Surrey and Sussex NHS Healthcare NHS Trust

TRUST BOARD IN PUBLIC	**Date: 30th October 2014** **Agenda Item: 4.1**	
REPORT TITLE:	SERIOUS INCIDENT REPORT	
EXECUTIVE SPONSOR:	Fiona Allsop Chief Nurse	
REPORT AUTHOR:	Katharine Horner Patient Safety & Risk Lead	
REPORT DISCUSSED PREVIOUSLY: (name of sub-committee/group & date)	Patient Safety Committee, Executive Committee for Quality & Risk	
Action Required:		
Approval (√)	**Discussion (√)**	**Assurance (√)**
Summary of Key Issues		
This paper provides the Board of Directors with a report on the serious incidents and an update on progress with safety themes arising from serious incidents.		
Relationship to Trust Strategic Objectives & Assurance Framework:		
SO1: Safe -Deliver safe services and be in the top 20% against our peers **SO2:** Effective - Deliver effective and sustainable clinical services within the local health economy **SO3:** Caring – Ensure patients are cared for and feel cared about		
Corporate Impact Assessment:		
Legal and regulatory implications	Compliance with CQC, MHRA and Audit Commission	
Financial implications	Serious incidents can become claims	
Patient Experience/Engagement	Improving the experience of patients and learning lessons is a key theme	
Risk & Performance Management	Reporting, investigation and learning from serious incidents informs risk management	
NHS Constitution/Equality & Diversity/Communication	Compliant	
Attachments: Serious Incident Report		

TRUST BOARD REPORT – October 2014
Proposed Future Serious Incident Report for Public Board

1. Introduction

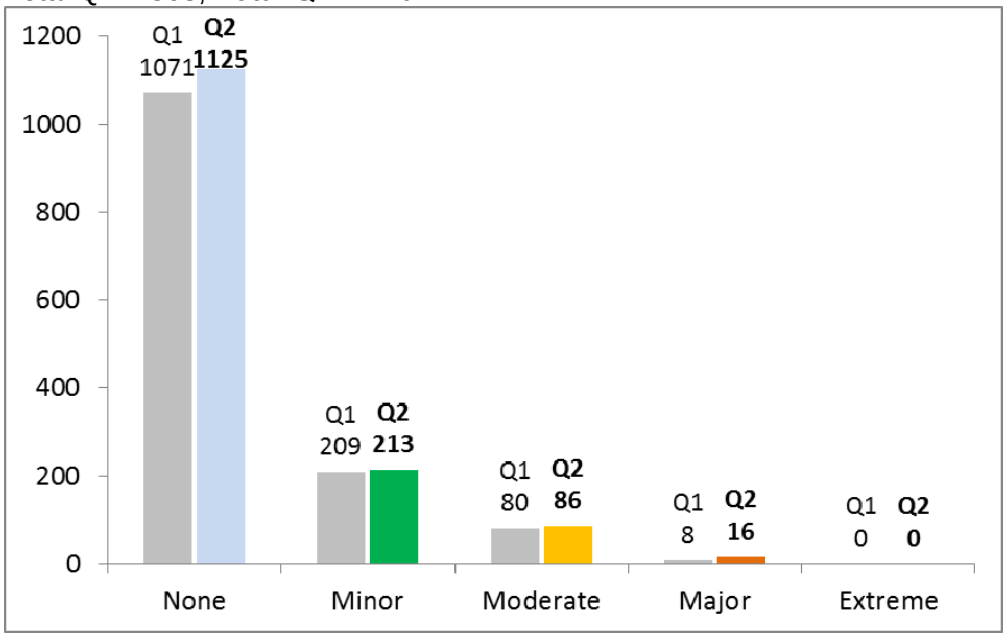
This report informs the Board about incidents occurring within the Trust that have been declared to the CCG as Serious Incidents (SIs).

All incidents are reported via the Datix database and any incidents that indicate major / extreme harm are considered as potential SIs however they may not all be declared as SIs. The National definition and criteria for an SI is always used when considering potential SIs and when declaring, or not, an SI.

There were a total of 1440 clinical / patient safety incidents that occurred during the last quarter (July-September 2014). The majority of clinical / patient safety incidents resulted in no harm or minor harm. Of the 102 moderate / major harm incidents 12 were declared as an SI.

2. Patient Safety Incidents in Quarter 1 & 2 2014/15

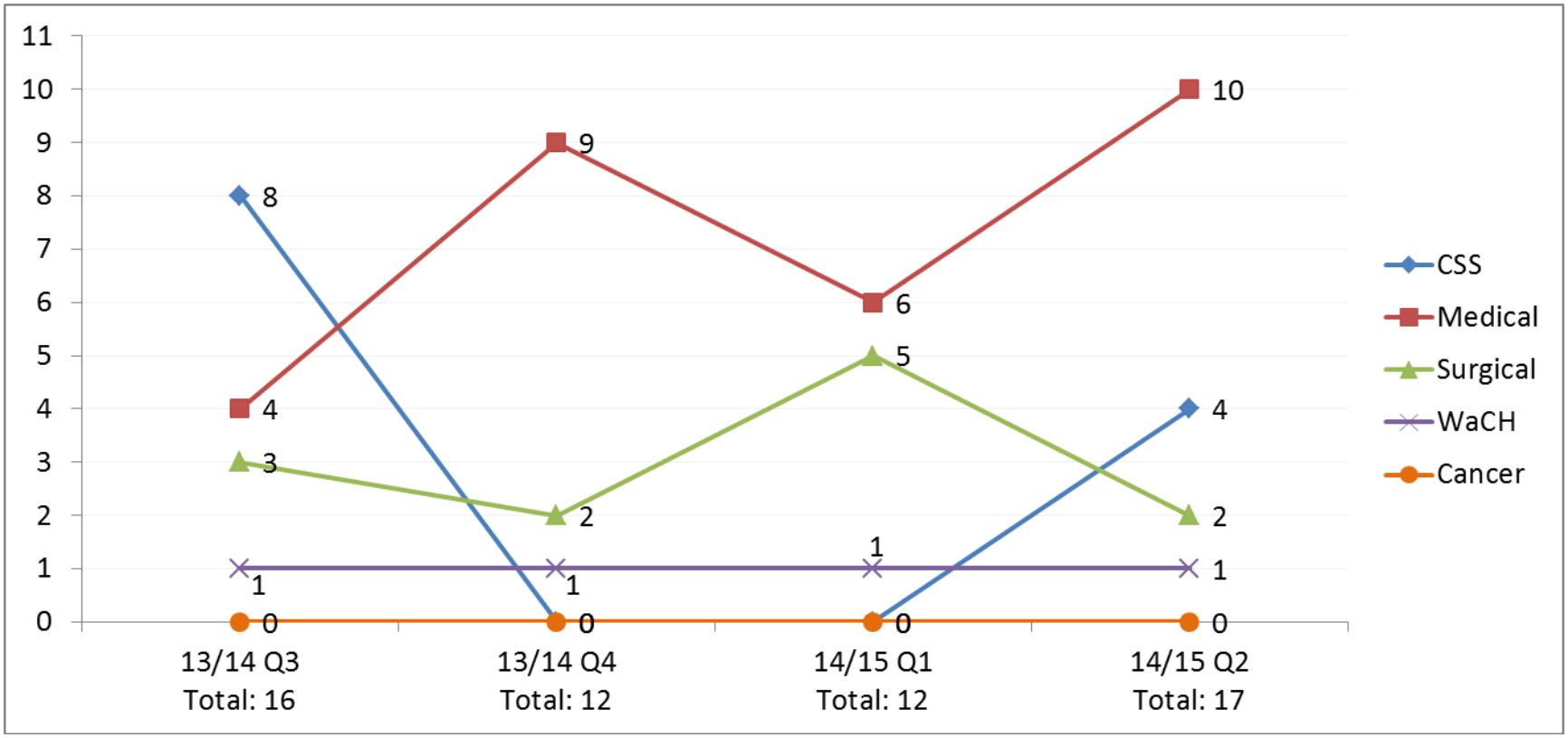
Total Q1: 1368; **Total Q2: 1440**



	MOD	MAJOR	Total
Maternity / Delivery	26	2	28
Pressure ulcers - hospital acquired	17		17
Falls, slips and trips (Patient)	7	7	14
Care implementation	11		11
Clinical diagnosis	2	6	8
Accidents other than falls (Patient)	5		5
Skin damage - hospital acquired	4		4
Treatment / Procedure	4		4
Blood / Blood products - Clinical area	2		2
Diagnostic imaging	2		2
Neonatal	1	1	2
Admission into hospital	1		1
Appointments	1		1
Communication problems	1		1
Surgery - management of operations	1		1
Sample / Specimen related	1		1
Totals:	**86**	**16**	**102**

3. Serious Incidents Declared in Quarter 2 2014/15

The graph below illustrates the number of SIs declared during the quarter by Division and in comparison to the previous 3 quarters. It shows that in this quarter there was an increase in the number of SIs declared within the Medical Division and CSS Division, a decrease within the Surgical Division, there was 1 SI declared within the WaCH Division and Cancer Division remained unchanged with 0 SI declared.



4. Serious Incidents Category Themes

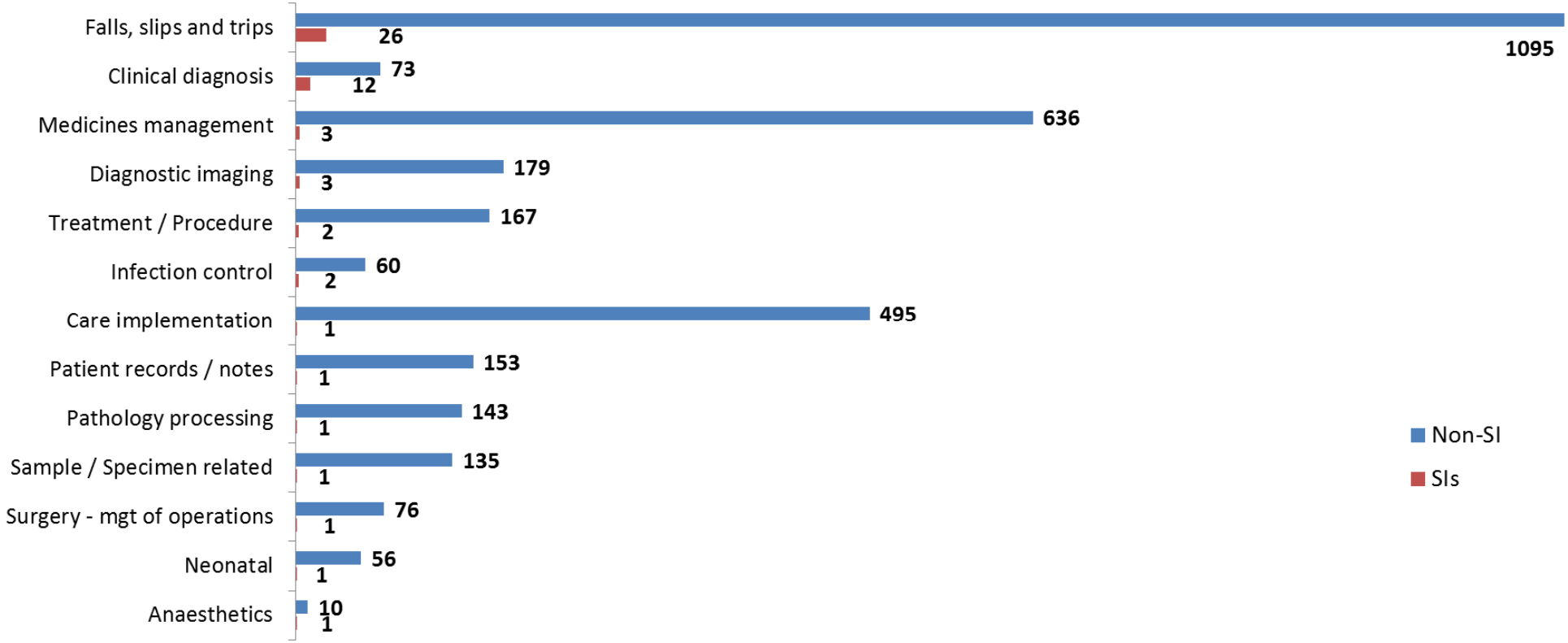
The table demonstrates the declared SI category themes identified this quarter in comparison to previous quarters. In quarter 2 patient falls, slips and trips formed the main type of SI declared which is similar to the previous quarters.

Clinical diagnosis also remains a regular theme although the number declared as SIs in this quarter has increased.

	13/14 Q3	13/14 Q4	14/15 Q1	14/15 Q2	Total
Falls, slips and trips (Patient)	**3**	**10**	**7**	**7**	**27**
Clinical diagnosis	**5**		**2**	**6**	**13**
Cancer - diagnosis failed / delayed	3		1	5	9
Other clinical diagnosis failed / delayed	1		1	1	3
Fracture - diagnosis failed / delayed	1				1
Diagnostic imaging	**3**				**3**
Unnecessary scan	2				2
Wrong body part X-rayed / scanned	1				1
Medicines management				**3**	**3**
Cancer drugs				1	1
All other drugs				2	2
Infection control: MRSA - bacteraemia case	**1**	**1**			**2**
Treatment / Procedure	**1**		**1**		**2**
Treatment / procedure delayed due to Trust factor	1				1
Cardiac arrest			1		1
Anaesthetics: Pneumothorax			**1**		**1**
Care implementation: Care - unavailable		**1**			**1**
Surgery - management of operations: Perforation			**1**		**1**
Neonatal: Neonatal death				**1**	**1**
Pathology processing: Wrong results relayed	**1**				**1**
Patient records / notes: Disclosed to another patient	**1**				**1**
Sample / Specimen related: No sample / specimen	**1**				**1**
Totals:	**16**	**12**	**12**	**17**	**57**

5. Comparison of Serious Incidents themes with non-SI incidents over last 12 months

The graph demonstrates the number of SIs by the incident date that occurred in the last 12 months compared to the number of non-SI incidents. Over the last 12 months only 2.4% of all reported patient slips, trips and falls and 16.4% of reported clinical diagnosis incidents were declared as an SI.



6. Recommendation

The Trust Board are asked to discuss the report and take assurance regarding the management of SIs and the on-going work to improve Trust Wide sharing of lessons learned and actions resulting from completed SI investigations.

Fiona Allsop
Chief Nurse
October 2014