The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting in Public
10 March 2022

Agenda item	044/22			
Report	Incident Overview Report – January 2022 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 – January 2022 Appendix Two – Learning and Actions – January 2022			
Lead Executive:				

1. Introduction

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

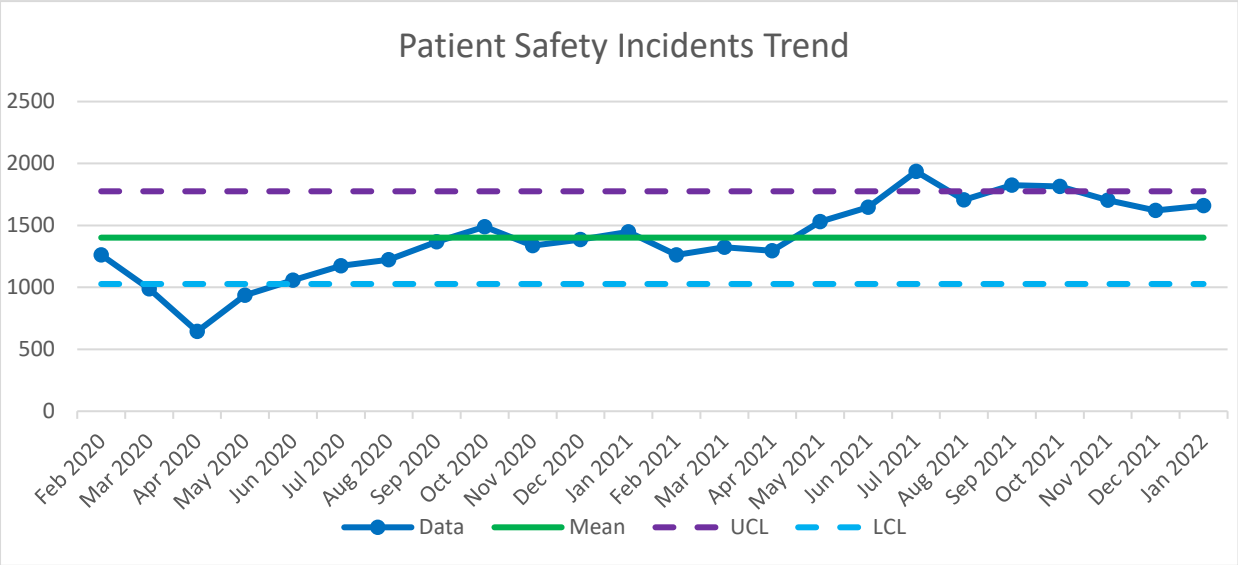
2. Patient Safety Development and Actions planned for March/April 2021/22

- 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 January 2022 Patient Safety Incident Reporting

The top five 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 this may relate to a more open reporting culture, during May to July 2022 it is planned to undertake a pulse survey of staff to test this assumption.

SPC Chart 1



3.1 Review of Top 5 Patient Safety Incidents

During January there were 1,659 Patient Safety Incidents reported which were classified as incidents attributable to Shrewsbury and Telford Hospitals. The top five reported incidents account for 34% of the reported incidents during January 2021 – see Table 1. The top five reported incidents are explored in more details below.

Table 1

Top 5 Patient Safety Incidents	Totals
Admission of patient	151
Inpatient Fall	137
Staffing Problems	105
Bed shortage	89
Care / Monitoring / Review Delays	79
Total	561

3.2 Admission of patients

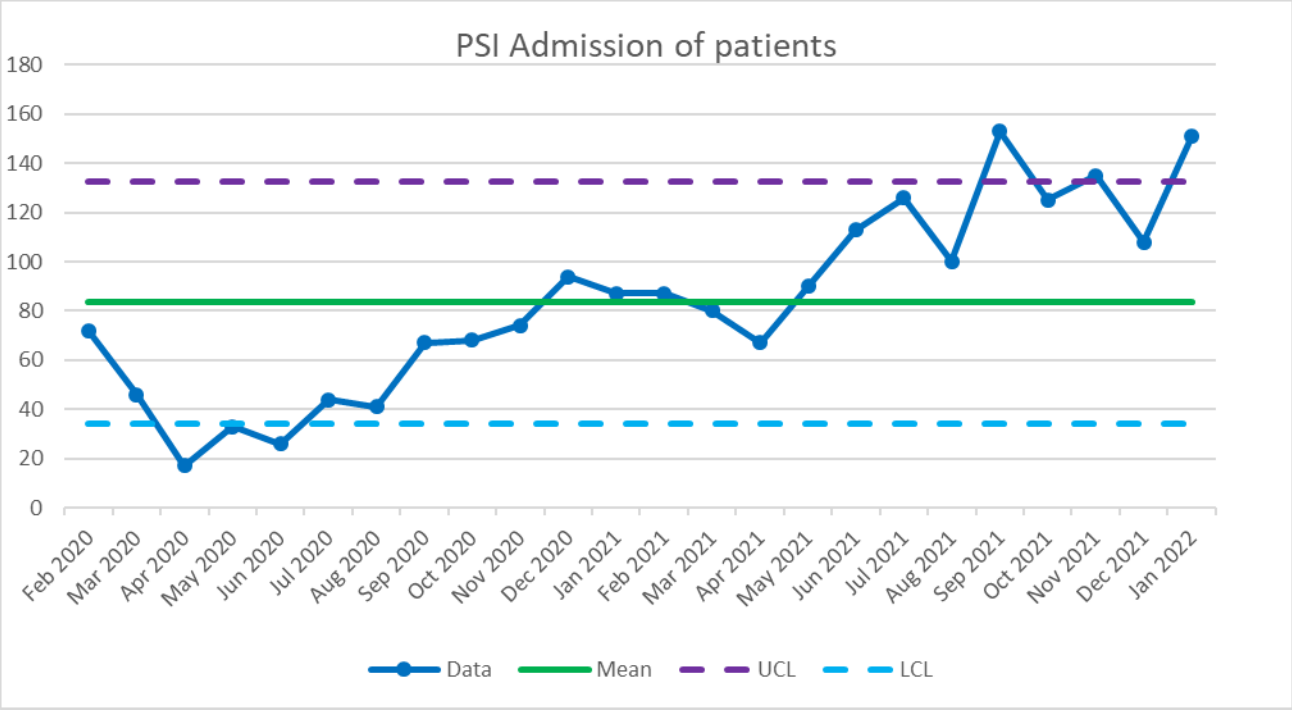
9.1% of all reported incidents during January (151) were categorised as incidents related to the admission of patients. This category covers a wide range of concerns relating to the admission of patients, such as ambulance offload delays and delay with allocation of beds out of the Emergency Department. The number of incidents and % of incidents has increased during January 2022.

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 2 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 January has once again exceeded the upper control limit and demonstrates significant pressure with the Emergency Department and capacity concerns with the Trust.

SPC Chart 2



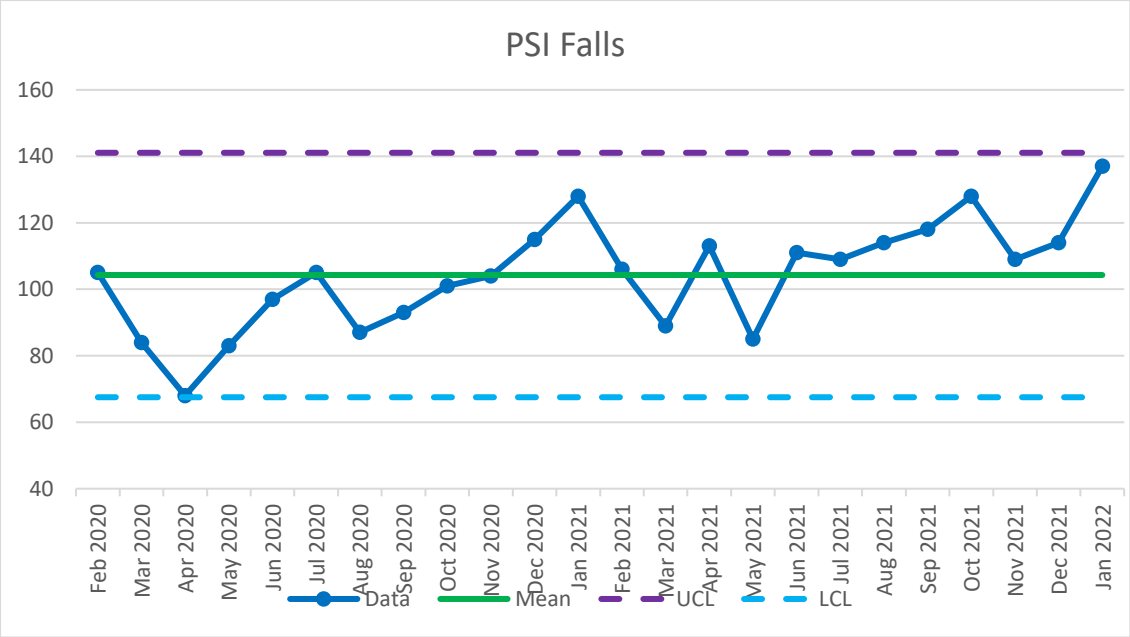
3.3 Falls

8.2% of all reported incidents during January (137) were categorised as a fall. Of these, three were reported as severe harm and 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 3 identifies an increasing trend in inpatient Falls reported, although there had been a reduction seen in November and December 2021, January 2022 has since seen a significant increase in 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 3



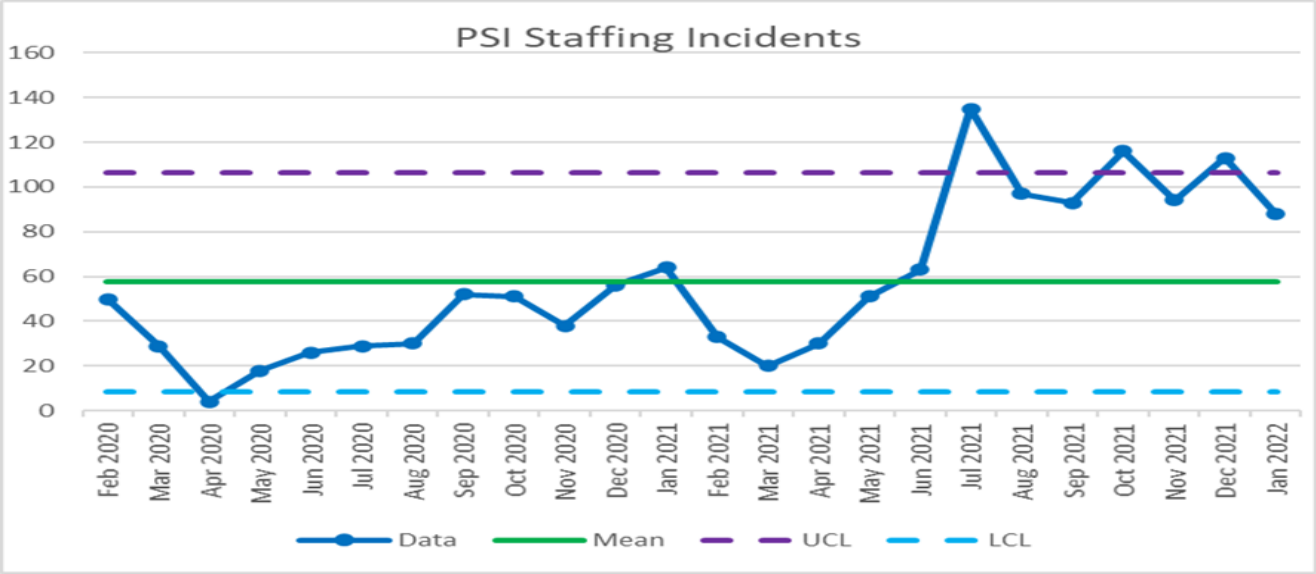
3.4 Staffing Problems

6.3% of all reported incidents during January (105) were categorised as Staffing Problems. Further analysis of these concerns show that of the 105 incidents reported 48 reported low harm, these relate to delays in undertaking observations, documentation, risk assessments, medication, treatment. The remaining 57 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.

SPC Chart 4 demonstrates that staffing incident reports have increased since June 2021 and have remained on or above the upper control limit, many of which related to COVID related/isolation absence.

SPC Chart 4

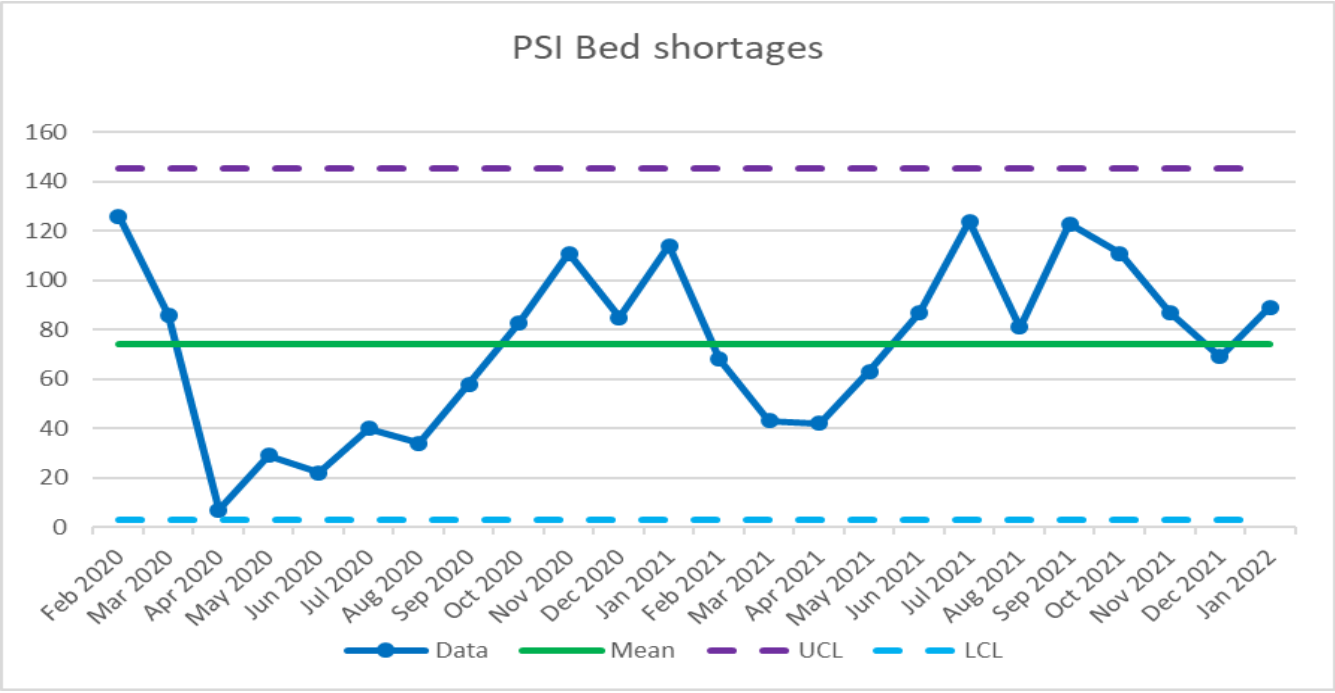


3.5 Bed Shortage

5.3% of all reported incidents during January (89) were categorised as bed shortages. These incidents include 12 hour breaches for patient admission from ED, it is important to note that one incident report for 12 hour breaches may contain multiple patient detail and delay in discharge from Intensive Care Unit to a ward bed. Further analysis of these incidents show 62 reporting low harm due to delay in appropriate care and the remaining 27 reporting no harm/near miss.

SPC Chart 5 shows common cause variation.

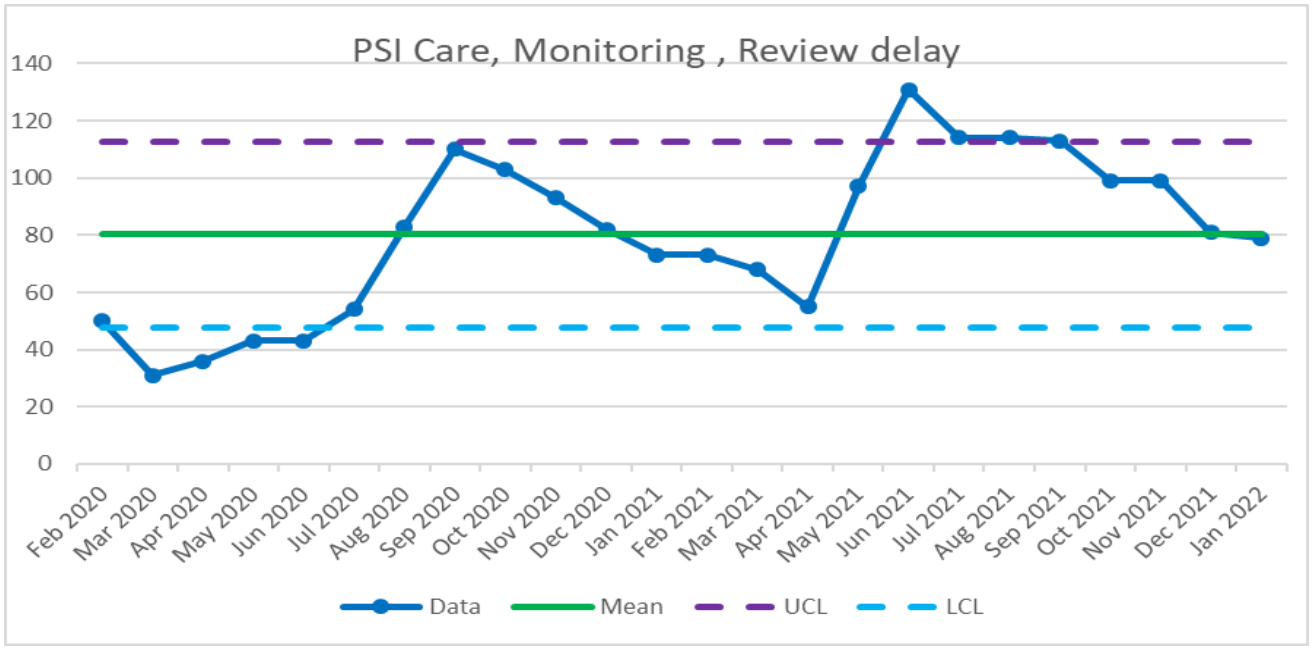
SPC Chart 5



3.6 Care Monitoring Delay

4.7% of all reported incidents in January (79) 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, and delays in observations. On analysis of harm for this category, of the 79 incidents, 40 were no harm/near miss, 37 were low harm due to some delay in care and one was moderate harm and one was reported as severe which are under investigation. Ongoing work in relation capacity, flow and staffing should help to mitigate harm. SPC Chart 6 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 January that the trend is now on a downward trajectory.

SPC Chart 6



4. Serious Incident Management

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

7 New case assessments were reviewed by RALIG during January, Chaired by the Co-Medical Director, resulting in three Serious Incident Investigations being commissioned and four Internal Investigations.

4.2 Nursing Incident Quality Review Meeting (NIQAM)

6 Serious Incidents Investigations were commissioned during January relating to three falls with severe harm and three relating to Category 3 Pressure Ulcers (See appendix 1 for detail).

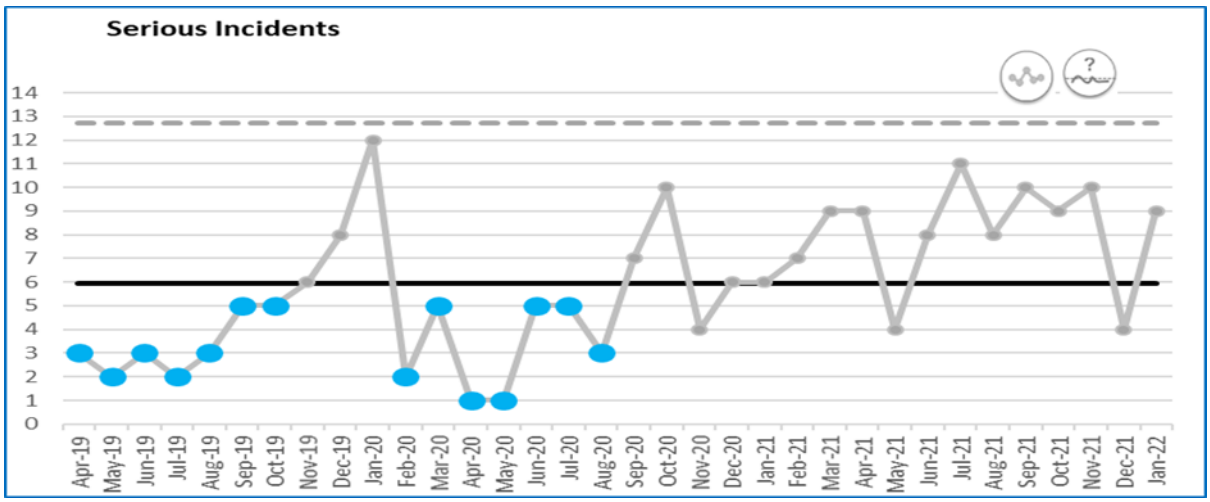
4.3 Maternity

There were no serious incidents reported for Maternity during January.

4.4 Serious Incident Reporting Year to Date

At the end of January 2021/22 the Trust had reported 82 serious incidents year to date.

SPC Chart 7



5. Never Events

There have been no Never Events reported in January 2022.

6. Lessons Learned and Action Plan Themes

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

7. Duty of Candour

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

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 Divisions

Appendix One

New Serious Incident Investigations - January 2022

A summary of the serious incidents reported in January 2022 is contained Table 1.

There were 9 serious incidents reported in January 2022.

Table 1

SI Reported January 2022
2022/207 Category 3 Pressure Ulcer
2022/202 Fall resulting in head injury
2022/335 Fall resulting fracture neck of femur
2022/447 Paediatric death
2022/564 Fall resulting in head injury and death
2022/803 Category 3 Pressure Ulcer
2022/1425 Delayed Treatment
2022/1547 Diagnostic Delay
2022/1727 Category 3 Pressure Ulcer

Closed Serious Incident Investigations – January 2022

SI – Closed January 2022
2021/22140 Fall resulting in fracture neck of femur
2021/22110 Fall resulting in death
2021/21085 Category 3 Pressure Ulcer
2021/19354 Category 3 Pressure Ulcer
2021/18478 Absconding patient/Head Injury
2021/15004 Surgical Invasive Procedure
2021/5859 Delayed Diagnosis
2021/4684 Fall resulting in fractured shoulder

Appendix Two

Learning identified from closed incidents in January

Key themes:

• Ensure COVID status established prior to moving patients between wards
• If a piece of equipment such as high low bed has been ordered by one ward – ensure that handover to receiving ward provides full detail of the equipment ordered so that the new ward can follow up if it does not arrive
• Raise awareness of the ability to complete a lying and sitting blood pressure assessment if a lying and standing assessment is not possible
• Enhanced Supervision Policy and documentation to be reviewed and updated.
• Ensure further dementia training included abbey pain scale is provided
• Develop an SOP for the opening of new ward areas/areas of escalation to include the stocking of essential items and equipment.
• Ensure prompt assessment of risk of pressure damage and take early action to order appropriate equipment.
• Ensure escalation processes followed if equipment is unavailable and ensure datix is completed.
• Agency staff to receive training in Mental Capacity Act
• Ensure appropriate interpretation services are accessed for patients who not speak English
• Refresher training for staff to be undertaken in the care and treatment of head injury
• Review of the Trust Adult head injury policy to be undertaken
• Ensure TCI forms are checked by the clinical team prior to sending to bookings
• Undertake an audit of TCI booking process
• Develop an SOP detailing roles and responsibilities in the case of a deteriorating patient to include clear lines of escalation
• Undertake risk assessment of lateral transfer using slide sheets in the radiology environment