Board of Directors' Meeting
9 May 2024

Agenda item		080/24		
Report Title		Incident Overview Report		
Executive Lead		Hayley Flavell, Executive Director of Nursing		
Report Author		Kath Preece, Assistant Director of Nursing, Quality Governance		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	BAF1, BAF2, BAF4, BAF7, BAF8, BAF9
Effective		Our people		
Caring		Our service delivery		**Trust Risk Register id:**
Responsive		Our governance	√	328/1353
Well Led		Our partners		
Consultation Communication		Quality Operational Committee – March and April 2024 Quality and Safety Assurance Committee – March and April 2024		
Executive summary:		1. The Board's attention is drawn to sections: **6** – remaining serious incident investigations **3 and 5** PSIRF incident management processes and cases		
Recommendations for the Board:		The Board of Directors is asked to: Take assurance from this report in relation to incident management.		
Appendices:		N/A		

1. Introduction

This report highlights the patient safety development and forthcoming actions for May/June 2024 for oversight. Detail of the number and themes of closed serious incidents during February and March 2024 are included. Lessons learned and action taken are reported, in detail, through Quality and Safety Committee. It will detail the number of new Patient Safety Incident Investigations (PSII) commissioned by RALIG and the number of After-Action Reviews (AAR) commissioned by the new Incident Response Oversight Group (IROG).

The incident management process within PSIRF consists of the following:

- Daily Datix Triage – identifying cases to be further reviewed at IROG
- IROG – full weekly MDT review of incidents, commissioning of learning responses and escalation to RALIG.
- Peer Review Group – weekly quality assurance review of cases, which have been identified at IROG to be presented to RALIG.
- Duty of Candour Group – monthly assurance group for assurance.
- Monthly Safety Triangulation Group will be set up to triangulate themes and trends from all sources.

Processes are undergoing PDSA cycles and will continue to develop over the next 12 months.

This incident management report will develop over time as we progress further with PSIRF and will incorporate outcomes from both PSII and AAR, along with themes/trends and improvements.

2. Patient Safety Development and Actions planned for May/June 2024

- Commence Reporting on progress of Trust priorities.
- Complete the Trust overarching Patient Safety Strategy
- Develop a quarterly Learning from Events and Safety Culture Report
- Develop a new learning response, Multi-Disciplinary Team learning review (MDT)
- Commence recruitment of Patient Safety Partners, currently on hold due to recruitment freeze

3. Incident Management

3.1 Serious Incidents Closed during February and March 2024

Lessons Learned and Actions taken are reported, in detail, through Quality and Safety Committee. There were 4 Serious Incidents closed in February 2024. A synopsis of the incident and action/learning is identified below in Table 1.
There were no Maternity reportable incidents closed during February 2024.

Clinical Area	**Incident 1**
Classification	Serious Incident
Incident Ref number	2023/20547
Incident Summary	**Delayed diagnosis – missed fracture**
Duty of Candour Met	Yes
Impact on patient/family	Distress caused, patient and family supported
Clinical Area	**Incident 2**

Classification	Serious Incident
Incident ref. no.	2023/20341
Incident Summary	**Fall resulting in head injury**
Duty of Candour Met	Yes
Impact on patient/family	Pain and distress caused
Clinical Area	**Incident 3**
Classification	Serious Incident
Incident ref. no.	2023/16243
Incident Summary	**Medication Error - ED**
Duty of Candour Met	Yes
Impact on patient/family	Anxiety caused.
Clinical Area	**Incident 4**
Classification	Serious Incident
Incident ref. no.	2023/16236
Incident Summary	**Inappropriate offload and Management of the deteriorating patient - ED**
Duty of Candour Met	Yes
Impact on patient/family	Anxiety and distress caused

There were 2 Serious Incidents closed in March 2024. A synopsis of the incident and action/learning is identified below in Table 2.

There were no Maternity reportable incidents closed during March 2024.

Table 2

Clinical Area	**Incident 1**
Classification	Serious Incident
Incident Ref number	2023/19974
Incident Summary	**Fall resulting in head injury - ED** Unwitnessed fall in ED. All actions are captured in the Trust overarching Falls Prevention Plan
Duty of Candour Met	Yes
Impact on patient/family	Distress caused, patient and family supported
Clinical Area	**Incident 2**
Classification	Serious Incident
Incident ref. no.	2023/19386
Incident Summary	**Delayed diagnosis and treatment - ED** Findings identified improvements required in the process of referral and escalation to speciality.

Duty of Candour Met	Yes
Impact on patient/family	Pain and distress caused

3.2 Open Serious Incidents

As at the 31 March 2024 the Trust has 17 serious incidents open and progressing through investigation.

3.3 Patient Safety Incident Investigations (PSII) commissioned during February and March 2024

A summary of the Patient Safety Incident Investigations (PSII) reported in February 2024 is contained Table 3.

Table 3

PSII	Number Reported
2024/2462 Complications following procedure/treatment	1
2024/2433 Missed diagnosis	1
Total	2

A summary of the Patient Safety Incident Investigations (PSII) reported in March 2024 is contained Table 4.

Table 4

PSII	Number Reported
There were 0 PSII commissioned in March	
Total	

A summary of the After-Action Reviews commissioned in February 2024 is contained Table 5.

Table 5

After Action Review (AAR)	Number Reported
Datix 267592 Absconded patient	1
Datix 266075 Deteriorating patient	1
Datix 267251 Omitted medication	1
Datix 267610 Delayed treatment	1
Datix 268160 Delay in diagnosis and treatment	1
Datix 264621 Delay in diagnosis and treatment	1
Total	6

A summary of the After-Action Reviews commissioned in March 2024 is contained Table 6

Table 6

After Action Review (AAR)	Number Reported
Datix 270512 Delay in diagnosis/incorrect referral/missed radiology	1
Datix 271585 Delay in diagnosis/lost to follow up	1
Total	2

3.4 IROG – initial update/themes

IROG, previously corporate rapid review meeting, is working well and is undergoing PDSA.

Each month, themes identified through IROG will be presented in this Incident Management Report.

The top issues from February and March were known themes, the rest are issues that have been emerging themes from IROG.

Known Themes
Delayed appointments
Delated treatment (ED- often related to ambulance offload delays)
Admission issues (availability of beds, acceptance by specialities)
Omitted doses of time critical medication (known Trust priority)
Falls (know Trust priority)
Delayed step down from ITU due to bed availability

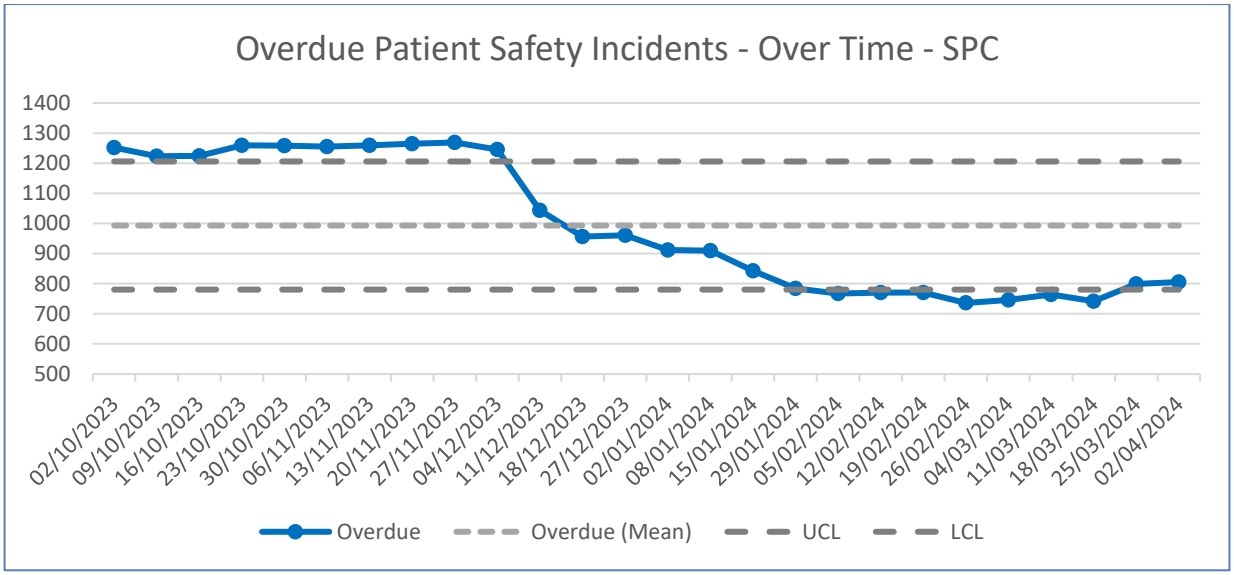
New Emerging Themes in February and March
Incorrect listing of patients for theatre
Potential harm to patients relating to delays on the colorectal pathway
Anticoagulation (DOAC) issues for patients undergoing endoscopy
PCA pumps
Dispensing errors from community pharmacy

4.0 Overdue Datix

SPC 1 shows that concentrated work within the emergency particularly has continued to reduce numbers of overdue Datix reports. Work is on-going to continue to review the overdue datix by the Division and supported by the Quality Governance team.

Mitigation and trajectory for improvement
All Datix's are reviewed daily by the patient safety team who filter out those Datix that require immediate actions. Datix triage is now in place since the 1st December 2023. All Divisions have a weekly incident review meeting to prioritise and escalate incidents, such as Neonatal and Obstetric risk meeting, Medicine incident review group, ED weekly incident review.

SPC Chart 1



5.0 Emergency Department Harm Reviews

The process for ED 12 hour breach harm reviews and Ambulance offload delay harm reviews has continued during February and March 2024.

5.1 12 hour breach harm reviews

Harm reviews have been completed for the longest 12-hour breach patients during January and February have been reviewed. A total of 40 harm reviews have been completed for each month, 20 for RSH and 20 for PRH.

No harm has been identified due to delays in transfer to ward, although it is acknowledged that patient experience would be poor.

5.2 Ambulance offload delay harm reviews

Ambulance offload delay harm reviews have been completed for every patient reported to have been held in the ambulance for over 6 hours during February and March 2024.

A total of 40 patients underwent harm review between during February 2024

- 2 patients had identified low harm due to a delay in administration of IV antibiotics for the treatment of sepsis. Once offloaded they were treated and continued with their care with no further concerns.
- 6 of the patients were living with dementia
- 95% of the patients were reviewed in the ambulance in line with the SOP

A total of 32 patients underwent harm review in March 2024.

- 5 patients had identified low harm due to a delay in administration of IV antibiotics for the treatment of sepsis. Once offloaded they were treated and continued with their care with no further concerns.
- 8 of the patients were living with dementia
- 95% of the patients were reviewed in the ambulance in line with the SOP

A summary of both harm reviews will form part of the Incident Management Report every month to both QOC and QSAC, for assurance.

The harm reviews will be undertaken by the Assistant Director of Nursing, Quality Governance or nominated representative, for the period of time that clinical pressures, within the Emergency Departments, require the most senior nurses within the ED team to remain working clinically. This will be reviewed every 6 months

Themes/Learning will be shared as part of this incident management overview report.