Board of Directors' Meeting
14 April 2022

The Shrewsbury and Telford Hospital NHS Trust

Agenda item	065/22			
Report	Incident Management Report – February 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 – February 2022 Appendix Two – Learning and Actions – February 2022			
Lead Executive:				

1. Introduction

This report highlights the patient safety development and forthcoming actions for April/May 2022 for oversight. It will then give an overview of the top five reported incidents during February 2022. Serious Incident reporting for February 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 February 2022 are included in Appendix 1. Detail relating to completed actions and lessons learned are included in Appendix 2.

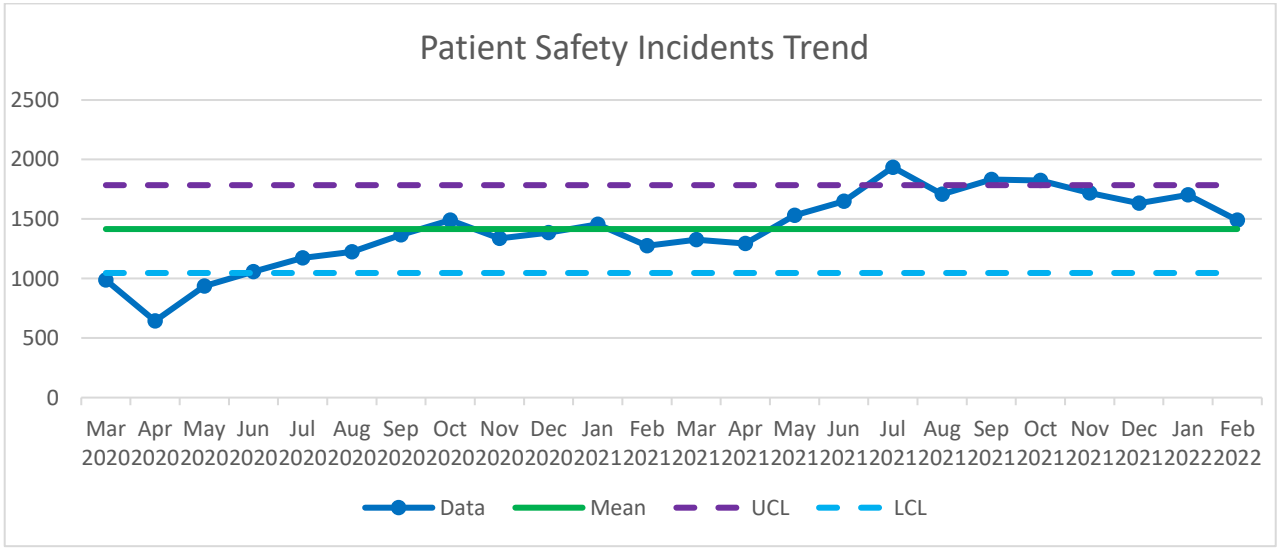
2. Patient Safety Development and Actions planned for April/May 2022/23

- 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 February 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 February there were 1,490 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 February 2022 – 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	138
Falls	131
Care / Monitoring / Review Delays	87
Staffing Problems	79
Bed shortage	65
Total	500

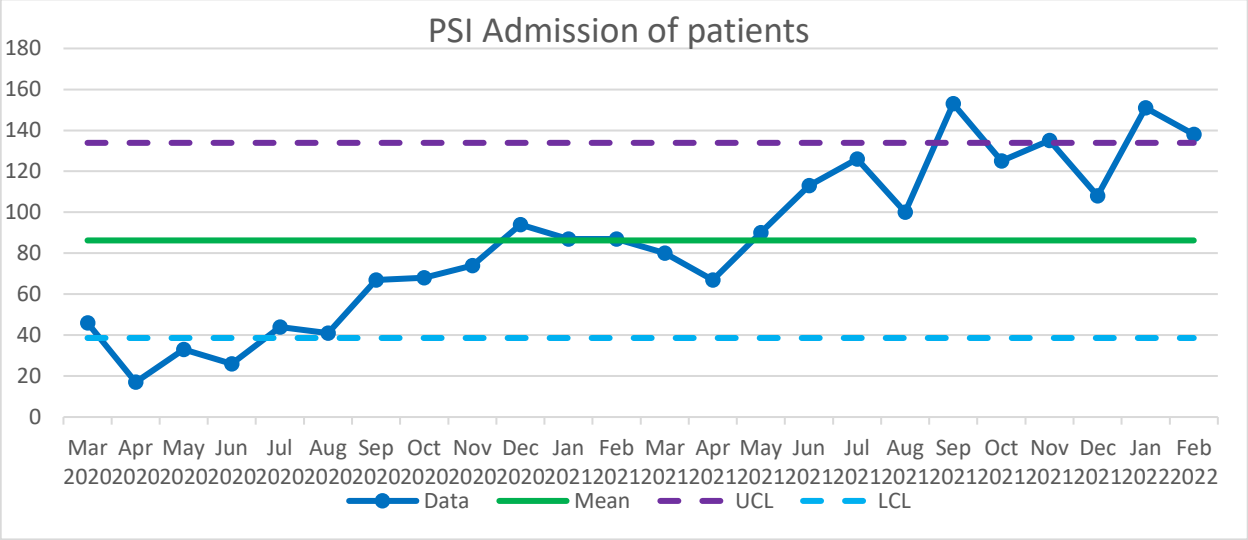
3.2 Admission of patients

9% of all reported incidents during February (138) 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 and February 2022.

Analysis of ambulance offload delay and long waits in the Emergency Department in demonstrates increased harm caused to patients. It is also important to note that each incident report for ambulance offload delay may have multiple patients attached to it – each patient is reviewed 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 and February 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

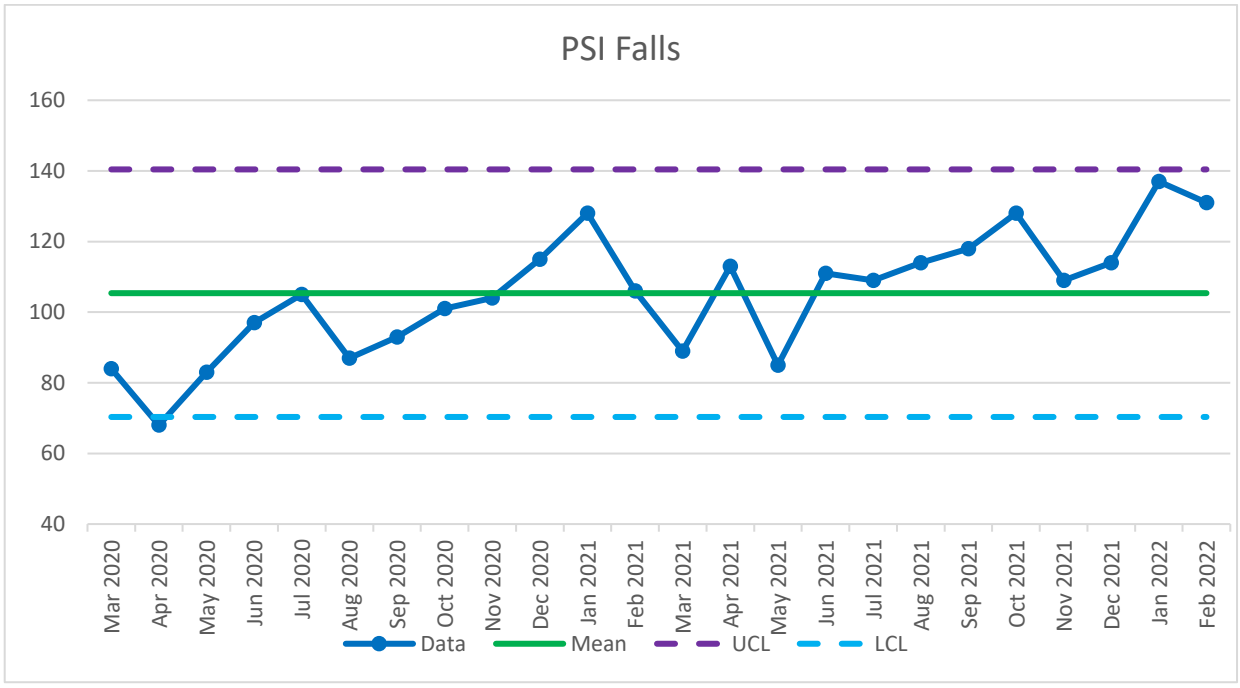
9% of all reported incidents during February (131) were categorised as a Fall. Of these, 4 were reported as severe harm and have been reported as Serious Incidents and are under investigation. Completed investigation reports are presented to the Nursing Incidents Quality Review Meeting (NIQAM) which 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 falls reported, although there had been a

reduction seen in November and December 2021, January and February 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.

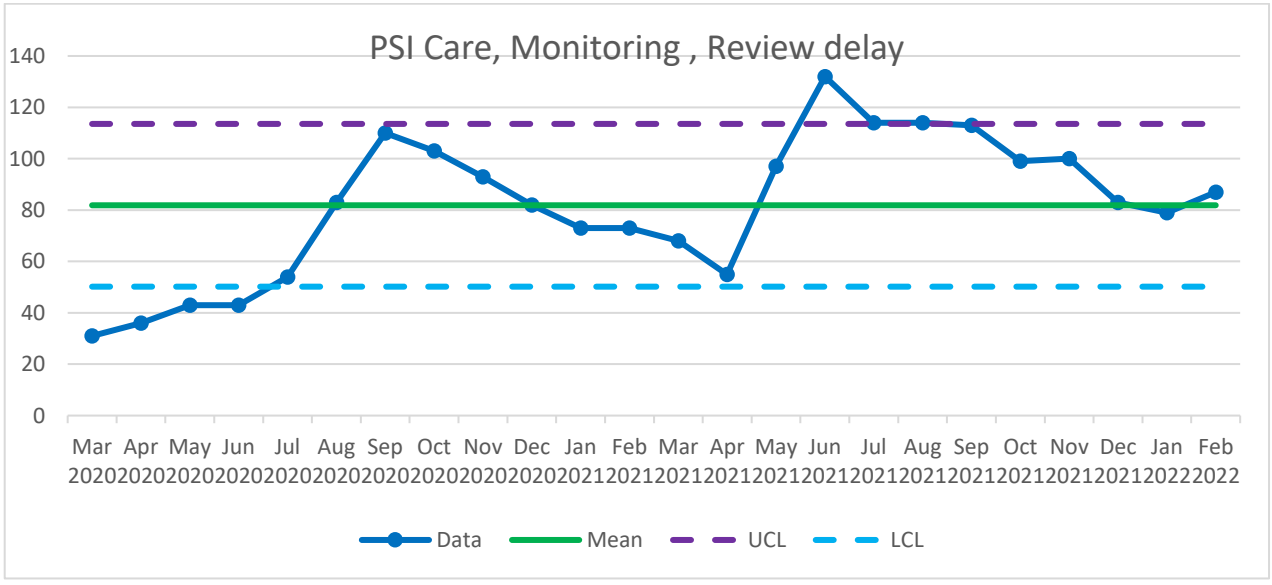
SPC Chart 3



3.4 Care Monitoring Delay

6% of all reported incidents in February (87) 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 87 incidents, 53 were no harm/near miss, 31 were low harm due to some delay in care and 2 were moderate harm and 1 was reported as severe 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 January that the trend is now on a downward trajectory.

SPC Chart 4



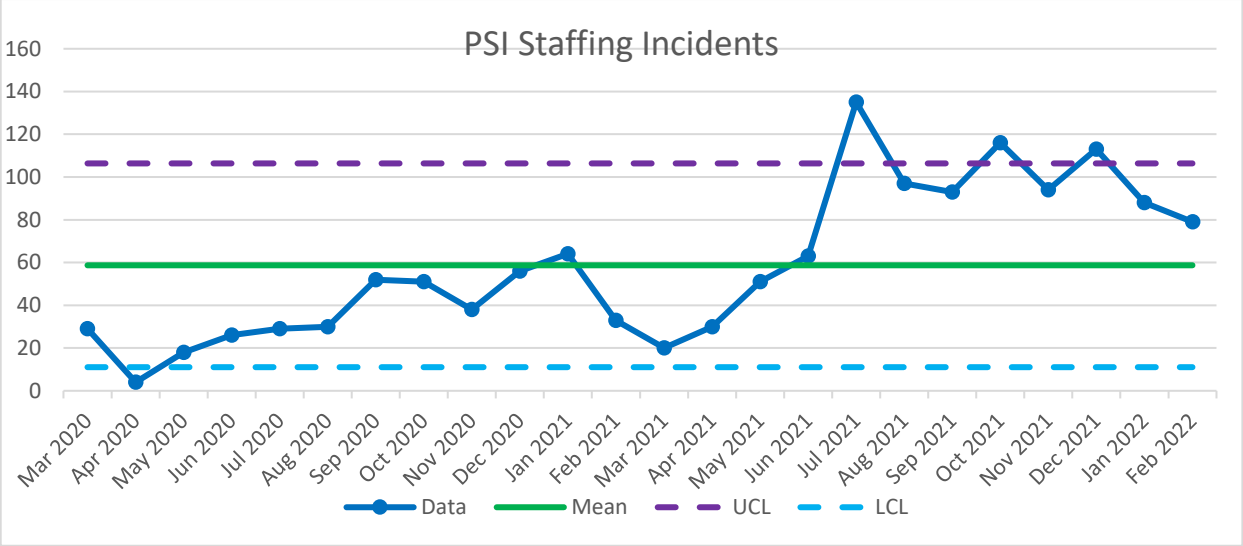
3.5 Staffing Problems

5% of all reported incidents during February (79) were categorised as Staffing Problems. Further analysis of these concerns show that of the 79 incidents reported 49 reported no harm, near miss, with the remaining 30 reporting low harm, these relate to delays in undertaking observations, documentation, risk assessments, medication, treatment.

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 5 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 5

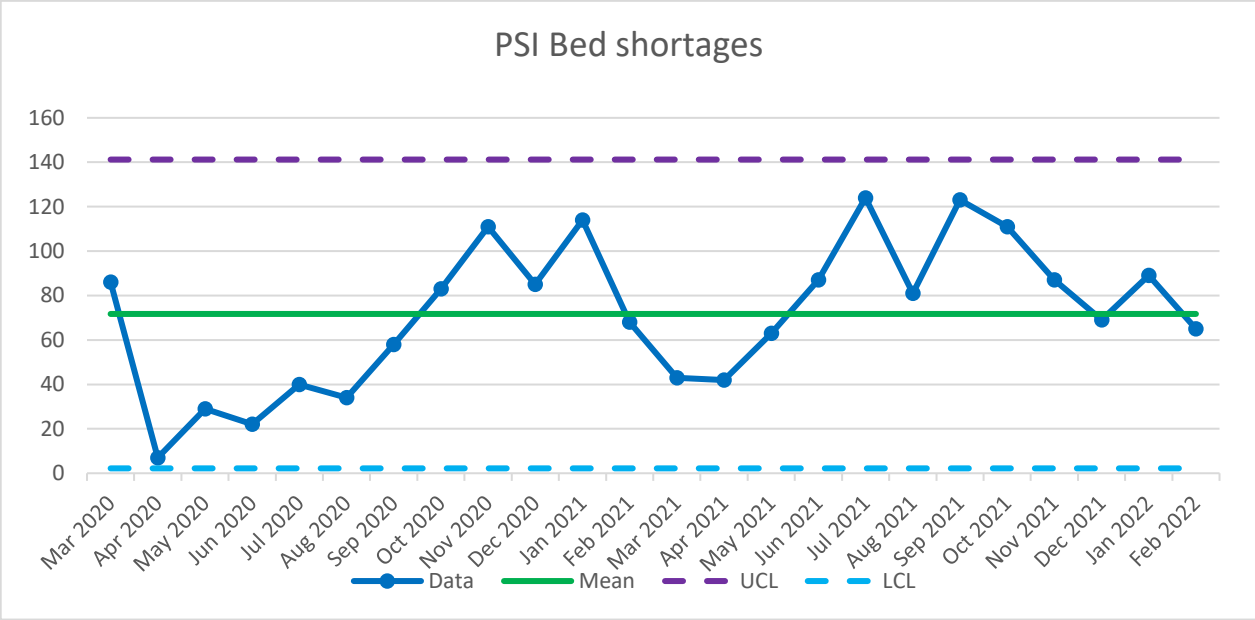


3.6 Bed Shortage

4% of all reported incidents during February (65) were categorised as bed shortages. These incidents include 12 hour breaches for patient admission from ED, it is important to note that 1 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 seven reporting low harm due to delay in appropriate care and the remaining 58 reporting no harm/near miss.

SPC Chart 6 shows common cause variation.

SPC Chart 6



4. Serious Incident Management

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

Four new case assessments were reviewed by RALIG during February, Chaired by the Co-Medical Director, resulting in two Serious Incident Investigations being commissioned and two Internal Investigations.

4.2 Nursing Incident Quality Review Meeting (NIQAM)

Four Serious Incidents Investigations were commissioned during February relating to four falls with severe harm (See appendix 1 for detail).

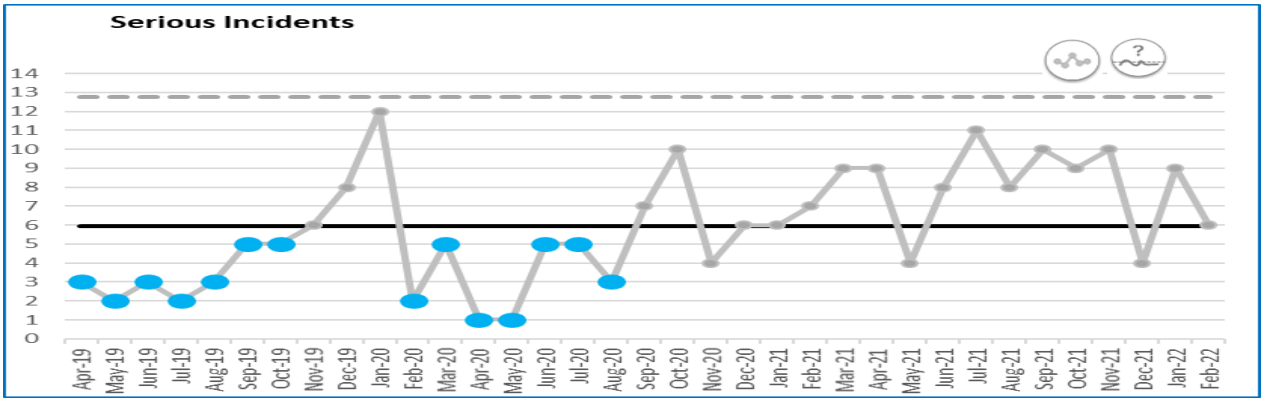
4.3 Maternity

There were no serious incidents reported for Maternity during February.

4.4 Serious Incident Reporting Year to Date

At the end of February 2021/22 the Trust had reported 88 serious incidents year to date.

SPC Chart 7



5. Never Events

There have been no Never Events reported in February 2022.

6. Lessons Learned and Action Plan Themes

There were six Serious Incidents closed in February 2022. 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 February.

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 - February 2022

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

There were 6 serious incidents reported in February 2022.

Table 1

SUI theme –	Number Reported
2022/2931 Fall – Open fracture to Arm	**1**
2022/3503 Fall - Fractured neck of femur	**1**
2022/3508 Fall – Fractured neck of femur	**1**
2022/3955 - Delay in treatment leading to death	**1**
2022/3878 – Fall - Subdural haemorrhage	**1**
2022/3946 - Sepsis from pancreatitis	**1**
Total	**6**

Closed Serious Incident Investigations – February 2022

SI – Closed February 2022
2021/3948 Death following restraint
2021/19353 Fall resulting in fracture neck of femur
2021/21795 Diagnostic Incident
2021/21859 Fall resulting in head injury
2021/22442 Fall resulting in fracture neck of femur
2021/23011 Category 3 Pressure Ulcer

Appendix Two

Learning identified from closed incidents in February

Key themes:

• Education for medical staff and nurses re importance of documentation compliance
• Estates have issued a staff bulletin re. importance of locking staff toilet doors, have fitted auto door closures to all staff toilets at PRH, and informed RSH estates of this incident
• Best practice regarding MCA and how to identify and comply with arrangements for when there is a health and welfare concerns
• A specific alert should be issued to all wards to be aware of the risk of falls for patients who have foot bandages for oedema that may be wet
• The Falls group should discuss if any specifics risk mitigations can be put in place related to the issue highlighted around foot bandages and leg oedema. This should include consideration of highlighting the risk in falls risk assessments and falls prevention management plans.
• Specific communication should be undertaken with wider Trust medical staff to reinforce and emphasise the role of medical staff in post falls assessment.
• To undertake an audit process or peer review programme in line with that recommended by the Royal College of radiologists it would be recommended that when resources allow this is brought into practice.
• To undertake a quarterly review of the quality assurance reports that are provided by Everlight, to be checked against previous quarter's results. Any reduction in quality standards to be investigated further and should evidence of continuous reduced quality be evident, alternative service providers sought.
• The Emergency Department to consider making changes to the review of assessments and timing of checks for patients admitted with confusion, rather than completing one single capacity assessment on admission. This will give assurance that issues with intermittent capacity will be more likely to be identified.
• Ward Manager to discuss the importance of staff extending families the opportunity to support with assessments, particularly where patients have fluctuating capacity or have been assessed as lacking capacity
• Anyone presenting with confusion should have a prompt and timely mental capacity assessment (MCA) completed and a referral to the Dementia Team made where applicable who can give specialist advice

- As a result of this investigation and other serious incident investigations, a standard handover sheet should be created for use across all wards which includes a section to highlight falls risk