trust.

Serious Incidents in NHS acute and community health trusts and Welsh health boards

Total number of Serious Incidents recorded in NHS acute and community health trusts and Welsh health boards across England and Wales

27,789 Serious Incidents have been recorded in the two financial years from 1st April 2015 through to 31st March 2017 by the 171 identified NHS acute and community trusts and Welsh health boards which granted permission for the figures to be published within this report.

The Serious Incidents recorded by NHS acute and community health trusts and Welsh health boards account for 68% of the total Serious Incidents recorded by all NHS trusts and health boards across England and Wales during the period 2016/2017.

13,755
Serious Incidents recorded in total by all acute and community health trusts
2015/2016

14,034
Serious Incidents recorded in total by all acute and community health trusts
2016/2017

The number of Serious Incidents recorded by NHS acute and community health trusts in 2016/2017 appears to have increased by 2% when compared to the data from 2015/2016. However, the figures provided for 2015/2016 are based on 166 NHS trusts and Welsh health boards as opposed to the 171 for 2016/2017, due to data for 2016/2017 being unavailable, incorrectly recorded or provided for the calendar year by five of the NHS trusts.

A full breakdown of the number of Serious Incidents recorded by each of the 171 NHS acute and community health trusts and Welsh health boards in the financial year 2016/2017 is shown in the following table.

27,789 Serious Incidents recorded

Table 1: Number of Serious Incidents recorded by each acute and community health trust and Welsh health board

Data in this table has been provided by NHS trusts and Welsh health boards directly via email or via the Trust or Welsh Health Board providing direction to an official Trust or Health Board document, in response to an FOI request. Where provided by direction to a document, footnotes referenced against the Trust or Health Board name identify this document.

Every effort has been taken to ensure the data in this table is accurate; however Blackwater Law has relied on the accuracy of the data as provided by individual NHS trusts and health boards.

This table contains public sector information licensed under the Open Government Licence v3.0.[6]. This data is identified where (OGL) appears in the table. Where data is licensed under the OGL, the compliant attribution statement can be found in Appendix B, arranged alphabetically by Trust/Health Board name. Where (RPSI) appears in the table, permission to re-use the data in this report has been granted by the Trust or Welsh Health Board directly pursuant to the Re-use of Public Sector Information Regulations (2015)[7].

NHS Trust or Welsh Health Board	Total number of Serious Incidents recorded in 2016/2017	OGL/ RPSI
Abertawe Bro Morgannwg University Health Board	219	RPSI
Aintree University Hospital NHS Foundation Trust	29	OGL
Airedale NHS Foundation Trust	33	OGL
Alder Hey Children's NHS Foundation Trust[8]	10	RPSI
Aneurin Bevan University Health Board	211	RPSI
Ashford and St Peter's Hospitals NHS Foundation Trust	101	RPSI
Barking, Havering and Redbridge University Hospitals NHS Trust	209	OGL
Barnsley Hospital NHS Foundation Trust	61	OGL
Barts Health NHS Trust[9]	290	OGL
Basildon and Thurrock University Hospitals NHS Foundation Trust	109	OGL
Bedford Hospital NHS Trust	38	OGL
Betsi Cadwaladr University Health Board	668	RPSI
Birmingham Community Healthcare NHS Foundation Trust	78	RPSI
Birmingham Women's and Children's NHS Foundation Trust[10]	62	RPSI
Blackpool Teaching Hospitals NHS Foundation Trust	57	RPSI
Bolton NHS Foundation Trust	20	OGL
Bradford Teaching Hospitals NHS Foundation Trust	80	OGL
Bridgewater Community Healthcare NHS Foundation Trust	95	RPSI
Brighton and Sussex University Hospitals NHS Trust	68	OGL
Buckinghamshire Healthcare NHS Trust	83	OGL
Burton Hospitals NHS Foundation Trust	131	RPSI
Calderdale and Huddersfield NHS Foundation Trust	69	RPSI
Cambridge University Hospitals NHS Foundation Trust	102	RPSI
Cambridgeshire Community Services NHS Trust	5	RPSI

6 *Open Government Licence for public sector information (delivered by The National Archives).* Accessible online via: http://www.nationalarchives.gov.uk/doc/open-government-licence/version/3/

7 Legislation.gov.uk (delivered by The National Archives). Accesible online via: http://www.legislation.gov.uk/uksi/2015/1415/contents/made

8 Noted at request of Trust: this trust manages two sites but operates over 30+.

9 Barts Health NHS Trust (2017); Quality Accounts 2016-17, page 12.

10 Comprises of The Birmingham Women's Hospital (BWH), The Birmingham Children's Hospital (BCH) and Forward Thinking Birmingham (FTB). Since 1st April 2016 the BCH data also includes SIRIs reported by the Forward Thinking Birmingham Partnership. FTB is an integrated new model of mental health care provision which is hosted by BCH. The merge between BWH and BCH occurred on the 1st of February 2017.

NHS Trust or Welsh Health Board	Total number of Serious Incidents reported in 2016/2017	OGL/ RPSI
Cardiff and Vale University Health Board[11]	62	RPSI
Central London Community Healthcare NHS Trust	14	RPSI
Chelsea and Westminster Hospital NHS Foundation Trust	87	RPSI
Chesterfield Royal Hospital NHS Foundation Trust	52	RPSI
City Hospitals Sunderland NHS Foundation Trust[12]	35	RPSI
Colchester Hospital University NHS Foundation Trust	130	RPSI
Countess Of Chester Hospital NHS Foundation Trust	70	RPSI
County Durham and Darlington NHS Foundation Trust[13]	91	OGL
Croydon Health Services NHS Trust	92	RPSI
Cwm Taf University Health Board	230	RPSI
Dartford and Gravesham NHS Trust	77	RPSI
Derby Teaching Hospitals NHS Foundation Trust	166	RPSI
Derbyshire Community Health Services NHS Foundation Trust	76	RPSI
Doncaster and Bassetlaw Hospitals NHS Foundation Trust[14]	53	RPSI
Dorset County Hospital NHS Foundation Trust	44	OGL
East and North Hertfordshire NHS Trust	60	OGL
East Cheshire NHS Trust	62	RPSI
East Kent Hospitals University NHS Foundation Trust	82	RPSI
East Lancashire Hospitals NHS Trust	42	RPSI
East Sussex Healthcare NHS Trust	58	OGL
Epsom and St Helier University Hospitals NHS Trust	26	RPSI
Frimley Health NHS Foundation Trust	74	OGL
Gateshead Health NHS Foundation Trust	54	OGL
George Eliot Hospital NHS Trust	64	RPSI
Gloucestershire Care Services NHS Trust	18	RPSI
Gloucestershire Hospitals NHS Foundation Trust	8	OGL
Great Ormond Street Hospital for Children NHS Foundation Trust	11	OGL
Great Western Hospitals NHS Foundation Trust	26	RPSI

11 Cardiff and Vale University Health Board (18th April 2017); Quality, Safety and Experience Committee, Page 27.

12 City Hospitals Sunderland NHS Foundation Trust; Annual Report 2016/2017, page 100. Accessible online via: https://chsft.nhs.uk/application/files/4515/0597/8824/CHS_Annual_Report_2016_17_.pdf (accessed on 20th October 2017)

13 Noted at request of Trust: From the 91 SI's reported in 2016/17, 8 were historic incidents.

14 Doncaster and Bassetlaw Hospitals NHS Foundation Trust; Agenda and Papers for the Meeting of the Board of Directors (25th April 2017), page 78 of PDF document. Accessible online via: https://www.dbth.nhs.uk/wp-content/uploads/2017/10/BoD-25.4.2017-Part-1.pdf (accessed on 22nd August 2017)

NHS Trust or Welsh Health Board	Total number of Serious Incidents reported in 2016/2017	OGL/ RPSI
Guy's and St Thomas' NHS Foundation Trust	121	OGL
Hampshire Hospitals NHS Foundation Trust[15]	40	OGL
Harrogate and District NHS Foundation Trust	130	RPSI
Heart Of England NHS Foundation Trust	286	RPSI
Hertfordshire Community NHS Trust	10	RPSI
Homerton University Hospital NHS Foundation Trust	79	RPSI
Hounslow and Richmond Community Healthcare NHS Trust[16]	15	RPSI
Hull and East Yorkshire Hospitals NHS Trust	68	RPSI
Hywel Dda Health Board[17]	166	OGL
Imperial College Healthcare NHS Trust	225	OGL
Isle Of Wight NHS Trust	63	OGL
James Paget University Hospitals NHS Foundation Trust[18]	37	RPSI
Kent Community Health NHS Foundation Trust[19]	39	RPSI
King's College Hospital NHS Foundation Trust	132	RPSI
Kingston Hospital NHS Foundation Trust	44	RPSI
Lancashire Teaching Hospitals NHS Foundation Trust	41	RPSI
Leeds Community Healthcare NHS Trust	92	RPSI
Lewisham and Greenwich NHS Trust	53	RPSI
Lincolnshire Community Health Services NHS Trust	233	RPSI
Liverpool Community Health NHS Trust	61	RPSI
Liverpool Heart and Chest Hospital NHS Foundation Trust[20]	3	OGL
Liverpool Women's NHS Foundation Trust	29	RPSI
Luton and Dunstable University Hospital NHS Foundation Trust	21	RPSI
Maidstone and Tunbridge Wells NHS Trust	105	RPSI
Manchester University NHS Foundation Trust (became a trust on 1st October 2017) Central Manchester University Hospitals NHS Foundation Trust University Hospital Of South Manchester NHS Foundation Trust[21]	 104 96	RPSI
Medway NHS Foundation Trust	116	OGL

15 Hampshire Hospitals NHS Foundation Trust; Annual Report and Account 2016/17, page 132. Accessible online via: http://www.hampshirehospitals.nhs.uk/media/529314/annual_report_and_accounts_2016.2017.pdf (accessed on 2nd August 2017)

16 Hounslow and Richmond Community Healthcare NHS Trust; Quality Account 2016/2017, page 20. Accessible online via: http://www.hrch.nhs.uk/about-us/quality/ (accessed on 5th July 2017)

17 Data for this Health Board for the year 2016-17 is under reported by no less than 1 and no more than 5 due to the way in which data was provided by the Trust.

18 James Paget University Hospitals NHS Foundation Trust (28th April 2017) Report to the Board of Directors 2017/18; Quality and Safety Report, page 8.

19 Attribution statement requested by Trust: Kent Community Health NHS Trust copyright.

20 Liverpool Heart and Chest Hospital NHS Foundation Trust; Annual Report and Accounts 2016/17, page 76. Accessible onine via: https://www.lhch.nhs.uk/media/5409/lhch-annual-report-2016-17-final.pdf (accessed on 1th June 2017).

21 Noted at request of Trust: serious untoward incidents (SUIs) defined as any incidents reported that were onward reported via the Steis system including any safeguarding which may be external and pressure ulcer incidents it may also include those that were subsequently downgraded.

NHS Trust or Welsh Health Board	Total number of Serious Incidents reported in 2016/2017	OGL/ RPSI
Mid Cheshire Hospitals NHS Foundation Trust[22]	34	RPSI
Mid Essex Hospital Services NHS Trust	111	RPSI
Milton Keynes University Hospital NHS Foundation Trust	74	RPSI
Moorfields Eye Hospital NHS Foundation Trust	12	RPSI
Norfolk Community Health and Care NHS Trust	276	RPSI
North Bristol NHS Trust	84	RPSI
North Cumbria University Hospitals NHS Trust	87	RPSI
North Middlesex University Hospital NHS Trust	80	RPSI
North Tees and Hartlepool NHS Foundation Trust	48	OGL
North West Anglia NHS Foundation Trust[23]	66	RPSI
Northampton General Hospital NHS Trust	15	RPSI
Northern Devon Healthcare NHS Trust	7	OGL
Northern Lincolnshire and Goole NHS Foundation Trust	75	RPSI
Northumbria Healthcare NHS Foundation Trust	117	OGL
Nottingham University Hospitals NHS Trust	94	OGL
Oxford University Hospitals NHS Foundation Trust	106	OGL
Plymouth Hospitals NHS Trust	48	RPSI
Poole Hospital NHS Foundation Trust	77	RPSI
Portsmouth Hospitals NHS Trust	389	OGL
Powys Teaching Health Board	57	RPSI
Public Health Wales	3	RPSI
Queen Victoria Hospital NHS Foundation Trust	10	RPSI
Royal Berkshire NHS Foundation Trust	54	OGL
Royal Brompton and Harefield NHS Foundation Trust	14	OGL
Royal Cornwall Hospitals NHS Trust	83	OGL
Royal Devon and Exeter NHS Foundation Trust	19	OGL
Royal Free London NHS Foundation Trust	106	OGL
Royal National Orthopaedic Hospital NHS Trust	12	RPSI

22 Noted at request of Trust: Central Cheshire Integrated Care Partnership (CCICP) joined the Organisation in October 2016. CCICP is a collaboration between Mid Cheshire Hospitals NHS FT (MCHFT), Cheshire and Wirral Partnership NHS Foundation Trust (CWP) and the South Cheshire and Vale Royal GP Alliance.

23 From 1st April 2017 Peterborough and Stamford Hospitals NHS Foundation Trust merged with Hinchingbrooke Health Care NHS Trust to form North West Anglia NHS Foundation Trust.

NHS Trust or Welsh Health Board	Total number of Serious Incidents reported in 2016/2017	OGL/ RPSI
Royal Papworth Hospital NHS Foundation Trust[24]	7	RPSI
Royal Surrey County Hospital NHS Foundation Trust	47	OGL
Royal United Hospitals Bath NHS Foundation Trust	36	RPSI
Salford Royal NHS Foundation Trust	38	RPSI
Salisbury NHS Foundation Trust[25]	46	OGL
Sandwell and West Birmingham Hospitals NHS Trust	64	RPSI
Sheffield Children's NHS Foundation Trust[26]	11	OGL
Sheffield Teaching Hospitals NHS Foundation Trust	41	RPSI
Sherwood Forest Hospitals NHS Foundation Trust	29	OGL
Shrewsbury and Telford Hospital NHS Trust[27]	63	RPSI
Shropshire Community Health NHS Trust	32	RPSI
South Tees Hospitals NHS Foundation Trust	71	OGL
South Tyneside NHS Foundation Trust	89	RPSI
South Warwickshire NHS Foundation Trust	36	OGL
Southend University Hospital NHS Foundation Trust	130	RPSI
Southport and Ormskirk Hospital NHS Trust	79	RPSI
St George's University Hospitals NHS Foundation Trust	93	RPSI
St Helens and Knowsley Hospitals NHS Trust	62	OGL
Staffordshire and Stoke On Trent Partnership NHS Trust	46	RPSI
Stockport NHS Foundation Trust	130	RPSI
Surrey and Sussex Healthcare NHS Trust[28]	35	RPSI
Sussex Community NHS Foundation Trust	39	OGL
Tameside and Glossop Integrated Care NHS Foundation Trust	48	RPSI
Taunton and Somerset NHS Foundation Trust	13	RPSI
The Christie NHS Foundation Trust[29]	1	RPSI
The Clatterbridge Cancer Centre NHS Foundation Trust	6	RPSI
The Ipswich Hospital NHS Trust	87	RPSI
The Hillingdon Hospitals NHS Foundation Trust	41	RPSI

24 Papworth Hospital NHS Foundation Trust was granted Royal title in September 2017 and its name changed in early 2018.

25 Data was provided by Salisbury NHS Foundation Trust under the Open Government Licence v2.0. Accessible online via: http://www.nationalarchives.gov.uk/doc/open-government-licence/version/2/

26 Sheffield Children's NHS Foundation Trust (May 2017); Annual Report and Accounts 2016/17, page 121. Accessible online via: https://www.sheffieldchildrens.nhs.uk/about-us/publications/ (accessed on 20th October 2017)

27 Shrewsbury and Telford Hospital NHS Trust; Draft Quality Account Report 2016/17 to Trust Board on 30th May 2017, page 53 of PDF. Accessible via: https://www.sath.nhs.uk/wp-content/uploads/2017/05/170530-07-Draft-Quality-Account-1617.pdf (accessed on 28th June 2017)

28 Surrey and Sussex Healthcare NHS Trust; Serious Incident Report for Q4 2016/17 for Trust Board public meeting on 27 April 2017, page 4. Accessible online via: https://www.surreyandsussex.nhs.uk/wp-content/uploads/2017/01/2.6_SI-report-Public-Trust-Board-Q4-data-24.04.17.pdf (accessed on 16th June 2017)

29 The Christie NHS Foundation Trust; Annual Report and Accounts 2016/17, page 83. Accessible online via: http://www.christie.nhs.uk/about-us/the-foundation-trust/annual-reports/ (accessed on 12th June 2016)

NHS Trust or Welsh Health Board	Total number of Serious Incidents reported in 2016/2017	OGL/ RPSI
The Leeds Teaching Hospitals NHS Trust	73	RPSI
The Mid Yorkshire Hospitals NHS Trust	106	RPSI
The Newcastle Upon Tyne Hospitals NHS Foundation Trust	85	OGL
The Pennine Acute Hospitals NHS Trust[30]	778	RPSI
The Princess Alexandra Hospital NHS Trust	26	OGL
The Queen Elizabeth Hospital King's Lynn NHS Foundation Trust	46	RPSI
The Robert Jones and Agnes Hunt Orthopaedic Hospital NHS Foundation Trust	14	RPSI
The Rotherham NHS Foundation Trust	52	OGL
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust[31]	25	OGL
The Royal Liverpool and Broadgreen University Hospitals NHS Trust	17	RPSI
The Royal Marsden NHS Foundation Trust	10	RPSI
The Royal Orthopaedic Hospital NHS Foundation Trust	39	RPSI
The Royal Wolverhampton NHS Trust[32]	124	RPSI
The Walton Centre NHS Foundation Trust	19	RPSI
Torbay and South Devon NHS Foundation Trust	25	RPSI
University College London Hospitals NHS Foundation Trust	54	RPSI
University Hospital Southampton NHS Foundation Trust	73	RPSI
University Hospitals Bristol NHS Foundation Trust[33]	52	RPSI
University Hospitals Coventry and Warwickshire NHS Trust	139	RPSI
University Hospitals Of Leicester NHS Trust	48	RPSI
University Hospitals Of Morecambe Bay NHS Foundation Trust	34	RPSI
University Hospitals of North Midlands NHS Trust	146	RPSI
Velindre NHS Trust	6	RPSI
Walsall Healthcare NHS Trust	135	RPSI
Warrington and Halton Hospitals NHS Foundation Trust	45	OGL
West Suffolk NHS Foundation Trust	97	RPSI
Western Sussex Hospitals NHS Foundation Trust	74	OGL

30 Noted at request of Trust: The trust recorded 643 "A&E Extended Wait For Assess (More Than 12 Hrs)" as Serious Incidents in 2016/17 which were no harm events, but the CCG requested we logged them as Serious Incidents.

31 The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust; Annual Report and Accounts 2016/17, page 46. Accessible online via: http://www.rbch.nhs.uk/about_the_trust/spend.php (accessed on 10th August 2017)

32 The Royal Wolverhampton NHS Trust; Quality Accounts 2016/17, page 10. Accessible online via: http://www.royalwolverhampton.nhs.uk/about-us/publications-and-documents/ (accessed on 7th July 2017)

33 University Hospitals Bristol NHS Foundation Trust; Quality Report 2016/17, page44. Accessible onlince via: http://www.uhbristol.nhs.uk/media/2935336/uhb_quality_report_2016-17_web.pdf (accessed on 20th June 2017)

NHS Trust or Welsh Health Board	Total number of Serious Incidents reported in 2016/2017	OGL/ RPSI
Weston Area Health NHS Trust	11	RPSI
Whittington Health NHS Trust[34]	58	OGL
Wirral Community NHS Foundation Trust[35]	49	RPSI
Wirral University Teaching Hospital NHS Foundation Trust	132	RPSI
Worcestershire Acute Hospitals NHS Trust[36]	109	RPSI
Worcestershire Health and Care NHS Trust	338	RPSI
Wrightington, Wigan and Leigh NHS Foundation Trust	32	RPSI
Wye Valley NHS Trust	119	RPSI
Yeovil District Hospital NHS Foundation Trust[37]	14	OGL
York Teaching Hospital NHS Foundation Trust	151	OGL
Total number of Serious Incidents	**14,034**	

There are significant variances in the number of Serious Incidents recorded by each individual physical and community health trust. 41 out of the 171 NHS trusts and Welsh health boards (24%) have recorded more than 100 Serious Incidents for 2016/2017 whereas 12 of the NHS trusts and Welsh health boards reported 10 or fewer Serious Incidents across the same time period.

A degree of variation is to be anticipated owing to the vast differences in patient numbers and patient contacts, treatments and procedures completed by each NHS Trust and Welsh Health Board. The number of Serious Incidents recorded by these NHS acute and community health trusts is therefore not, on its own, an accurate measure of the quality of health care being provided by a Trust or Health Board.

34 Whittington Health NHS Trust (May 2017); Trust Board meeting papers, Serious Incidents - Monthly Update Report, page 3. Accessible online via: http://www.whittington.nhs.uk/default.asp?c=26656 (accessed on 16th June 2017)

35 Wirral Community NHS Foundation Trust; Quality Report 2016/17, page 41. Accesible onlince via: http://www.wirralct.nhs.uk/about-us/our-organisation/our-publications (accessed on 17th July 2017)

36 Worcestershire Acute Hospitals NHS Trust; Annual Report 2016/17, page 48. Accessible online via: http://www.worcsacute.nhs.uk/our-trust/corporate-information/annual-report-and-review-of-the-year (accessed on 16th November 2017)

37 Attribution statement requested by Trust: data provided by Yeovil District Hospital NHS Foundation Trust, 9 June 2017

Table 2: 10 acute and community health trusts and Welsh health boards recording the highest and lowest number of of Serious Incidents in 2016/2017

Data in this table has been provided by NHS trusts and Welsh health boards directly via email or via the Trust or Welsh Health Board providing direction to an official Trust or Health Board document, in response to an FOI request. Where provided by direction to a document, footnotes referenced against the Trust or Health Board name identify this document.

Every effort has been taken to ensure the data in this table is accurate; however Blackwater Law has relied on the accuracy of the data as provided by individual NHS trusts and health boards.

This table contains public sector information licensed under the Open Government Licence v3.0.[38]. This data can be identified by cross-referencing with Table 1. Where data is licensed under the OGL, the compliant attribution statement can be found in Appendix B, arranged alphabetically by Trust/Health Board name.

Highest Number of Serious Incidents in 2016/2017		Lowest number of Serious Incidents in 2016/2017	
Trust Name	**Number of Serious Incidents recorded**	**Trust Name**	**Number of Serious Incidents recorded**
The Pennine Acute Hospitals NHS Trust[39]	**778**	The Christie NHS Foundation Trust[40]	**1**
Betsi Cadwaladr University Health Board	**668**	Liverpool Heart and Chest Hospital NHS Foundation Trust[41]	**3**
Portsmouth Hospitals NHS Trust	**389**	Public Health Wales	**3**
Worcestershire Health and Care NHS Trust	**338**	Cambridgeshire Community Services NHS Trust	**5**
Barts Health NHS Trust[42]	**290**	The Clatterbridge Cancer Centre NHS Foundation Trust	**6**
Heart of England NHS Foundation Trust	**286**	Velindre NHS Trust	**6**
Norfolk Community Health and Care NHS Trust	**276**	Northern Devon Healthcare NHS Trust	**7**
Lincolnshire Community Health Services NHS Trust	**233**	Royal Papworth Hospital NHS Foundation Trust[43]	**7**
Cwm Taf University Health Board	**230**	Gloucestershire Hospitals NHS Foundation Trust	**8**
Imperial College Healthcare NHS Trust	**225**	Alder Hey Children's NHS Foundation Trust[44]	**10**
		Queen Victoria Hospital NHS Foundation Trust	**10**
		The Royal Marsden NHS Foundation Trust	**10**

The number of Serious Incidents recorded is not, on its own, an accurate measure of the quality of care being provided and it is not known whether any of the seven NHS trusts for which data is not considered in this report may have featured within this table.

38 *Open Government Licence for public sector information (delivered by The National Archives).* Accessible online via: http://www.nationalarchives.gov.uk/doc/open-government-licence/version/3/

39 Noted at request of Trust: The trust recorded 643 "A&E Extended Wait For Assess (More Than 12 Hrs)" as Serious Incidents in 2016/17 which were no harm events, but the CCG requested we logged them as Serious Incidents.

40 The Christie NHS Foundation Trust; Annual Report and Accounts 2016/17, page 83. Accessible online via: http://www.christie.nhs.uk/about-us/the-foundation-trust/annual-reports/ (accessed on 12th June 2016)

41 Liverpool Heart and Chest Hospital NHS Foundation Trust; Annual Report and Accounts 2016/17, page 76. Accessible onine via: https://www.lhch.nhs.uk/media/5409/lhch-annual-report-2016-17-final.pdf (accessed on 1th June 2017).

42 Barts Health NHS Trust (2017); Quality Accounts 2016-17, page 12.

43 Papworth Hospital NHS Foundation Trust was granted Royal title in September 2017 and its name changed in early 2018.

44 Noted at request of Trust: this trust manages two sites but operates over 30+.

Categories of Serious Incident – acute and community health

96 (56%) of the 171 NHS acute and community health trusts and Welsh health boards across England and Wales provided a categorisation/description of each Serious Incident that was recorded by their organisation in 2016/2017. This revealed 679 different categorisations/descriptions of 7,867 Serious Incidents and provided Blackwater Law with a greater level of insight into the Serious Incidents recorded by NHS acute and community health trusts and boards in England and Wales in 2016/2017.

In the absence of standardised categorisations/descriptions across different trusts, and in order to determine the most commonly recorded types of Serious Incidents, the categorisation/descriptions were grouped into similar categories of Serious Incident by Blackwater Law. A list detailing the exact categorisations/descriptions of the 7,867 Serious Incidents as provided by the 96 NHS acute and community health trusts and Welsh health boards can be requested.[45]

The five Serious Incident types most commonly recorded by NHS acute and community health trusts and Welsh health boards are provided in the table below.

> *"It is particularly concerning to see that more than 5% of the Serious Incidents for which Blackwater Law was provided a category/description related to maternity, labour and delivery including neonatal. Injuries to babies can be catastrophic and significantly life-limiting. Whilst not all of these particular Serious Incidents will involve medical negligence, given the potential implications for the future of that child and the family, the fact some of these incidents may have been avoidable is distressing to say the least."*
>
> **Jason Brady**
> Partner, Blackwater Law

Table 3: the most frequently recorded categories of Serious Incidents across NHS acute and community health trusts and Welsh health boards in England and Wales for 2016/2017

Serious Incident type	Number of incidents recorded in 16/17 which were categorised/described and grouped within this type of Serious Incident	As a percentage of the 16/17 incidents for which a category/description was provided by the NHS
Pressure damage/sore/ulcers	**1762**	**22.4%**
Accident to service users or staff including slip, trip, fall (actual or suspected)	**1361**	**17.3%**
Delays and diagnostic incidents	**1300**	**16.5%**
Clinical/patient care issues including sub-optimal care of the deteriorating patient, tests and test results	**1248**	**15.9%**
Maternity, labour and delivery including neonatal	**439**	**5.6%**

45 Blackwater Law is under no obligation to provide this data and Blackwater Law reserves the right to refuse to supply this data. Where this data is provided this will be subject to limitations and restrictions placed upon Blackwater Law by the NHS trusts and Welsh health boards to which the data applies. This data will not be identifiable by NHS Trust or Health Board.

Pressure damage/sores/ulcers are the most commonly recorded Serious Incident:

From the data available, the type of Serious Incident most commonly recorded by NHS acute and community health trusts and Welsh health boards was *pressure damage/sores/ulcers*, which accounted for 1,762 separate Serious Incidents recorded in 2016/2017.

The NHS Serious Incident Framework 2015 Frequently Asked Questions[46] states that not all category 3 or 4 (the most severe categories of pressure ulcer) should be classified as Serious Incidents as this could result in a burden of investigation, rather consideration should be given to the overall severity and circumstances of each pressure ulcer/sore. The number presented therefore only reflects the most serious pressure ulcers/sores/damage cases.

Pressure ulcers, particularly those severe enough to be recorded and investigated as a Serious Incident, can cause significant suffering.

> *"Pressure ulcers represent a major burden of sickness and reduced quality of life for people and their carers. They can be debilitating for the patient, with the most vulnerable people being those aged over 75. Pressure ulcers can be serious and lead to life-threatening complications such as blood poisoning or gangrene."*
>
> **NICE**
> National Institute for Health and Care Excellence [47]

> *"Avoidable pressure ulcers are a key indicator of the quality and experience of patient care."*
>
> **Stop the Pressure**
> NHS Improvement [48]

46 NHS Improvement; *NHS England Serious Incident Framework Frequently Asked Questions (March 2016)*;
Accessible online via https://improvement.nhs.uk/uploads/documents/serious-incdnt-framwrk-faqs-mar16.pdf
NHS Improvement does not endorse any analysis within this report.

47 National Institute for Health and Care Excellence; Pressure Ulcers.
Accessible online via: https://www.nice.org.uk/guidance/qs89/chapter/introduction (accessed on 29th January 2018).
NICE does not endorse any analysis within this report.

48 NHS Improvement; *Stop the Pressure website.*
Accessible online via: http://nhs.stopthepressure.co.uk/index.html (accessed on 29th January 2018)

Number of Serious Incidents by region – acute and community health

Each NHS acute and community health trust and Welsh health board has been assigned to their relevant region, determined by their main location listed on the NHS Choices website[49]. It is acknowledged that a number of NHS trusts will have more than one site, which may in some instances span two regions, or have services which span multiple regions. In these instances, each NHS Trust has been listed against the corresponding region based on their main address alone, as published by NHS Choices, as opposed to appearing in multiple regions.

The number of trusts within each of the 11 regions ranges from 8 in the East Midlands and North East through to 30 in the North West[50]. Given the varying number of NHS trusts within each region, with significant differences in patient numbers and number of patient contacts, there is a vast difference in the number of Serious Incidents recorded by NHS trusts within each region.

Whilst identifying the number of Serious Incidents being recorded within each region, this data alone cannot be used to determine difference in the quality of health care being delivered across regions.

Serious Incident type by region

Further analysis of the collated Serious Incident data was undertaken to establish whether the most commonly recorded categories of Serious Incident differ by region and the top three most commonly reported Serious Incident category type were established for each region.

The three most commonly recorded Serious Incident categories for 10 out of the 11 regions was consistent with the four most common categories recorded by NHS trusts and Welsh health boards across the whole of England and Wales, these being:

- Pressure damage/sore/ulcers
- Accident to service users or staff including slip, trip, fall (actual or suspected)
- Delays and diagnostic incidents
- Clinical/patient care issues including sub-optimal care of the deteriorating patient, tests and test results

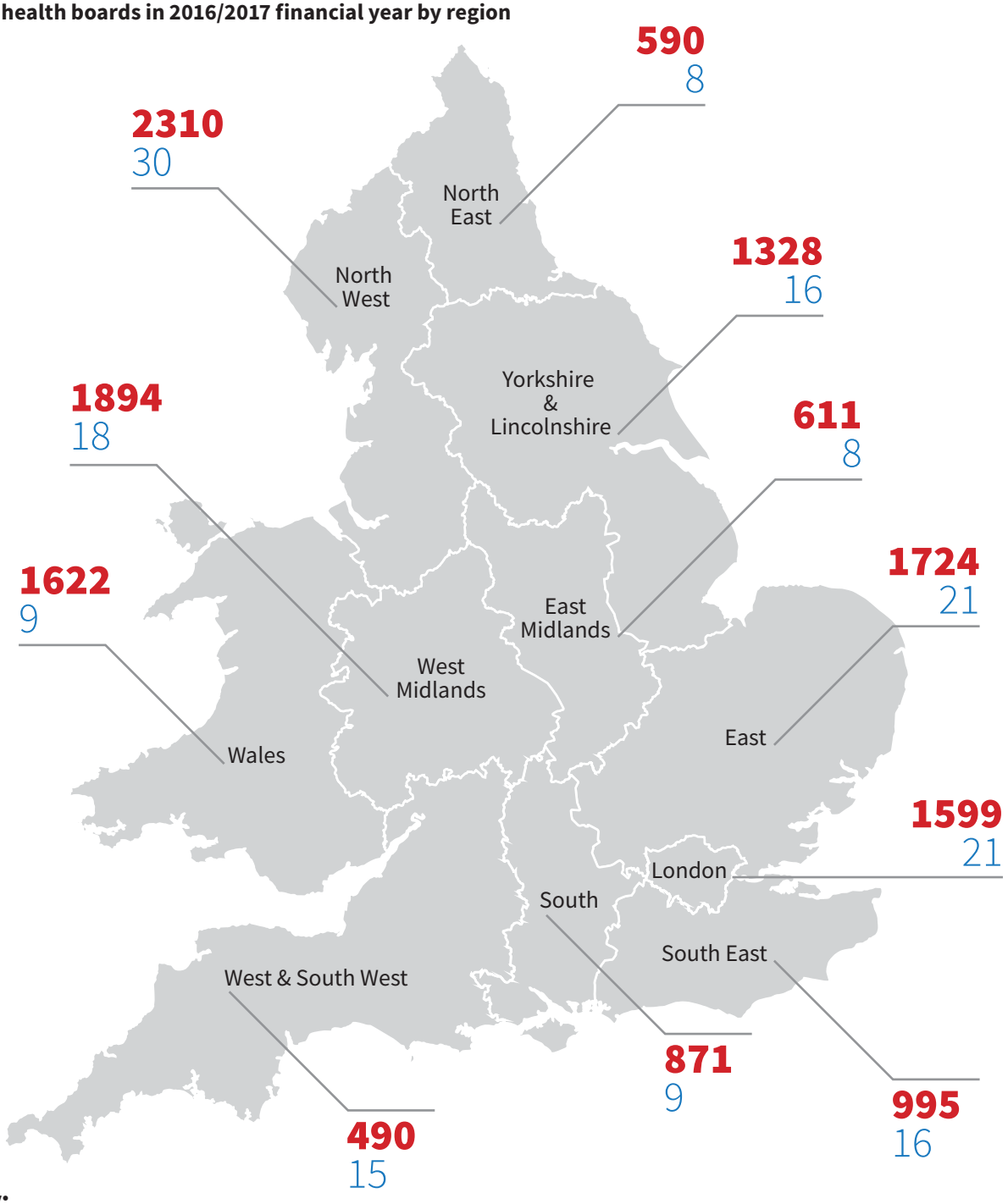
However, there was variation as to the exact position of these categories within the top three across regions.

Wales was the only region where one of the three most common categories of Serious Incident recorded by NHS trusts and Welsh health boards within the region did not appear in the national list of most commonly recorded Serious Incident types, namely *Infrastructure (including capacity, beds and resources), health and safety, environment and security issues*.

49 NHS Choices.
Accessible online via: https://www.nhs.uk/pages/home.aspx (accessed on 13th November 2017)

50 30 Trusts in the North West includes two separate sets of figures and incident data for Central Manchester University Hospitals NHS Foundation Trust and University Hospital of South Manchester NHS Foundation Trust although these have since merged to Manchester University NHS Foundation Trust

Map 2: Serious Incidents recorded by NHS acute and community health trusts and health boards in 2016/2017 financial year by region



Key:

Number of Serious Incidents recorded in 2016/2017

Total number of NHS trusts and health boards in region

Blackwater Law

Data reflects 171 NHS trusts and Welsh health boards. There are 30 trusts in the North West region although separate data was provided for Central Manchester University Hospitals NHS Foundation Trust & University Hospital of South Manchester NHS Foundation Trust, but these trusts have since merged to form Manchester University NHS Foundation Trust on 1st October 2017.

Serious Incidents in NHS mental health trusts

Total number of Serious Incidents recorded in NHS mental health trusts in England

An FOI request was sent to the 53 NHS mental health trusts in England in order to ascertain the number and type of Serious Incidents that have been recorded by these trusts. All of these NHS trusts responded to these requests and consented to their figures being published within this report.

In the two financial years from 1st April 2015 through to 31st March 2017 a total of 11,872 Serious Incidents recorded by NHS mental health trusts in England. This accounts for 29% of the total Serious Incidents recorded by all 235 NHS trusts and Welsh health boards across England and Wales from which Blackwater Law has useable data.

Total number of Serious Incidents in Mental Health Trusts in England per financial year (from 2015/2016 to 2016/2017)

5,999
Serious Incidents recorded in total by all NHS mental health trusts
2015/2016

5,873
Serious Incidents recorded in total by all NHS mental health trusts
2016/2017

The number of Serious Incidents recorded by NHS mental health trusts in England in 2016/2017 appears to have fallen by 2% when compared to data from 2015/2016. The data for Tees, Esk & Wear Valleys NHS Foundation Trusts was not available for the period 2015/2016 but was included in the figure for 2016/2017.

11,872 Serious Incidents recorded

Table 4: Number of Serious Incidents recorded by each mental health trust in England

Data in this table has been provided by NHS trusts and Welsh health boards directly via email or via the Trust or Welsh Health Board providing direction to an official Trust or Health Board document, in response to an FOI request. Where provided by direction to a document, footnotes referenced against the Trust or Health Board name identify this document.

Every effort has been taken to ensure the data in this table is accurate; however Blackwater Law has relied on the accuracy of the data as provided by individual NHS trusts and health boards.

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NHS Trust	Total number of Serious Incidents recorded in 2016/2017	OGL/ RPSI
2gether NHS Foundation Trust	42	RPSI
Avon and Wiltshire Mental Health Partnership NHS Trust	121	RPSI
Barnet, Enfield and Haringey Mental Health NHS Trust	60	OGL
Berkshire Healthcare NHS Foundation Trust	69	RPSI
Birmingham and Solihull Mental Health NHS Foundation Trust	123	RPSI
Black Country Partnership NHS Foundation Trust	64	RPSI
Bradford District Care NHS Foundation Trust	43	RPSI
Cambridgeshire and Peterborough NHS Foundation Trust	89	RPSI
Camden and Islington NHS Foundation Trust	47	RPSI
Central and North West London NHS Foundation Trust[53]	155	RPSI
Cheshire and Wirral Partnership NHS Foundation Trust	164	RPSI
Cornwall Partnership NHS Foundation Trust[54]	134	RPSI
Coventry and Warwickshire Partnership NHS Trust	119	RPSI
Cumbria Partnership NHS Foundation Trust	73	RPSI
Derbyshire Healthcare NHS Foundation Trust	61	RPSI
Devon Partnership NHS Trust	57	RPSI
Dorset Healthcare University NHS Foundation Trust	143	OGL
Dudley and Walsall Mental Health Partnership NHS Trust[55]	43	RPSI
East London NHS Foundation Trust	150	RPSI
Essex Partnership University NHS Foundation Trust[56]		
North Essex Partnership University NHS Foundation Trust	97	
South Essex Partnership University NHS Foundation Trust	71	RPSI
Greater Manchester Mental Health NHS Foundation Trust[57]	155	RPSI
Hertfordshire Partnership University NHS Foundation Trust[58]	69	RPSI
Humber NHS Foundation Trust	29	RPSI
Kent and Medway NHS and Social Care Partnership Trust	159	RPSI
Lancashire Care NHS Foundation Trust	115	RPSI
Leeds and York Partnership NHS Foundation Trust	61	OGL

51 *Open Government Licence for public sector information (delivered by The National Archives).* Accessible online via: http://www.nationalarchives.gov.uk/doc/open-government-licence/version/3/

52 *Legislation.gov.uk (delivered by The National Archives). Accesible online via: http://www.legislation.gov.uk/uksi/2015/1415/contents/made*

53 Central and North West London NHS Foundation Trust (July 2017) Quality Annual Reports: 2016/17 Serious Incidents Annual Report, page 3.

54 Noted at request of Trust: As of 1st April 2016 Cornwall Partnership NHS FT is also commissioned to provide Adult Community Services throughout Cornwall, in addition to Mental Health and Children's Services.

55 Dudley and Walsall Mental Health Partnership NHS Trust; papers for Public Meeting of the Trust Board on 4th May 2017, Quality and Safety Report, page 11. Accessible onlne via: http://www.dwmh.nhs.uk/wp-content/uploads/2017/01/1.-Public-Trust-Papers-4.5.17-combined-2.pdf (acccessed on 14th June 2017)

56 North Essex Partnership University NHS Foundation Trust; Quality Report 1 April 2016 - 31 March 2017, page 37.

57 On the 01/01/17 Greater Manchester West Mental Health NHS FT (GMW) merged with Manchester Mental Health and Social Care Trust (MMHSC) forming Greater Manchester Mental Health NHS Foundation Trust (GMMH). The data supplied are for GMW from 01/04/2016 - 31/12/2016 and GMMH from 01/01/2017 - 31/03/2017.

58 Hertfordshire Partnership University NHS Foundation Trust; papers for Board of Directors Public Meeting on 26th April 2017, page 38. Accessible online via: http://www.hpft.nhs.uk/media/1787/2017-04-26-public-board-pack.pdf (accessed on 6th July 2017)

NHS Trust	Total number of Serious Incidents recorded in 2016/2017	OGL/ RPSI
Leicestershire Partnership NHS Trust	66	RPSI
Lincolnshire Partnership NHS Foundation Trust	41	RPSI
Mersey Care NHS Foundation Trust[59]	252	RPSI
Norfolk and Suffolk NHS Foundation Trust[60]	242	RPSI
North East London NHS Foundation Trust	224	RPSI
North Staffordshire Combined Healthcare NHS Trust[61]	57	RPSI
North West Boroughs Healthcare NHS Foundation Trust (previously 5 Boroughs Partnership NHS Foundation Trust)	75	RPSI
Northamptonshire Healthcare NHS Foundation Trust	37	OGL
Northumberland, Tyne and Wear NHS Foundation Trust	197	RPSI
Nottinghamshire Healthcare NHS Foundation Trust	303	RPSI
Oxford Health NHS Foundation Trust[62]	95	RPSI
Oxleas NHS Foundation Trust	61	OGL
Pennine Care NHS Foundation Trust	94	OGL
Rotherham Doncaster and South Humber NHS Foundation Trust	23	RPSI
Sheffield Health and Social Care NHS Foundation Trust	28	RPSI
Solent NHS Trust	221	RPSI
Somerset Partnership NHS Foundation Trust	34	OGL
South London and Maudsley NHS Foundation Trust	104	RPSI
South Staffordshire and Shropshire Healthcare NHS Foundation Trust	184	OGL
South West London and St George's Mental Health NHS Trust	100	RPSI
South West Yorkshire Partnership NHS Foundation Trust	65	OGL
Southern Health NHS Foundation Trust	230	RPSI
Surrey and Borders Partnership NHS Foundation Trust	137	OGL
Sussex Partnership NHS Foundation Trust	262	OGL
The Tavistock and Portman NHS Foundation Trust	3	RPSI
Tees, Esk and Wear Valleys NHS Foundation Trust	103	RPSI
West London Mental Health NHS Trust	122	RPSI
Total number of serious incidents recorded per financial year:	**5,873**	

59 Noted at request of Trust: formally acquired Calderstones Partnership NHS Foundation Trust on 1 July 2016.

60 Norfolk and Suffolk NHS Foundation Trust; Board of Directors (BoD) Public Papers 22nd September 2016, page 35 of PDF; BOD Public Papers 24th November 2016, page 41 of PDF; BOD Public Papers 3rd February 2017, page 36 of PDF; BOD Public Papers 25th May 2017, page 88 of PDF.
Accessible online via: http://www.nsft.nhs.uk/About-us/Pages/BOD-public-meetings.aspx (accessed on 14th November 2017)

61 North Staffordshire Combined Healthcare NHS Trust; papers of the public Meeting of the Trust Board on 13th July 2017, page 2 of the Serious Incident Annual Report 2016/17.
Accessible online via: https://www.combined.nhs.uk/media/1448/final-open-trust-board-papers.pdf (accessed on 23rd August 2017)

62 Oxford Health NHS Foundation Trust; Quality Report 2016/17, page 38.

The data shows significant differences in the number of Serious Incidents recorded by NHS mental health trusts with 25 trusts (47%) recording 100 or more Serious Incidents in the financial year 2016/2017. Differences in the number of Serious Incidents recorded by each NHS Mental Health Trust are to be anticipated due to varying patient and patient contact numbers, as well as variation in level/types of services offered by each individual NHS Mental Health Trust. The number of Serious Incidents recorded by a mental health trust is not, on its own, an accurate measure of the quality of health care being provided by the Trust.

47% of trusts recorded 100 or more

Categories of Serious Incident - mental health

29 (55%) of the 53 NHS mental health trusts in England provided a categorisation/description of each of the Serious Incidents their trust had recorded for the financial year 2016/2017. This revealed 175 different categorisations/descriptions of 3,254 Serious Incidents, providing Blackwater Law with a greater level of insight into the Serious Incidents recorded by NHS mental health trusts in England in 2016/2017.

In the absence of standardised categorisations/descriptions across different NHS mental health trusts and in order to determine the most commonly recorded types of Serious Incidents, the categorisations/descriptions were grouped into similar categories by Blackwater Law. A list detailing the exact categorisations/descriptions of the 3,254 Serious Incidents as provided by the 29 NHS mental health trusts in England is available on request.[63]

175 different categorisations/ descriptions of Serious Incidents

63 Blackwater Law is under no obligation to provide this data and Blackwater Law reserves the right to refuse to supply this data. Where this data is provided this will be subject to limitations and restrictions placed upon Blackwater Law by the NHS trusts to which the data applies. This data will not be identifiable by NHS Trust.

Table 5: the most frequently recorded categories of serious incident across NHS mental health trusts in England for 2016/2017

Serious Incident type	Number of incidents recorded in 16/17 which were categorised/described and grouped within this type of Serious Incident	As a percentage of the 16/17 incidents for which a category/description was provided by the NHS
Unknown/unexplained death - cause not disclosed	**787**	**24.2%**
Self-harm and suicide, attempted and actual including threats	**756**	**23.2%**
Clinical/patient care procedure (including substance misuse, pressure ulcer, moisture leision, wound) medication error/incident/delay	**423**	**13%**
Abuse/aggression (including violence) actual or alleged to patient or staff	**263**	**8.1%**
Accidents to service users or staff, falls and ill health	**169**	**5.2 %**

"The data relating to mental health trusts is particularly concerning. To learn that approximately 24% of Serious Incidents recorded by these Trusts related to unexplained death and approximately a further 23% to suicide and self-harm, including attempted and alleged, concerns not only us, but we expect also the public. Blackwater Law has seen a noticeable increase in enquiries from individuals and families relating to alleged failings in mental health services in the recent past; this data provides a background as to why that may be."

Dominic Graham
Senior Solicitor, Blackwater Law

Serious Incidents in NHS ambulance trusts

Total number of Serious Incidents recorded in NHS ambulance trusts in England and Wales

Serious Incident data was provided by 11 Ambulance Trusts in England and Wales (10 in England, 1 in Wales). A total of 1,007 Serious Incidents have been recorded by NHS ambulance trusts in the two financial years between 1st April 2015 through to 31st March 2017.

Total number of Serious Incidents recorded by NHS ambulance trusts in England and Wales per financial year (from 2015/16 to 2016/17)

481
Serious Incidents recorded in total by ambulance trusts in England & Wales **2015/2016**

526
Serious Incidents recorded in total by ambulance trusts in England & Wales **2016/2017**

1,007 Serious Incidents recorded

The number of Serious Incidents recorded by NHS ambulance trusts in England and Wales for 2016/2017 has increased by 9.4% compared to the previous financial year. It is acknowledged that this number must be considered in light of the total number of patient contacts dealt with by these NHS trusts during the period and that increases in Serious Incidents being recorded can be caused by increasing patient contacts and may not necessarily be indicative of decreasing standards of health care being provided.

Each of these incidents may have had a significant impact on the health of the patient/s involved or the trusts' ability to provide a reasonable level of health care to the public. In addition, they may have been potentially avoidable and ultimately they would have been considered severe enough to have been recorded by a member of NHS staff under the Serious Incident Framework (2015). [64]

64 NHS England Patient Safety Domain (27 March, 2015); *Serious Incident Framework: Supporting learning to prevent reoccurance.* Accessible online via: https://improvement.nhs.uk/uploads/documents/serious-incidnt-framwrk.pdf (accessed on 29th January 2018).

Table 6: Number of Serious Incidents recorded by each ambulance trust in England and Wales in 2016/2017

Data in this table has been provided by NHS trusts and Welsh health boards directly via email or via the Trust or Welsh Health Board providing direction to an official Trust or Health Board document, in response to an FOI request. Where provided by direction to a document, footnotes referenced against the Trust or Health Board name identify this document.

Every effort has been taken to ensure the data in this table is accurate; however Blackwater Law has relied on the accuracy of the data as provided by individual NHS trusts and health boards.

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NHS Trust	Total number of Serious Incidents recorded 2016/2017	OGL/ RPSI
East Midlands Ambulance Service NHS Trust	44	OGL
East Of England Ambulance Service NHS Trust	95	RPSI
London Ambulance Service NHS Trust	85	RPSI
North East Ambulance Service NHS Foundation Trust	29	RPSI
North West Ambulance Service NHS Trust	43	RPSI
South Central Ambulance Service NHS Foundation Trust	7	RPSI
South East Coast Ambulance Service NHS Foundation Trust	58	RPSI
South Western Ambulance Service NHS Foundation Trust[67]	60	RPSI
West Midlands Ambulance Service NHS Foundation Trust	32	RPSI
Yorkshire Ambulance Service NHS Trust[68]	46	RPSI
Welsh Ambulance Services NHS Trust	27	RPSI
Total number of serious incidents	**526**	

65 *Open Government Licence for public sector information (delivered by The National Archives).* Accessible online via: http://www.nationalarchives.gov.uk/doc/open-government-licence/version/3/

66 Legislation.gov.uk (delivered by The National Archives). Accesible online via: http://www.legislation.gov.uk/uksi/2015/1415/contents/made"

67 Noted at request of Trust: figures in context, South Western Ambulance Service NHS Foundation Trust attends approximately 900,000 calls annually.

68 Yorkshire Ambulance Service NHS Trust; Quality Account 2016-17, page 45. Accessible online via: http://www.yas.nhs.uk/Publications/Annual_Report.html (accessed on 10th August 2017)

Categories of Serious Incident – ambulance trusts

Categories of Serious Incidents Ambulance Trusts

Seven of the 11 NHS ambulance trusts in England and Wales (64%) provided a categorisation/description of the Serious Incidents that had been recorded by the Trust for the financial year 2016/2017. This revealed 106 different categorisations/descriptions of 386 Serious Incidents, providing Blackwater Law with a greater level of insight into the Serious Incidents recorded.

In the absence of standardised categorisations/descriptions across different NHS ambulance trusts and in order to determine the most commonly recorded types of Serious Incidents, the categorisations/descriptions were grouped into similar categories by Blackwater Law. A list detailing the exact categorisations/descriptions of the 386 Serious Incidents as provided by the seven NHS ambulance trusts in England and Wales can be provided on request.[69]

Table 7: the most frequently recorded categories of serious incident across NHS ambulance trusts in England and Wales for 2016/2017

Serious Incident type	Number of incidents recorded in 16/17 which were categorised/ described and grouped within this type of Serious Incident	As a percentage of the 16/17 incidents for which a category/description was provided by the NHS
Clinical and patient care and delays	**210**	**54%**
Non conveyance	**31**	**8%**
Accidents including slip, trip and falls and traffic accidents	**22**	**5.7%**

69 Blackwater Law is under no obligation to provide this data and Blackwater Law reserves the right to refuse to supply this data. Where this data is provided this will be subject to limitations and restrictions placed upon Blackwater Law by the NHS trusts to which the data applies. This data will not be identifiable by NHS Trust.

Conclusion

The Blackwater Law report into serious incidents at NHS trusts and health boards in England and Wales shows, for what may be the first time, the worrying frequency with which Serious Incidents are being recorded by NHS trusts and Welsh health boards each and every year. Particularly worrying findings from the research include the estimate that nearly half of all Serious Incidents recorded by NHS mental health trusts in the year 2016/2017 relate to unexplained death, suicide and self-harm - including suspected, alleged and threatened.

Of concern also is the estimated 22.4% of Serious Incidents at NHS acute and community health trusts relating to pressure sores, which can cause significant suffering and yet are often preventable; with NHS Improvement's Stop the Pressure[70] campaign recognising rates of avoidable pressures ulcers as an indicator of the quality of patient care.

It is also concerning to see Serious Incidents relating to labour and neonatal care being in the top five categories of Serious Incident being recorded by acute and community health trusts given the severe impact injury or illness suffered by a baby can have on their future health, as well as the significant emotional and often financial impact on the parents and family.

The difficultly in collating and analysing the data set out in this report leads the authors to ask whether there should be greater transparency surrounding the number and nature of recorded Serious Incidents in future years to provide for improved learning across and benchmarking the NHS.

"There has been much said recently about compensation payments made by the NHS to patients. In light of our research and other statistics made available by NHS Improvement, I firmly believe the fairest and most sustainable means of reducing the total amount of compensation paid to victims of medical negligence by the NHS is to reduce the frequency of negligent incidents. To simply reduce the amount of compensation provided to patients that have suffered, from levels currently deemed fair and appropriate by Courts, is simply to deny financial remedy to people who, in many cases, require support for on-going and sometimes life-long care, revisions to property and lost future earnings, to name just some examples."

Jason Brady
Partner, Blackwater Law

70 NHS Improvement; Stop the Pressure website.
Accessible online via: http://nhs.stopthepressure.co.uk/index.html (accessed on 29th January 2018).

Appendix A

Obtaining Serious Incident data

A Freedom of Information (FOI) (2000) request was sent to all 242 NHS trusts and Welsh health boards in England and Wales[71]. The request asked for the number of Serious Incidents recorded by the individual NHS trust for both of the financial years 2015/2016 and 2016/2017 as well as a breakdown of incident type, where this could be provided for the financial year 2016/2017.

Five trusts provided data but explicitly refused permission for their organisations Serious Incident data to be used within this report and therefore have been omitted from the report in its entirety. These trusts are:

- Kettering General Hospital NHS Foundation Trust
- University Hospital Birmingham NHS Foundation Trust
- The Dudley Group NHS Foundation Trust
- United Lincolnshire Hospitals NHS Trust
- West Hertfordshire Hospitals NHS Trust

In addition, the report features no data relating to the below NHS trusts which did not respond to the original FOI sent to them, or subsequent re-approaches:

- London North West University Healthcare NHS Trust
- Norfolk & Norwich University Hospitals NHS Foundation Trust

As a result of the above, this report features the data for Serious Incidents recorded by 228 NHS trusts in England and Wales and 7 Welsh health boards.

Under the Freedom of Information Act (2000), the NHS trusts and Welsh health boards had 20 working days to respond to our request for the data. 49 of the 242 Trusts or Welsh health boards (20%) did not provide the requested data within the 20 working days timeframe.

Five NHS trusts blocked use of data

Categorisation of trusts

Given the different services being provided by NHS mental health, physical and community health and ambulance trusts, the different situations and challenges these face and the varying types of Serious Incidents that may be recorded, this report has separate sections presenting data for each of these three types of NHS trust and health board.

Each of the 235 trusts has been identified as a mental health, physical and community health or ambulance trust based on NHS Choices' list of Authorities and Trusts[72].

It is acknowledged that some mental health trusts may provide some acute health services, including community health and sexual health services, and acute and community health trusts may also provide some mental health services. It is also recognised that Welsh health boards and Welsh

71 NHS Choices; *Authorities and Trusts, NHS Trusts*.
Accessible online via: https://www.nhs.uk/ServiceDirectories/Pages/NHSTrustListing.aspx (accessed on 8th May 2017)
and *NHS Wales; Structure*.
Accessible via: http://www.wales.nhs.uk/nhswalesaboutus/structure (accessed on 8th May 2017).

72 NHS lists of different types of trust; as identified in Organisation Patient Safety Incident Reports (27th September 2017).
Accessible online via: https://improvement.nhs.uk/resources/organisation-patient-safety-incident-reports-27-september-2017/ (accessed on 29th January 2018)

NHS trusts provide both ranges of services to a greater extent than NHS trusts in England. Owing to the fact that the significant majority of the NHS Wales budget[73] is directed to health services not related to mental health services, Welsh NHS trusts and health boards have been categorised within the NHS acute and community health trusts group.

171 NHS trusts in England and Wales (including seven Welsh health boards) were identified as acute and community health trusts

53 NHS trusts in England were identified as mental health trusts

11 NHS trusts in England and Wales are ambulance trusts

Data interpretation

132 of the 235 NHS trusts and Welsh health boards covered by this report provided Blackwater Law with categorisations/descriptions for all of the Serious Incidents they recorded in the year 2016/17. Blackwater Law was therefore in possession of categorisations/descriptions for 11,507 (56%) of the 20,433 total Serious Incidents that had been recorded in the period, a sizeable sample.

Due to there being no apparent standardised categorisations/descriptions across NHS trusts and Welsh health boards, this insight revealed 960 different categorisations/descriptions of Serious Incidents that had been recorded.

In order to better understand the types of Serious Incident that were most commonly recorded across each of the three different types of NHS trust – acute and community health, mental health and ambulance – the data was interpreted and categorisations/descriptions grouped into similar categories.

How do Never Events relate to Serious Incidents?

Never Events are required to be reported and fully investigated as a Serious Incident as set out in NHS England's Serious Incident Framework (2015)[74]. The number of Serious Incidents recorded by a trust will include any Never Events that have been reported.

A trust may record Serious Incidents but not have reported any Never Events. This will be due to none of the recorded Serious Incidents meeting the criteria of a Never Event as set out by NHS Improvement.

A definition of a Never Event is provided by NHS Improvement[75] and is set out in the excerpt below:

"Never Events are patient safety incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic

Two NHS trusts did not respond

73 Welsh Government (26 April 2017) NHS Expenditure Programme Budgets: 2015-16. Accessible online via: http://gov.wales/docs/statistics/2017/170426-nhs-expenditure-programme-budgets-2015-16-en.pdf (accessed on 9th January 2018).

74 NHS England Patient Safety Domain (27 March, 2015); *Serious Incident Framework: Supporting learning to prevent reoccurrence*, pages 7 &12. Accessible online via: https://improvement.nhs.uk/uploads/documents/serious-incidnt-framwrk.pdf (accessed on 29th January 2018).

75 NHS Improvement (January 2018); *Never Event Policy and Framework*, revised, page 6. Accessible online via: https://improvement.nhs.uk/uploads/documents/Revised_Never_Events_policy_and_framework_FINAL.pdf (accessed on 29th January 2018).

protective barriers are available at a national level and have been implemented by healthcare providers.

"Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death does not need to have happened as a result of a specific incident for that incident to be categorised as a Never Event."

The types of Serious Incidents defined as Never Events using the criteria set out by NHS Improvement are listed in the Never Events List 2018[76].

Data relating to the reporting of Never Events by NHS trusts in England is published by NHS Improvement[77]. 445 Never Events were reported by NHS trusts in England between 1st April 2016 and 31st March 2017.

How do Patient Safety Incidents relate to Serious Incidents?

A Patient Safety Incident is defined by NHS Improvement[78] as:

"Any unintended or unexpected incident that could have led or did lead to harm for one or more patients receiving NHS-funded healthcare."

NHS trusts report a material number more Patient Safety Incidents than they do Serious Incidents. Identification of a Patient Safety Incident may act as a trigger for staff to record the incident as a Serious Incident where the consequences for patients, staff or the organisation are so significant, or the potential for learning so great, that a heightened level of investigation is appropriate.

Data relating to the reporting of Patient Safety Incidents by NHS trusts in England is published by NHS Improvement[79]. 1,818,019 Patient Safety Incidents were reported by NHS trusts in England between 1st April 2016 and 31st March 2017.

Data limitations

This report has been completed with the data from 235 NHS trusts and Welsh health boards across England and Wales out of a possible 242 that existed during the period considered. Owing to the fact that data was not included for seven NHS trusts, it falls short of providing a complete picture of the total number of Serious Incidents being recorded in England and Wales.

In addition, not all Serious Incident data was available for each Trust for 2015/2016 where a figure was available for 2016/2017. A total of six NHS trusts were unable to provide figures for 2015/2016 which meant that no figures for these NHS trusts could be included when determining the total number of Serious Incidents that were recorded for the year 2015/2016, but data for these NHS trusts was included in the total figure of recorded

Categorisations/ descriptions for 11,507 Serious Incidents

76 NHS Improvement (January 2018) *Never Events list 2018*.
Accessible online via: https://improvement.nhs.uk/uploads/documents/Never_Events_list_2018_FINAL_v2.pdf
(accessed on 29th January 2018).

77 NHS Improvement, Never Events data.
Accessible online via: https://improvement.nhs.uk/resources/never-events-data/

78 NHS England Patient Safety Domain (27 March, 2015); *Serious Incident Framework: Supporting learning to prevent reoccurrence*, Glossary pages.
Accessible online via: https://improvement.nhs.uk/uploads/documents/serious-incidnt-framwrk.pdf
(accessed on 29th January 2018).

79 NHS Improvement, *Organisation Patient Safety Incident Reports*.
Accessible online via: https://improvement.nhs.uk/resources/organisation-patient-safety-incident-reports-data/

Serious Incidents for 2016/2017. The impact of this would be to exacerbate any perceived increase in the total number of recorded Serious Incidents for the period 2016/2017 compared to 2015/2016 or reduce any perceived decrease. However, based on the number of Serious Incidents recorded by these trusts for the period 2016/2017, if similar figures were to have been recorded in the 2015/2016 period by these NHS trusts, there would not have been a material difference to the total number of Serious Incidents recorded by all NHS trusts and Welsh health boards across England and Wales in 2015/2016 and so no material impact in the difference between the years 2015/2016 and 2016/2017.

54% of the NHS trusts and Welsh health boards provided Blackwater Law with categorisations/descriptions for all of the Serious Incidents they recorded. Blackwater Law was in possession of categorisations/descriptions for 11,507 of the 20,433 total Serious Incidents that had been recorded in the 2016/2017 year, a sample of 56%. However, due to their being no standardised categorisations/descriptions across NHS trusts and Welsh health boards, this insight revealed 960 different categorisations/descriptions of Serious Incidents that had been recorded. This made it particularly difficult to identify the types of Serious Incidents that were being recorded most commonly.

In order to understand the types of Serious Incident that were most commonly recorded across each of the three different types of NHS trust – acute and community health, mental health and ambulance – in the financial year 2016/2017, the data was interpreted and categorisations/descriptions grouped into similar categories. Blackwater Law acknowledges that there was an element of subjectivity in this lengthy exercise but argues this subjectivity was only due to a lack of any apparent standardisation in recording categorisations/descriptions across NHS trusts and Welsh health boards in England and Wales. Lists of the categorisations/descriptions of Serious Incidents as provided by NHS acute and community health (trusts and Welsh health boards, mental health trusts and ambulance trusts across England and Wales can be made available on request.[80]

80 Blackwater Law is under no obligation to provide this data and Blackwater Law reserves the right to refuse to supply this data. Where this data is provided this will be subject to limitations and restrictions placed upon Blackwater Law by the NHS trusts to which the data applies. This data will not be identifiable by NHS Trust/Health Board.

Appendix B

Open Government Licence v.2.0. and v3.0. compliance

Find below the OGL compliant attribution statements applying to data supplied by NHS trusts and Welsh health boards under the Open Government Licence v3.0.[81] or, in the case of Salisbury NHS Foundation Trust, the Open Government Licence v2.0.[82]

Aintree University Hospital NHS Foundation Trust, 2017
Airedale NHS Foundation Trust, 2017
Barking, Havering and Redbridge University Hospitals NHS Trust, 2017
Barnet, Enfield and Haringey Mental Health NHS Trust, 2017
Barnsley Hospital NHS Foundation Trust, 2017
Barts Health NHS Trust, 2017
Basildon and Thurrock University Hospitals NHS Foundation Trust, 2017
Bedford Hospital NHS Trust, 2017
Bolton NHS Foundation Trust, 2017
Bradford Teaching Hospitals NHS Foundation Trust, 2017
Brighton and Sussex University Hospitals NHS Trust, 2017
Buckinghamshire Healthcare NHS Trust, 2017
County Durham and Darlington NHS Foundation Trust, 2017
Dorset County Hospital NHS Foundation Trust, 2017
Dorset Healthcare University NHS Foundation Trust, 2017
East and North Hertfordshire NHS Trust, 2017
East Midlands Ambulance Service NHS Trust, 2017
East Sussex Healthcare NHS Trust, 2017
Frimley Health NHS Foundation Trust, 2017
Gateshead Health NHS Foundation Trust, 2017
Gloucestershire Hospitals NHS Foundation Trust, 2017
Great Ormond Street Hospital for Children NHS Foundation Trust, 2017
Guy's and St Thomas' NHS Foundation Trust, 2017
Hampshire Hospitals NHS Foundation Trust, 2017
Hywel Dda Health Board, 2017
Imperial College Healthcare NHS Trust, 2017
Isle Of Wight NHS Trust, 2017
Leicestershire Partnership NHS Trust, 2017

81 *Open Government Licence for public sector information (delivered by The National Archives).* Accessible online via: http://www.nationalarchives.gov.uk/doc/open-government-licence/version/3/

82 *Open Government Licence for public sector information (delivered by The National Archives).* Accessible online via: http://www.nationalarchives.gov.uk/doc/open-government-licence/version/2/

Liverpool Heart and Chest Hospital NHS Foundation Trust, 2017
Medway NHS Foundation Trust, 2017
North Tees and Hartlepool NHS Foundation Trust, 2017
Northamptonshire Healthcare NHS Foundation Trust, 2017
Northern Devon Healthcare NHS Trust, 2017
Northumbria Healthcare NHS Foundation Trust, 2017
Nottingham University Hospitals NHS Trust, 2017
Oxford University Hospitals NHS Foundation Trust, 2017
Oxleas NHS Foundation Trust, 2017
Pennine Care NHS Foundation Trust, 2017
Portsmouth Hospitals NHS Trust, 2017
Royal Berkshire NHS Foundation Trust, 2017
Royal Brompton and Harefield NHS Foundation Trust, 2017
Royal Cornwall Hospitals NHS Trust, 2017
Royal Devon and Exeter NHS Foundation Trust, 2017
Royal Free London NHS Foundation Trust, 2017
Royal Surrey County Hospital NHS Foundation Trust, 2017
Salisbury NHS Foundation Trust, 2017[83]
Sheffield Children's NHS Foundation Trust, 2017
Sherwood Forest Hospitals NHS Foundation Trust, 2017
Somerset Partnership NHS Foundation Trust, 2017
South Staffordshire and Shropshire Healthcare NHS Foundation Trust, 2017
South Tees Hospitals NHS Foundation Trust, 2017
South Warwickshire NHS Foundation Trust, 2017
South West Yorkshire Partnership NHS Foundation Trust, 2017
St Helens and Knowsley Hospitals NHS Trust, 2017
Surrey and Borders Partnership NHS Foundation Trust, 2017
Sussex Community NHS Foundation Trust, 2017
Sussex Partnership NHS Foundation Trust, 2017
The Newcastle Upon Tyne Hospitals NHS Foundation Trust, 2017
The Princess Alexandra Hospital NHS Trust, 2017
The Rotherham NHS Foundation Trust, 2017
The Royal Bournemouth and Christchurch Hospitals NHS Foundation Trust, 2017
Warrington and Halton Hospitals NHS Foundation Trust, 2017

83 *Open Government Licence for public sector information (delivered by The National Archives).*
Accessible online via: http://www.nationalarchives.gov.uk/doc/open-government-licence/version/2/

Western Sussex Hospitals NHS Foundation Trust, 2017

Whittington Health NHS Trust, 2017

Yeovil District Hospital NHS Foundation Trust, 2017

York Teaching Hospital NHS Foundation Trust, 2017

To speak to Blackwater Law contact 0800 083 5500.