Bedfordshire Hospitals NHS Foundation Trust

12/07/2021

Dear Requester,

Thank you for your Freedom of Information request.

In accordance with S.1 (1) (a) of the Freedom of Information Act 2000 (FOIA), I can confirm that we do hold the information relevant to your request. FOI 340

You asked:

Response from Luton and Dunstable University Hospital

1. Number of 'never Event' (point 6 c) started by the organisation since the 23rd May, 2019.
Total Never Events during the period:

Year	Never Event	Description	Learning
2019	Wrong site block	A nerve block was placed in the incorrect side of patients lower spine	Introduction of 'Stop before you Block' National Campaign Trust wide learning is shared with all relevant teams
2019	Misplaced NG tube	NG tube was incorrectly assessed as being in the correct position and patient received some feed	Two person check to minimise error As long as there is no emergency, ensure check procedure is undertaken during minimal distractions Portable X-ray machine is not ideal- department to purchase large screens computers to resolve this
2020	Wrong site block	Nerve block in incorrect side	Checking procedure form required to be read out to all in the room prior to any procedure and confirmed again verbally with the patient just before injecting. Implemented 'Stop before you Block' within the department. Formal checklist used in all departments

2020	**Retained swab**	**Retained Vaginal Swab**	**Education and training to all midwifery and support staff. Management of swabs during patient transfer is reflected in standard operating procedure. All clinical staff are aware of responsibility of documentation of swab counting. To ensure use of additional stickers where additional swabs are involved. Arrangements for Shared learning.**

2. If, there has been a 'never event' commissioned as per point 6 c), has this report been published in any forum and if so where?

This would be published by NHS England at the following link:

https://www.england.nhs.uk/patient-safety/never-events-data/

The information would also be published in the Trust's annual Quality Account.

3. If, there has been a 'never event' commissioned as per point 6 c), what learning was found?
As above

Questions 4,5,6,7 **below**

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4) Number of Staff suspensions in 2017, 2018, 2019 and 2020 by respective year

	2017	2018	2019	2020
Number of Suspensions	10	9	3	4

5) **In decisions to suspend staff, is there any formal written assessment the organisation conducts to assess the effect on health and welfare of suspension of the staff member the organisation is considering suspending, if so please disclose a copy?**

The Trust's disciplinary policy states that all staff who are suspended are offered access to employee services such as the Trust's employee assistance programme and the Occupational Health department as sources of support during their suspension.

In addition, every employee who is suspended is also allocated a 'buddy' during the period of their suspension. The role of a 'buddy' is to maintain regular contact with the employee and keep them up to date about general work related issues or news so that their return to the workplace is as smooth as possible. A copy of the 'buddy' guidance is attached.

6) Number of staff disciplinary investigations started in 2017, 2018, 2019 and 2020 by respective year.

	2017	2018	2019	2020
Number of Disciplinary Investigations (Internal Investigator)	35	30	39	25
Number of Disciplinary Investigations (External Investigator)	1	0	0	0

7) Number of staff disciplinary investigations started in 2017, 2018, 2019 and 2020 by respective year split down by investigated by an internally employed investigator or an externally contracted investigator.

See table above.

Response from Bedford Hospital

1. Number of 'never Event' (point 6 c) started by the organisation since the 23rd May, 2019.

Bedford Hospital has reported 2 Never Events. Both of these have occurred in 2020. There were no Never events on the Bedford site in 2019.

2. If, there has been a 'never event' commissioned as per point 6 c), has this report been published in any forum and if so where?

This would be published by NHS England at the following link:

https://www.england.nhs.uk/patient-safety/never-events-data/

The information would also be published in the Trust's annual Quality Account.

3. If, there has been a 'never event' commissioned as per point 6 c), what learning was found?

As below:

1. Wrong route medication incident:

The incident involved disconnection of an epidural catheter and connection of it to a peripheral cannula. The incident was identified quickly and no harm came to the patient.

Key Learning Points:

· **An epidural infusion should not at any time be disconnected unless under the instruction of the anaesthetic team or pain service.**

· **Staff who are not trained or competent to care for a patient with an epidural should not be assigned to their care. All staff who care for patients with epidural infusions to carry out yearly competency assessment.**

· **Sourcing compatible system products in line with national guidance relating to Safer Spinal (intrathecal) epidural devices.**

· **Reviewing where patients with epidurals are admitted to post-operatively.**

. **Incorrect tooth extraction: remains under investigation.**

Immediate learning re ensuring documentation re which tooth is to be removed is correctly documented in the medical notes including on the consent form, medical notes, discharge letter etc.

4. Number of staff suspensions in 2017, 2018, 2019 and 2020 by respective year.

	2017	2018	2019	2020
Number of Suspensions	16	11	13	7

5. In decisions to suspend staff, is there any formal written assessment the organisation conducts to assess the effect on health and welfare of suspension of the staff member the organisation is considering suspending, if so please disclose a copy ?

Staff suspended from duties following a disciplinary investigation are referred to Trust Occupational Health Services. Following assessment from this team, a written report is completed and made available to department management and the Trust HR team to provide advice and support recommendations.

Staff suspended from duties following a disciplinary investigation are also signposted to the Employee Assistance Programme in place as well as having on-going access to occupational health services.

All staff are assigned a 'single point of contact' whilst on suspension. Within the Luton & Dunstable site, this role as been formalised into a 'Buddy' system and the role of the 'buddy' is to maintain regular contact with the employee and provide them with updates on general work related issues and news, so that their return to the workplace is as smooth as possible. A copy of this 'buddy' guidance has been attached.

The Trust is in the process of amalgamating its policies following merger and this process is likely to be rolled out across the Trust as part of this process.

6. Number of staff disciplinary investigations started in 2017, 2018, 2019 and 2020 by respective year.

	2017	2018	2019	2020
Number of Disciplinary Investigations (Internal Investigator)	56	60	67	45
Number of Disciplinary Investigations (External Investigator)	1	---	---	---

7. Number of staff disciplinary investigations started in 2017, 2018, 2019 and 2020 by respective year split down by investigated by an internally employed investigator or an externally contracted investigator.

See above

If you are not satisfied with the Trust review under the Freedom of Information Act 2000 you may apply directly to the Information Commissioners Officer (ICO) for a review of your appeal decision. The ICO can be contacted at: ICO, Wycliffe House, Water Lane, Wilmslow, Cheshire, SK9 5AF www.ico.org.uk

Yours sincerely,

IG/FOI Coordinator

Please note that the Trust has a formal internal review and complaints process which is managed by the Information Governance Manager/Data Protection Officer. Should you have any concerns with our response, you can make a formal request for an internal review. Requests for internal review should be submitted within three months of the date of receipt of the response to your original letter, and should be addressed to: dataprotectionofficer@ldh.nhs.uk