The Shrewsbury and Telford Hospital NHS Trust

Board of Directors’ Meeting
14 November 2024

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<tr><td colspan="2">Report Title</td><td colspan="3">Incident Overview Report</td></tr>
<tr><td colspan="2">Executive Lead</td><td colspan="3">Hayley Flavell, Director of Nursing</td></tr>
<tr><td colspan="2">Report Author</td><td colspan="3">Kath Preece, Assistant Director of Nursing, Quality Governance</td></tr>
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<tr><td colspan="2">CQC Domain:</td><td colspan="2">Link to Strategic Goal:</td><td>Link to BAF / risk:</td></tr>
<tr><td>Safe</td><td>√</td><td>Our patients and community</td><td>√</td><td rowspan="2">BAF1, BAF2, BAF4, BAF7, BAF8, BAF9</td></tr>
<tr><td>Effective</td><td></td><td>Our people</td><td></td></tr>
<tr><td>Caring</td><td></td><td>Our service delivery</td><td></td><td>Trust Risk Register id:</td></tr>
<tr><td>Responsive</td><td></td><td>Our governance</td><td>√</td><td rowspan="2">328/1353</td></tr>
<tr><td>Well Led</td><td></td><td>Our partners</td><td></td></tr>
<tr><td colspan="2">Consultation Communication</td><td colspan="3">Quality Operational Committee – September - October 2024
Quality and Safety Assurance Committee – September - October 2024</td></tr>
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<tr><td colspan="2">Executive summary:</td><td colspan="3">1. The Board’s attention is drawn to section:

2 – Closed serious incident investigations
3 - PSIRF incident management processes and cases</td></tr>
<tr><td colspan="2">Recommendations for the Board:</td><td colspan="3">The Board is asked to:

Take assurance from this report in relation to patient safety incident management processes.</td></tr>
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1. Introduction

This report provides assurance regarding the number and themes of closed serious incidents during August and September 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 August and September 2024

Lessons learned and actions taken are reported, in detail, through Quality and Safety Committee. There were 3 Serious Incidents closed in August 2024. A synopsis of the incident and action/learning is identified below in Table 1. No maternity reportable incidents were closed during August 2024.

Clinical Area	**Incident 1**
Classification	Serious Incident
Incident Ref number	2023/21646
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.	2023/20717
Incident Summary	**Delay in treatment** Key actions focus on Trust Priority for deteriorating patients
Duty of Candour Met	Yes
Impact on patient/family	Pain and distress caused
Clinical Area	**Incident 3**
Classification	Serious Incident
Incident ref. no.	2023/20518
Incident Summary	**Delayed Diagnosis** Key actions focussed on the Trust priority for deteriorating patients
Duty of Candour Met	Yes
Impact on patient/family	Pain Anxiety caused.

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

Table 2

Clinical Area	**Incident 1**
Classification	Serious Incident
Incident Ref number	2023/21297
Incident Summary	**Fall resulting in fractured neck of femur** All action contained within the Overarching falls prevention plan
Duty of Candour Met	Yes full involvement with family and support provided
Impact on patient/family	Anxiety and distress
Clinical Area	**Incident 2**
Classification	Serious Incident
Incident ref. no.	2023/19827
Incident Summary	**Deteriorating patient – NIV disconnection** Key actions contained within the Trust priority for deteriorating patient
Duty of Candour Met	Yes
Impact on patient/family	Pain Anxiety caused.

2.2 Open Serious Incidents

As at the 30 September 2024 the Trust has 7 serious incidents open and progressing through investigation, it is anticipated that the remaining serious incidents will be completed by December 2024.

3. PSIRF – Patient Safety Learning Responses

3.1 Patient Safety Incident Investigations (PSII) commissioned during August and September 2024

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

Table 3

PSII August 2024	**PSII September 2024**
2024/6929 Delay in treatment - Medicine	No cases reported
2024/7546 Wrong site surgery, incorrect person Biopsy.	
PSII Closed August 2024	**PSII Closed September 2024**
	2024/3907 Delay in diagnosis and treatment PE

In August and September 1 After-Action Review/MDT learning responses were commissioned through RALIG and reported through QOC and QSAC. Table 3 and 4 contains detail of 1 PSII and 4 After Action Reviews closed through RALIG in August and September 2024.

Table 4

After Action Review Commissioned
Datix 280060 Lab/IT issues
After Action Review Closed
Omitted dose medication leading to DKA
Lost to follow up/delayed diagnosis
Mortuary issues
Delayed Diagnosis and treatment

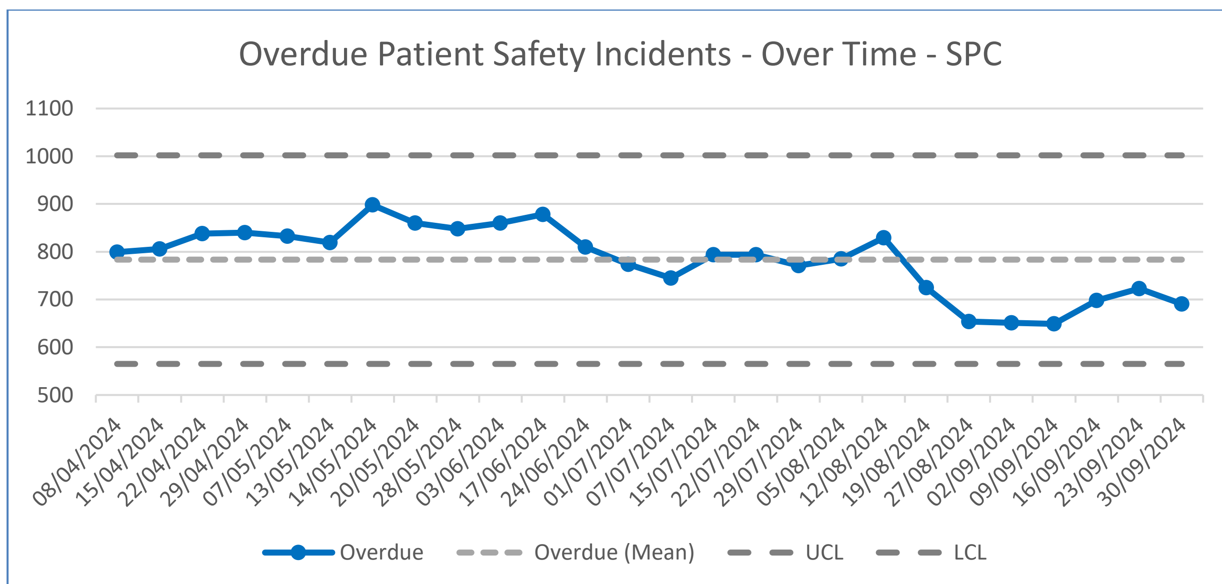
Learning response themes and trends will be reported through QOC and QSAC and shared widely across the Trust to support improvement.

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



In January 2025 a new format for the Incident Management Overview Report will be brought to Board, which will include safety intelligence and summary of themes and improvements made within the reporting period.