Board of Directors' Meeting

10 February 2022

The Shrewsbury and Telford Hospital NHS Trust

Agenda item	012/22			
Report	Incident Management Report			
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 – December 2021 Appendix Two – Learning and Actions – December 2021			
Lead Executive:				

1. Introduction

This report highlights the patient safety development and forthcoming actions for Feb/March 2022 for oversight. It will then give an overview of the top 5 reported incidents during December 2021. Serious Incident reporting for December 2021 and also rates year to date are highlighted. Further detail of the number and themes of newly reported Serious Incidents and those closed during December 2021 are included in Appendix 1. Detail relating to completed actions and lessons learned are included in Appendix 2.

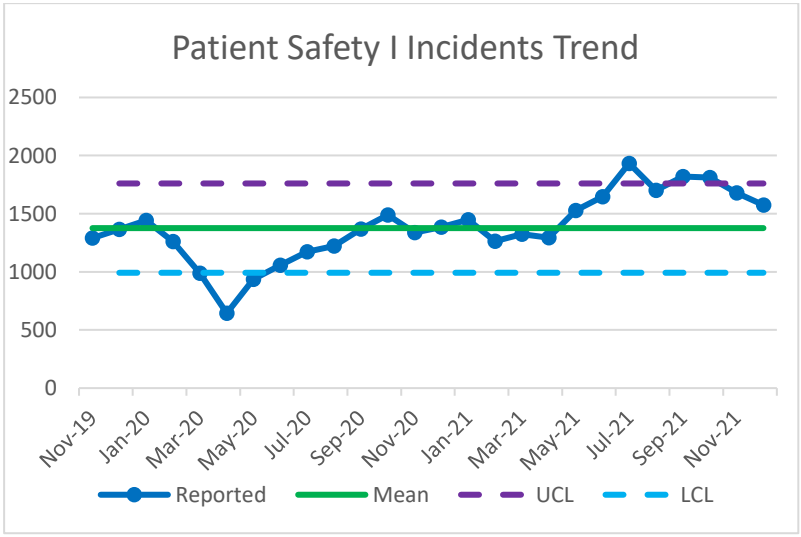
2. Patient Safety Development and Actions planned for Feb/March 2021/22

- Work with the National and Regional Patient Safety Network to develop a clear plan for progress to the new National Patient Safety Incident Response Framework, which will require significant changes to the way in which the Trust approaches patient safety investigations – due to be rolled out Nationally during 2022.
- Develop Safety links/champions in all ward areas to support learning and sharing.
- Embed the new Divisional Quality Governance Teams and Quality Governance Framework
- COVID19 communication/second stage duty of candour for hospital acquired harm

3. Analysis of December 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 upward trend in reporting which may relate to a more open reporting culture.

SPC Chart 1



3.1 Review of Top 5 Patient Safety Incidents

During December there were 1,574 Patient Safety Incidents reported which were classified as incidents attributable to Shrewsbury and Telford Hospitals. The top 5 reported incidents account for 34% of the reported incidents during December 2021 – see Table 1. The top 5 reported incidents are explored in more details below.

Table 1

Top 5 Patient Safety Incidents	Totals
Staffing Problems	138
Inpatient Fall	114
Admission of patient	109
Communication	97
Care / Monitoring / Review Delays	80
Total	538

3.2 Staffing Problems

8.8% of all reported incidents during December (138 in total) were categorised as Staffing Problems. Further analysis of these concerns show that of the 138 incidents reported 43 reported low harm, these relate to delays in undertaking observations, documentation, risk assessments, medication, treatment. The remaining 95 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.

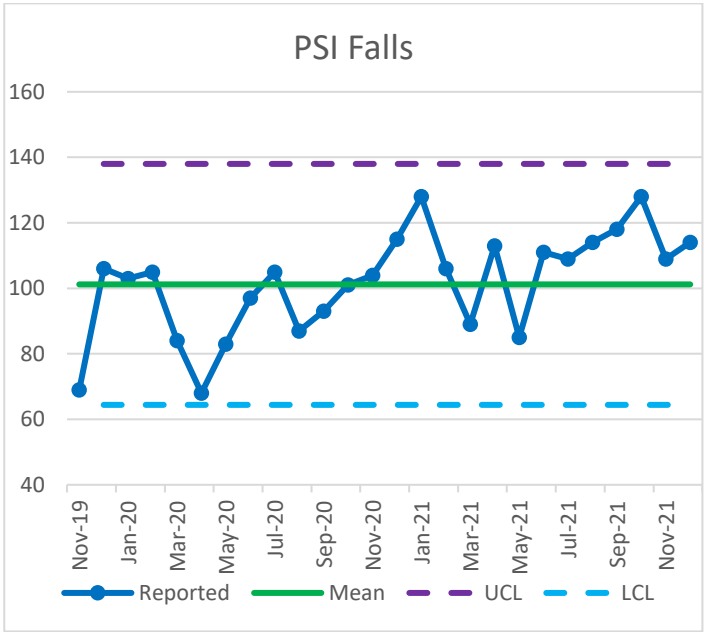
3.3 Falls

7.2% of all reported incidents during December (114 in total) were categorised as a Fall. Of these, 2 were reported as severe harm. The 2 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, although there has been a reduction seen in November and December 2021. 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



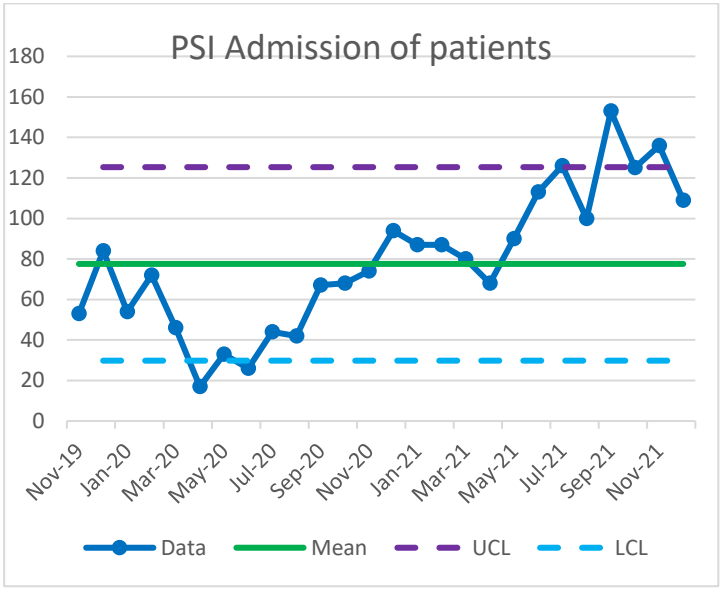
3.4 Admission of patients

6.9% of all reported incidents during December (109) were categorised as incidents related to the admission of patients. This category covers a wide range of concerns relating to the admission of patients, such as ambulance offload delays and delay with allocation of beds out of the Emergency Department. Analysis of harm due to the admission concerns have identified 32 low harm incidents, which include delays in observations, delay in IV antibiotics and delays in pain relief and 77 no harm/near miss incidents.

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.

The data shows that during September, October and November incidents exceeded the upper control limit it is noted the during December there was a small reduction in incidents however this remains close to the upper control limit and demonstrates significant pressure with the Emergency Department and capacity concerns with the Trust.

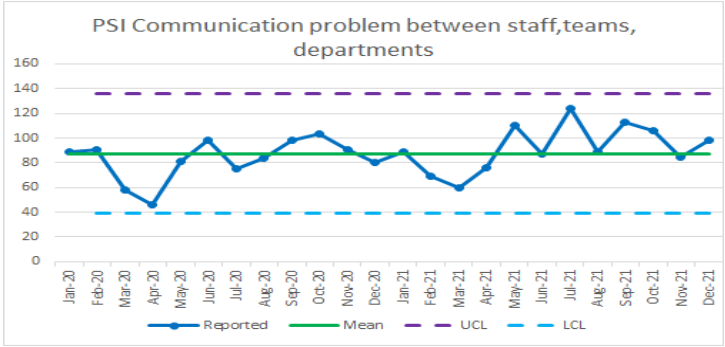
SPC Chart 3



3.5 Communication section

6.1% of all reported incidents during December (97) were categorised as incidents related to communication. This category covers a wide range of concerns. Analysis of harm due to communication have identified 1 moderate harm which is under investigation, 21 low harm incidents where communication delayed treatment and 75 no harm/near miss. SPC Chart 4 shows common cause variation.

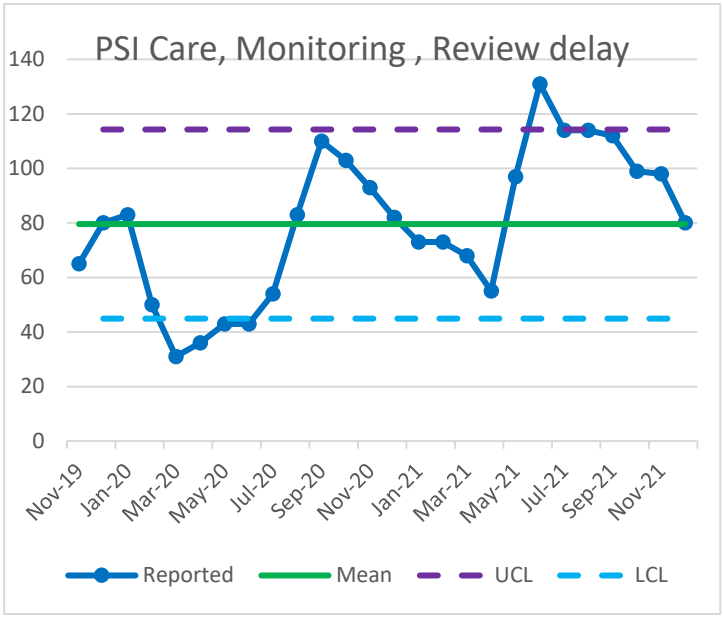
SPC Chart 4



3.6 Care Monitoring Delay

5.1% of all reported incidents in December (80 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. On analysis of harm for this category, of the 80 incidents, 40 were no harm/near miss, 37 were low harm due to some delay in care and 3 were moderate harm which are under investigation. Ongoing work in relation capacity, flow and staffing should help to mitigate harm. 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 December the trend is now on a downward trajectory.

SPC Chart 5



4. Serious Incident Management

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

4 New case assessments were reviewed by RALIG during December, Chaired by the Co-Medical Director, resulting in 1 Serious Incident Investigations being instigated and 3 Internal Investigations.

4.2 Nursing Incident Quality Review Meeting (NIQAM)

2 Serious Incidents Investigations were commissioned during December relating to falls with severe harm and 1 Serious Incident Investigation relating to Category 3 Pressure Ulcers (See appendix 1 for detail).

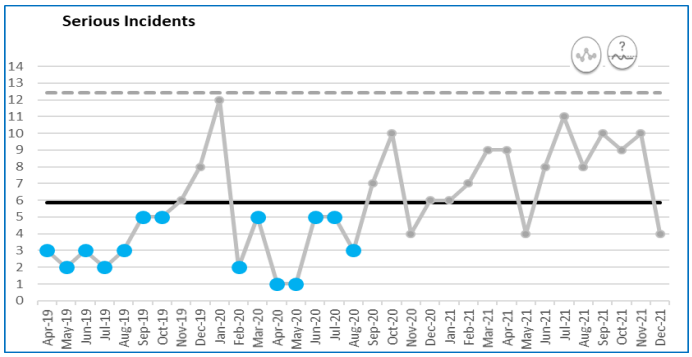
4.3 Maternity

There was 1 Serious Incident (HSIB) relating to Maternity reported during December and is under investigation.

4.4 Serious Incident Reporting Year to Date

At the end of December 2021/22 the Trust had reported 73 serious incidents year to date.

SPC 6



5. Never Events

There have been no Never Events reported in December 2021.

6. Lessons Learned and Action Plan Themes

There were 10 Serious Incidents closed in December. 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 December.

8. Quality Governance Framework

The new Quality Governance Framework and structure is now in place to support Divisional Quality Governance teams to create a robust resource to enable a standardised approach to Quality Governance across the Division

Appendix One

New Serious Incident Investigations - December 2021

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

There were 4 serious incidents reported in December 2021.

Table 1

SI – December 2021	**Number Reported**
2021/24701 Fall resulting in fracture	1
2021/24979 Fall – Fall Fracture Neck of Femur	1
2021/25777 Category 3 Pressure Ulcer	1
2021/26019 Maternity – Cooled baby - HSIB	1
Total	4

Closed Serious Incident Investigations - December 2021

SI – Closed December 2021
2020/14096 Never Event – wrong site procedure
2021/7291 Delayed Treatment
2021/10851 Maternity – Soft Tissue Birth Injury
2021/13531 Gynaecology Clinic – Procedural Issues
2021/15975 Delayed Diagnosis
2021/17651 Fall fractured tibia
2021/17882 Fall with fracture neck of femur
2021/18124 Fall with fracture neck of femur
2021/5876 Delay in Medical Review
2020/22150 Delayed Diagnosis – Pancreatitis

Appendix Two

Learning identified from closed incidents in December

Key themes:

• Reviewed process for booking in relation to outpatient clinics
• Reviewed patient information and identified ways to ensure reliable delivery to patients before clinic appointments
• Reviewed process for one-stop clinics to ensure privacy and dignity during communication
• Improved communication and follow up of OPD appointments with clear guidelines and responsibilities defined for follow up.
• All referrals to other specialists following an inpatient stay should be made via a formal referral letter which clearly states the clinical problem and question being asked, rather than relying on a discharge letter.
• Reviewed how cancer trackers can be better involved in ensuring the timely completion of investigations and progress through the diagnostic pathway. The emphasis here should be on how they receive the initial information that a new patient needs to be tracked.
• All clinicians made aware that patients under their care may have had delayed diagnostic tests (radiology and others) as a result of COVID and be vigilant to the possibility that they may identify such patients.
• Ensure that the EPS assessments are carried out as required and that the assessment sheet is used in its entirety to determine final score and actions – audit documentation
• Inclusion of Hi-low bed/crash mats in the trusts falls training
• Ensure that documentation around the footwear patients were wearing at the time that they sustain inpatient falls is accurate and consistent