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Sandwell and West Birmingham Hospitals NHS
NHS Trust

Report Title	Serious Incident Investigations: Quarter 2		
Sponsoring Executive	Kathleen French, Interim Chief Nurse		
Report Author	Sindeep Chatha, Head of Patient Safety and Risk		
Meeting	Trust Board	**Date**	3rd December 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 2, 2020 and the incident actions still ongoing from a SIs reported in Quarter 1 2020-21.

Details of new serious incidents reported in Quarter 2, 2020-21 is presented in Appendix 2.

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.

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 Board: 3rd December 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).

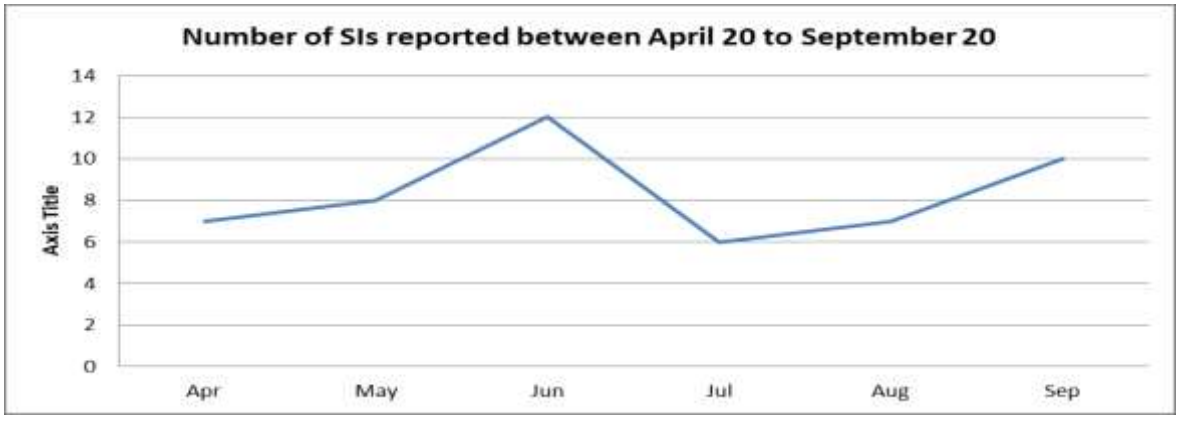
1.2. This report provides an update to the Board on Serious Incidents (SIs) reported from 1st July 2020 to 31st September 2020 (Quarter 2, 2020-21).

1.3. 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 2, 2020-21)

2.1. All data shown in this report are incidents escalated as a Serious Incident during July 2020 to September 2020, including falls and pressure sores.

2.2. There were 23 SIs reported during Q2.



3. Type of categories reported per month

3.1. The table below shows the number of SIs reported by incident category. Grade 3 and 4 pressure ulcer is the most commonly reported category.

Incident category	Jul	Aug	Sept	Total
Diagnostic incident including delay meeting SI criteria (including failure to act on test results)	0	0	1	1
HCAI/Infection control incident meeting SI criteria	0	0	1	1
Maternity/Obstetric incident meeting SI criteria: baby*	1	1	2	4
Medication Incident	0	0	1	1
Sub-optimal care of deteriorating patient	0	1	1	2
Apparent/suspected self-inflicted harm	1	0	0	1
Pressure Ulcers	3	3	2	8
Falls resulting in fracture	1	2	2	5
Grand Total	**6**	**7**	**10**	**23**

4. Number of Serious Incidents reported by Group

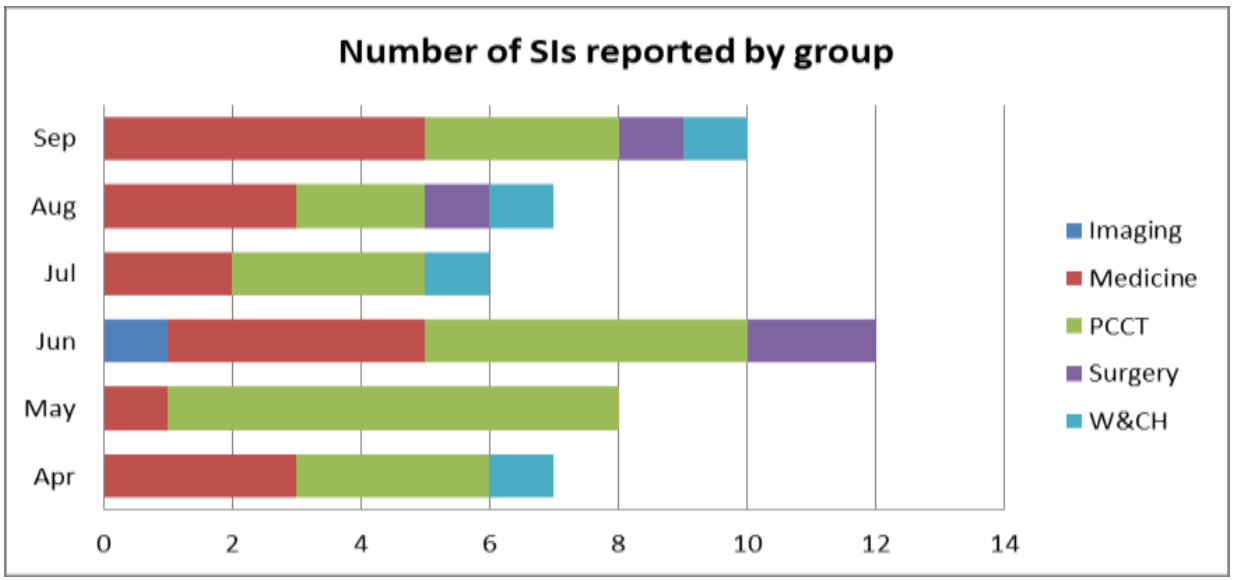
4.1. In Quarter 2, reported Sis are broken down per Group as follows:

4.2. **Primary Care and Community Therapies (PCCT)** reported 8 serious incidents; 6 were related to grade 3 pressure ulcers and 2 were in relation to falls resulting in fracture.

4.3. **Women and Child Health** reported 4 serious incidents all of which resulted in a baby being born in poor condition.

4.4. **Medicine and Emergency Care** reported 10 SIs; 3 relating to falls resulting in fracture and 2 relating to a grade 3 pressure ulcer, 2 incidents involved sub optimal care of a deteriorating patient resulting in death.

4.5. **Surgery** reported one grade 3 pressure ulcer and one MRSA infection control incident. Three SIs relating to possible delayed diagnosis were reported by imagining.



5. Update on the Serious Incidents

5.1 Details of new serious incidents reported in this quarter are presented on Appendix 2. Updates on actions from previous reported SIs can be found in appendix 3.

5.2 During the investigation, opportunity is given to the patient and/or their family to be part of the investigation process. Patient or family participation has been established 90% of the time. Non-participation occurred 5% of the time however they have been willing to meet the investigation team after to receive the findings. The remaining 5% includes those investigations where it has proved difficult to contact the next of kin to inform them of the investigation.

5.3 On average it takes 80 working days to finally approve a serious incident investigation report, excluding SIs relating pressure ulcers or falls. This position has remained the same as the previous three quarters. The Trust's internal deadline is 50 working days, so the need for improvement is acknowledged.

5.4 There are a number of challenges which can create delay within the process which have been detailed below.

5.5 **Assigning an SI Lead:** Delays in assigning an SI lead that is independent to each case is identified as a contributory factor. It can take up to 10 working days to assign the lead; this is influenced by the reduced number of SI trained leads within the Trust. To address this issue, further advanced investigation training sessions were provided during August and as a result a new cohort of SI leads have been identified. 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.

5.6 **Groups sign off – final report:** Review of this part of the process identifies that the delay is largely influenced by ensuring the actions plans are robust to meet the recommendations. To address this issue the Trust has set up an SI sign off meeting on a weekly basis, chaired by the Medical Director, to strengthen the approval process between the Groups and the Trust sign off. The first meeting took place in August 2020. Improvements are expected to be seen in Quarter 3 and 4.

5.7 **Variation in process for Pressure Ulcer and Falls SIs:** The investigation into grade 3 and 4 pressure ulcers and falls with harm incidents historically have been managed separately to the SI process, with the ownership sitting at Group level. This has seen some Pressure Ulcer and Falls with harm Sis sit significantly outside the timeframe for reporting and investigating. This has also impacted on learning opportunities. To address this, these incidents are now managed in line with the SI process, with the expectation that these investigations will be managed within the timeframe moving forward.

6 Update on outstanding Serous Incidents

6.1 There is one outstanding Serious Incidents from 2019-20; this is an IT related serious incident which has been previously presented at Committee level for discussion.

6.2 In addition, the Trust has had a backlog of pending incidents relating to falls with fracture with the oldest incident being reported back in 2018. To address the increased backlog, the Deputy Chief Nurse has worked with the Groups and responsible ward managers to go through the report prior to sign off. This approach proved to be valuable and 7 reports out of 13 were approved and submitted to the CCG. The remaining reports have been included in a thematic review, which is currently in progress and will be signed off in Quarter 3 2020-21. There are currently three outstanding reports, which were not signed off at the meeting nor included in the thematic review. These are awaiting further information from the Medicine and Emergency Care Group.

6.3 As with the falls incidents, the same approach was adopted to address the back log of incidents involving Grade 3 and 4 Pressure Ulcers. At the same meeting, five pressure ulcers reports were discussed and finally approved. The ten remaining incidents have been thematically reviewed and are currently in progress to be signed off in Quarter 3 2020-21.

7. Learning from previously approved serious incidents reports

7.1 **Primary Care and Community Therapies** have identified a trend in relation to training and knowledge within their completed investigations, especially in relation to tissue viability care. The Group has rolled out a number of training packages focussing on the management of

pressure ulcers within the community. These include the Practice Education Team providing training to all the Community staff that had expired training requirements. The Education team have also been working with the Trust's Tissue Viability Team and external companies to provide additional training on pressure ulcer development and categorisation and pressure ulcer prevention and management. Furthermore, the Group identified four Band 6 Link Nurses currently in post within the District Nursing teams. They will provide assistance to the Tissue Viability Nurses to ensure that staffs are competent on a skills framework around pressure ulcers including its management and prevention.

7.2 **Surgery** have identified some key learning around the use of vague terms and abbreviations following two never events. Use of such terms should be avoided on the consent forms as this can lead to miscommunication between the surgical team. This learning as well as other actions in relation swab count, correct body marking, instrument count are being captured in the Safety Policy for Invasive Procedure and Intervention. This policy is yet to be approved.

7.3 **Medicine and Emergency Care (MEC) Group** have recognised poor documentation within ED to be a contributory factor for some of their reported serious incidents. To strengthen this gap the emergency department have started having regular huddles, handovers and governance meetings as well as induction in which importance of full documentation is re-iterated to juniors and consultants. This will be considered as an ongoing action due to change of medical staff every 4-6 months in ED.

7.4 The MEC Group have also recognised the need to improve the Silver trauma pathway in ED following an SI whereby major injury was not suspected and the patient was discharged. This patient later died at another Hospital with a bleed to the brain. The Group recognised that the trauma policy only comes into effect when major trauma is suspected. This Group reviewed the Trauma Standard Operational Procedure (SOP) and made some amendments to include Silver trauma management to be considered in most cases. This is further strengthened with regular multispecialty simulations sessions for trauma.

7.5 **Women and Child Health** identified communication to be one of the common contributory factors, especially when escalating concerns to senior members of the team. The Group identified that work still needs to be done to ensure the senior doctor or consultant are present on site to review the patient's clinical profile in order to make prompt decisions of care. The Group have improved the escalation process by producing clinical triggers for staff to use for when a consultant is needed as well as amending the on-call consultant guideline to include consultants to attend site when requested.

8. Conclusion

8.1 Actions identified during the course of incident investigations do not always provide a solution to an identified problem.

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 to utilise the RCA analytical tools to identify a clear root cause and put forward robust actions to address the cause.

8.4 An SI sign off committee has been set up and will be led by Executives where the Medical Director and/or Chief Nurse can review and challenge the investigation report. This will ensure the correct root cause has been identified and the actions are robust to prevent the incident from happening again.

9. Recommendations

Trust Board is recommended to:

- **NOTE** the update on serious incidents reported Q1 and Q2
- **NOTE** the current work taking place to strengthen the current SI process

Sindeep Chatha
Head of Patient Safety and Risk

26 November 2020

Annex 1: Serious Clinical Incident Summary reported from 01 July 2020 - 31st September 2020
Annex 2: Serious Clinical Incident Summary – Q2 Overdue Actions