The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
13 March 2025

Agenda item		052/25		
Report Title		Patient Safety Incident Response Overview Report – December 2024 and January 2025 data.		
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 December 2024 and January 2025 Quality and Safety Assurance Committee December 2024 and January 2025		
Executive summary:		The Board's attention is drawn to section: Section 2 Incident Management Section 5 Learning from Patient Safety Events		
Recommendations for the Board:		The Board of Directors 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 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, an overview of learning/themes identified through learning responses and identification of new emerging themes from incidents. Work is ongoing to produce a patient safety dashboard to support performance review of PSIRF and will be reported to QOC and QSAC early in Quarter 1 2025.

2. Incident Management

2.1 Patient Safety Incident Investigations (PSII) and Learning responses commissioned during December 2024 and January 2025.

In December 2024 and January 2025 there were two PSII commissioned, and 4 After-Action Review/MDT learning responses commissioned through RALIG and reported through QOC and QSAC. Table 1 and 2 contains PSII and After Action Reviews commissioned and also those closed through RALIG in December 2024 and January 2025.

Table 1

PSII December 2024	**PSII January 2025**
2024/101943 MNSI accepted case. Intrapartum Stillbirth	2025/509 Fall with head injury leading to death
PSII Closed December 2024	**PSII Closed January 2025**
Zero cases closed	2024/6206 Post operative bleed leading to death
	2024/4814 MNSI Maternity case – Neonatal death

Table 2

After Action Review (AAR) Commissioned
Datix 288902 Unlabelled specimen sample in theatre
Datix 284887 Missed referrals and delays to treatment – Dermatology pathway/Head and Neck
Datix 291883 Lost to follow up – delay in treatment
Datix 290134 Consent issues with surgery
After Action Review Closed
Datix 271442 – AAR Missed referral delay in treatment
Datix 270512 – AAR Delay in diagnosis due to missed radiology results and incorrect referral
Datix 261928 – AAR End of life pathway and transport issues

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

Initial working groups have been formed. The Deputy Medical Director is reviewing the groups and meet leads to ensure clarity of the terms of reference and initial priorities of each group. Project Management Office support is being sought as this is a complex programme to track and deliver.

The Deputy Medical Director is also having further discussions to clarify governance and reporting arrangements. This includes clarifying the role, membership, and terms of reference of the existing Deteriorating Patient Group (DPG).

3.2 Omitted Doses of Time Critical Medication

A specific programme of work is being shaped around 'Time Critical Medications' publication and quality improvement programme from the RCEM in the ED setting. The programme had already been initiated in ED. The timescale and work programme for this element are being further mapped out in February 2025.

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. An outline a scoping document has been produced for discussion. An additional meeting is being scheduled to bring together key stakeholders to further clarify options. Discussion will need to focus around, the balance of risk, resource (given current financial challenges) and relative priority given the timescale for longer term IT based mitigations.

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. Structured observations are being planned to understand work systems issues.

4. 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
Management of massive blood loss in neonates	Local pathway review to be embedded including timely emergency escalation

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 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.
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.
Clinical handover	A number of actions have been identified in relation to clinical handover between teams. Recommendations have been made to commence a handover improvement project
Discharge	A number of actions have been identified in relation to discharge concerns. A discharge improvement group is planned to understand the themes and issues.

5. Emerging Themes from Incidents during the period

Patients arriving for cancelled appointments - not being informed of cancellations
Increasing Wrong Blood In Tube reports
Suboptimal handovers from acute areas to wards
Consent issues
ED/Acute Med team responses – clarity of roles
Issues around nimbus/pressure relieving mattress availability – linked to increased demand