Board of Directors' Meeting
9 June 2022

Agenda item	108/22			
Report	Incident Overview Report – April 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 – April 2022 Appendix Two – Learning and Actions – April 2022			
Lead Executive:	[signatures]			

1. Introduction

This report highlights the patient safety development and forthcoming actions for June/July 2022 for oversight. It will then give an overview of the top 5 reported incidents during April 2022. Serious Incident reporting for April 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 April 2022 are included in Appendix 1. Detail relating to completed actions and lessons learned are included in Appendix 2.

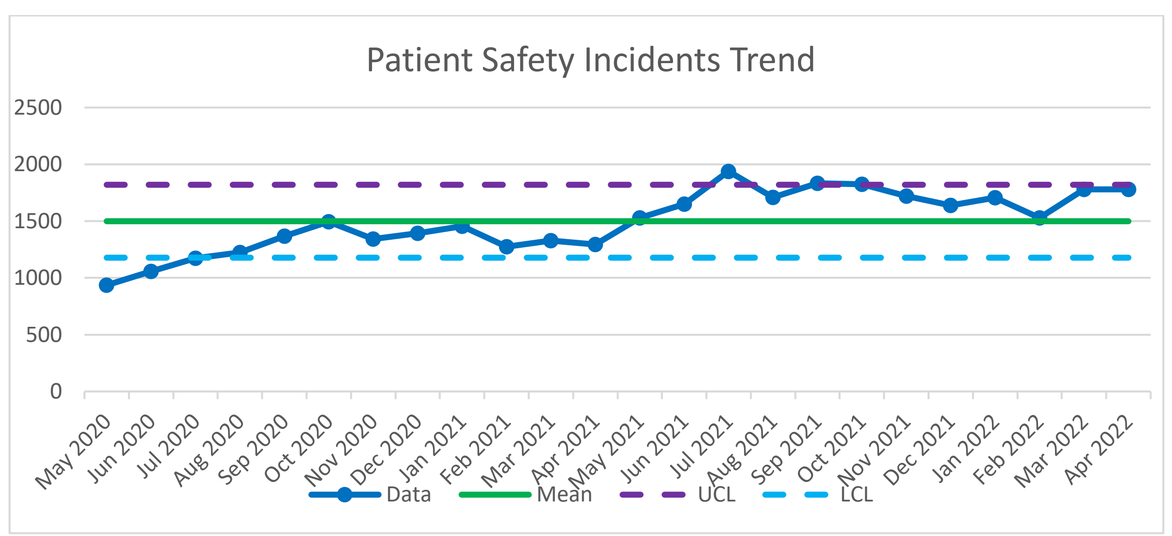
2. Patient Safety Development and Actions planned for June/July 2022/23

- 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

3. Analysis of April 2022 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 this may relate to a more open reporting culture, during 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 April there were 1,779 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 April 2022 – see Table 1. The top 5 reported incidents are explored in more details below.

Table 1

Top 5 Patient Safety Incidents	Totals
Admission of patient	182
Bed shortage	129
Falls	120
Communication	103
Staffing Problems	78
Total	612

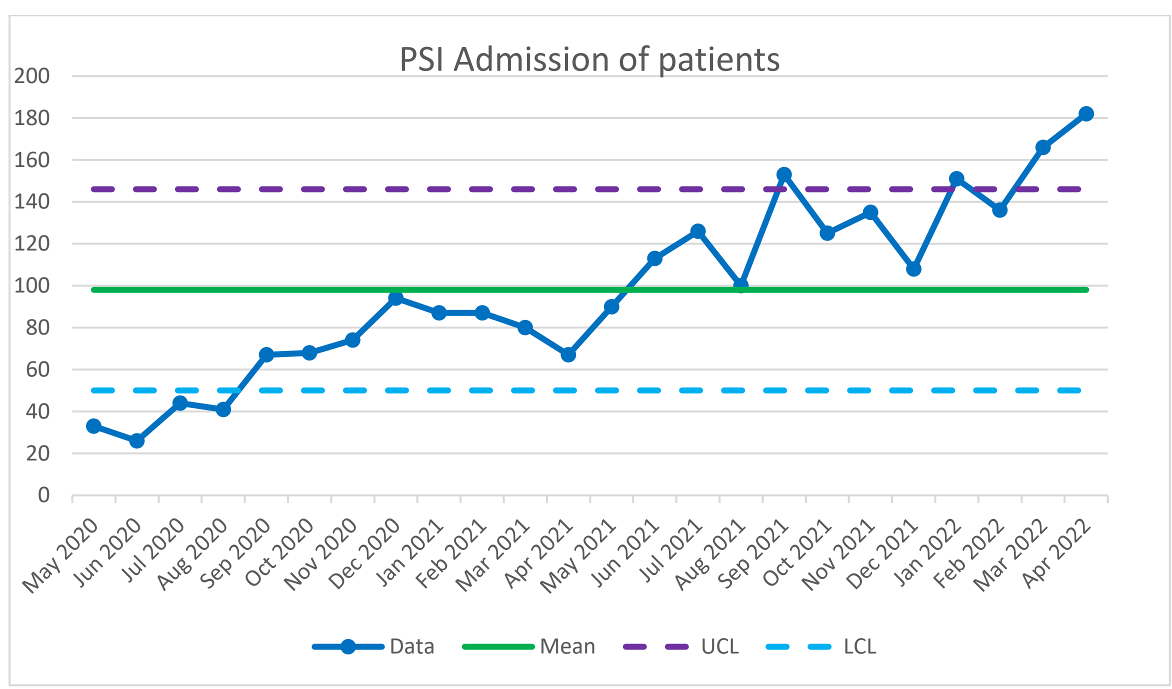
3.2 Admission of patients

10% of all reported incidents during April (182) 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 continued to increase since January 2022.

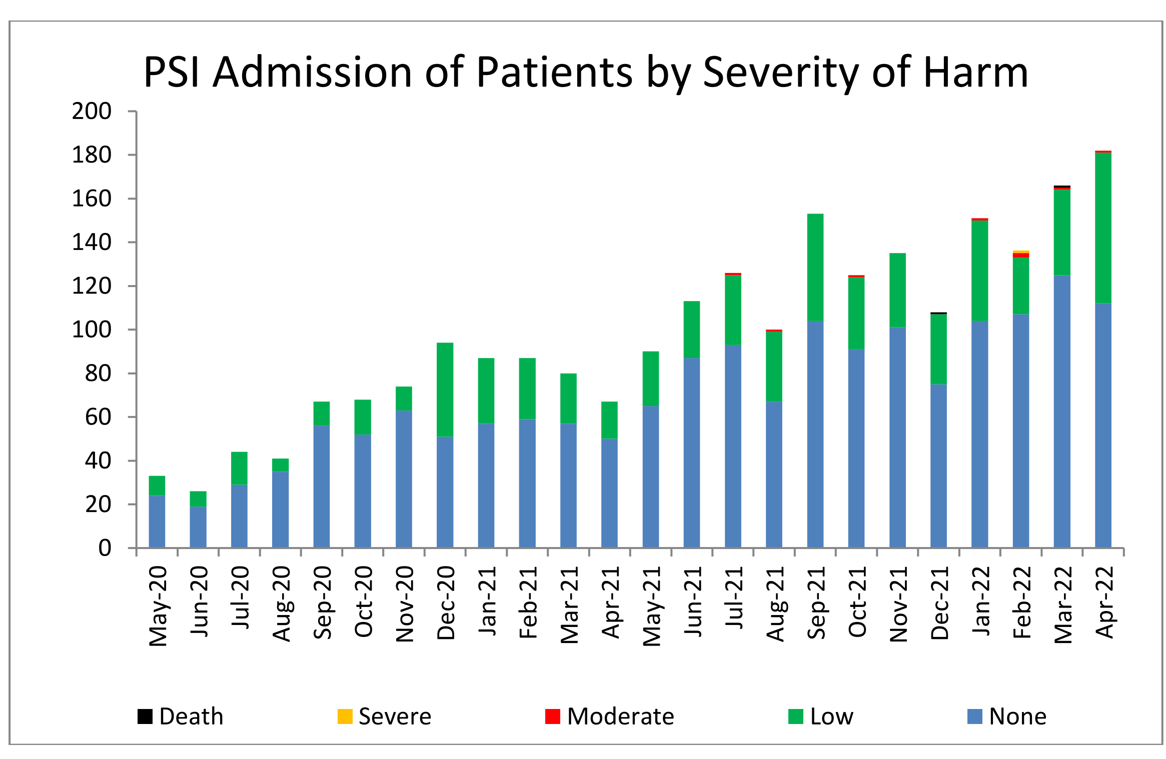
Analysis of ambulance offload delay and long waits in the Emergency Department in demonstrates increased harm caused to patients. It is also important to note that each incident report for ambulance offload delay may have multiple patients attached to it – each patient is reviewed to assess any harm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

SPC chart 4 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 since February 2022 the numbers have exceeded the upper control limit and demonstrates significant pressure with the Emergency Department and capacity concerns with the Trust.

SPC Chart 2



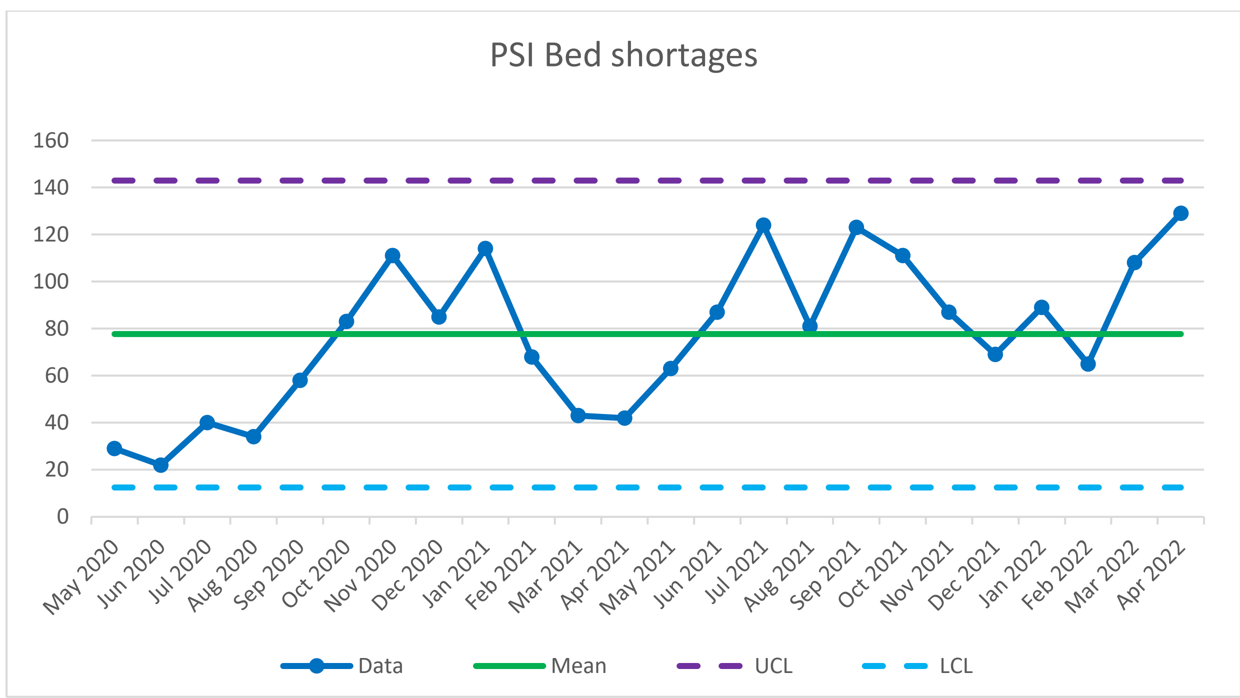
Graph 1 – Severity of Harm Admission of Patients



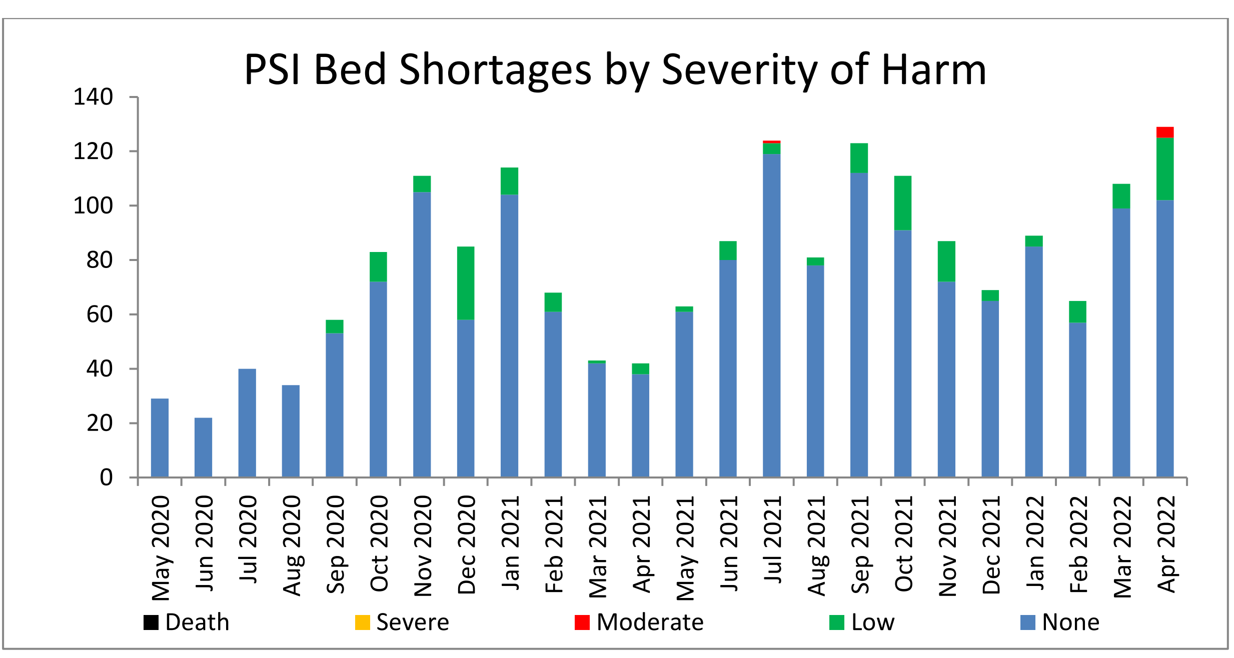
3.3 Bed Shortage

7.3% of all reported incidents during April (129) 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.

SPC Chart 3



Graph 2 Severity of Harm Bed Shortages



3.4 Falls

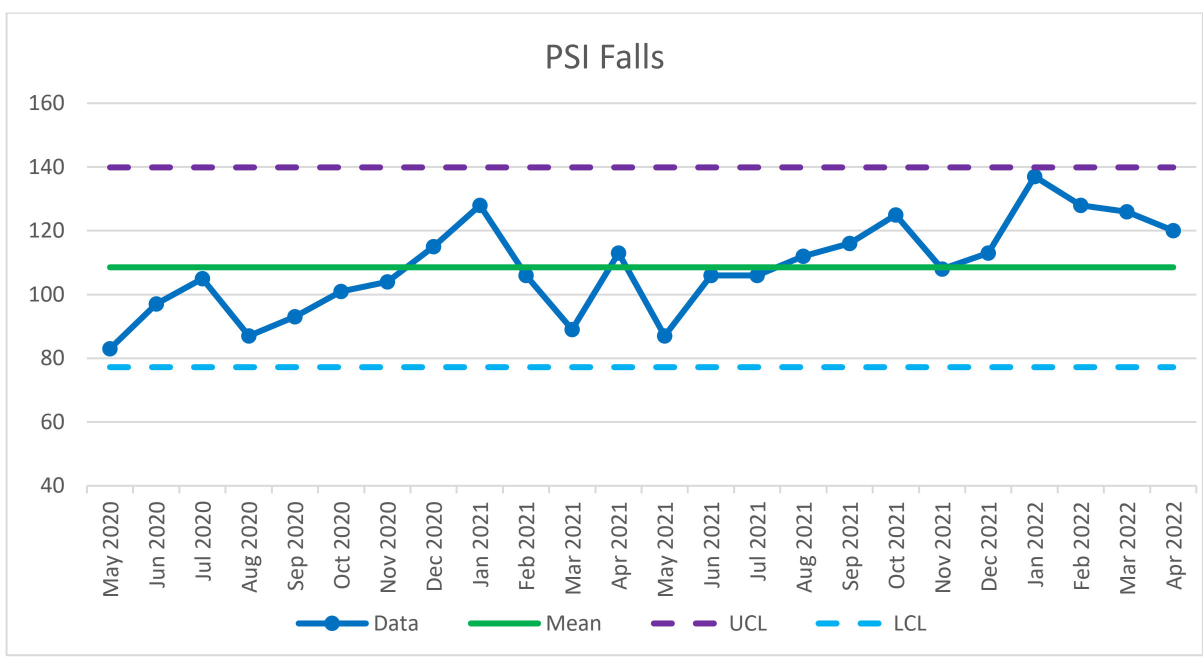
6.7% of all reported incidents during April (120) were categorised as a Fall. Of these, 1 was reported as severe harm and has been reported as a Serious Incident and are under investigation. Completed investigation reports are presented to the Nursing Incidents Quality Review Meeting (NIQAM) which is 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

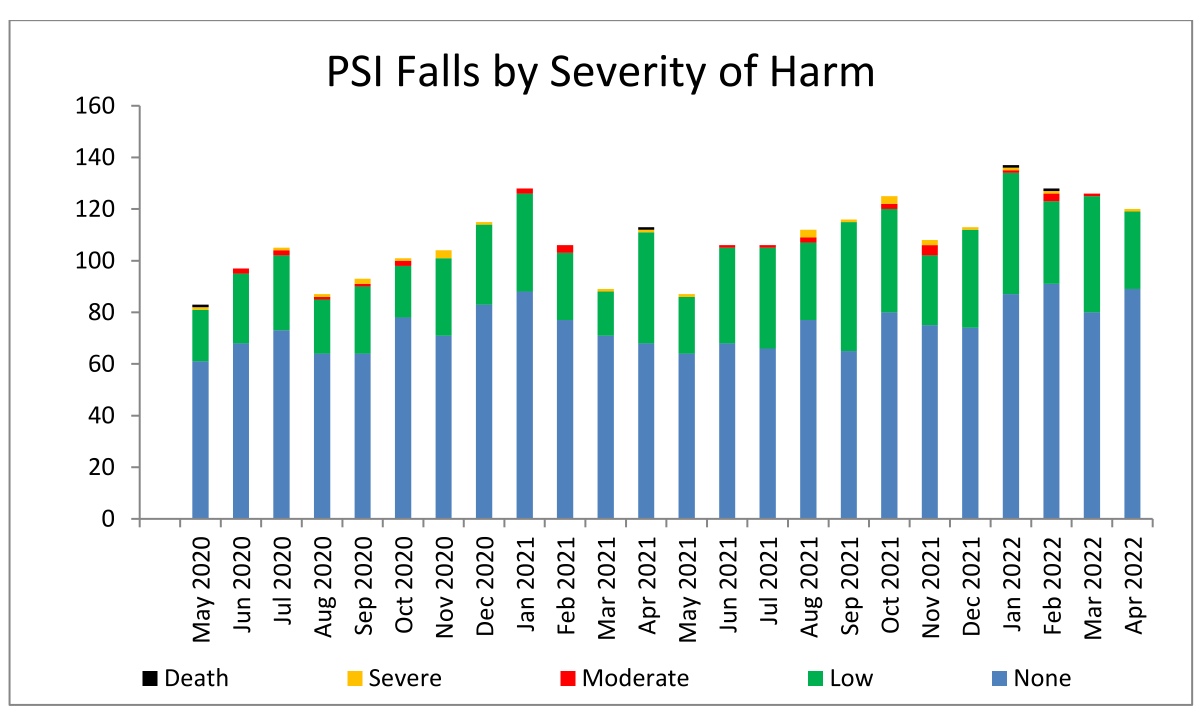
Practitioner, identifying areas for improvement and shared learning.

SPC Chart 4 identifies a reduction in inpatient Falls reported since January 2022. 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 4



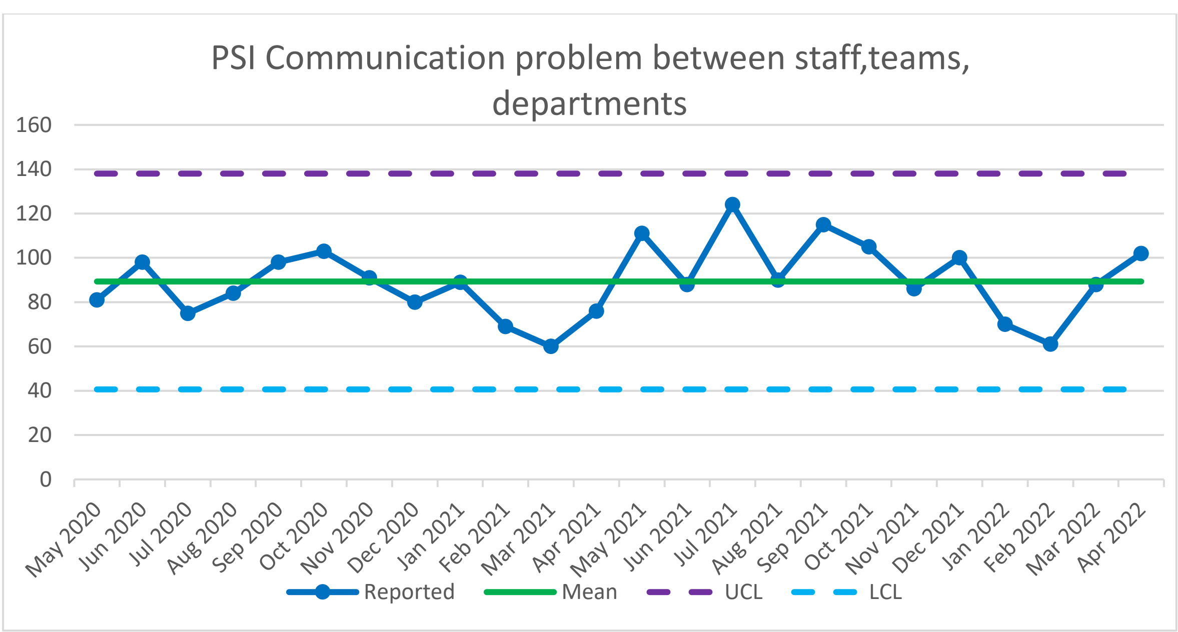
Graph 3 – Severity of Harm Falls



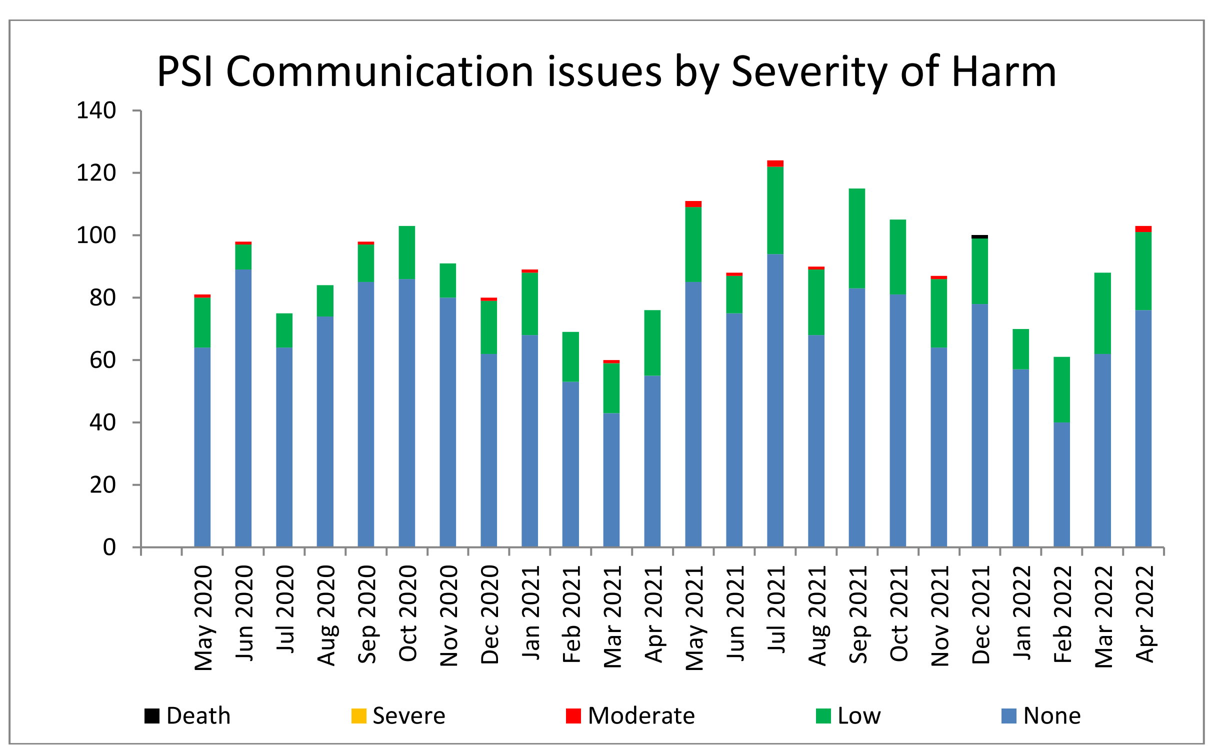
3.5 Communication between staff, teams and departments

5.8% of all reported incidents during April (103) were categorised communication between staff, teams and departments. April is the first month that communication with colleagues within the Trust has been in the top 5 reported incidents, which may be a reflection on the sustained pressure experienced by staff within the Trust.

SPC Chart 5



Graph 4 Severity of harm communication



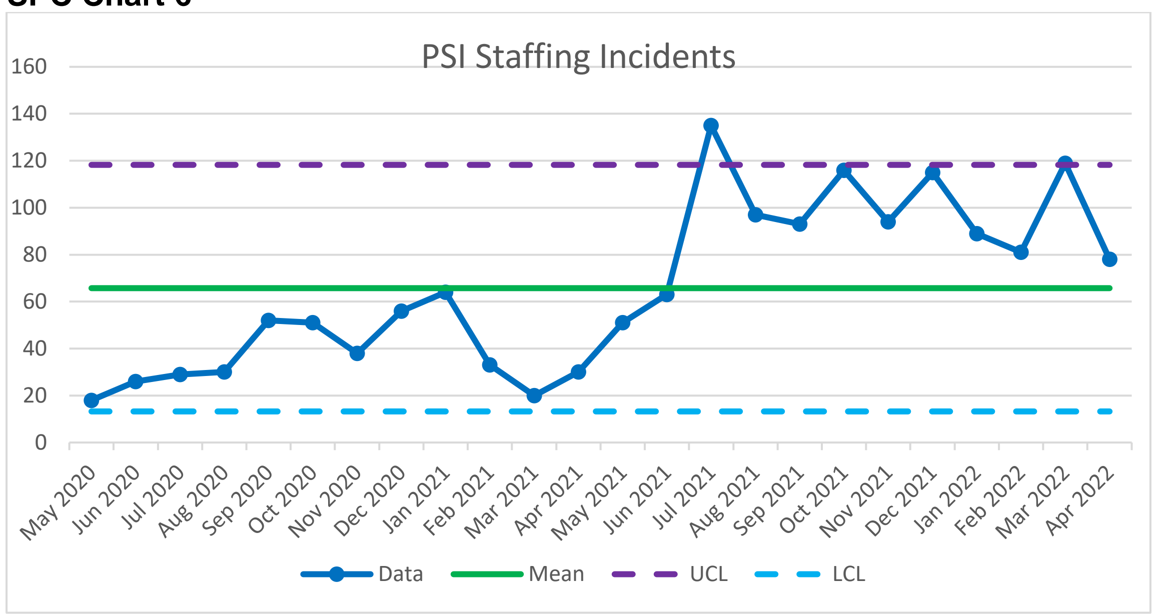
3.6 Staffing

4.4% of all reported incidents during April (78) were categorised as Staffing Problems.

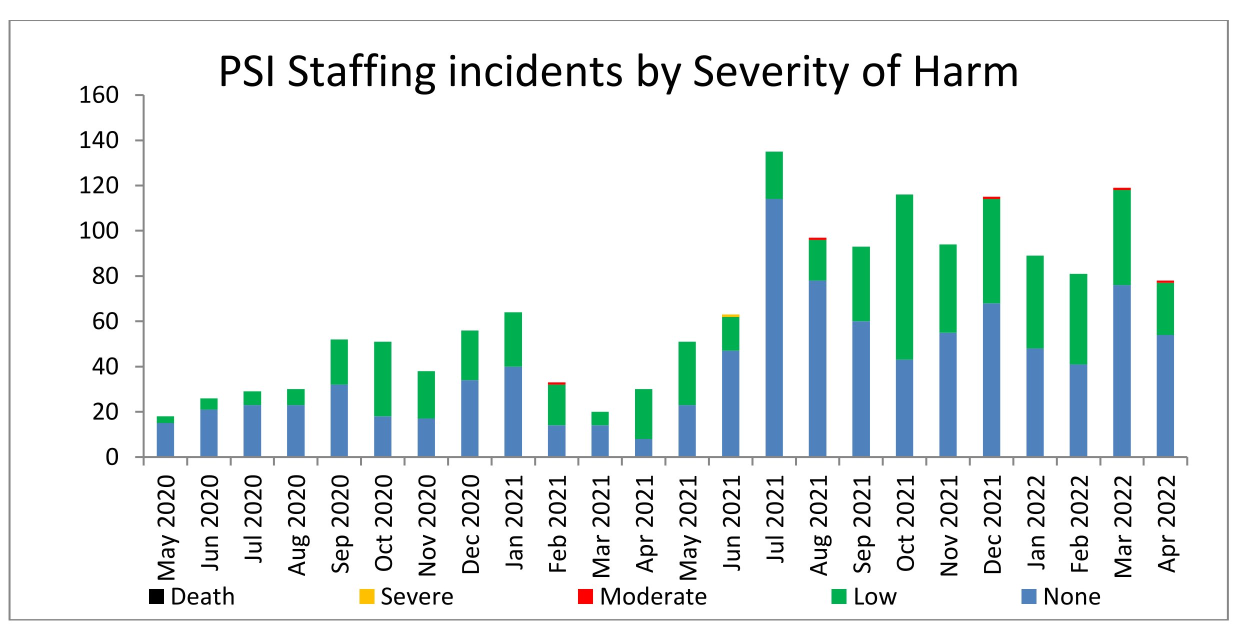
Data relating to staffing incidents is triangulated with quality metrics and reported through the Divisional Directors and the Director of Nursing through to Quality and Safety Assurance Committee.

SPC Chart 6 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 6



Graph 5



4. Incident Management including Serious Incident Management

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

6 New case assessments were reviewed by RALIG during April, Chaired by the Co-Medical Director, resulting in 4 Serious Incident Investigations being commissioned and 2 Internal Investigations.

4.2 Nursing Incident Quality Review Meeting (NIQAM)

1 Serious Incident Investigations were commissioned during April relating to a fall with severe harm. (See appendix 1 for detail).

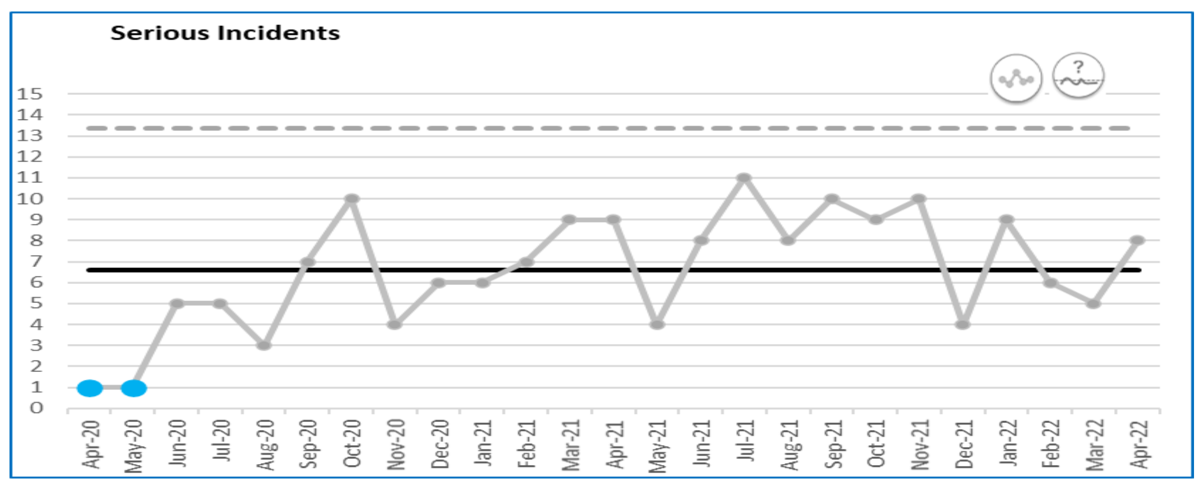
4.3 Maternity

There was 1 serious incident reported for Maternity during April, which is a HSIB Investigation (See Appendix 1 for detail).

4.4 Serious Incident Reporting Year to Date

At the end of April 2022/2023 the Trust had reported 8 serious incidents.

SPC Chart 7



5. Never Events

There have been no Never Events reported in April 2022.

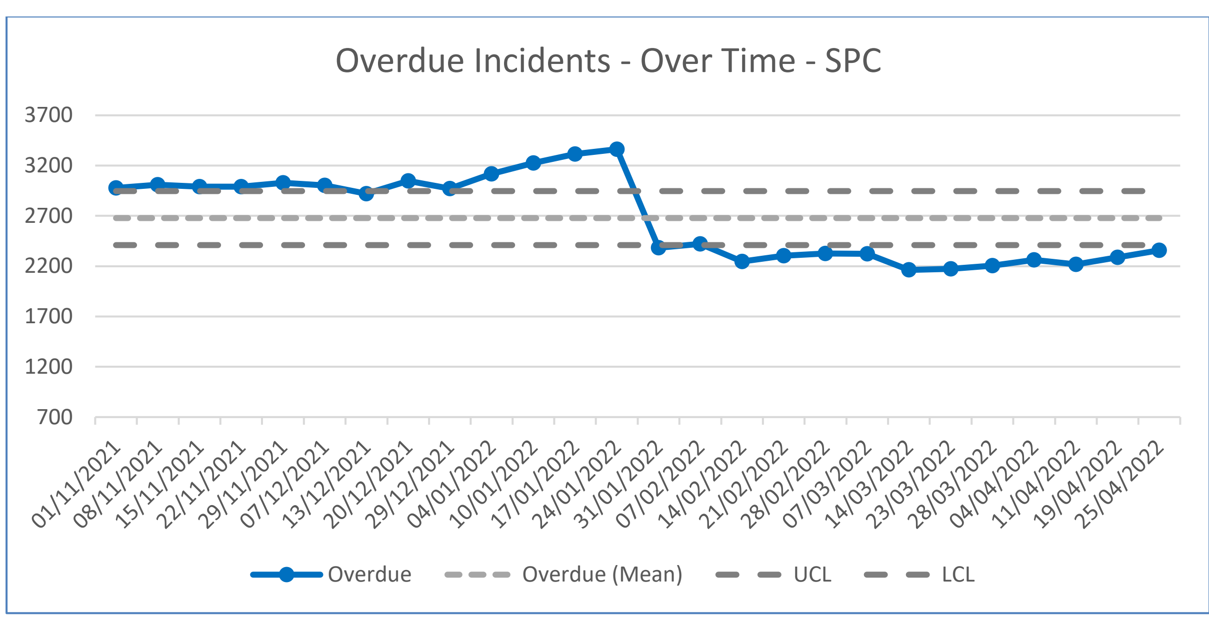
6. Overdue datix overtime

SPC 8 shows that the improvement of overdue incidents has been sustained since the introduction of the Divisional Quality Governance teams who are supporting the clinical teams with reviews

Mitigation and trajectory for improvement

All datix are reviewed daily by the Quality Governance/Safety teams who filter out those datix that require immediate actions. Moderate harm or above incidents are reviewed at the weekly Review of Incident Chaired by the Assistant Director of Nursing. All Divisions have a weekly incident review meeting to prioritise and escalate incidents, such as Neonatal and Obstetric risk meeting, Medicine incident review group, ED weekly incident review.

SPC Chart 8



7. Lessons Learned and Action Plan Themes

There were 8 Serious Incidents closed in April. A sample of the learning identified can be found in Appendix 2 and 3.

8. Duty of Candour

There have been no reported breaches in Duty of Candour during April. An internal audit of duty of candour is due in July 2022, the results will be reported in September 2022.

9. 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 - April 2022

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

There were 8 serious incidents reported in April 2022.

Table 1

SI	Number Reported
2022/6543 Delay in treatment leading to death	**1**
2022/6977 Death following airway issues/tracheostomy	**1**
2022/7101 Suboptimal Care/inappropriate discharge	**1**
2022/7516 Term Intrauterine death (HSIB) - Maternity	**1**
2022/7947 Suboptimal care blood glucose management	**1**
2022/8466 Suboptimal care	**1**
2022/8485 Delayed Diagnosis	**1**
2022/8597 Fall Head Injury	**1**
Total	**8**

Closed Serious Incident Investigations – April 2022

SI – Closed April 2022
2021/8055 Maternity Obstetric affecting baby – HSIB
2021/18693 Maternity Obstetric affecting baby – HSIB
2021/21808 Delayed Diagnosis
2021/238892 Suboptimal care of the deteriorating patient
2021/24701 Fall resulting in fractured neck of femur
2021/24979 Fall resulting in fractured neck of femur
2021/25777 Category 3 Pressure Ulcer
2021/564 Fall resulting in head injury and death

Appendix Two

Learning identified from closed incidents in April

Key themes:

• The Trust to ensure that mothers are aware of and fully informed of the different types of fetal monitoring available with different labour and birth choices. Mothers should be central to decision making and planning of her care with clear documentation of discussions that are undertaken
• The Trust to ensure that when there is any evidence of progression to the second stage of labour staff are supported to increase the frequency of intermittent auscultation in line with national guidance.
• The Trust to ensure that staff are supported to complete IA in line with local and national guidance
• HSIB recommends the Trust ensure that all mothers should receive objective advice on vaccination, based on the best available evidence ensuring all mothers have access to COVID-19 vaccination leaflets
• HSIB recommends the Trust ensure that all clinical staff should be provided with the training required to enhance their knowledge and confidence to discuss any updated pregnancy advice and recommendations with regard to COVID-19
• Review of staffing levels, and the processes to escalate and then adequately deal with staffing defects specifically around Doctor shortages
• To review the EPS policy and ensure staff are fully aware of their role whilst carrying out EPS duties, ensuring observational charts are completed in a meaningful way as well as considering the maximum number of hours one member of staff covers EPS during a shift.
• Clarity required around frequency of log rolling required as nursing paperwork does not demonstrate comprehensive risk assessment to support the frequency that log rolling took place
• Training to be rolled out for log rolling across the Trust to ensure there are sufficient trained staff on duty at any one time to support this as clinically required
• All ED nursing staff need to do a falls prevention training/refresher training CNE training for falls nurse. Bed rails training to be covered during falls prevention training
• Documentation/recording and reporting training for completion of the cascard to be provided to all staff in the ED who complete the Cas card