Paper ref:	TB (08/20) 015

Sandwell and West Birmingham Hospitals NHS Trust

Report Title	Serious Incident Investigations: mid-year report		
Sponsoring Executive	Dr David Carruthers, Medical Director		
Report Author	Sindeep Chatha		
Meeting	Trust Board (Public)	**Date**	6th August 2020

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

The Board is presented with an update on the serious incidents reported in Quarter 3 and 4, 2019/20 and the incident actions still ongoing from a SIs reported in Quarter 1 and 2, 2019/20.

Details of new serious incidents reported in Quarter 1, 2020/21 are presented.

Learning remains the key aim of investigating serious incidents, so work continues to ensure we are able to achieve this.

The SI process is currently under review and some suggested changes are presented in this report.

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

Safety Plan	**X**	Public Health Plan		People Plan & Education Plan	**X**
Quality Plan	**X**	Research and Development		Estates Plan	
Financial Plan	**X**	Digital Plan	**X**	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 update on serious incidents reported in Q3 and Q4, 2019/20
b.	**NOTE** the current work taking place to strengthen the current SI process

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: August 2020

Serious Incident Investigations: Update report

1. Introduction

1.1. Serious Incidents are incidents that occur in relation to NHS-funded services where care results in unexpected or avoidable death, serious harm, organisational capability, allegations of abuse or a Never Event (Policy for the reporting, management and investigations of incidents).

1.2. Appendix 1 provides an overview of the serious incident investigation process. Currently, this process is under review in order to improve the robustness of monitoring the actions and recommendations following investigation.

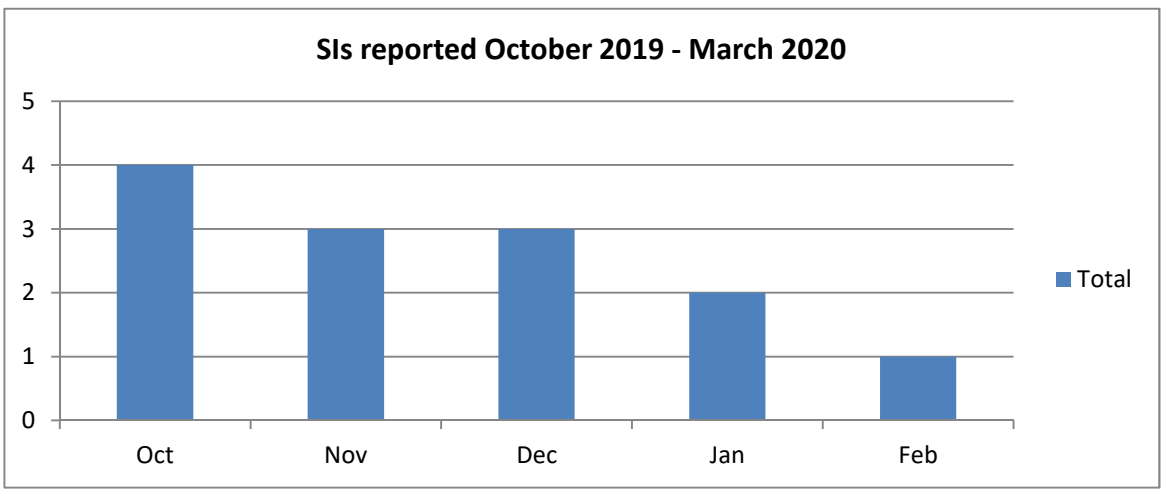
1.3. This report provides an update to the Board on the Serious Incidents (SIs) reported from 1st October 2019 to 31st March 2020 (Quarter 3 and 4, 2019/20).

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

2. Number of Serious Incidents reported per month (Quarter 3 and 4, 2019/20)

2.1. All data shown in this report are incidents escalated as a Serious Incident during October 2019 – March 2020 excluding falls and pressure sores.

2.2. There were 13 SIs reported during Q3 and Q4 (October 2019 to March 2020) this compares to 15 during the previous year Q3 and Q4. There were 0 SIs reported in March 2020 compared to 2 in March 2019.



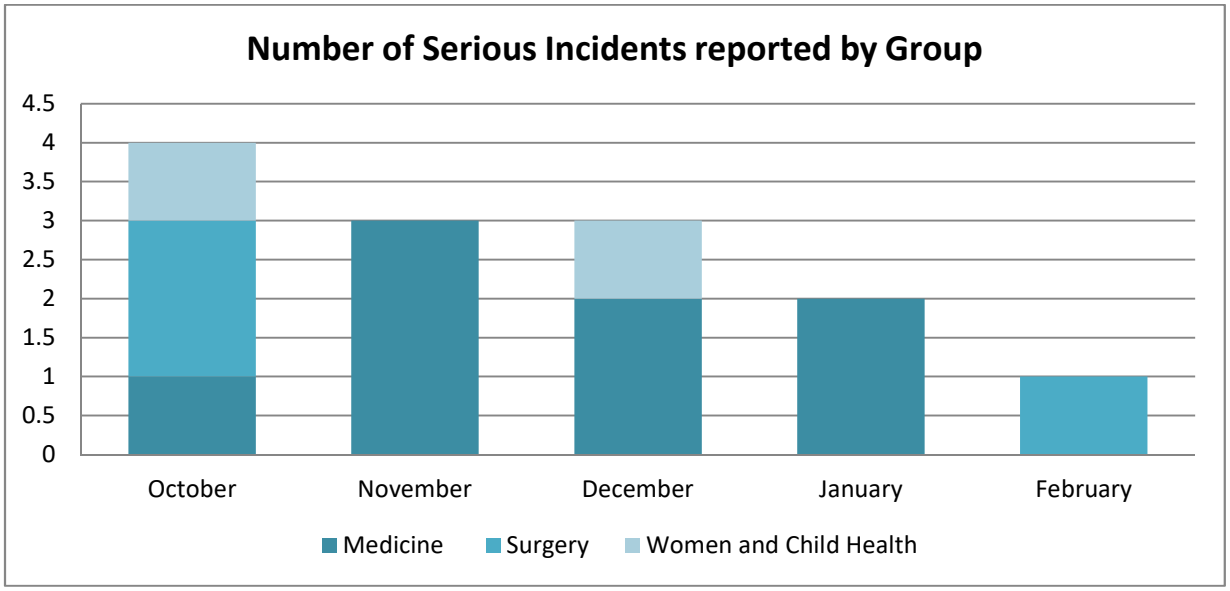
3. Type of categories reported per month

3.1. The table below shows the number of SIs reported by incident category. Delay in treatment is the most commonly reported SI. This includes, delayed cancer diagnosis, delay in follow up treatment and any deaths resulting from delay in treatment.

Incident category	Oct 2019	Nov 2019	Dec 2019	Jan 2020	Feb 2020	Grand Total
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	2	1	1	1		5
HCAI/Infection control incident meeting SI criteria				1		1
Maternity/Obstetric incident meeting SI criteria: baby*	1		1			2
Surgical/invasive procedure incident meeting SI criteria	1					1
Unsafe Transfer		2				2
VTE meeting SI criteria			1		1	2
Grand Total	**4**	**3**	**3**	**2**	**1**	**13**

4. Serious Number of Serious Incidents reported by per Group

4.1. In Quarter 3 and 4; Medicine reported 8 serious incidents; 4 were related to delay in diagnosis, 2 were in relation to unsafe transfer, 1 was a VTE related harm and 1 infection control issue. Surgery reported 3 serious incidents; 1 in relation to delayed diagnoses, 1 Never Event and 1 in relation to VTE issue. Women and Child Health reported 2 serious incidents, both in relation to baby born in poor condition.



5. Update on the Serious Incidents reported in Quarter 3 and 4

5.1 Details of new serious incidents reported in these quarters are presented on Appendix 2; including updates on actions for those which are completed and those which are currently overdue.

5.2 92% of the reported serious incidents have completed the investigation and recommendations and actions have been presented. Once the SI report is signed off, these actions are monitored by the relevant Group through their governance meetings. At present, 46% of the actions have been completed, 22% of actions are within their deadline and 32% of actions are overdue. Those actions which are overdue are being monitored by the patient safety team. A renewed focus on completion of outstanding actions is needed now COVID-19 peak has passed.

5.3 During the investigation, opportunity is given to the patient and/or their family to be part of the investigation process. 80% of the time the patient or family have been in contact with the investigation team during this time. 20% of the time the patients or family have declined to be involved but willing to meet the investigation team after to receive the findings.

5.4 On average it is taking 80 working days to finally approve a serious incident investigation report. The Trust's internal deadline is 50 working days. The delay is due to a number of steps within the process. Firstly, it can take up to 10 working days to assign an independent lead to agree to investigate an SI and this is due to reduced number of SI trained leads owing to recent retirements or change in job roles. To address this issue the Trust is running two advanced investigation training sessions in August and September to recruit a new cohort of SI leads. In addition to this, specialist leads are being established within each Clinical group to help the SI lead with their investigation. This will improve the time it takes to gather the required information. Second delay is the Groups signing off the final report. This delay is caused by ensuring the action plans are robust to meet the recommendations but this in turn results in missing the deadline. To address this issue the Trust has set up an SI sign off meeting on a monthly basis to strengthen the approval process between the Groups and the Trust sign off.

6 New Serious incidents reported in Quarter 1, 2020/21

6.1 In Quarter 1 2020/21, 4 Serious incidents have been reported compared to 9 reported in Quarter 1 in 2019/20. This decrease is likely to be due to the Covid 19 pandemic which saw a number of services being suspended. Details of these incidents can be found in Appendix 3.

7 Update on Serous Incidents reported in Quarter 1 and 2, 2019/20

7.1 There are 4 outstanding Serious Incidents from Q1 and Q2 2019/20; 3 of those are never events and 1 IT related serious incident. These have been presented previously (January 2020)

7.2 All actions have now been completed for the retained vaginal swab never event and this report is awaiting final sign off from the Chief Executive. The wrong site surgery and retained instrument events are still awaiting final sign off of the revised safety policy for invasive procedures and interventions. Once this has been completed all actions are complete and reports are ready for sign off by the Chief Executive.

7.3 1 serious incident reported in relation to IT systems is still awaiting an investigation report to be submitted.

8. Conclusion

8.1 Actions identified during the course of incident investigations do not always provide a solution to an identified problem. Changes to the review process will hopefully address this.

8.2 The SI process is being reviewed in order to improve the robustness of the investigation and the actions.

8.3 Looking forward at the investigations yet to be completed, the focus will be on identifying the actions that would prevent recurrence.

8.4 To tighten the robustness of SI sign off committee, led by executives. The remit will be to review and challenge solutions with Group Directors and Investigation leads and to monitor the identified and agreed actions.

9. Recommendations

Trust Board is recommended to:

- **NOTE** the update on serious incidents reported in Q3 and Q4, 2019/20
- **NOTE** the current work taking place to strengthen the current SI process

Sindeep Chata,

Head of Patient Safety and Risk

31st July 2020