The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
16 January 2025

Agenda item		023/25		
Report Title		Patient Safety Incident Response Overview Report		
Executive Lead		Paula Gardner Interim Chief Nursing Officer		
Report Author		Kath Preece, Head of Clinical 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 October and November 2024 Quality and Safety Assurance Committee October and November 2024		
Executive summary:		The Board's attention is drawn to section: Section 2 Incident Management Section 4 New Family Liason Service Update Section 5 Learning from Patient Safety Events		
Recommendations for the Board:		The Board is asked to: Take assurance from this report in relation to the management of patient safety incidents through the PSIRF processes and the outcomes for patients and families		
Appendices:		N/A		

1. Introduction

This report provides oversight of the number and any themes of closed serious incidents during October and November 2024. Lessons learned and action taken are reported, in detail, through the Quality and Safety Assurance Committee (QSAC). It will detail the number of new and closed 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 report will provide updates on PSIRF Trust priorities, the new Family Liaison Service and an overview of learning/themes identified through learning responses. Work is ongoing to produce a patient safety dashboard to support performance review of PSIRF and will be reported to the Quality Operational Committee (QOC) and QSAC early in Quarter 1 2025.

2. Incident Management

2.1 Serious Incidents Closed during October and November 2024

There were no serious incidents closed during October and November 2024. There are now only 2 historical open serious incidents, which are scheduled to be presented to RALIG during January for sign off; this will then complete the previous serious incident process.

2.2 Patient Safety Incident Investigations (PSII) and Learning responses commissioned during October and November 2024

In October and November there were no PSII commissioned, and two After-Action Review/MDT learning responses commissioned through RALIG and reported through QOC and QSAC. Tables 1 and 2 contain PSII and After Action Reviews closed through RALIG in October and November 2024.

Table 1

PSII October 2024	**PSII November 2024**
Zero cases reported	Zero cases reported
PSII Closed October 2024	**PSII Closed November 2024**
Zero cases closed	Zero cases closed

Table 2

After Action Review Commissioned
Datix 285552 Missed Trauma scan – ED focus
Datix 285552 Missed Trauma scan – Trauma and Ortho focus
After Action Review Closed
Datix 277172 Lamotrigine review - October
Datix 275804 Prednisolone overdose - October

Learning response themes and trends will be reported through QOC and QSAC in detail and shared widely across the Trust to support improvement. Duty of candour is monitored through a monthly assurance meeting to ensure full compliance; there have been no reported breaches.

3. PSIRF – Patient Safety Incident Response Framework – Trust Priorities Update

Progress with the overarching Trust safety priorities agreed under the PSIRF framework.

3.1 Adult Deterioration

Following workshops in late 2023 a suggested longer term improvement plan for the adult deteriorating patient has been drafted and discussed with the Deputy Medical Director in terms of initiating a longer-term improvement programme, with an initial three-year planning horizon with proposed improvement workstreams. Datix's relating to deterioration continue to be monitored and reflect themes and trends identified by the systems review undertaken to inform the longer-term plan. An initial view of the overarching steering group, key workstreams and short life working groups needed to oversee the work has been formed and has been further refined.

3.2 Omitted Doses of Time Critical Medication

Initial audit work has been undertaken on a small number of wards to begin assessing themes and issues. Observational work using a human factors/ergonomics approach and staff focus groups are being planned alongside review of existing evidence and literature. The audit work (based around wider omitted doses) has identified some initial themes. A structured observation tool has been drafted and observations are being undertaken across several wards by the Medications Safety Officer and the Patient Safety Team. The outcome of these observations will be fed into staff focus groups in the New Year to further explore issues and recommend targeted areas for improvement.

3.3 Missed Radiology Results

A thematic review of the key issues has been undertaken and has been fed into further discussions around short/medium and long-term potential mitigations to reduce the risk of critical radiology results being missed. Further focussed review has suggested a potential medium-term mitigation based on the use of RadAlert combined with a dispersed model of the 'investigations team' approach. Datix's relating to this theme continue to be monitored and are aligning with the issues highlighted in the systems review.

3.4 Falls with harm

There is an ongoing falls improvement plan. All falls are reviewed with the ward/clinical area by the Quality Team. Falls resulting in fractured neck of femur are subject to a hot debrief. All learning is triangulated into the ongoing falls action plan. Any fall which is reviewed and highlights significant new learning can be escalated for consideration of an After-Action Systems Review. Themes, trends, and causal factors underlying falls are consistent and well understood. Raising falls with harm as a safety priority was intended to focus on reviewing the existing improvement plan to understand if improvement interventions were valid.

The lead from the patient safety team and Quality Matron have met to plan the approach to this improvement stream and align with ongoing falls improvement work. Work is going to focus on vision checks in line with key priorities from NAIF and as an area which has not previously been targeted for significant improvement work. Structured observations are being planned to understand work systems issues.

4. Family Liaison Officer Update

The Family Liaison (FLO) service was established in Spring 2024, since then the FLO team have provided support to more than 14 families who have been involved in Patient Safety Incident Investigations (PSIIs), learning responses, and SaTH staff whose close family

members have been involved in patient safety incident reviews. Feedback is now being sought from those who have utilised the service. The feedback received so far has been overwhelmingly positive with families stating they felt well supported by the service, they were kept updated with progress and that their questions were answered by the end of the process.

During supporting families, the FLO team identified that attending Coroners Court was a source of stress and anxiety for those families involved in the inquest process and there was minimal support available to them. The FLO team have worked closely with the Shropshire Coroner's Office, including meeting both Coroners to develop relationships and improve the sharing of information between all those involved. There is now a formal agreement with the Shropshire Deputy Coroner that FLOs can attend inquests to support families in court and will not be called to the stand. A meeting is being requested with the main Shropshire Coroner to request a similar agreement for his inquests.

The FLO team have updated and improved the Duty of Candour (DoC) policy to make it more user friendly, produced various supporting materials for completion of DoC and implemented a new training programme to empower staff to feel confident to apologise to patients and families when incidents occur. The team are also providing practical support to those completing DoC where required, including visiting patients with staff, sitting with them when they make phone calls and supporting with the completion of DoC letters.

5. Learning from Patient Safety Events

Learning responses have been cross-referenced for thematic learning. The tables below outline this learning. The learning is characterised into broad groups:

- Significant systems learning from a single learning response
- Themes which are represented across several learning response which represent wider systems issues.

Table 3: Systems issues highlighted by a single learning response

Summarised theme/learning	Improvement activity
Anti-coagulation for patients undergoing endoscopy procedures	Significant work being undertaken led by Endoscopy governance lead.
Use of alerts on IT systems for complex/rare conditions	Alert created for risk of GI bleed with pancreatic transplant patients.
Discharge of patients with complex medications	Medication reducing sheet has been redesigned with input from patients/families and is being further tested.
Patients with AAA's being contacted for screening programmes	A virtual clinic system has been established by vascular CNSs to track patients who need to be contacted regarding AAA screening. Radiology reports with AAA findings include a recommendation of referral for screening. Linked to PSIRF radiology results improvement priority.
Side by side working for patients needing mental health support	Significant joint improvement actions agreed between MPFT and SaTH focussed on side by side working and the processes to support side by side working.

Table 4: Systems issues highlighted by more than one learning response

Summarised theme/learning	Improvement activity
Clinical guidelines, availability, accessibility, and use	There is currently work being undertaken to review the overall approach to guidelines. It is suggested further

Summarised theme/learning	Improvement activity
	discussion is required in terms of clarity of direction, leadership, and resources for this work.
Results handling	A number of actions have been developed based on individual learning responses. Significant work based on an MDT review in Gynaecology. Incoming IT system ICE assumed to mitigate a number of issues/risks relating to results. It is suggested this assumption needs testing and challenging as part of the IT programme.
Use of the bleep system and ability to contact clinical staff	A bleep working group has been formed which is overseeing a business case for regarding replacement of the current bleep system and work that needs to be undertaken to create a process to manage the system effectively.
Referral pathways between clinical teams (particularly too outpatient appointments)	A number of actions have been identified across individual learning responses and specific pathways to reduce risk.
Listening to families	A number of learning responses have highlighted issues around listening and responding to families' concerns relating to their relative's treatment. Some of these have been closely related to concerns around deterioration. The overarching adult deterioration programme has outlined development of a 'call for concern model' as a key aim of the response workstream. This will be informed by the outputs of the national pilot programme relating to Martha's rule.