The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
11 July 2024

Agenda item	112/24			
Report Title	Incident Overview Report			
Executive Lead	Hayley Flavell, 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 – May and June 2024 Quality and Safety Assurance Committee – May and June 2024
Executive summary:	1. The Board's attention is drawn to sections: **3** – remaining serious incident investigations and PSIRF incident management processes and cases **6** – PSIRF update and improvement progress to date
Recommendations for the Board:	The Board 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 August/September 2024 for oversight. Detail of the number and themes of closed serious incidents during April and May 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) and Multi-Disciplinary Team Reviews (MDT) commissioned by 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, AAR and MDT reviews along with themes/trends and improvements.

2. Patient Safety Development and Actions planned for August/September 2024

- Refine Reporting on progress of Trust priorities.
- Complete the Trust overarching Patient Safety Strategy
- Develop a quarterly Learning from Events and Safety Culture Report
- Recruitment of Patient Safety Partners

3. Incident Management

3.1 Serious Incidents Closed during April and May 2024

Lessons learned and actions taken are reported, in detail, through Quality and Safety Committee.

There were 6 Serious Incidents closed in April 2024. A synopsis of the incident and action/learning is identified below in Table 1.

There were no Maternity reportable incidents closed during April 2024.

Clinical Area	**Incident 1**
Classification	Serious Incident
Incident Ref number	2023/21642
Incident Summary	**Category 3 Pressure Ulcer**

	Key actions are included within the overarching Pressure Ulcer Prevention Improvement plan and is one of the Trust Quality priorities.
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.	2023/19169
Incident Summary	**Category 3 Pressure Ulcer** Key actions are included in the overarching Pressure Ulcer Prevention plan
Duty of Candour Met	Yes
Impact on patient/family	Pain and distress caused
Clinical Area	**Incident 3**
Classification	Serious Incident
Incident ref. no.	2023/18971
Incident Summary	**Fall resulting in fracture neck of femur** Key actions are included in the overarching Falls Prevention plan and is one of the Trust PSIRF priorities
Duty of Candour Met	Yes
Impact on patient/family	Pain Anxiety caused.
Clinical Area	**Incident 4**
Classification	Serious Incident
Incident ref. no.	2023/19077
Incident Summary	**Delayed diagnosis** Learning identified around sharing of diagnostic results across the relevant parts of the system, in this case between GP and Acute provider, this work will feed into work already underway for the digital roadmap.
Duty of Candour Met	Yes
Impact on patient/family	Anxiety and distress caused
Clinical Area	**Incident 5**
Classification	Serious Incident
Incident ref. no.	2023/12819
Incident Summary	**Transfer issues** Learning has identified issues with communications between the Trust and specialist centres, also communications within the Trust's own teams – actions taken to improve communication through SOPs and education.
Duty of Candour Met	Yes
Impact on patient/family	Anxiety and distress caused
Clinical Area	**Incident 6**

Classification	Serious Incident
Incident ref. no.	2023/6272
Incident Summary	**Missed diagnosis.** Learning has been identified the need for single points of contact within the team such as a major trauma co-ordinator and for spinal patients to be placed on the correct speciality ward where appropriately trained staff can support care. Action underway for the recruitment of a major trauma co-ordinator.
Duty of Candour Met	Yes
Impact on patient/family	Anxiety and distress caused

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

There were no Maternity reportable incidents closed during May 2024.

Table 2

Clinical Area	Incident 1
Classification	Serious Incident
Incident Ref number	2023/12832
Incident Summary	**Power outage – Women and Children Building PRH** Full review of incident undertaken across the Trust in addition to the Serious incident review. Actions taken to reduce the risk of recurrence. Many examples of good practice noted. A full review of each patient affected by the closure of the unit has been undertaken and presented to QOC. No adverse outcome has been identified as a direct result of the outage and subsequent closure.
Duty of Candour Met	Yes
Impact on patient/family	Explanation given to all families involved.
Clinical Area	**Incident 2**
Classification	Serious Incident
Incident ref. no.	2023/16236
Incident Summary	**Deteriorating patient** Key actions are included in the Trust PSIRF improvement programme for the deteriorating patient.
Duty of Candour Met	Yes
Impact on patient/family	Anxiety caused

3.2 Open Serious Incidents

As at the 31st May 2024 the Trust has 10 serious incidents open and progressing through investigation.

3.3 Patient Safety Incident Investigations (PSII) commissioned during April and May 2024

A summary of the Patient Safety Incident Investigations (PSII) reported in April 2024 is contained Table 3. 1 new Maternity MNSI case reported in April 2024.

Table 3

PSII	Number Reported
2024/3907 Missed diagnosis	1
2024/4328 Maternity MNSI Case - MI037179	1
Total	2

A summary of the Patient Safety Incident Investigations (PSII) reported in May 2024 is contained Table 4. 1 new Maternity MNSI case reported in May 2024.

Table 4

PSII	Number Reported
2024/4814 Maternity MNSI case – MI-037285	1
Total	1

A summary of the learning responses - After-Action Reviews/MDT reviews commissioned in April 2024 is contained Table 5.

Table 5

After Action Review (AAR)	Number Reported
Datix 267461 Delay in treatment	1
Datix 270255 Deteriorating Patient	1
Datix 271442 Missed Referral	1
Total	3

A summary of the learning responses - After-Action Reviews/MDT reviews commissioned in May 2024 is contained Table 6

Table 6

After Action Review (AAR)/Multi-Disciplinary Team Revew (MDT)	Number Reported
Datix 271664 Delay in diagnosis - MDT Review	1
Total	1

The number of open PSII/AAR/MDT reviews as at 31st May 2024 is contained in Table 7.

Table 7

PSII	AAR	MDT
11 Open	**10 Open**	**5 Open**
By Division		
2 SACC **7 MECC** **2 Maternity**	**4 SACC** **3 MECC** **1 Joint MECC/W&C** **2 W&C** **(1 Paeds, 1 Maternity)**	**1 SACC** **3 MECC** **1 Maternity**

3.3 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 April and May were known themes, the rest are issues that have been emerging themes from IROG, with work now underway to understand the issues and support the Divisions with improvement.

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
Gynaecology Pathways, booking issues and delays.
Anti-coagulation for invasive procedures
Paediatric diabetes pathways
Discharge issues.
SDEC referrals – process issues

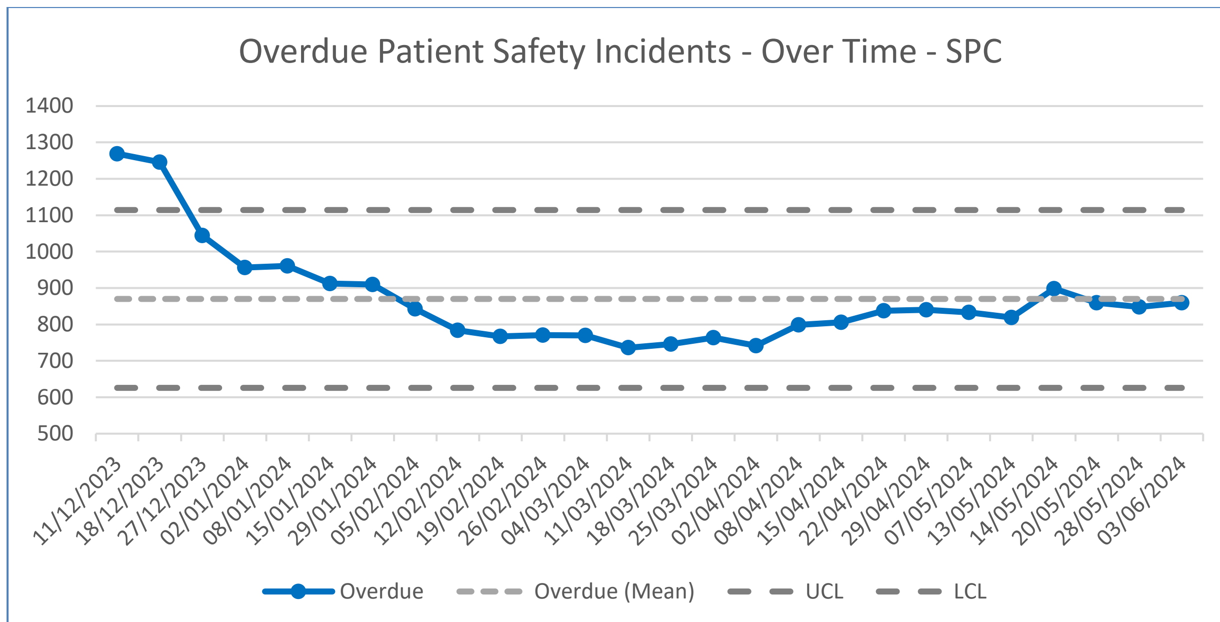
4.0 Overdue Datix

SPC 1 shows that the progress with overdue incidents is being sustained, although there has been an increase in the number since last reported, however the number remains within the upper and lower control limit. Work is ongoing with the Divisions to return the trend to a downward trajectory.

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 April and May 2024.

5.1 12 hour breach harm reviews

Harm reviews have been completed for the longest 12-hour breach patients during April and May have been reviewed. A total of 40 harm reviews have been completed for each month, with a focus on reviewing the longest length of stay in the departments.

There is no evidence of harm identified, at the time of the individual harm review known at the time of review, 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 April and May 2024.

A total of 35 patients underwent harm review between during April 2024

- 9 patients had identified low harm. 6 due to a delay in administration of IV antibiotics for the treatment of sepsis, 2 patients had a delay in adequate pain relief for fracture neck of femur patients, 1 patient had a delay in blood transfusion Once offloaded they were treated and continued with their care with no further concerns.
- 4 of the patients were living with dementia.
- 10 of the patients remained on the ambulance for more than 10 hours.
- 100% of the patients were reviewed in the ambulance in line with the SOP.

A total of 16 patients underwent harm review between during May 2024. There has been a reduction in the number of over 6-hour ambulance offload delays reported during May 2024.

- In May only 1 patient had identified low harm and this due to the inability to provide an Iliac block as pain relief for fracture neck of femur patients.
- 6 of the patients were living with dementia.
- 1 of the patients remained on the ambulance for 10 hours.
- 100% 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.

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

6.0 PSIRF Update, progress to date

- A Board safety culture session and a PSIRF oversight training day have taken place, which were well attended and feedback was positive.

- Work is underway to review alignment between safety assumptions under PSIRF and HR processes following patient safety incidents. A working group of key stakeholders is being formed, which will review current processes and make recommendations to QOC on alignment of processes and the implications for policies (with the intention of revising policies following these discussions).
- RALIG and QOC have begun to receive themes and trend updates from IROG and via the new daily Datix triage process. Several clusters of incidents have been identified, which have been flagged with the Divisions and are identified in the QOC and QSAC Incident Management Overview report, alongside action which is being taken at Divisional/cross Divisional level.

- Externally reportable incidents such as Human Fertilisation & Embryology Authority (HFEA) incidents, Human Tissue Authority Reportable Incidents (HTARI) are all now reported and presented to RALIG for oversight and assurance around actions.

- PSIRF processes are broadly working as anticipated with ongoing troubleshooting. Feedback is being continually sort and will feed into the planned annual review of PSIRF as outlined in the Patient Safety Incident Response Plan.

- Guidance, SOP's and supporting materials have been redrafted, following a PDSA approach, for learning responses (After Action Review/MDT reviews).

6.1 PSIRF improvement priorities update:

- Following workshops in late 2023 a suggested longer term improvement plan for the adult deteriorating patient has been drafted. A session is planned with the Associate Medical Director on in July to fully outline key workstreams, leads and oversight/governance arrangements.

- A broad proposal for a short/medium terms solution relating to missed radiology results is being further developed for discussion with Divisions and at QOC. Further work is being undertaken in July with a view to bringing a paper to QOC for discussion in August. The patient safety team is engaging with the IT team to understand the timescale for

implementation of the ICE system and how a review of ICE functionality could be undertaken based on current understanding of risks and hazards relating to radiology results being actioned.

- The scope of the omitted doses priority has been refined. Initial audit work is being undertaken on a small number of wards to begin assessing themes and issues. Observational work using a human factors/ergonomics plan is being planned. QOC will be updated on progress in July.

- In relation to Falls improvement work remains ongoing via the Corporate Nursing Quality Team. A plan to review elements of quality improvement activity with a member of the patient safety team with extensive QI experience will take place during July and August.

6.2 Family Liaison Officers

- The two-Family Liaison Officers (FLO) are now in post.

- The FLO's are beginning to support families/patients involved in investigations.

- An initial draft of the revamped DOC policy has been produced and will be presented to QOC in July for approval.

- The FLO's have already done extensive work on mapping what is available locally in terms of support for families and patients so they can be signposted for further support.

- The FLOs will be attending South Tees Hospitals NHS Foundation Trust during the summer, to learn from the FLO programme, which has been established for a couple of years. South Tees have offered places on their training and annual conference for our FLOs, which will help them to network and support improvements within our Trust.