

Ref: 22-317

Freedom of Information Request

16 September 2022

By Email

Dear Sir/Madam

Thank you for your request for information under the Freedom of Information Act 2000. The Trust's response is as follows:

We can confirm that we do hold some of the information you are requesting

For each of the financial years 2015/16, 2016/17, 2017/18, 2018/19, 2019/20, 2020/21, 2021/22 and 2022/23 (up to and including 31 May), How many serious incidents were reported by the trust relating to its A&E department?

| Year | Bristol Royal Infirmary | Weston General Hospital** | Bristol Royal Hospital for Children |
|-----------|----------------------------|------------------------------|---|
| 2015-2016 | * | 11 | * |
| 2016-2017 | * | 51** | 0 |
| 2017-2018 | * | * | 0 |
| 2018-2019 | * | 9 | 0 |
| 2019-2020 | * | * | 0 |
| 2020-2021 | 0 | * | 0 |
| 2021-2022 | 10 | 7 | * |
| 2022-2023 | 0 | * | 0 |

^{**}Please note that 39 of the serious incidents reported in Weston General Hospital in 2016/17 were no harm 12-hour trolley breaches which, with hindsight, did not meet serious incident guidance at the time. We recommend that these 39 incidents are discounted when considering this data. For further information please see the link below:

serious-incdnt-framwrk-faqs-mar16.pdf (england.nhs.uk)

Please note: Where the figures are between 1 and 5, this has been denoted by *. Due to the low numbers, we have considered that there is the potential for individuals to be identified from the information provided, when considered with other information that may also be in the public domain. In our view disclosure of these low figures would breach one of the Data Protection Principles set out in Schedule 1 of the Data Protection Act, namely Principle 1. The Trust therefore finds that the Section 40(2) exemption contained within the Freedom of information Act 2000 is engaged. (Section 40 is the exemption for personal information).

For each year, please detail how many of the incidents resulted in a) no harm b) low harm c) moderate harm d) severe harm, e) death – according to the definitions in the National Reporting and Learning System Data Set.

Please note these are the Datix harm categories. We do not have access to the NRLS system; however, incidents are reported to NRLS using the following mappings:

| Result | Code | Description | NRLS | Active? | | | | | |
|------------|---|------------------------|----------|------------|------------|-------------|---------|--|--|
| HARM | DEATH | Catastrophic | E | Υ | | | | | |
| HARM NOHAF | INVE | Unexpected Death | В | | | | | | |
| HARM | LOW | Minor | В | Υ | | | | | |
| HARM | MAJOR | Major | D | Υ | | | | | |
| HARM | MODRTE | Moderate | C | Υ | | | | | |
| NRMISS | NEAR | None - Near Miss | | Υ | | | | | |
| HARM | NEGL | Negligible | В | Υ | | | | | |
| NOHARM | NONE | None | | Υ | | | | | |
| NOHARM | UNAVOD | Unavoidable Death | В | Υ | | | | | |
| | | | | | | | | | |
| _ | | | | | | | | | |
| В | | arm to patients - requ | | | | | | | |
| С | Moderate (Sho | rt term harm to patier | its, req | uired furt | her treatm | ent, or pro | cedure) | | |
| D | Severe (Permar | nent or long term harn | ո) | | | | | | |
| E | Death (Caused by the patient safety incident) | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |
| | | | | | | | | | |

In addition, pre-merger incidents used a different Datix system, and their harm ratings used have been standardised with the current system for these purposes.

12-hour breaches

| Hospital/harm level | 2015- 2016 | 2016- 2017 | 2017- 2018 | 2018- 2019 | 2019- 2020 | 2020- 2021 | 2021- 2022 | 2022- 2023 |
|------------------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|---------------|
| Bristol Royal | | | | | | | | |
| Infirmary | | | | | | | | |
| None | * | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Moderate | 0 | 0 | 0 | 0 | 0 | 0 | * | 0 |
| Weston | | | | | | | | |
| General | | | | | | | | |
| Hospital | | | | | | | | |
| None | * | 39 | 0 | 0 | 0 | 0 | 0 | 0 |

Other Incidents

| Hospital/harm | 2015- | 2016- | 2017- | 2018- | 2019- | 2020- | 2021- | 2022- |
|----------------------|-------|-------|-------|-------|-------|-------|-------|-------|
| level | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 |
| Bristol Royal | | | | | | | | |
| Infirmary | | | | | | | | |

| | | | _ | | | | * | • |
|-------------------------------|---|---|---|---|---|---|---|---|
| None | 0 | 0 | 0 | 0 | 0 | 0 | | 0 |
| None – Near Miss | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Minor | 0 | 0 | * | 0 | 0 | 0 | 0 | 0 |
| Major | 0 | * | 0 | * | * | 0 | * | 0 |
| Moderate | 0 | 0 | 0 | 0 | * | 0 | 0 | 0 |
| Catastrophic | 0 | 0 | * | 0 | * | 0 | 0 | 0 |
| Unavoidable | 0 | * | 0 | 0 | 0 | 0 | 0 | 0 |
| death | | | | | | | | |
| Unexpected | 0 | 0 | 0 | 0 | 0 | 0 | * | 0 |
| death | | | | | | | | |
| Bristol Royal Hospital for | | | | | | | | |
| Children | _ | _ | _ | _ | _ | _ | _ | _ |
| None | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| None – Near Miss | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Minor | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Major | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Moderate | * | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Catastrophic | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Unavoidable death | * | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Unexpected death | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| Weston | | | | | | | | |
| General | | | | | | | | |
| Hospital | | | | | | | | |
| None | * | * | * | * | 0 | * | 0 | 0 |
| None – Near | 0 | * | 0 | 0 | 0 | 0 | 0 | 0 |
| Miss | | | | | | | | |
| Minor | 0 | * | * | 0 | 0 | 0 | 0 | * |
| Major | * | * | * | * | 0 | * | 0 | 0 |
| Moderate | * | * | * | * | * | 0 | * | 0 |
| Catastrophic | 0 | 0 | 0 | 0 | 0 | * | 0 | 0 |
| Unavoidable | 0 | 0 | 0 | 0 | 0 | 0 | 0 | 0 |
| death | | | | | | | | |
| Unexpected | * | 0 | 0 | 0 | 0 | * | * | * |
| death | | | | | | | | |
| | | | | | | | | |

Please note: Where the figures are between 1 and 5, this has been denoted by *. Due to the low numbers, we have considered that there is the potential for individuals to be identified from the information provided, when considered with other information that may also be in the public domain. In our view disclosure of these low figures would breach one of the Data Protection Principles set out in Schedule 1 of the Data Protection Act, namely Principle 1. The Trust therefore finds that the Section 40(2) exemption contained within the Freedom of information Act 2000 is engaged. (Section 40 is the exemption for personal information).

For each year, how many of these serious incidents related to long waits in A&E for treatment? Please indicate how many of these incidents resulted in a) no harm b) low

harm c) moderate harm d) severe harm, e) death

By definition, all the 12-hour breaches are related to long waits in A&E – please see the table above.

| Hospital/harm | 2015- | 2016- | 2017- | 2018- | 2019- | 2020- | 2021- | 2022- |
|----------------------|-------|-------|-------|-------|-------|-------|-------|-------|
| level | 2016 | 2017 | 2018 | 2019 | 2020 | 2021 | 2022 | 2023 |
| Bristol Royal | | | | | | | | |
| Infirmary | | | | | | | | |
| Catastrophic | 0 | 0 | 0 | 0 | * | 0 | 0 | 0 |
| Unexpected | 0 | 0 | 0 | 0 | 0 | 0 | * | 0 |
| death | | | | | | | | |
| Weston | | | | | | | | |
| General | | | | | | | | |
| Hospital | | | | | | | | |
| Unexpected | 0 | 0 | 0 | 0 | 0 | * | 0 | 0 |
| death | | | | | | | | |

Please note: Where the figures are between 1 and 5, this has been denoted by *. Due to the low numbers, we have considered that there is the potential for individuals to be identified from the information provided, when considered with other information that may also be in the public domain. In our view disclosure of these low figures would breach one of the Data Protection Principles set out in Schedule 1 of the Data Protection Act, namely Principle 1. The Trust therefore finds that the Section 40(2) exemption contained within the Freedom of information Act 2000 is engaged. (Section 40 is the exemption for personal information).

Have any thematic reviews been undertaken into serious incidents in A&Es in the last two years? If so, please detail a) when they were done b) what they looked into c) what the findings and conclusions were. Please provide copies of any thematic reviews.

Yes – please see below:

- 1) Review of incidents related to potential delays in transfers/transport between hospital
 - a. This review was commenced on 9th June 2022.
 - b. The panel looked into 27 cases where there were apparent delays in patient transfers between sites and Trusts between April 2021 June 2022. This work covered all UHBW sites including the emergency departments in Weston, BRI and BCH.
 - c. The review is currently still in progress and therefore findings and conclusions are not available at this time.
- 2) Bristol Royal Infirmary Emergency department (BRI ED) thematic review of transfer of gynae transfer patients to St Michael's Hospital, UHBW.
 - a. Thematic review of six incidents 2017-2021 of transfers from BRI ED to Ward 78 St Michael's hospital where the patient had arrived in a shocked condition who required immediate additional support and resuscitation on arrival (no deaths occurred).
 - b. All six transfers were undertaken by ambulance after 6pm in the evening / at weekends.
 - c. Findings identified improvements were required in the nursing/ medical handover of the patient's status prior to transfer for the receiving team at St Michael's.
 - d. A handover proforma including immediate observations before transfer has been developed and is now in operational use.

This concludes our response. We trust that you find this helpful, but please do not hesitate to contact us directly if we can be of any further assistance.

If, after that, you are dissatisfied with the handling of your request, you have the right to ask for an internal review. Internal review requests should be submitted within two months of the date of receipt of the response to your original letter and should be addressed to:

Data Protection Officer
University Hospitals Bristol and Weston NHS Foundation Trust
Trust Headquarters
Marlborough Street
Bristol
BS1 3NU

Please remember to quote the reference number above in any future communications.

If you are not content with the outcome of the internal review, you have the right to apply directly to the Information Commissioner for a decision. The Information Commissioner can be contacted at: Information Commissioner's Office, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF

<u>Publication</u>

Please note that this letter and the information included/attached will be published on our website as part of the Trust's Freedom of Information Publication Log. This is because information disclosed in accordance with the Freedom of Information Act is disclosed to the public, not just to the individual making the request. We will remove any personal information (such as your name, email and so on) from any information we make public to protect your personal information.

To view the Freedom of Information Act in full please click here.

Yours sincerely

Freedom of Information Team University Hospitals Bristol and Weston NHS Foundation Trust