Board of Directors' Meeting
10 November 2022

The Shrewsbury and Telford Hospital NHS Trust

Agenda item	216/22			
Report Title	Incident Overview Report – September 2022 data			
Executive Lead	Hayley Flavell, Director of Nursing			
Report Author	Kath Preece, Assistant Director of Nursing, Quality Governance			
	Link to strategic goal:		**Link to CQC domain:**	
	Our patients and community	√	Safe	√
	Our people		Effective	
	Our service delivery		Caring	
	Our governance	√	Responsive	
	Our partners		Well Led	
	Report recommendations:		**Link to BAF / risk:**	
	For assurance	√	BAF1, BAF2, BAF4, BAF7, BAF8, BAF9,	
	For decision / approval		**Link to risk register:**	
	For review / discussion			
	For noting			
	For information			
	For consent			
Presented to:	2022.10.26 Quality and Safety Assurance Committee			
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 – September 2022 Appendix Two – Learning and Actions – September 2022			
Executive Lead				

1.0 Introduction

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

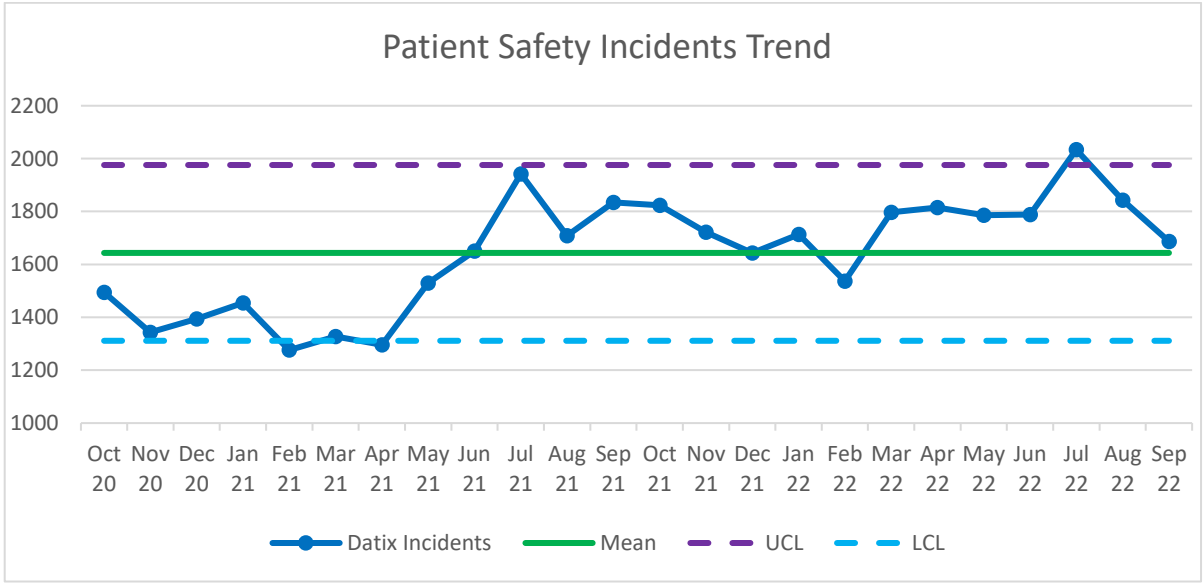
2.0 Patient Safety Development and Actions planned for November/December 2022/23

- 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.
- Develop Safety links/champions in all ward areas to support learning and sharing.

3.0 Analysis of September 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 demonstrates common cause variation.

SPC Chart 1



3.1 Review of Top 5 Patient Safety Incidents

During September there were 1,687 Patient Safety Incidents reported which were classified as incidents attributable to Shrewsbury and Telford Hospitals. The top 5 reported incidents account for 32% of the reported incidents during September 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	147
Bed shortage	118
Inpatient Falls	125
Care/monitoring/review delay	87
Communication problems between teams/staff	71
Total	548

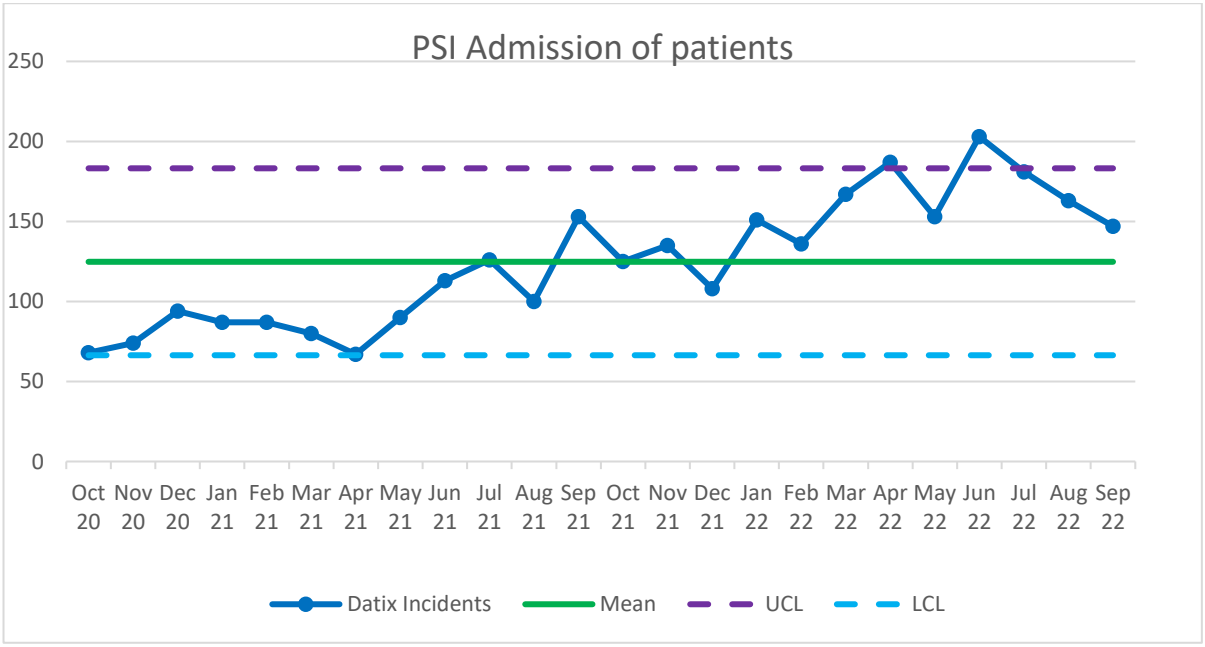
3.2 Admission of patients

8.7% of all reported incidents during September (147) 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.

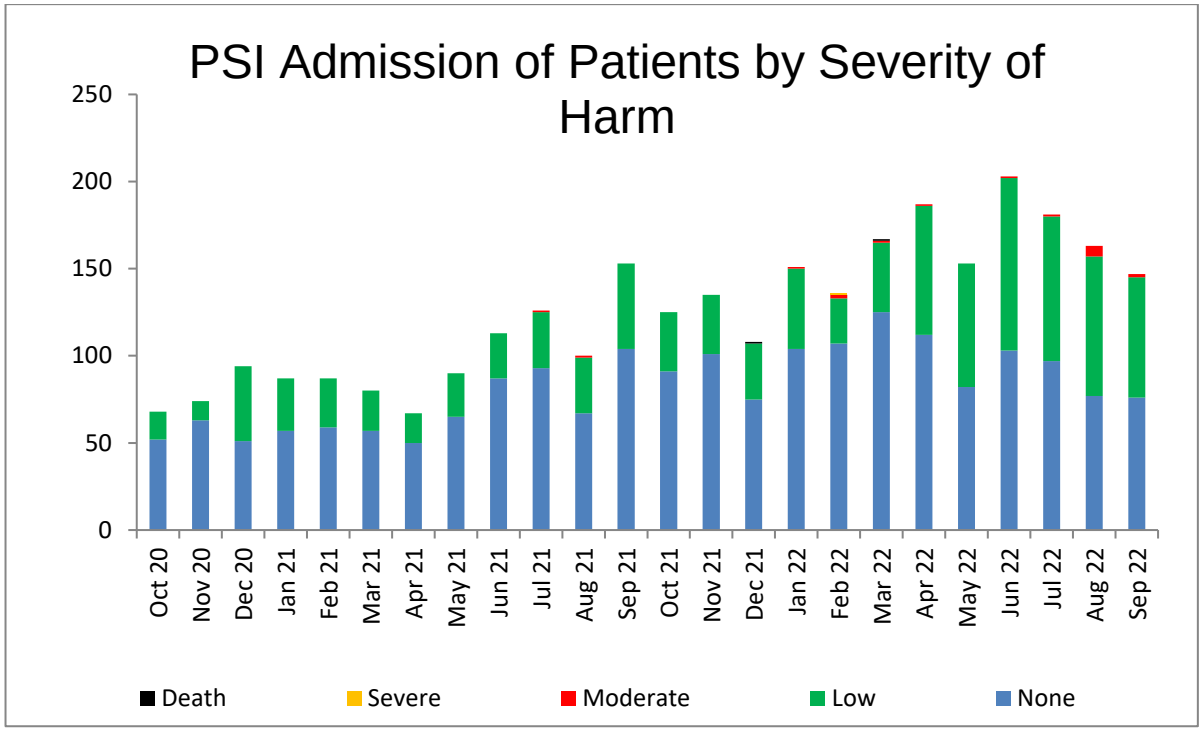
Analysis of ambulance offload delay and long waits in the Emergency Department in demonstrates increased harm caused to patients. It is also important to note that each incident report for ambulance offload delay may have multiple patients attached to it – each patient is reviewed to assess any harm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

SPC chart 2 showed an upward trend, which peaked in June 2022, when incidents exceeded the upper control limit, the last three months has seen a reduction in reported incidents however this remains towards the upper control limit which demonstrates the significant and ongoing pressure within the Emergency Department and capacity concerns with the Trust.

SPC Chart 2



Graph 1 – Severity of Harm Admission of Patients

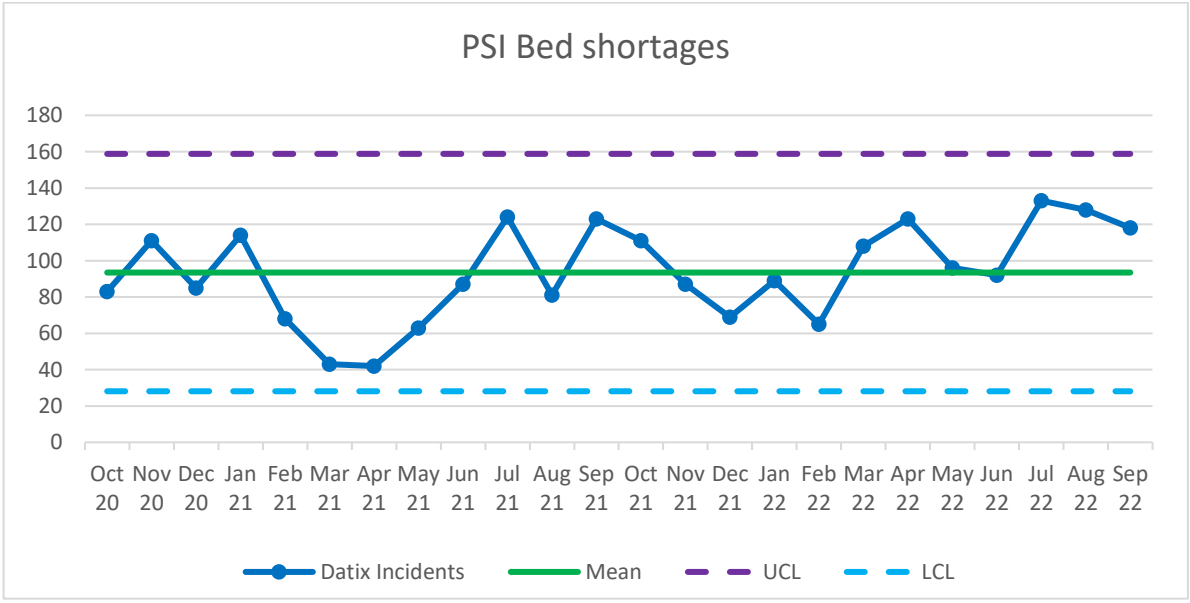


3.3 Bed Shortage

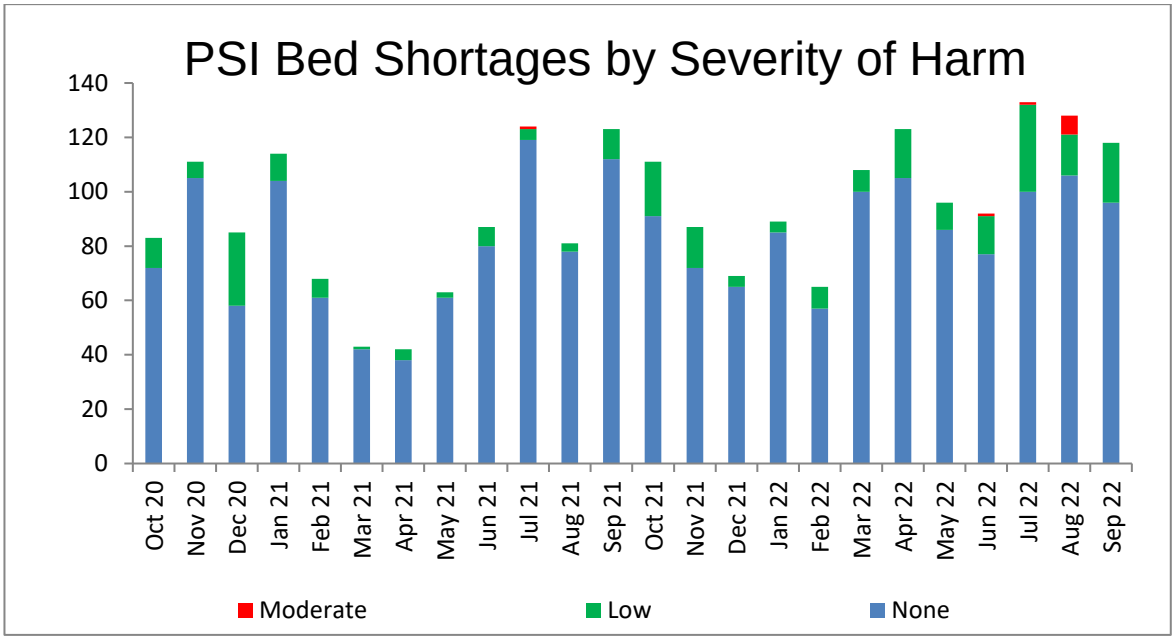
7% of all reported incidents during September (118) were categorised as bed shortages. These incidents include 12 hour breaches for patient admission from ED, it is important to note that 1 incident report for 12 hour breaches may contain multiple patient detail and delay in discharge from Intensive Care Unit to a ward bed.

SPC Chart 3 demonstrated an upward trend, the past two months have seen a lower number of incidents reported.

SPC Chart 3



Graph 2 Severity of Harm Bed Shortages



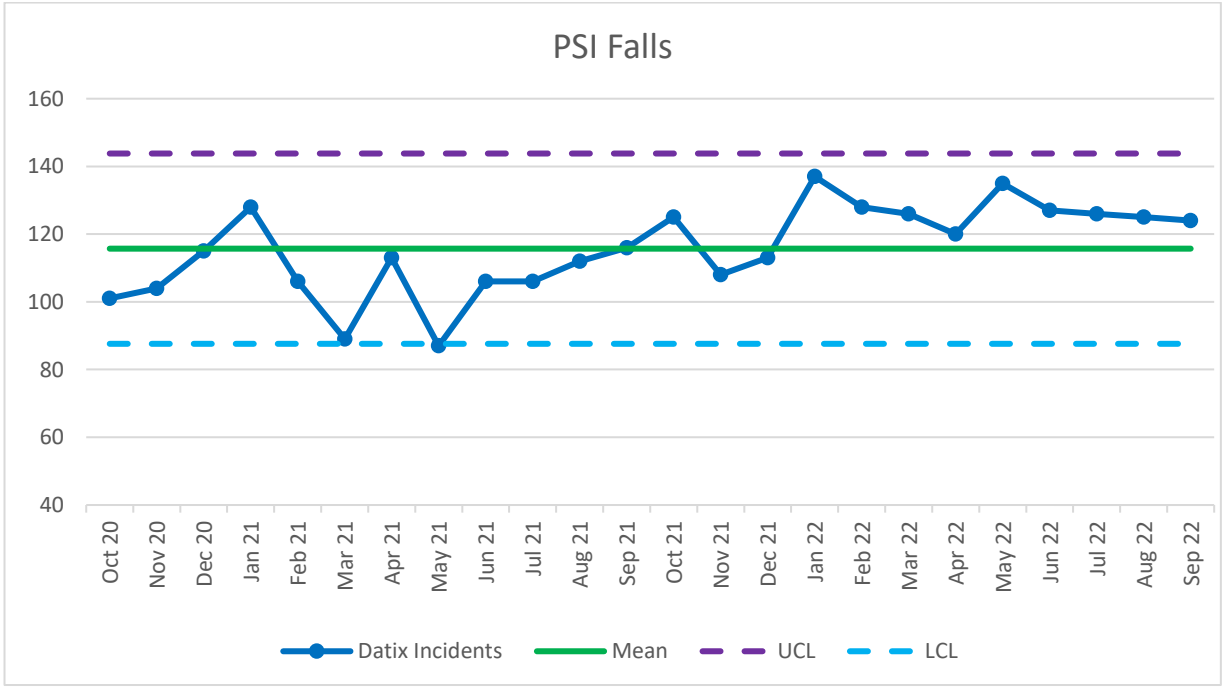
3.4 Inpatient Falls

7.4% of all reported incidents during September (125) were categorised as a Fall. Of these, 3 were reported 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.

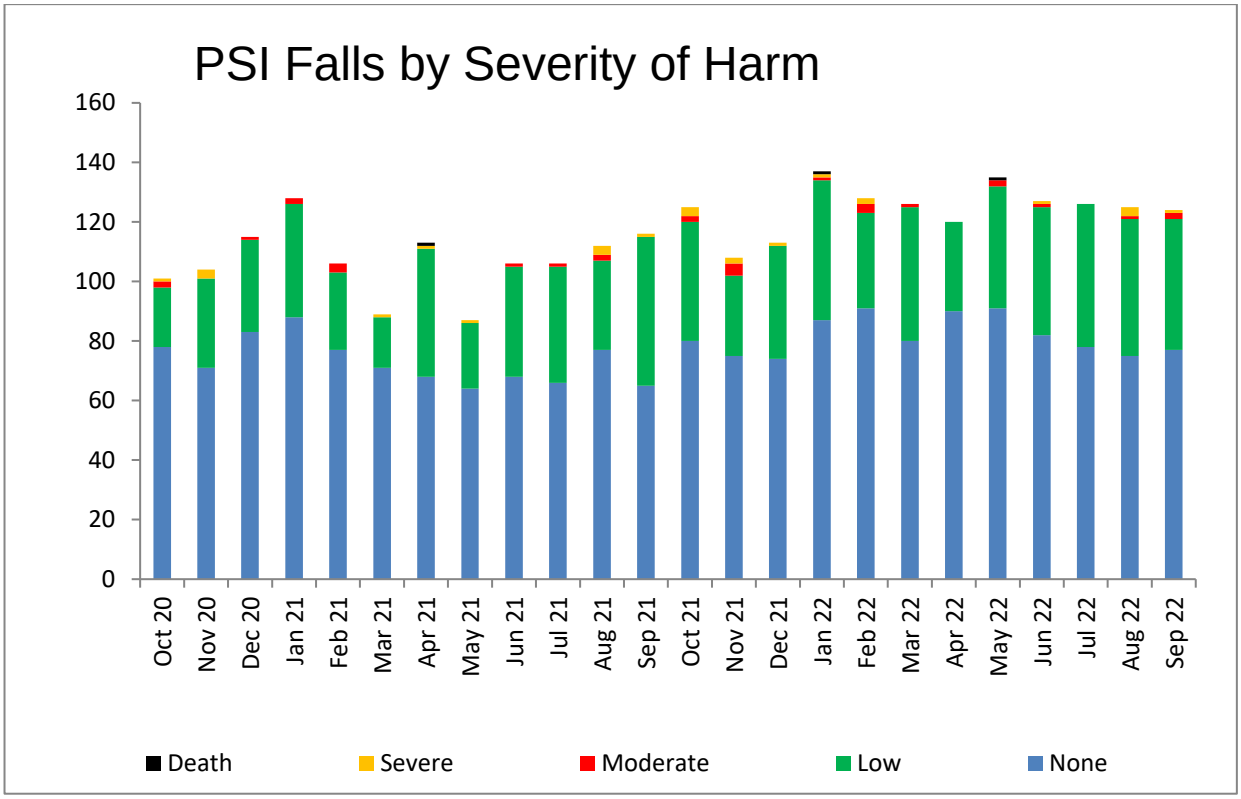
All inpatient falls are reviewed daily by the Quality Matrons and the Falls Lead Practitioner, identifying areas for improvement and shared learning.

SPC Chart 4 identifies that inpatient Falls reported remains high. 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



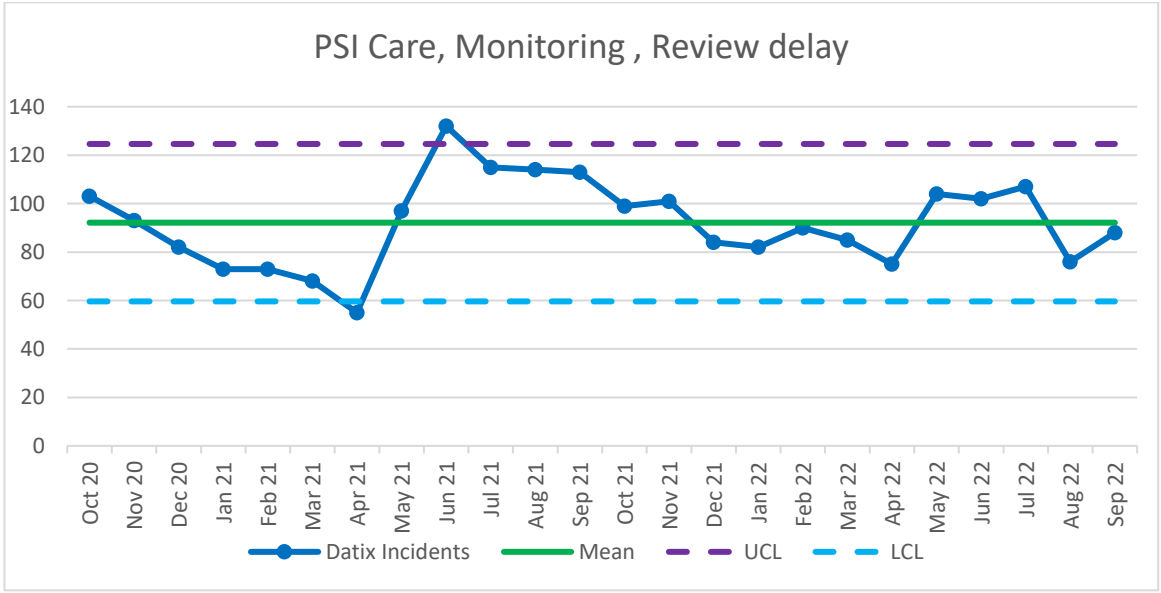
Graph 3 – Severity of harm inpatient falls



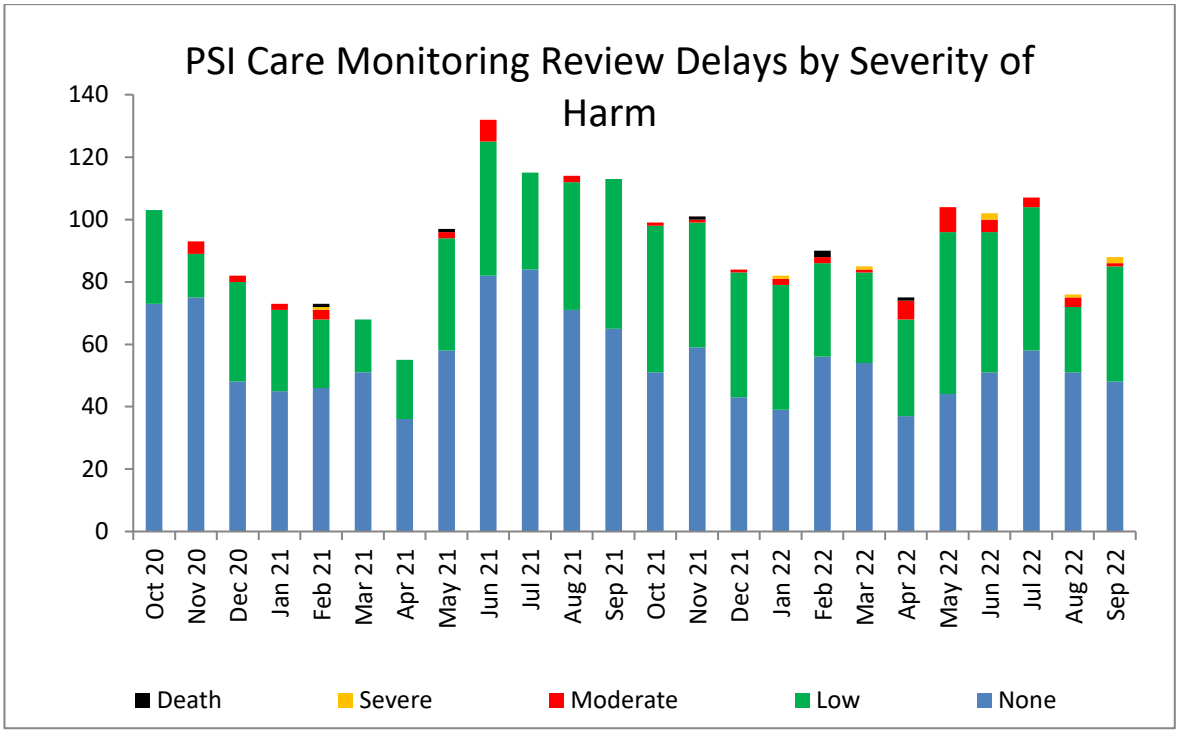
3.5 Care Monitoring Delay

5.2% of all reported incidents in September (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. Ongoing work in relation capacity, flow and staffing should help to mitigate harm. SPC Chart 5 demonstrates common cause variation.

SPC Chart 5



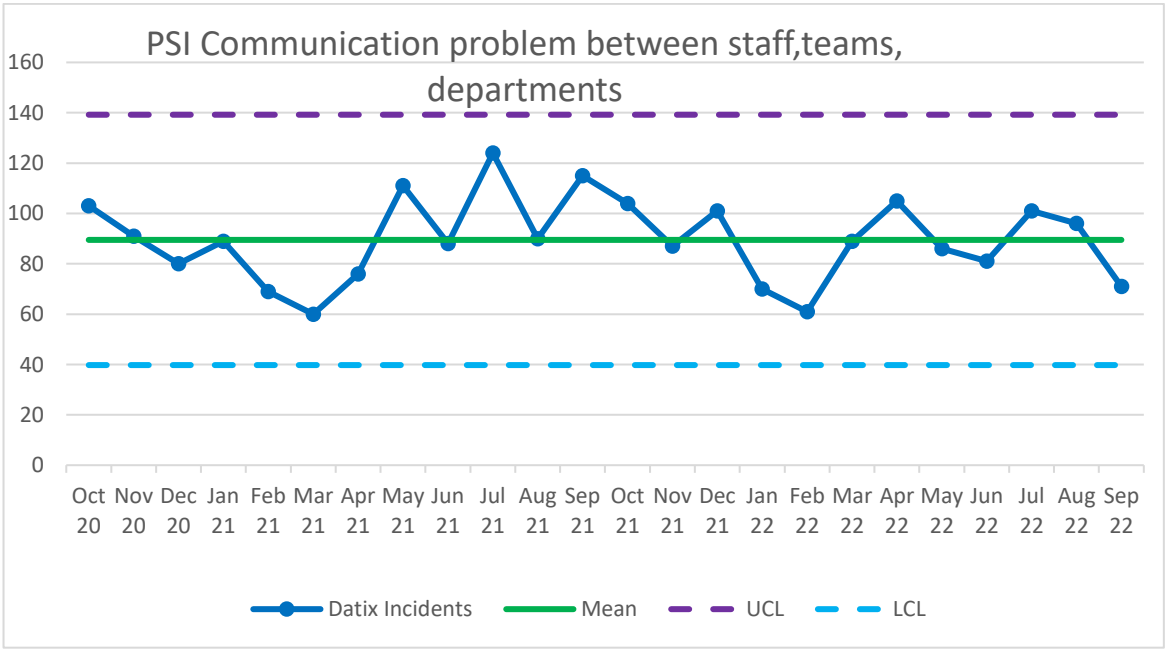
Graph 4



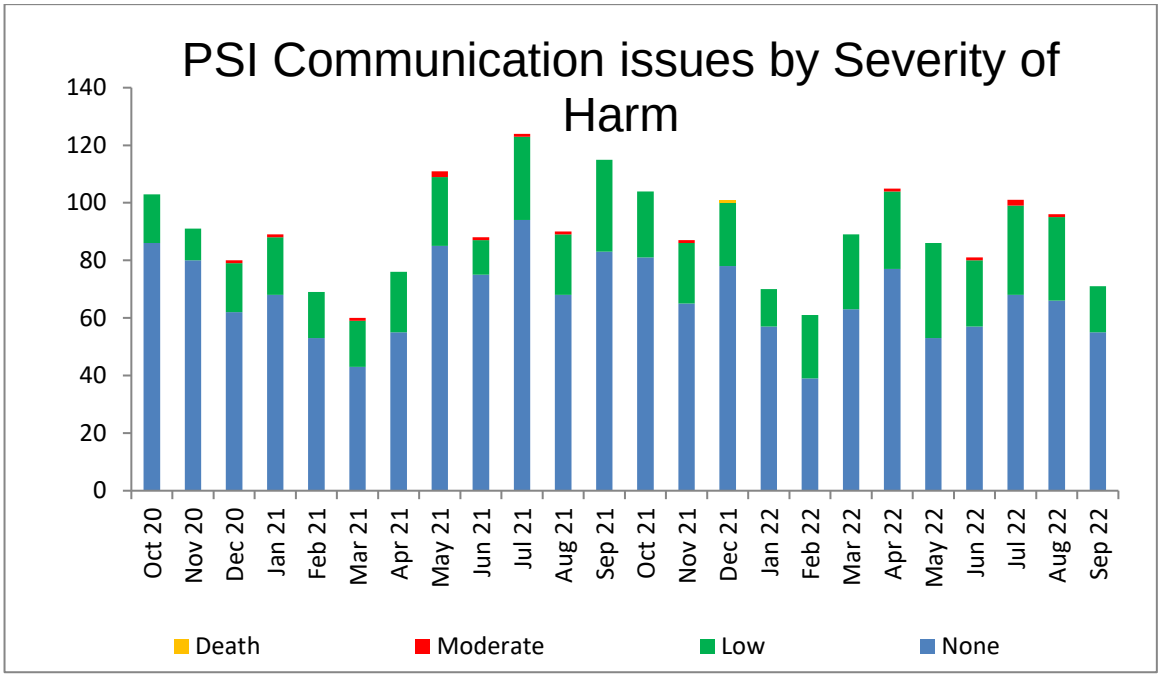
3.6 Communication problems between teams/staff

4% of all reported incidents during September (71) were categorised as communication between staff, teams and departments. August and September are only the time 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 6



Graph 5



4.0 Incident Management including Serious Incident Management

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

15 New case assessments were reviewed by RALIG during September, Chaired by the Medical Director, resulting in 10 Serious Incident Investigations being commissioned (see appendix 1)

4.2 Nursing Incident Quality Review Meeting (NIQAM)

5 Serious Incident Investigations were commissioned during September relating to 3 falls severe harm and 2Category 3 Pressure Ulcer (See appendix 1).

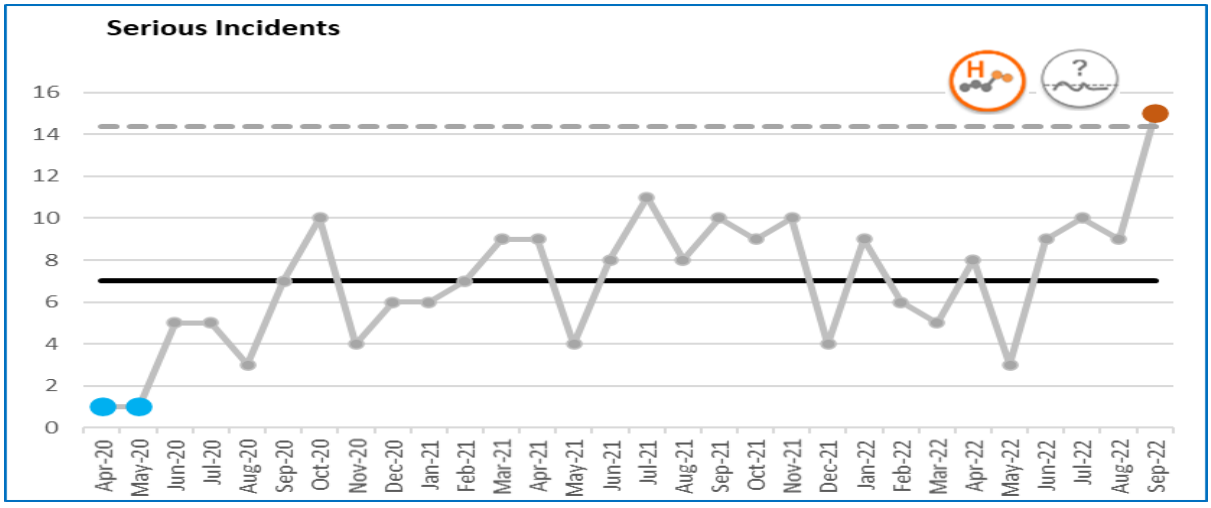
4.3 Maternity

There were 2 serious incidents reported for Maternity during September (See appendix 1).

4.4 Serious Incident Reporting Year to Date

At the end of September 2022/2023, the Trust had reported 54 serious incidents.

SPC Chart 7



5.0 Never Events

There have been no Never Events reported in September 2022.

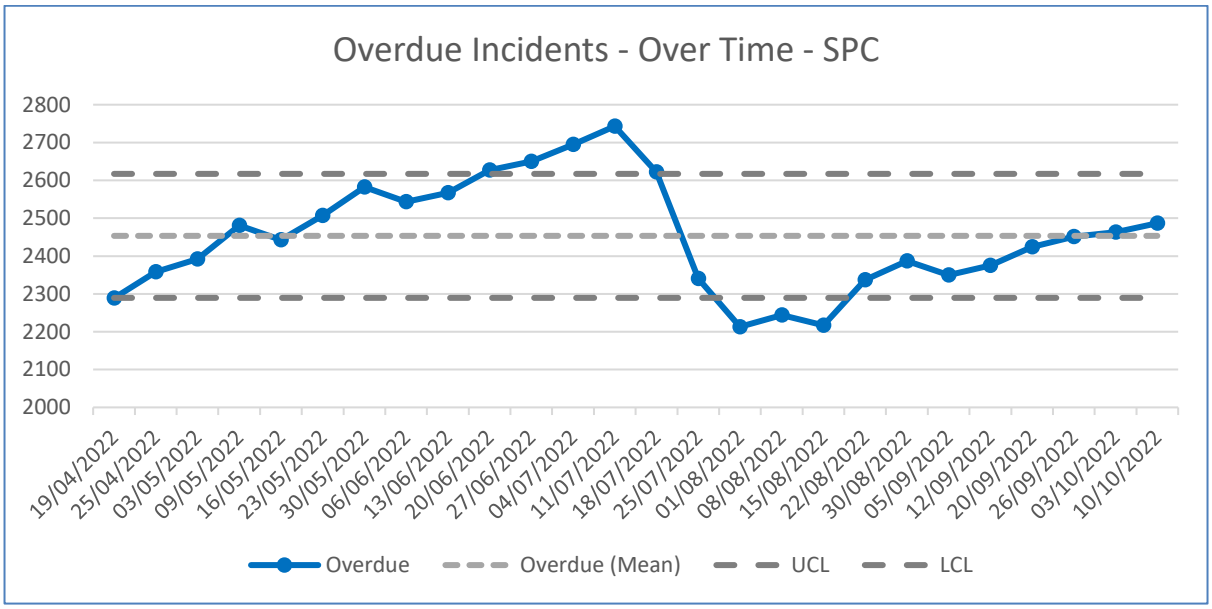
6.0 Overdue datix overtime

SPC 8 shows that the progress with overdue incidents has slightly decreased further during September with the majority of overdue 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



7.0 Lessons Learned and Action Plan Themes

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

8.0 Duty of Candour

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

9.0 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 - September 2022

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

There were 15 serious incidents reported in September 2022.

Table 1

SI – Reported in September 2022
2022/18848 Delay diagnosis / treatment – Surgical/Clinical Support Services
2022/18829 Deteriorating patient – Women and Children
2022/19583 Intrapartum stillbirth – Women and Children
2022/19676 Fall Skull fracture – Medicine
2022/19764 Fall fracture neck of femur – Medicine
2022/20010 Delay In treatment – Surgical
2022/20025 Cat 3 Pressure Ulcer – Surgical
2022/20135 Clotting in the Superior Sagittal Vein – Women and Children
2022/20242 Cat 3 Pressure Ulcer – Medicine
2022/20370 Delayed Diagnosis – Urgent and Emergency
2022/20378 Delay in Treatment – Urgent and Emergency
2022/20662 Fall Head Injury – Medicine
2022/20872 Delay in Treatment – Surgical
2022/21007 Delay Diagnosis – Women and Children
2022/20909 Delay Diagnosis – Urgent and Emergency
Total

3 Closed Serious Incident Investigations – September 2022

SI – Closed - September 2022
2022/8485 Delayed Diagnosis – Urgent and Emergency
2022/6977 Airway incident – Critical Care
2021/21110 – Medication Error - Surgical

Appendix Two

Learning identified from closed incidents in September

Key themes:

• Review of signposting for patient needing support Out of Hours (OOH)
• Following any medical or surgical intervention, ED clinicians to ensure discussion with appropriate specialist for advice when patients attend the department with a suspected complication
• ED clinicians to use the safe discharge policy, specifically relating to mobility and frailty assessment pre discharge for the over 70's and that the discharge check list is completed in full.
• The learning from this case to be used to reinforce the guidelines for senior doctor face to face assessment of patients reattending with the same symptoms/condition within 72 hours.
• Neuro observations to be undertaken in line with Trust policy and NICE guidelines for patients who have sustained a head injury and a focus week to be used to reinforce this with all ED clinicians
• Review the way ventilation tubing is held in place to minimise the risk of tension developing with patient movement.
• Consider standardisation of surgical tracheostomy technique to one which makes the stoma more easily identifiable and easier to re-intubate in cases of tracheostomy tube dislodgement
• Ensure that all staff on ICU have regular scenario/ simulation-based training in complex airway management including a familiarity with the contents of the complex airway trolley and the management of surgical tracheostomy following major head and neck surgery.
• For all patients to be admitted into hospital all medication should be prescribed on a drug card this keeping a clear record of all the medication patients had, this easily accessible for the nurses
• For both doctors and nurses to check blood results on clinical portal before prescription or administration of Gentamicin. This should be documented in the patient's notes
• There should be a clearly defined, documented process of handover across the Trust for all staff, to mitigate the risk of pertinent information being missed

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.