TRUST BOARD IN PUBLIC		Date: 27th July 2017 Agenda Item:
REPORT TITLE:		Serious Incident Report for Q1 2017/8
EXECUTIVE SPONSOR:		Fiona Allsop
REPORT AUTHOR (s):		Kim Rayment
REPORT DISCUSSED PREVIOUSLY: (name of sub-committee/group & date)		n/a
Action Required:		
Approval ( )	**Discussion (✓)**	**Assurance (✓)**
Purpose of Report:		
This paper provides the Board of Directors with a report on the serious incidents declared in Q1 and an update on the overall position with regard to the management of serious incidents within the Trust.		
Summary of key issues		
• The Trust reported 9 serious incidents in Q1 2017/18. All incidents were reviewed and escalated appropriately. • There were no never events • As at 19 July 2017 the Trust has 14 serious incidents open with the CCG, of which 1 has been conditionally closed, 5 have been submitted for closure.		
Recommendation:		
The Board is asked to note the contents of this report.		
Relationship to Trust Strategic Objectives & Assurance Framework:		
SO1: Safe – Deliver safe, high quality care and improving services which pursue perfection and be in the top 25% of our peers **SO2:** Effective – As a teaching hospital, deliver effective and improving sustainable clinical services within the local health economy **SO3:** Caring – Work with compassion in partnership with patients, staff, families, carers and community partners		
Corporate Impact Assessment:		
Legal and regulatory impact		Compliance with CQC, MHRA and Audit Commission
Financial impact		Serious incidents often become claims
Patient Experience/Engagement		
Risk & Performance Management		Reporting, investigation and learning from serious incidents informs risk management
NHS Constitution/Equality & Diversity/Communication		

Surrey and Sussex NHS
Healthcare NHS Trust

TRUST BOARD REPORT
Serious Incident Report – period: Q1 2017/18

1. Introduction

1.1 A report on Serious Incidents (SI) is produced each month to provide assurance that they are being managed, investigated and acted upon appropriately and that action plans are developed from the Root Cause Analysis investigations.

1.2 This paper looks specifically at those incidents that are considered as SIs following the guidance from the NHS England's 'Serious Incident Framework" published March 2015.

1.3 A summary of open SIs is published weekly and circulated to Execs.

1.4 SI reports are reviewed by the Sussex Scrutiny Group. The Patient Safety and Risk Lead presents the reports to the panel and provides feedback to the Trust Serious Incident Review Group.

2. Patient Safety Incidents in 2017/18 Q1

2.1 There were a total of 2418 incidents reported on DatixWeb in Q1 2017/18 of which 2056 (85%) were clinical/patient safety incidents. These incidents breakdown as follows:

	April 2017	May 2017	June 2017	Total
None	503	583	519	1605
Low	139	125	160	424
Moderate	3	10	7	20
Severe	2	1	3	6
Death	0	0	1	1
Totals:	**647**	**719**	**690**	**2056**

Over the quarter 451 of the 2056 incidents (22%) caused harm to a patient.

The last eight quarters are as follows:

	15/16 Q2	15/16 Q3	15/16 Q4	16/17 Q1	16/17 Q2	16/17 Q3	16/17 Q4	17/18 Q1	Total
None	1208	1132	1326	1310	1396	1365	1395	1605	10737
Low	375	358	393	379	412	415	423	424	3179
Moderate	15	9	9	16	19	15	16	20	119
Severe	4	6	16	8	10	6	1	6	57
Death	2	1	2	0	0	0	0	1	6
Totals:	**1604**	**1506**	**1746**	**1713**	**1837**	**1801**	**1835**	**2056**	**14098**
% of Harm	**25%**	**25%**	**24%**	**24%**	**24%**	**24%**	**24%**	**22%**	**24%**

2.2 The incident categories are shown for those patient safety incidents reported in Q1 2017/18 as moderate harm, severe harm or death.

	Moderate	Severe	Death	Total
Accidents other than falls	1			1
Clinical diagnosis	3			3
Falls, slips and trips	3	2		5
Surgery operations	1			1
Infection control	6			6
Maternity / Neonatal	3	2	1	6
Skin damage - hospital acquired	3			3
Treatment / Procedure		2		2
Totals:	20	6	1	27

3. Serious Incidents declared in Q1 2017/18

3.1 The Trust declared 9 serious incidents in Q1 2017/18; 1 in April, 4 in May and 4 in June.

Declared	Steis	Category	Description
26/04/2017	2017/10931	Treatment / Procedure	Failure of interprovider metastatic spinal cord compression pathway resulting in paralysis.
02/05/2017	2017/11369	Accidents other than falls	Patient sustained an unexpected level of injury (periprosthetic fracture) following a managed lowering to the floor.
09/05/2017	2017/12066	Maternity / Neonatal	Category 2 EMCS, baby born with 9cm laceration on right side of head extending to ear. Delivered by obstetric registrar.
15/05/2017	2017/12543	Maternity / Neonatal	IUD. Scan showed growth <5th centile. Referred to St George's hospital for further assessment. IUD found at St George's hospital.
31/05/2017	2017/13928	Clinical diagnosis	In October 2016 the patient attended ED where bloods were taken as part of the triage process in accordance with agreed protocol. The bloods were abnormal but were not checked according to cerner. The patient was transferred to GAU but the bloods were not flagged or reviewed. The patient represented in May 2017 20 weeks into her current pregnancy, the previous blood results from October 2016 were reviewed and a diagnosis of chronic kidney disease (CKD) stage 3 was made.
06/06/2017	2017/14368	Maternity / Neonatal	Misinterpretation of the CTG which gave false reassurance of the baby's condition and impacted on the decision to undertake an emergency section. The baby was born with poor Apgar scores; required full resuscitation; admission to SCBU and then transfer to a tertiary unit for cooling therapy. On the 26/4/17 the Trust were informed that the decision had been made to withdraw treatment from the baby.

Declared	Steis	Category	Description
06/06/2017	2017/14342	Treatment / Procedure	Failure to give therapy to a patient with learning difficulties and challenging behaviours resulting in lower limb contractures which may prevent future mobilisation. The investigation will review the decision making process, the team and clinical communication and whether there were any system failures.
07/06/2017	2017/14546	Maternity / Neonatal	The woman had been assessed as high risk in early pregnancy. This concern escalated as her pregnancy progressed as she required sequential scans and CTGs. However ay EDD+9 she was managed as low risk pregnancy resulting in a term stillbirth.
13/06/2017	2017/14990	Falls, slips and trips (Patient)	Patient was found on floor by nurse, according to patient in next bed patient had fallen on her left side after slipped on floor (patient had pass water). Patient was sitting on floor and started to complain of pain on her left leg. A peri-prosthetic fracture was confirmed via imaging.

3.2 SI themes over the last 12 months

The serious incidents are shown by the month in which they occurred, not the month in which they were declared. The date of knowledge and therefore declaration may be different.

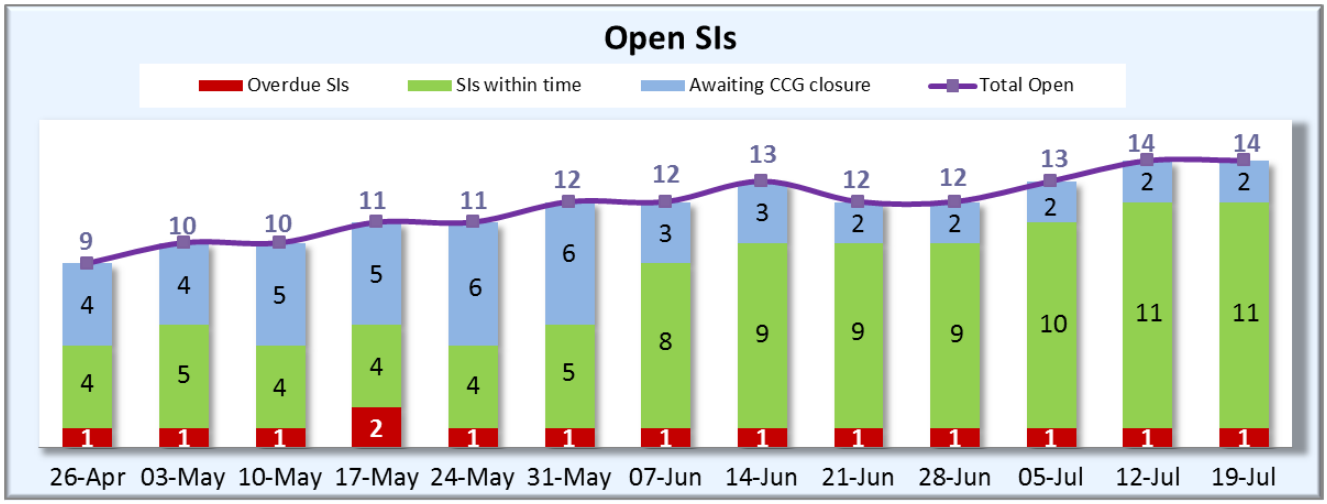
52% (17) of the serious incidents that occurred in the last twelve months relate to patient falls.

	2016 07	2016 08	2016 09	2016 10	2016 11	2016 12	2017 01	2017 03	2017 04	2017 05	2017 06	Total
Accidents other than falls									1			1
Care implementation		1										1
Clinical diagnosis			1							1		2
Falls, slips and trips	3	3	3	3		3	1				1	17
Surgery operations					1							1
Infection control	1	1										2
Maternity / Neonatal	1						1	1	1	1	1	6
Treatment / Procedure		1							1		1	3
Totals:	**5**	**6**	**4**	**3**	**1**	**3**	**2**	**1**	**3**	**2**	**3**	**33**

4. Weekly overview

A weekly open SIs overview summary is sent to the Patient Safety and Risk Lead and the Chief Nurse which indicates overall Trust and Divisional performance in completing SI investigations within the National timeframe. The Serious Incident Review Group closely monitors the investigation and submission process. The Divisions are asked to include an update on RCA reports to the Patient Safety and Clinical Risk Sub-Committee.

This is the latest reported Trust position at 19 July 2017.



@19/07/2017

Serious Incidents	CANCER	CORP	MEDIC	SURG	WACH	Total
RED - Overdue				1		**1**
AMBER - due in <=20 days			2		2	**4**
GREEN - due in >20 days		1	3		3	**7**
Awaiting CCG closure	1			1		**2**
Total Open SIs	**14**					
Total Overdue SIs	**1**					
Total SIs on time	11					

5. 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 performance on completing SI investigations within the National timeframe.

Name of Director Fiona Allsop
Title of Director Chief Nurse
July 2017