Paper ref:	TB (01/20) 007

Sandwell and West Birmingham Hospitals NHS Trust

Report Title	Serious Incident Investigations: mid-year report		
Sponsoring Executive	Kam Dhami, Director of Governance		
Report Author	Allison Binns, Deputy Director of Governance		
Meeting	Public Trust Board	**Date**	2nd January 2020

1. Suggested discussion points *[two or three issues you consider the Board should focus on]*

This paper is a follow-up to the mid-year SI report presented to the Board in November 2019, requested at the time for an update on the incomplete actions.

The Post Mortem result for the latest Maternal death shows the same cause as three previous Maternal Deaths. The Healthcare Safety Investigation Branch (HSIB) are investigating this incident as part of their routine nation-wide programme of work.

Learning remains the key aim of investigating serious incidents although not always easy to elicit, so work continues to ensure we are able to achieve this.

2. Alignment to 2020 Vision *[indicate with an **'X'** which Plan this paper supports]*

Safety Plan		Public Health Plan		People Plan & Education Plan	
Quality Plan		Research and Development		Estates Plan	
Financial Plan		Digital Plan		Other *[specify in the paper]*	**X**

3. Previous consideration *[where has this paper been previously discussed?]*

Individual SIs to EQC and Executives.

4. Recommendation(s)

Trust Board is asked to:

a.	**NOTE** the comments regarding overdue actions.
b.	**NOTE** the update on incidents currently in investigation
c.	**APPROVE** the proposal for tighter governance of the SI actions

5. Impact *[indicate with an **'X'** which governance initiatives this matter relates to and where shown elaborate]*

Trust Risk Register	x	Risk Number(s):						
Board Assurance Framework		Risk Number(s):						
Equality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed		
Quality Impact Assessment	Is this required?	Y		N	x	If 'Y' date completed		

SANDWELL AND WEST BIRMINGHAM HOSPITALS NHS TRUST

Report to the Trust Board: 2nd January 2020

Serious Incident Investigations: Update report

1. Introduction

1.1 This report provides an update to the Board on the Serious Incidents (SIs) following the previous update in November 2019, specifically on those actions which are overdue for completion.

1.2 The report also provides information on the investigations which are currently in progress and have not yet had actions identified.

2. Update on 2018/19 SIs

2.1 There is one outstanding Serious Incident from 2018/19 which has actions overdue. This can be seen in **Appendix A.**

2.2 The Trust already follows the British Society of Gastroenterologists guideline for iron deficiency anaemia. The process for tests and investigations is being defined through a flowchart and will be discussed, to ensure alignment with Haematology and Acute Medicine, in February at the QIHD.

2.3 A change request will then be made to ensure that the flow chart can be linked through into Unity, making it easier for clinicians to follow the appropriate steps.

2.4 With regard to the virtual clinics, these are run by a senior Registrar under a named Consultant, who is available for advice. At the outcome of the review, a letter is generated and sent to the patient's GP. No further action is planned.

3. 2019/2020 Serious Incidents

3.1 **Appendix B** provides an update on actions for those Serious Incidents which are completed and those which are currently overdue**.**

3.2 **Page 1, Incident ref: 1** – The Head Injury Pathway has been revised to take account of referrals for neuro and general rehabilitation. Once approved the Pathway will be shared across the Trust. (January 2020)

3.3 **Page 2, Incident ref: 3** – The swab policy had been updated to reflect changes made following the Never Event. Further changes in practice are required to change the colour of swabs used during catheterisation in theatre. These swabs and throat swabs are also counted and documented separately to the general swab use.

3.4 Once this procurement change is made, the swab policy will be implemented.

3.5 The Post Mortem has been returned as an Amniotic Fluid Embolus on the most recent maternal death, which is being investigated by the Healthcare Safety Investigation Branch (HSIB) as they have routinely taken over investigating maternal and neonatal deaths currently.

3.6 Since the Board's mid-year update the Trust has reported a further 10 Serious Incidents which are all presently being investigated.

3.7 There have been some unexpected deaths. Four adults, one of which was during a planned elective procedure and one baby. In addition there has been an intrauterine death and a VTE related death.

3.8 One incident is being investigated as a possible delay in initiating treatment for a metastatic spinal cord compression, a possible delay in diagnosing cancer and a patient who was involved in a road traffic accident who was admitted elsewhere, after being discharged from our ED, with a bleed on the brain.

4. Conclusion

4.1 The numerous actions identified during the course of incident investigations do not always provide a solution to an identified problem. Some of the actions in the appendices are not unreasonable but do not go to the heart of the problem that is trying to be solved.

4.2 Looking forward at the investigations yet to be completed, the focus will shift to identifying the solution that would prevent recurrence. To tighten the robustness of this a small Executive group, will be established to meet monthly to review serious incident investigation outcomes pre-final case sign-off by the Medical Director.
Group Directors and Investigation Leads will present the identified solutions or be helped to do so if this is missing from the draft report. The assurance methods to test effective action plan delivery and on-going monitoring at directorate-level will also be checked.

5. Recommendations

Trust Board is recommended to:

- **NOTE** the comments regarding overdue actions.
- **NOTE** the update on incidents currently in investigation
- **APPROVE** the proposal for tighter governance of the SI investigation sign-off

Allison Binns
Deputy Director of Governance

23 December 2019