The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
12 September 2024

Agenda item		137/24		
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 – July and August 2024 Quality and Safety Assurance Committee – July and August 2024		
Executive summary:		1. The Board's attention is drawn to section: 2 – Closed serious incident investigations 3 - PSIRF incident management processes and cases		
Recommendations for the Board:		The Board is asked to: Take assurance from this report in relation to patient safety incident management processes.		
Appendices:		N/A		

1. Introduction

This report provides assurance regarding the number and themes of closed serious incidents during June and July 2024. 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).

2. Incident Management

2.1 Serious Incidents Closed during June and July 2024

Lessons learned and actions taken are reported, in detail, through Quality and Safety Committee. There were 4 Serious Incidents closed in June 2024. A synopsis of the incident and action/learning is identified below in Table 1. 1 Maternity reportable incident was closed during June 2024.

Clinical Area	**Incident 1**
Classification	Serious Incident
Incident Ref number	2023/21641
Incident Summary	**Delayed Diagnosis** Key actions focussed on the review of patients awaiting offload from ambulance and escalation of concern
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.	2023/21022
Incident Summary	**Management of Diabetic Foot Ulcer** Key actions focus on education to support assessment
Duty of Candour Met	Yes
Impact on patient/family	Pain and distress caused
Clinical Area	**Incident 3**
Classification	Serious Incident
Incident ref. no.	2023/21646
Incident Summary	**Delayed Diagnosis** Key actions focussed on education and training
Duty of Candour Met	Yes
Impact on patient/family	Pain Anxiety caused.
Clinical Area	**Incident 4**
Classification	Serious Incident
Incident ref. no.	2023/11850
Incident Summary	**Birth Trauma**

	Action focussed on training and education and update of guidelines.
Duty of Candour Met	Yes
Impact on patient/family	Anxiety and distress caused

There was 1 Serious Incidents closed in July 2024. A synopsis of the incident and action/learning is identified below in Table 2. There were no Maternity reportable incidents closed during July 2024.

Table 2

Clinical Area	**Incident 1**
Classification	Serious Incident
Incident Ref number	2023/15355
Incident Summary	Delayed Diagnosis Multiple actions in place supported by ward-based improvement programme.
Duty of Candour Met	Yes full involvement with family and support provided
Impact on patient/family	Anxiety and distress

2.2 Open Serious Incidents

As at the 31st July 2024 the Trust has 7 serious incidents open and progressing through investigation, it is anticipated that the remaining serious incidents will be completed by September 2024.

3. PSIRF – Patient Safety Learning Responses

3.1 Patient Safety Incident Investigations (PSII) commissioned during June and July 2024

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

Table 3

PSII June 2024	**PSII July 2024**
No new cases	2024/6206 Post Operative Bleed
	2024/6511 Maternity MNSI MI037530
	2024/6520 Maternity MNSI MI037627

In June and July, a total of 5 After-Action Reviews/MDT learning responses were commissioned through RALIG and reported through QOC and QSAC. Table 4 contains detail of 1 PSII and 2 After Action Reviews closed through RALIG in June and July 2024.

Table 4

PSII closed
2024/2462 Complications relating to coagulation - Endoscopy
After Action Review Closed
AAR Failure to monitor AAA surveillance
AAR Absconded patient – SAU

Learning response themes and trends will be reported through QOC and QSAC and shared widely across the Trust to support improvement.

Overdue Datix

SPC 1 provides assurance that the progress with overdue incidents is sustained, and the number remains within the upper and lower control limit.

All Datix's are reviewed daily by the patient safety team who filter out those Datix that require immediate actions. 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