Board of Directors' Meeting
14 July 2022

The Shrewsbury and Telford Hospital NHS Trust

Agenda item	128/22			
Report	Incident Overview Report – May 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 – May 2022 Appendix Two – Learning and Actions – May 2022			
Lead Executive:				

1. Introduction

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

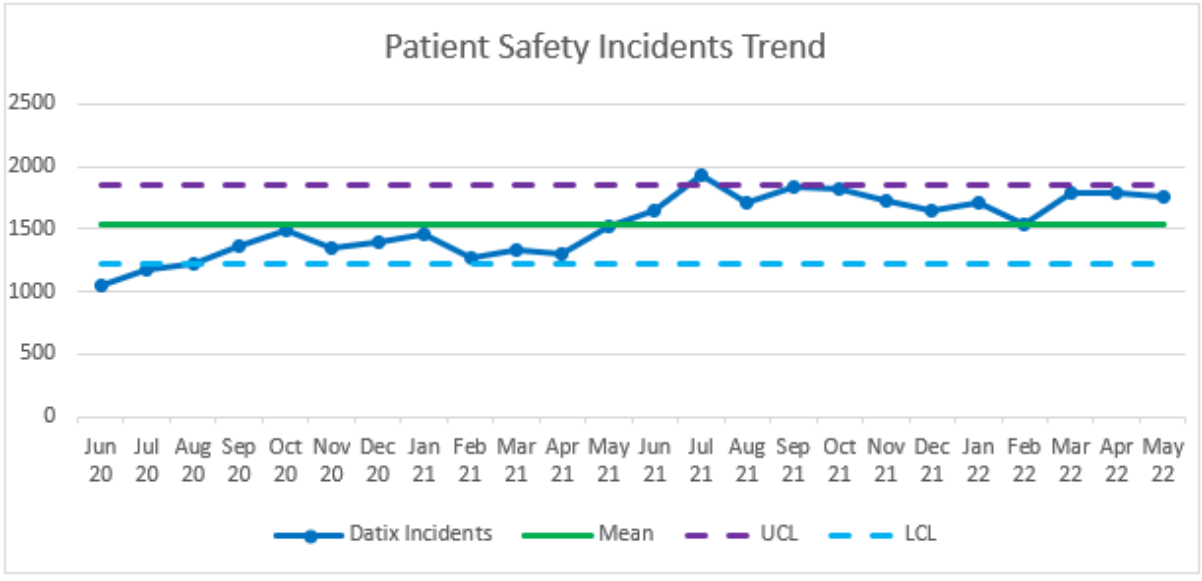
2. Patient Safety Development and Actions planned for July/August 2022/23

- 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
- Internal Audit of Duty of Candour for Serious Incidents planned for July.

3. Analysis of May 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 September 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 May there were 1,754 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 May 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	143
Inpatient Falls	135
Bed shortage	104
Care/Monitoring/Review Delays	104
Absconded patients	103
Total	589

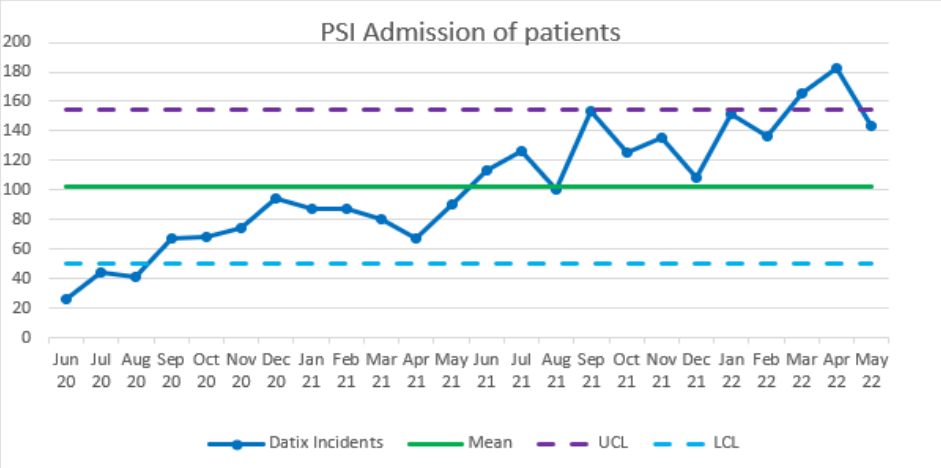
3.2 Admission of patients

8% of all reported incidents during May (143) 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.

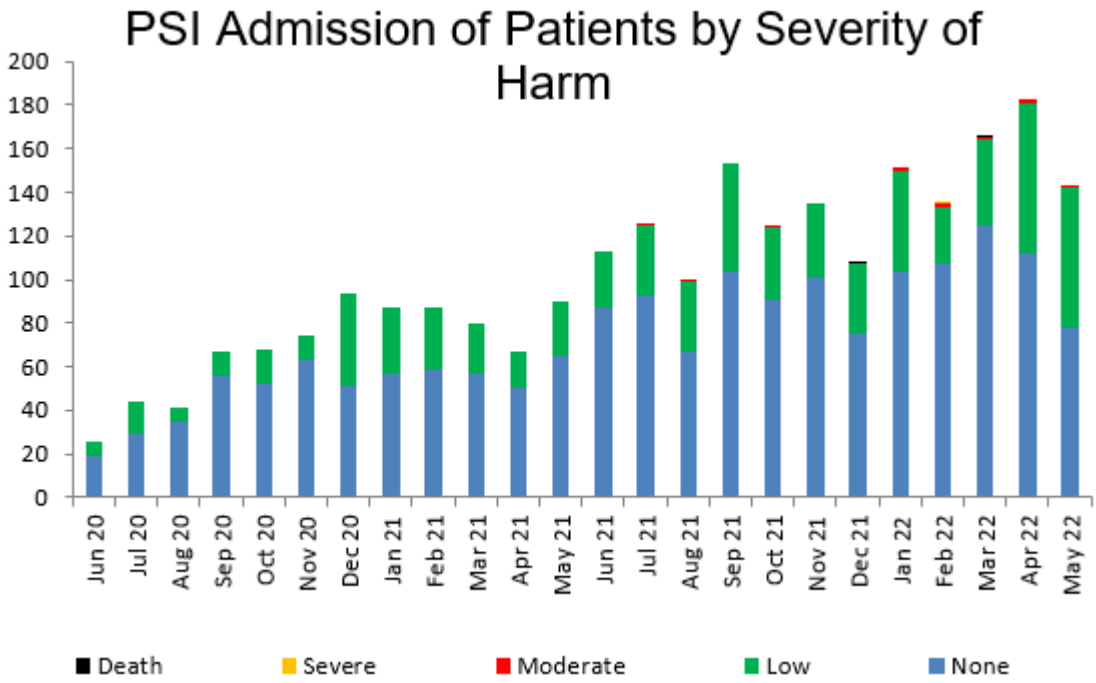
Analysis of ambulance offload delay and long waits in the Emergency Department in demonstrates increased harm caused to patients. It is also important to note that each incident report for ambulance offload delay may have multiple patients attached to it – each patient is reviewed to assess any harm 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 since February 2022 the numbers have exceeded the upper control limit with May showing a slight decline however this demonstrates significant pressure with the Emergency Department and capacity concerns with the Trust.

SPC Chart 2



Graph 1 – Severity of Harm Admission of Patients



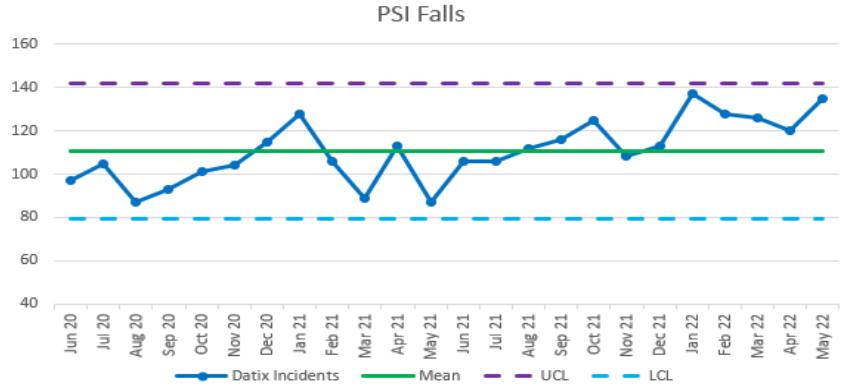
3.3 Inpatient Falls

7.8% of all reported incidents during May (135) 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, with a further 3 falls with moderate harm undergoing Divisional review. 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.

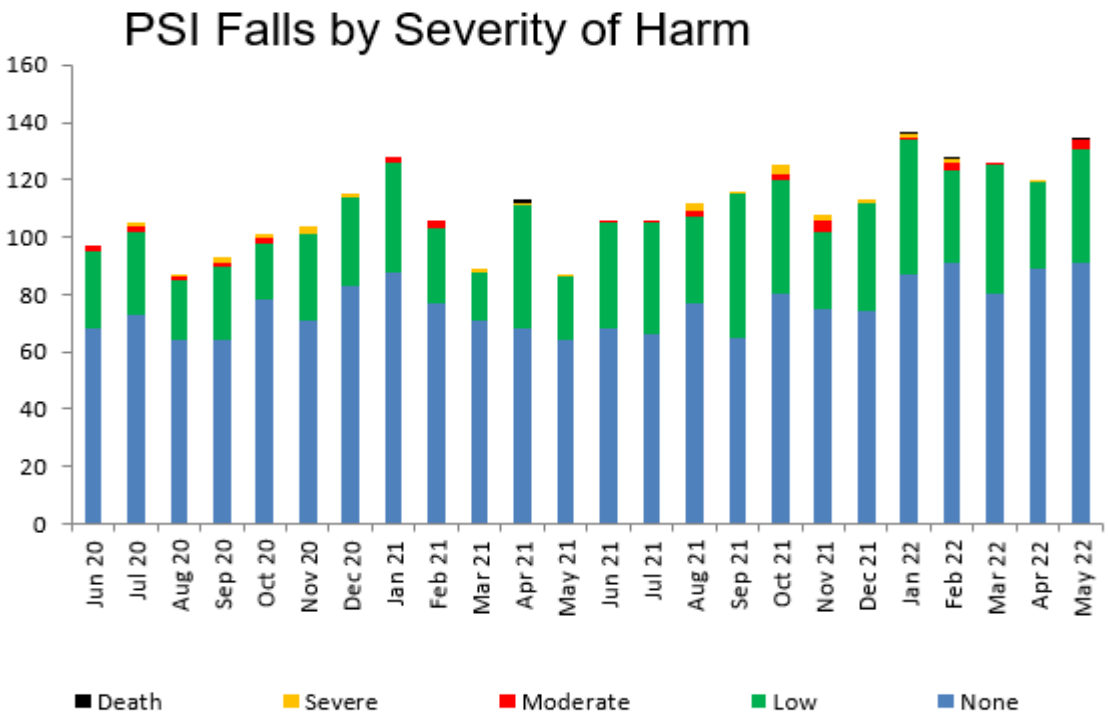
All inpatient falls are reviewed daily by the Quality Matrons and the Falls Lead Practitioner, identifying areas for improvement and shared learning.

SPC Chart 3 identifies a reduction in inpatient Falls reported since January 2022 however in May the number of reported falls has increased. 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



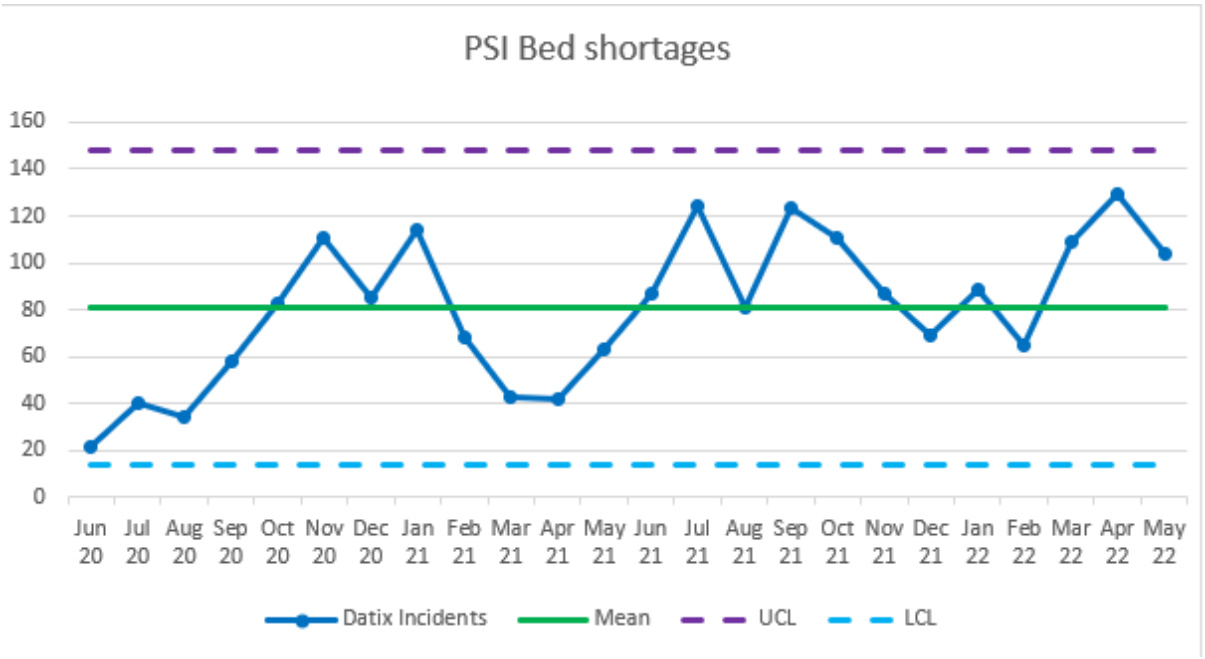
Graph 2 Severity of Harm Inpatient falls



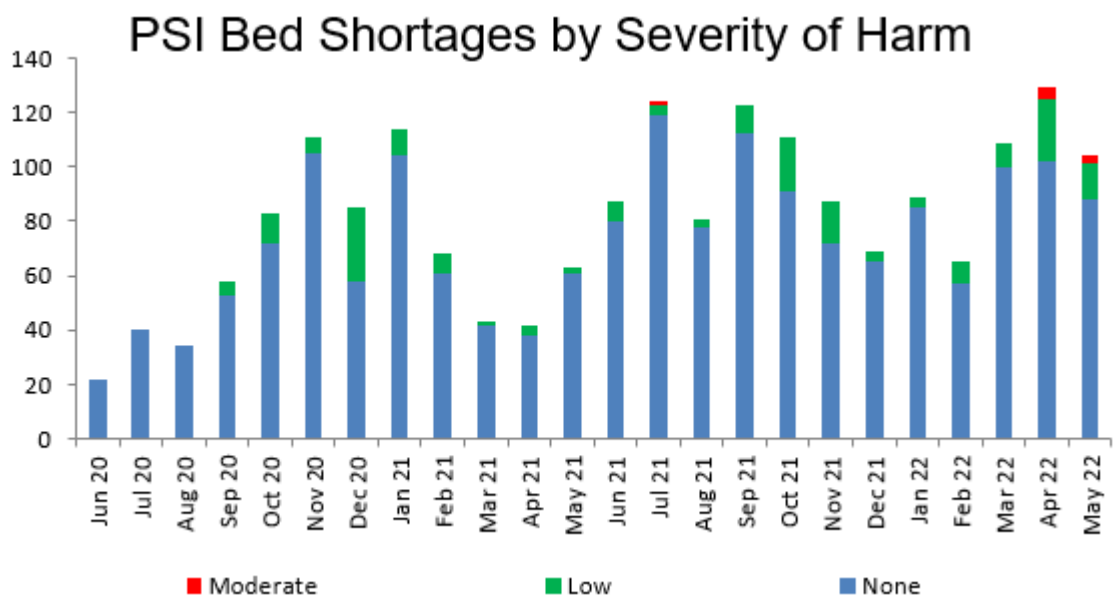
3.4 Bed Shortage

5.9% of all reported incidents during May (104) 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 4



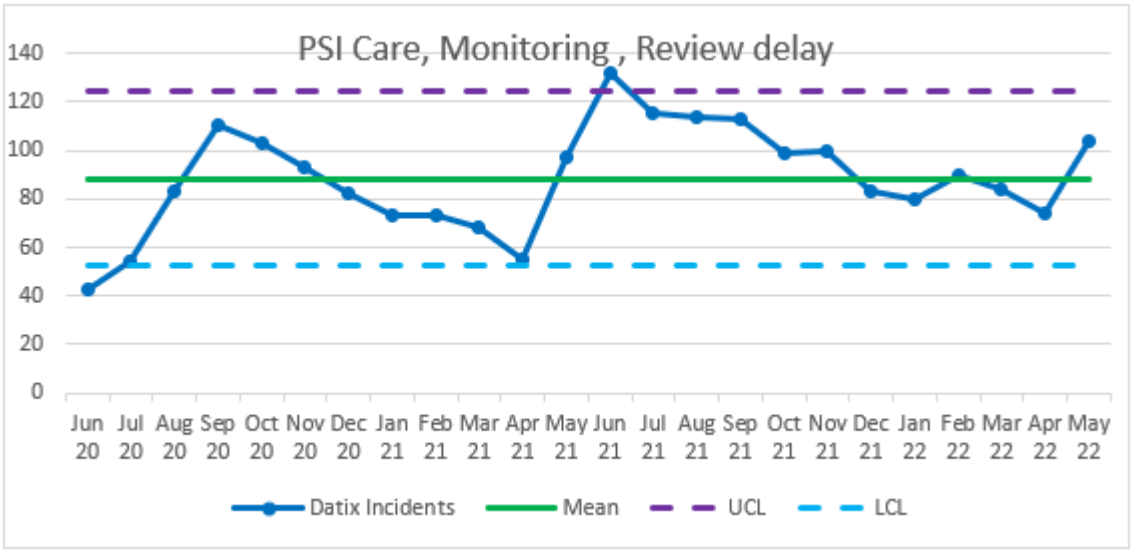
Graph 3 – Severity of Bed Shortages



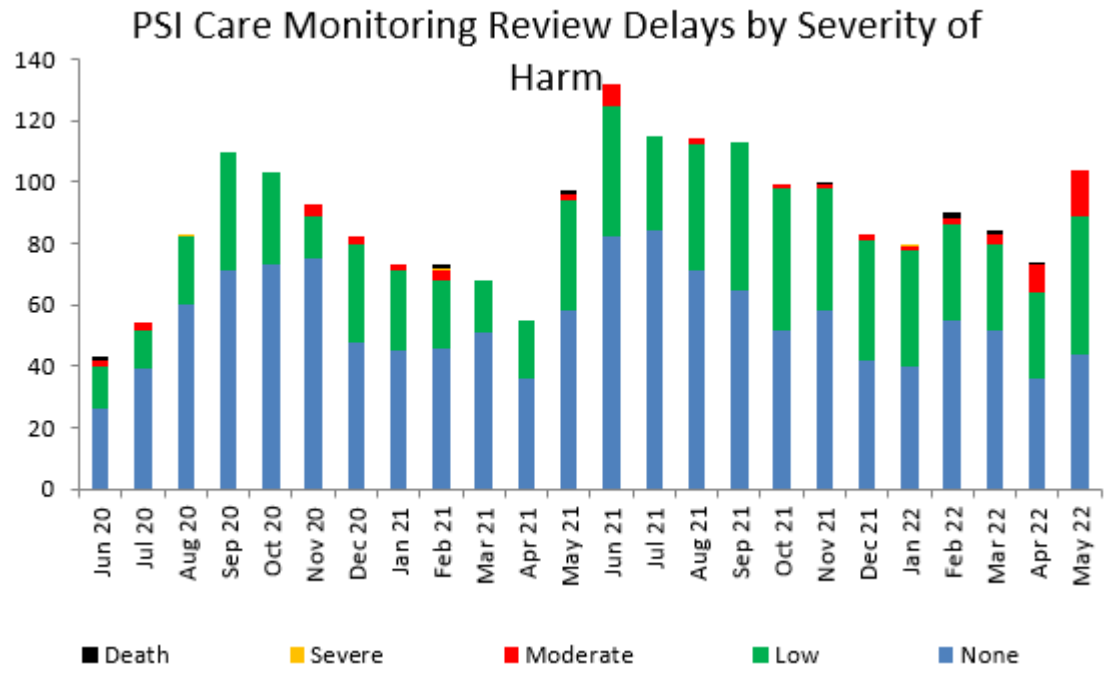
3.5 Care Monitoring Delay

5.9% of all reported incidents in May (104) 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. 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 April that the trend was on a downward trajectory, however May has seen an increase which may relate to sustained and increased pressure within the emergency assessment areas such as ED.

SPC Chart 5



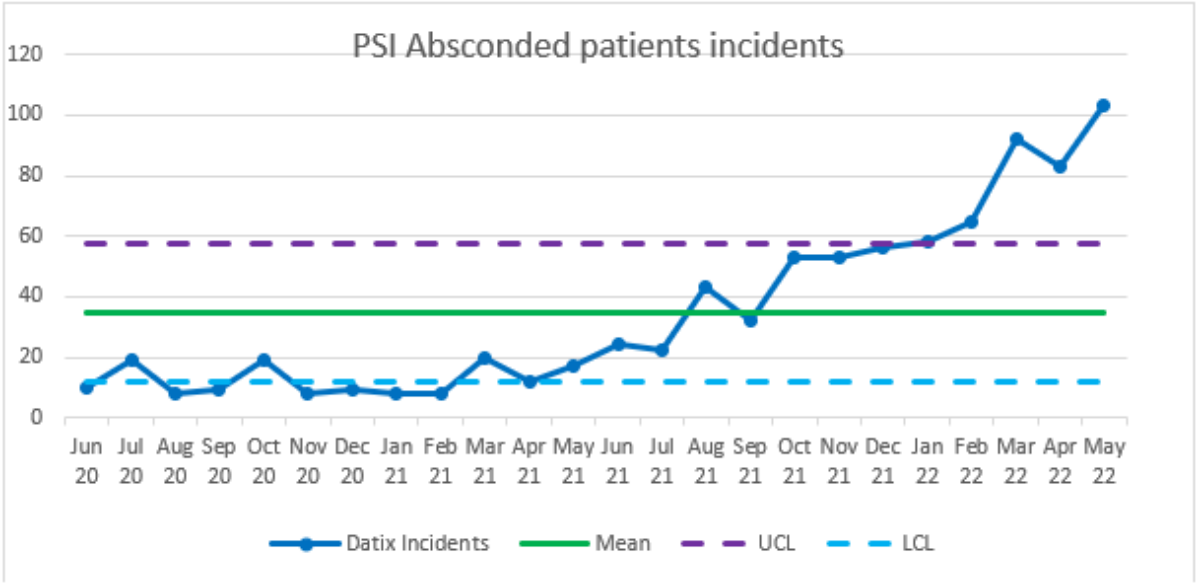
Graph 4



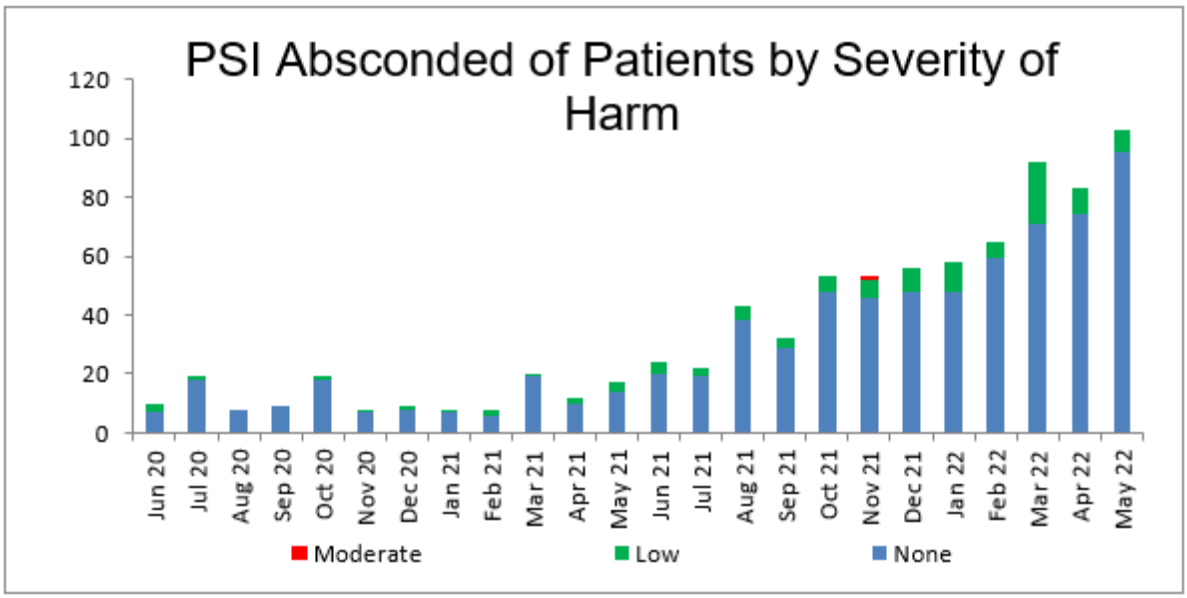
3.6 Absconded Patients

5.9% of incidents reported during May (103) relate to the category absconded/missing patient. This is a wide category that includes patients who absconded from Ward/Trust care, left without being seen after attending the ED. SPC Chart 6 shows an increasing trend in reporting which may relate to an increase in patients who left without being seen in ED due to waiting times. Level of harm for these patients is low (see Graph 5). Standard processes are in place in relation to both missing patient and patients who leave without being seen in the ED.

SPC Chart 6



Graph 5



4. Incident Management including Serious Incident Management

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

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

4.2 Nursing Incident Quality Review Meeting (NIQAM)

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

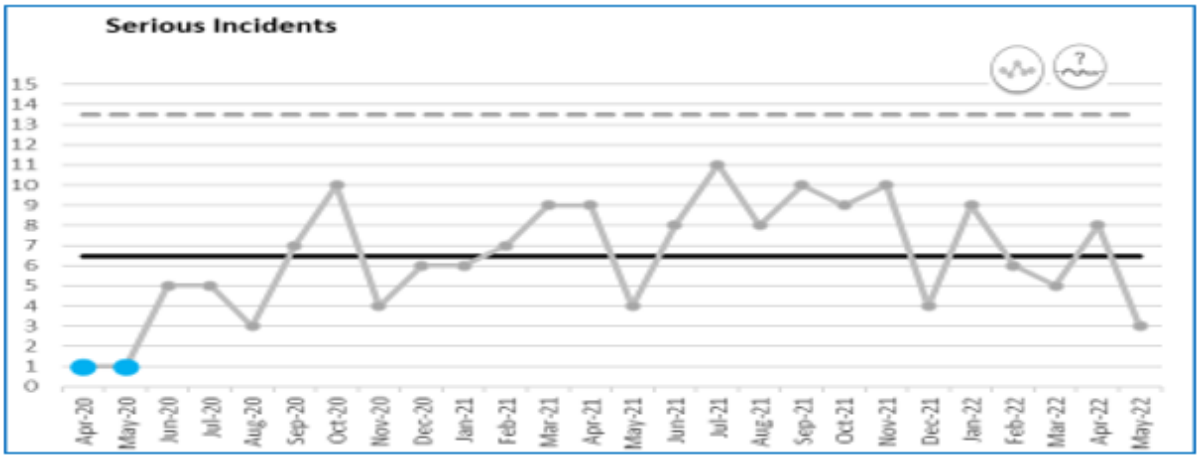
4.3 Maternity

There were no serious incident reported for Maternity during May.

4.4 Serious Incident Reporting Year to Date

At the end of May 2022/2023 the Trust had reported 11 serious incidents.

SPC Chart 7



5. Never Events

There have been no Never Events reported in May 2022.

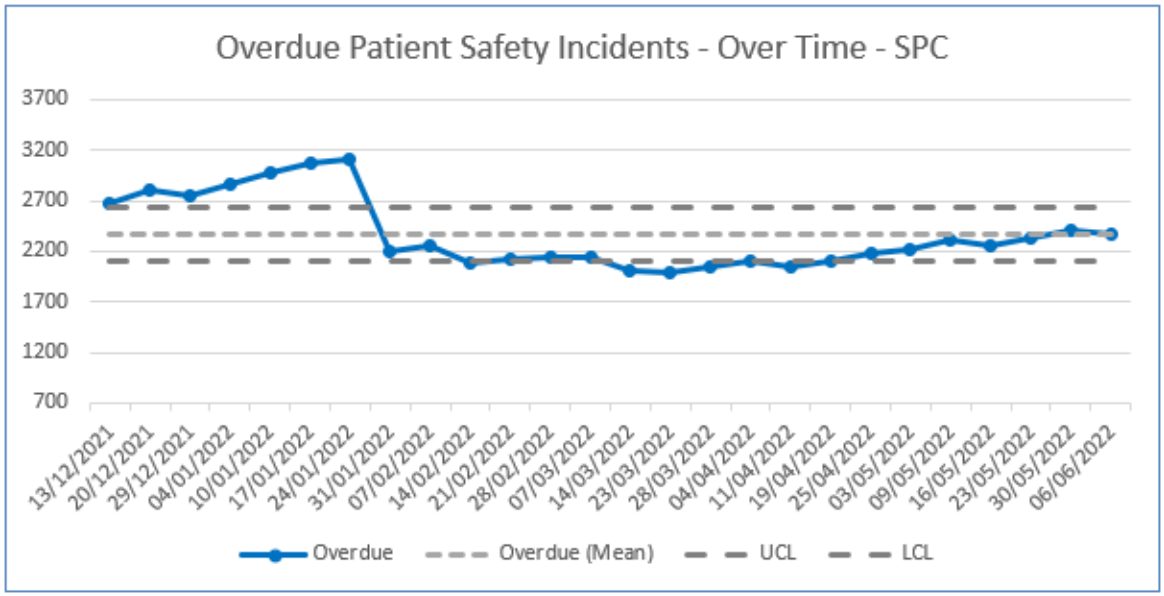
6. Overdue datix overtime

SPC 8 shows that the progress with overdue incidents has deteriorated during May 2022 with 1456 overdue with the Medicine/Emergency Division, 1050 of which are within the ED this may reflect the sustained and unrelenting pressure seen within the Emergency Department.

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 was 1 Serious Incidents closed in May. 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 May. 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 - May 2022

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

There were 3 serious incidents reported in May 2022.

Table 1

SI	Number Reported
2022/9029 CDOP notification, Paediatric Death	**1**
2022/10793 Fall resulting in Head Injury and Death	**1**
2022/10684 Diagnostic Incident – results not acted upon	**1**
Total	**3**

1 Closed Serious Incident Investigations – May 2022

SI – Closed April 2022
SI 2021/17862 – Maternity Affecting Baby

Appendix Two

Learning identified from closed incidents in May

Key themes:

• Review the guideline Management of Suspected Fetal Macrosomia, all women diagnosed with a large gestational aged baby following a growth scan is to be escalated for a priority review with a Senior Obstetrician regardless of any other labour plans that may already be in place
• Transparent training log identifying compliance with PROMPT training in shoulder dystocia
• Documentation training is required in the accurate use of the shoulder dystocia proforma, addressing timing, responsibility, clear roles of individuals, and correct written content
• Consider a 1-page separate set of clear and concise instructions on manoeuvres so explicit, simple to follow and adhere to in an emergency, For Algorithm on the management of Shoulder Dystocia: RCOG, Green Top Guideline No 42, March 2012.
• Staff would benefit greatly from additional training on situational awareness, psychological safety, effective communication, and effective leadership as part of their mandatory training
• Review and update Patient Information so women who are diagnosed with large gestational aged babies are given accurate and consistent advice, so they can make an informed decision on the options available.

Action and learning from incidents are tracked and monitored through the Divisional Quality Governance Processes. Plans are in place to introduce learning and sharing forums cross divisions. Action tracking will be monitored through Divisional Governance Committees.