Sherwood Forest Hospitals
NHS Foundation Trust

Board of Directors Meeting in Public - Cover Sheet

Subject:	Serious Incidents and Never Events	**Date: 29/03/2018**	
Prepared By:	Head of Governance		
Approved By:	Director of Governance & Quality Improvement		
Presented By:	Director of Governance & Quality Improvement		
Purpose			
To enable the Board to understand exposure to serious incidents in the year to date and the actions being taken by the Trust to learn, improve and reduce risk for service users.		**Approval**	
		Assurance	**X**
		Update	
		Consider	

Strategic Objectives				
To provide outstanding care to our patients	**To support each other to do a great job**	**To inspire excellence**	**To get the most from our resources**	**To play a leading role in transforming health and care services**
X				

Overall Level of Assurance				
	Significant	**Sufficient**	**Limited**	**None**

Risks/Issues	
Financial	**Ongoing exposure to serious incidents may result in increased claims expenditure.**
Patient Impact	**Exposure to serious incidents does not provide a positive patient experience and can be detrimental to recovery.**
Staff Impact	**Exposure to serious incidents is stressful for staff and often requires action to support colleagues or, in rare cases, action to protect the public. These may lead to periods of absence from work or restrictions being applied.**
Services	**Exposure to serious incidents and Never Events at core service level may impede the Board's efforts to become rated as outstanding.**
Reputational	**Exposure to serious incidents represents a concern for the public, stakeholders and regulators, and may adversely impact upon the Trust's reputation.**

Committees/groups where this item has been presented before

Patient Safety & Quality Board and Quality Committee (routinely).

Executive Summary

This paper updates the Board on the nature and frequency of serious incidents:

1. **In the 2017/18 year to date, as at 19/03/2018, 28 incidents crossed the threshold for reporting as Serious Incidents** in accordance with NHS England's Serious Incident Framework. In 2014 the Trust experienced on average 8 serious incidents per month. Sustained improvement in risk reduction and serious incident handling have reduced this to an average of 3 serious incident per month in 2017/18. However, during November-17 to Feb-18, as we have seen in previous years, we have experienced above average numbers of serious incidents.
2. **During 2017/18 year to date there were two Never Events reported.** These incidents have previously been shared with the Board. This follows two Never Events reported in 2016/17. For ease of reference these events included wrong site surgery, wrong implant, misplaced nasogastric tube and retained swab post procedure. In the report we outline the

actions being taken to learn and reduce the risk for patients undergoing treatment at the Trust. Never Events are increasing across the NHS in England, particularly surgical Never Events. The Board are invited to consider this report alongside a more detailed analysis of Never Events provided by the Director of Governance & Quality Improvement to the Board at their meeting held in December 2017.

3. **Delays in diagnosis or treatment** (in particular detecting, communicating and acting on abnormal radiological or pathological findings) and **falls involving serious harm** account for 50% of serious incidents in the current year. The Patient Safety & Quality Board have led the renewal of the control framework – with particular emphasis on divisional and specialty responsibilities so that more effective controls are in place to recognise and respond to abnormal clinical findings. This work continues. In respect of falls involving serious harm, on the advice of the Director of Governance & Quality Improvement, the Board agreed to a recommendation to classify certain fractures (long bone, skull, sternum, spinal, pelvic) as serious harms and, if there were actual or suspected defects in care identified at Scoping Review, these cases would be classified and reported as serious incidents. This change came into effect in December 2017.
4. **The Director of Governance & Quality Improvement initiated a Causal Factor Analysis (CFA) for all serious incidents in 2016/17 and those declared in the first 6 months of 2017/18**. CFA seeks to isolate the underlying weaknesses within the control framework and help target learning and improvement. CFA has revealed human factors plays a very significant role in direct and indirect causation. This manifests as: (i) not following policy or procedure at critical points in the patient's care; (ii) poor communication – written and verbal leading to errors; (iii) erroneous clinical decision making; (iv) poor design of control framework; (v) and the nature and complexity of the patient's clinical condition and presentation. Other causal factors have been identified but occur less frequently. These causal factors can be broadly grouped into communication, team working and competence.
5. **The Trust continues to act to address underlying causal factors**. In the report we set out what each Division is doing in response to serious incidents, and how the Trust is responding to Never Events.
6. **The Board can be assured that Duty of Candour (Regulation 20) is being met for all qualifying incidents.**