Board of Directors' Meeting
7 October 2021

The Shrewsbury and Telford Hospital NHS Trust

Agenda item	247/21			
Report	Serious Incidents Oversight Report – July/August 2021 Data			
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:	Quality and Safety Assurance Committee			
Dependent upon (if applicable)**:**				
Executive summary:	The purpose of this report is to inform the Board of Directors of the current position in relation to: • Serious incident reporting rates year to date • Number and themes of serious incidents reported in July/August 2021. The meeting is asked to note the contents of the paper.			
Appendices	None			
				

1.0 Introduction

This report highlights the patient safety development and forthcoming actions for October/November 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 July/August 2021, the number of current open serious incidents.

2.0 Serious Incidents (SI) Reporting

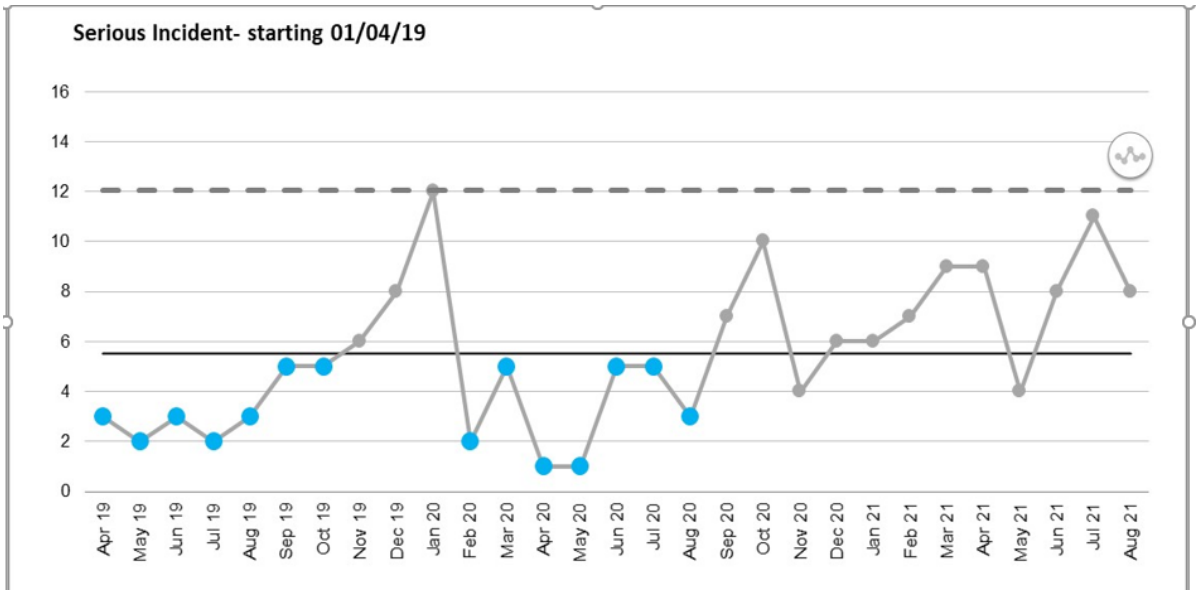
The outcome of all serious incident investigations are reported to the Review, Action and Learning from Incidents Group (RALIG) and Nursing Quality Assurance Meeting (NIQAM) where more detailed discussions about each investigation takes place. At these meetings there is open debate and challenge to each 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 August 2021/22, the Trust reported 40 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 July/August

SI - July	Number Reported
2021/14115 Maternity – Baby transfer for cooling - HSIB	1
2021/14186 Category 3 Pressure Ulcer	1
2021/14486 Maternity affecting baby – Blood glucose management	1
2021/14711 Category 3 Pressure Ulcer	1
2021/14915 Screening Incident	1
2021/15004 Surgical invasive procedure	1
2021/15019 Maternity affecting baby potential missed opportunity for earlier intervention	1

2021/15021 Maternity affecting mother – management of massive obstetric haemorrhage	1
2021/15326 Fall fractured neck of femur	1
2021/15333 Major incident	1
2021/15778 Maternity affecting baby – birth injuries/lacerations/bruising	1
	11

SI - August	**Number Reported**
2021/15975 – Delayed diagnosis	1
2021/16956 – Fall resulting in a fractured neck of femur	1
2021/17275 – HCAI/IPC incident – Overarching Trust acquired Covid deaths	1
2021/17426 – Delayed diagnosis – Sickle Cell	1
2021/17831 – Delayed diagnosis of DiGeorge syndrome	1
2021/17862 – Obstetric – Shoulder dystocia leading to Erb's Palsy	1
2021/17863 – Obstetric – Ruptured uterus and major obstetric haemorrhage	1
2021/17651 – Fall resulting in fractured tibia	1
Total	8

2.3 SI closed in month

Table 2 – 2 Serious Incidents closed in July/August

July

Division	**Brief Descriptor**
Surgical	COVID Outbreak
Surgical	Hospital Acquired Infection – MRSA Bacteraemia
W&C	HSIB Maternity Investigation
Surgical	Suboptimal care of the deteriorating patient
Medicine	Delayed treatment
Surgical	Fall – fracture greater trochanter

August

Division	**Brief Descriptor**
Medicine	Hospital Acquired Infection – C-Diff
Medicine	Category 3 Pressure Ulcer

2.4 Theme/Learning

- Compliance patient mask wearing and the documentation relating to this
- Risks associated with lack of side room capacity – on risk register
- Compliance with PPE/Bare Below the Elbows
- Accurate risk assessment for pressure ulcer risk/prevention
- Further training in pressure ulcer prevention and risk assessment – in progress

2.5 Never Events

No Never Events were reported during July/August 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 July/August

Table 3 – Incident themes in July**.**

Category
Pressure Ulcer / Skin damage
Falls from height or on same level
Staffing Problems
Admission of patients
Bed Shortage

Table 4 – Incident themes in August.

Category
Pressure Ulcer / Skin damage
Falls from height or on same level
Appointment problems
Staffing Problems
Admission of patients