Board of Directors' Meeting
5 August 2021

Agenda item	217/21			
Report	Serious Incidents Report			
Executive Lead	Medical Director Director of Nursing			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people		Effective	
	Our service delivery		Caring	
	Our partners		Responsive	
	Our governance	√	Well Led	
	Report recommendations:		**Link to BAF / risk:**	
	For assurance		All aspects of BAF	
	For decision / approval		**Link to risk register:**	
	For review / discussion			
	For noting	√		
	For information			
	For consent			
Presented to:	QSAC			
Dependent upon (if applicable)**:**				
Executive summary:	The purpose of this report is to inform the Public Trust Board of the current position in relation to: • Serious incident reporting rates year to date • Number and themes of serious incidents reported in June 2021. • Number of serious incidents closed in June 2021. The meeting is asked to note the contents of the paper.			
Appendices				
				

1.0 Introduction

This report highlights the patient safety development and forthcoming actions for Sept/October 2021 for oversight. It will then give an overview of the Serious Incident reporting rates year to date. It will provide detail of the number and themes of newly reported incidents and those closed during June 2021, the number of current open serious incidents.

2.0 Serious Incidents (SI) Reporting

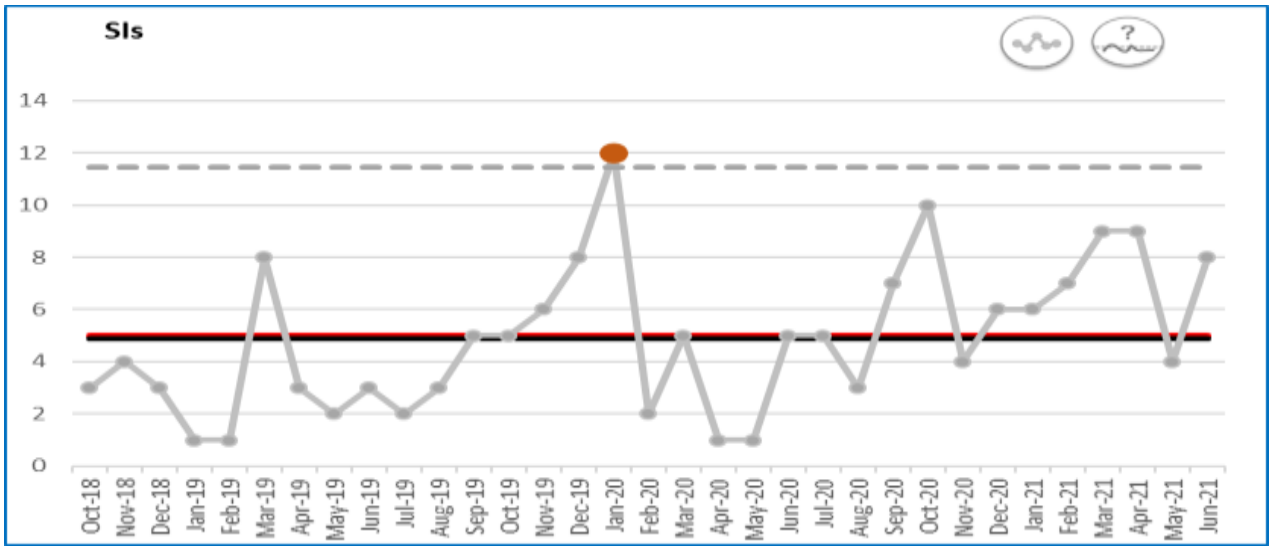
The outcome of all serious incident investigations are reported to the Review, Action and Learning from Incidents Group (RALIG) and Nursing Quality Assurance Meeting (NIQAM) where more detailed discussions about each investigation takes place. At these meetings there is open debate and challenge to each investigation's findings and actions as a means of seeking assurance that the Trust is identifying and acting upon any areas that require attention and improvement. An overview report is presented to Quality Operational Committee monthly. A more detailed learning report is presented quarterly.

The Trust meets with commissioners each month to discuss investigation reports

2.1 Serious Incidents reported year to date

At the end of June 2021 the Trust reported 21 Serious Incidents so far in year. SPC chart 1 shows the serious incident reporting rate per month during the previous 12 month period, which demonstrates a common cause variation.

SPC Chart 1



2.2 Serious Incidents reported in month

Table 1- 8 Serious Incidents reported in month.

Division	Brief Descriptor
W&C	Maternity Obstetric – Delivery concern
Medicine	Fall Fracture Neck of Femur
W&C	HSIB referral – Downgraded to Divisional Investigation as does not meet the SI framework
Surgical	Delayed Diagnosis Bowel Obstruction

Emergency	Delayed Diagnosis – CT scan clearance
Medicine	Category 3 Pressure Ulcer
W&C	Complication of procedure
Medicine	Treatment Delay

2.3 SI closed in month

Table 2 – 4 Serious Incidents closed in month

Division	Brief Descriptor
Surgical	Infection control/COVID19
Medicine	Collapse/fall
Medicine	Category 3 Pressure Ulcer
W&C	Miscommunication

2.4 Never Events

No Never Events were reported during June 2021, with the last reported Never Event in December 2020. Work continues on the actions arising from previous Never Events.

3.0 Top 5 incident themes during June

Table 3 – Incident themes in June.

Category
Falls from height or same level
Care monitoring delay
Admission of patients (includes ambulance offload delays)
Bed shortage
Pressure ulcers

Hayley Flavell
Director of Nursing
August 2021

Richard Steyn
Co-Medical Director
August 2021