Board of Directors' Meeting
9 December 2021

Agenda item	297/21			
Report	Incident Management Overview Report (October 2021 data)			
Executive Lead	Director of Nursing Medical Director			
	Link to strategic pillar:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people		Effective	
	Our service delivery		Caring	
	Our partners		Responsive	√
	Our governance	√	Well Led	
	Report recommendations:		**Link to BAF / risk:**	
	For assurance		BAF 1, BAF 2, BAF 4, BAF7, BAF 8, BAF 9	
	For decision / approval		**Link to risk register:**	
	For review / discussion			
	For noting	√		
	For information			
	For consent			
Presented to:				
Dependent upon (if applicable)**:**				
Executive summary:	This paper is presented to the Board of Directors monthly to provide assurance of the efficacy of the incident management and Duty of Candour compliance processes. Incident reporting supporting this paper has been reviewed to assure that systems of control are robust, effective and reliable thus underlining the Trust's commitment to the continuous improvement of incident and harm minimisation. The report will also provide assurances around Being Open, number of investigations and themes emerging from recently completed investigation action plans, a review of datix incidents and associated lessons learned.			
Appendices:	Appendix One – Serious Incidents – October 2021 Appendix Two – Learning and Actions – October 2021			
Lead Executive:				

1. Introduction

This report highlights the patient safety development and forthcoming actions for Dec/Jan 2021 for oversight. It will then give an overview of the top 5 reported incidents during October 2021. Serious Incident reporting for October 2021 and also rates year to date are highlighted. Further detail of the number and themes of newly reported incidents and those closed during October 2021 are included in Appendix 1. Detail relating to completed actions and lessons learned are included in Appendix 2.

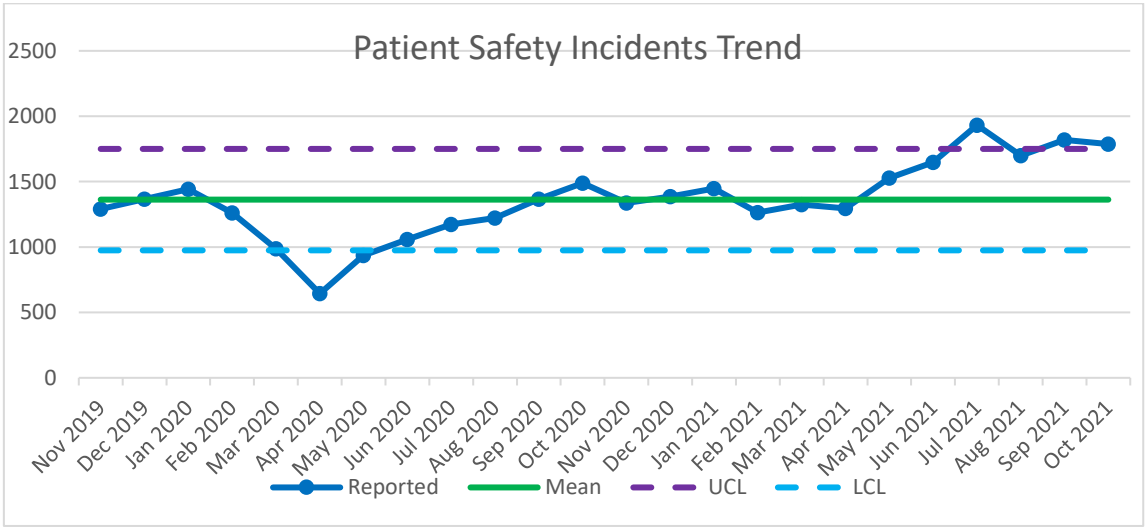
2. Patient Safety Development and Actions planned for Dec/Jan 2021/22

- New Quality Governance Framework implementation during December including realigning resource to support Divisional quality governance improvement
- Approve new Incident Management Policy – December Quality Operational Committee

3. Analysis of October Patient Safety Incident Reporting

The top 5 patient safety concerns reported via Datix are reviewed using Statistical Process Charts (SPC). Any deviation in reporting, outside of what should reasonably be expected, is analysed to provide early identification of a potential issue or assurance that any risks are appropriately mitigated. SPC Chart 1 demonstrates Patient Safety Incident reporting over time which shows an increasing trend in incident reporting across the Trust, which may be attributed to an improving safety and reporting culture. Work is planned during January to test assumptions related to a change in culture through the use of pulse surveys.

SPC Chart 1



3.1 Review of Top 5 Patient Safety Incidents

During October there were 1,787 Patient Safety Incidents reported which were classified as incidents attributable to Shrewsbury and Telford Hospitals. The top 5 reported incidents account for 32% of the reported incidents during October 2021 – see Table 1. The top 5 reported incidents are explored in more details below.

Table 1

Top 5 Patient Safety Incidents	Totals
Inpatient Fall	127
Admission of patients	125
Staffing Problems	117
Bed Shortage	111
Care / Monitoring / Review Delays	97
Total	577

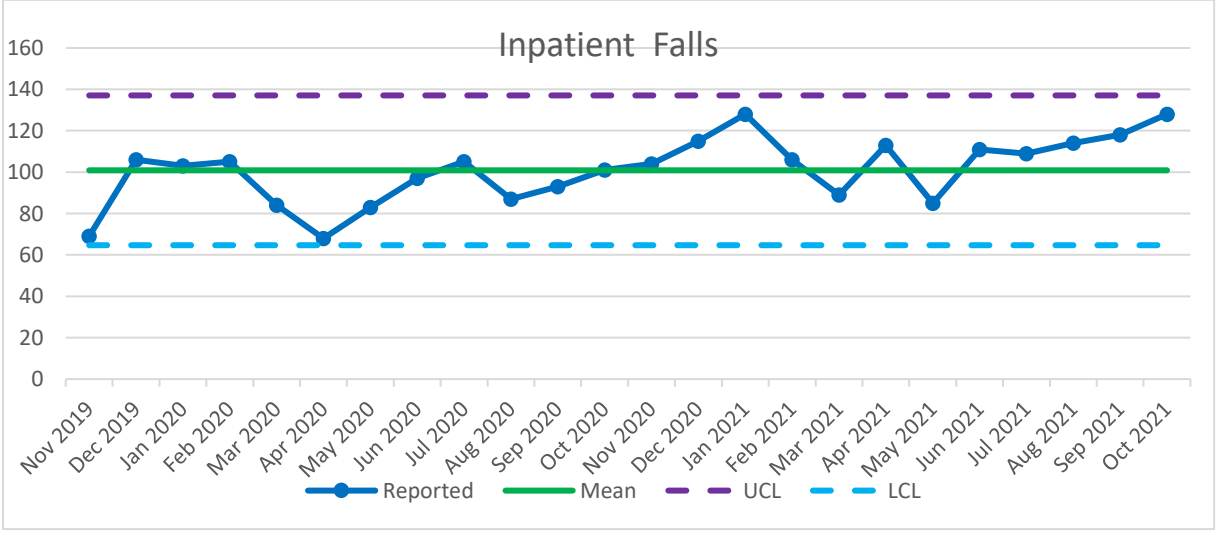
3.2 Falls

7.1% of all reported incidents during October (127 in total) were categorised as a Fall. Of these, 2 were reported as moderate harm, these incidents are investigated internally to identify learning and 3 were reported as severe harm. The 3 severe harm incidents have been reported as Serious Incidents and are under investigation. Completed investigation reports are presented to the Nursing Incidents Quality Review Meeting (NIQAM) which is Chaired by the Deputy Director of Nursing where learning is identified and shared.

All inpatient falls are reviewed daily by the Quality Matrons and the Falls Lead Practitioner, identifying areas for improvement and shared learning.

SPC Chart 2 identifies an increasing trend in inpatient Falls reported. The Trust is part of the Regional Falls Group working to share learning and falls prevention strategies. The Group have noted an increase in falls Nationally, which may be linked to the COVID 19 pandemic.

SPC Chart 2



3.3 Staffing Problems

6.5% of all reported incidents during October (117 in total) were categorised as Staffing Problems. Further analysis of these concerns show that of the 117 incidents reported 74 reported low harm, these relate to delays in undertaking observations, documentation, risk assessments, medication, treatment. The remaining 43 assessed as no harm/near miss.

Data relating to staffing incidents is triangulated with quality metrics and reported through the Divisional Directors and the Director of Nursing through to Quality and Safety Assurance Committee.

3.4 Admission of patients

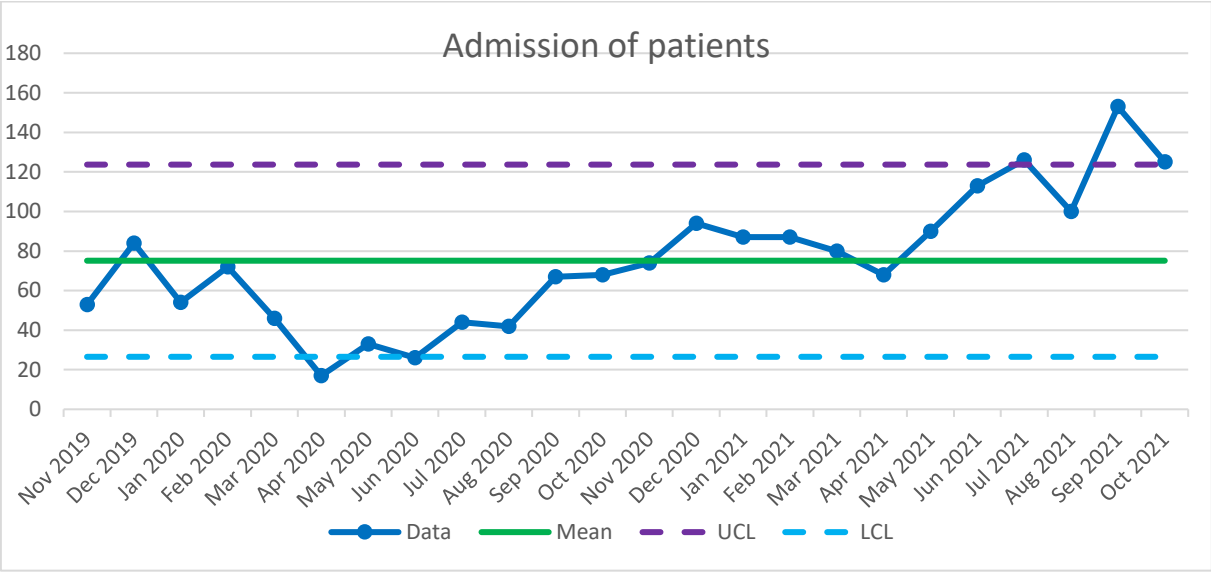
7% of all reported incidents during October (125) were categorised as incidents related to the admission of patients. This category covers a wide range of concerns relating to the admission of patients. Analysis of this category has identified four themes, see below in Table 2. Analysis of harm due to the admission concerns have identified two moderate harm incidents, which are under investigation, 32 low harm incidents and 91 no harm/near miss.

Further analysis is underway in relation to ambulance offload delay and long waits in the Emergency Department in relation to review of harm. It is also important to note that each incident report for ambulance offload delay may have multiple patients attached to it – each patient is currently under review to assess any harm caused due to delay in admission. SPC Chart 3 demonstrates an increasing trend with September/October reaching and exceeding the upper control limit.

Table 2

Admission of Patients	Totals
Ambulance Offload Delay/12 hour breaches	99
Delay in obtaining clinical assistance	20
Incorrect Triage	5
Referral from UCC	1
	125

SPC Chart 3



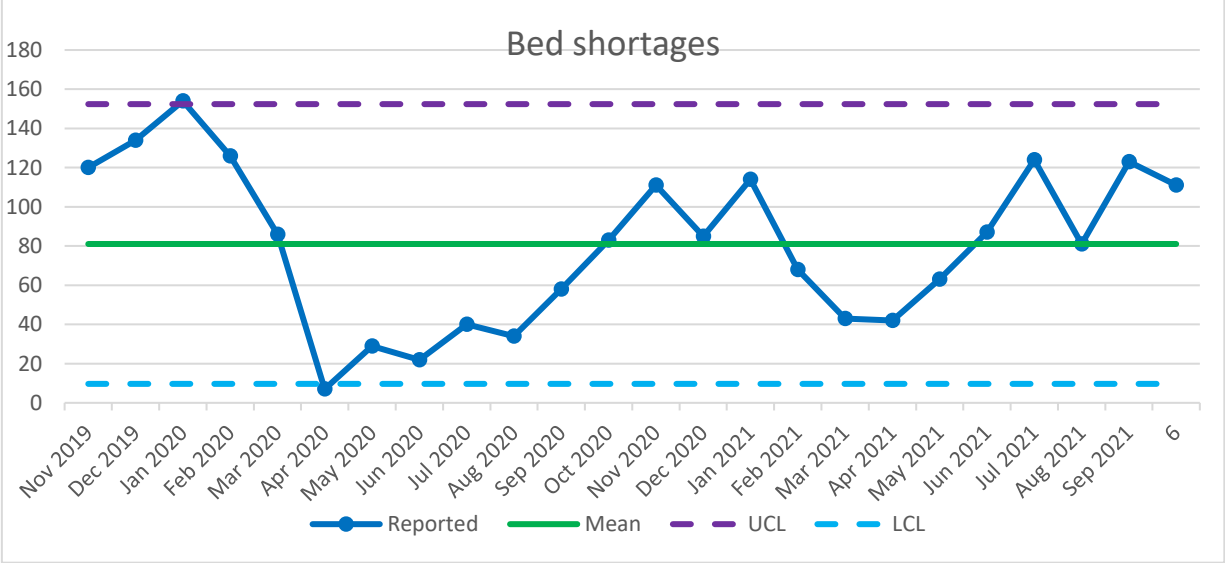
3.5 Bed Shortage

6.2% of all reported incidents in October (111 in total) were categorised as Bed Shortage. Analysis of this group of datix shows that 65 of the 111 datix refer to lack of beds to transfer a patient from the Emergency Department to a ward bed. The impact of bed shortages triangulate with the number of incidents reported in relation to ambulance offload delays. SPC Chart 4 demonstrates common cause variation.

Table 3

Bed Shortage	Totals
12 Hour Trolley Breach	28
Delayed transfer from ITU due to no bed	31
No bed available	37

SPC Chart 4



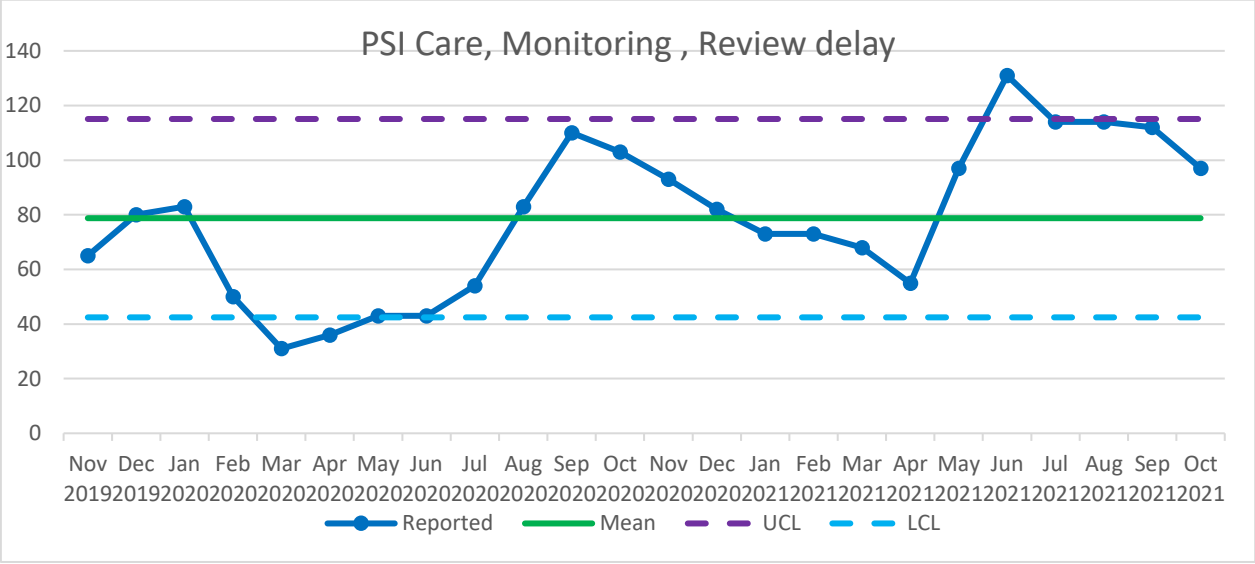
3.6 Care Monitoring Delay

5.4% of all reported incidents in October (97 in total) were categorised as Care Monitoring Delays. Analysis of this group of datix is complex and identifies a wide range of issues, which relate to delays due to staffing, delays due to lack of beds, delays in escalation, delays in observations. Importantly on analysis of harm for this category, of the 97 incidents 54 were no harm/near miss, 42 were low harm due to some delay in care and 1 was moderate harm which is under investigation. Ongoing work in relation capacity, flow and staffing should reduce delays in care. SPC Chart 5 demonstrates a rise in incidents between April 2021 and June 2021 which correlates to pressures seen within the Trust, particularly attendances to the Emergency Department. It is noted that during August through to October the trend is now on a downward trajectory.

Table 4

Care Monitoring Delay	Totals
Delay in undertaking investigations	15
Delay in obtaining clinical review	10
Delay in following clinical guidelines	11
Delay in implementing care	45
Delay in monitoring care	12

SPC Chart 5



4. Serious Incident Management

4.1 Review, Action and Learning from Incident Group (RALIG)

9 New case assessments were reviewed by RALIG, Chaired by the Co-Medical Director, resulting in 1 Never Event Serious incidents Investigation and 4 Serious Incidents Investigations being instigated. 2 Internal Investigations, 1 Structured Judgement Review and 1 System wide review being commissioned (See appendix 1 for detail).

4.2 Nursing Incident Quality Review Meeting (NIQAM)

3 Serious Incidents Investigations instigated relating to falls severe harm and 1 Serious Incident Investigation instigated relating to Category 3 Pressure Ulcers (See appendix 1 for detail).

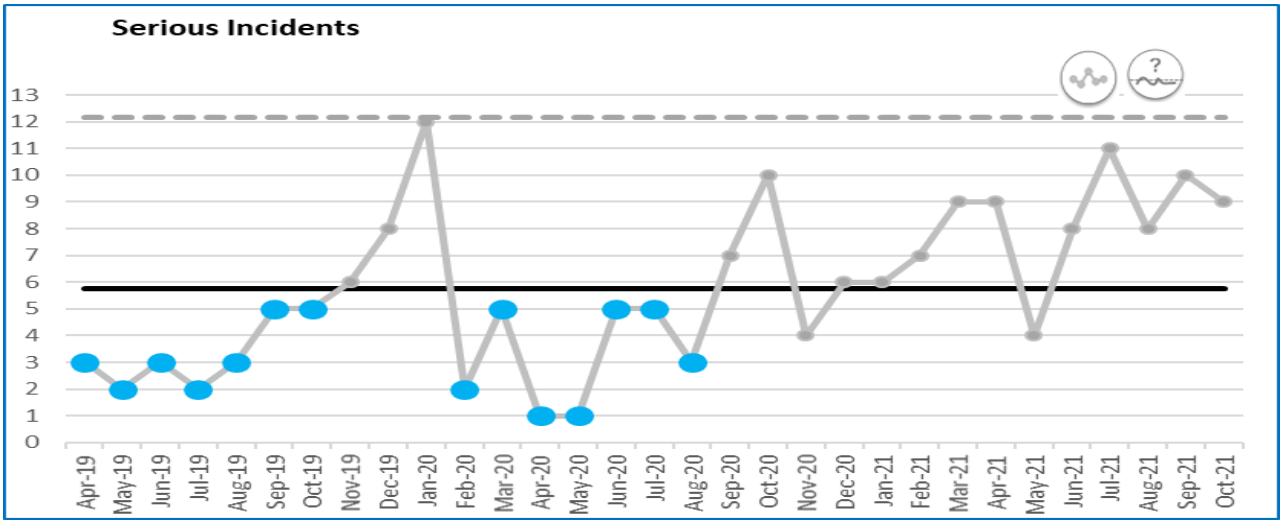
4.3 Maternity

There were no reported Serious Incidents relating to Maternity during October.

4.4 Serious Incident Reporting Year to Date

At the end of October 2021/22 the Trust had reported 59 year to date.

SPC 6



5. Never Events

There has been 1 Never Event Serious Incident reported in October 2021, which is the first Never Event in the Trust since December 2020. (See appendix 1)

6. Lessons Learned and Action Plan Themes

There were 3 Serious Incidents closed in October. A sample of the learning identified and completed actions can be found in Appendix 2 and 3.

7. Duty of Candour

There have been no breaches in Duty of Candour during October.

8. Quality Governance Framework

As part of the new Quality Governance Framework the current Patient Safety Team is in the process of realignment with Divisional Quality Governance teams to create a robust resource to enable a standardised approach to Quality Governance across the Divisions. Implementation has commenced during November and will embed during December.

Appendix One

New Serious Incident Investigations - October 2021

A summary of the serious incidents reported in October is contained Table 1.

There were 9 serious incidents reported in October 2021.

Table 1

SI – STEIS Reportable	Number Reported
2021/21808 Delayed Diagnosis	1
2021/21085 Category 3 Pressure Ulcer	1
2021/21110 Medication Error – Gentamycin	1
2021/21080 Never Event wrong site surgery	1
2021/21558 Potential delay in diagnosis of breast cancer	1
2021/21795 Diagnostic incident - Radiology	1
2021/21859 Fall resulting in head injury	1
2021/22110 Fall resulting in head injury and subsequent death	1
2021/22140 Fall resulting in fracture neck of femur	1
Total	9

Closed Serious Incident Investigations - October 2021

SI – Closed October 2021
2021/12745 Category 3 Pressure Ulcer
2021/9150 Post TRUSS Infection
2021/2261 Delayed Treatment

Appendix Two

Learning identified from closed incidents in October

Key themes:

- Duplication of information – Action: streamlining of documentation and reducing duplication across nursing documentation
- Importance of completing all risk assessments – Action: Ongoing work with compliance and monitoring as part of Getting to Good Programme – Fundamentals of Care
- Importance of shared learning across wards – Action: Safety/Learning and Sharing Board to be rolled out in new year – monthly flashcards
- Decontamination processes and Environmental cleaning – Actions taken as part of review include audit of decontamination processes which are undertaken outside of central decontamination unit.
- Action taken: Airflow System reviewed along with the environment for TRUSS Biopsy
- Internal review completed by Infection Prevention and Control Team
- Staffing requirement to facilitate decontamination reviewed and a now include a third person to undertake this role.
- Routine appointments ceased due to COVID however no system was put in place to identify a small group of patients who were at risk due to the delay. Action taken: new clinic code created to identified this group of patients in order to ensure timely follow up.
- Action taken: workforce resilience, the service now has 2 Optometrists supported with clinical leadership to ensure a robust service.