Board of Directors' Meeting
8 December 2022

The Shrewsbury and Telford Hospital NHS Trust

Agenda item	245/22			
Report Title	Incident Overview Report			
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:	*2022.11.23 Quality & 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 – October 2022 Appendix Two – Learning and Actions – October 2022			
Executive Lead				

1. Introduction

This report highlights the patient safety development and forthcoming actions for December/January 2023 for oversight. It will then give an overview of the top 5 reported incidents during October 2022. Serious Incident reporting for October 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 October 2022 are included in Appendix 1. Detail relating to lessons learned from closed SI in October 2022 are included in Appendix 2.

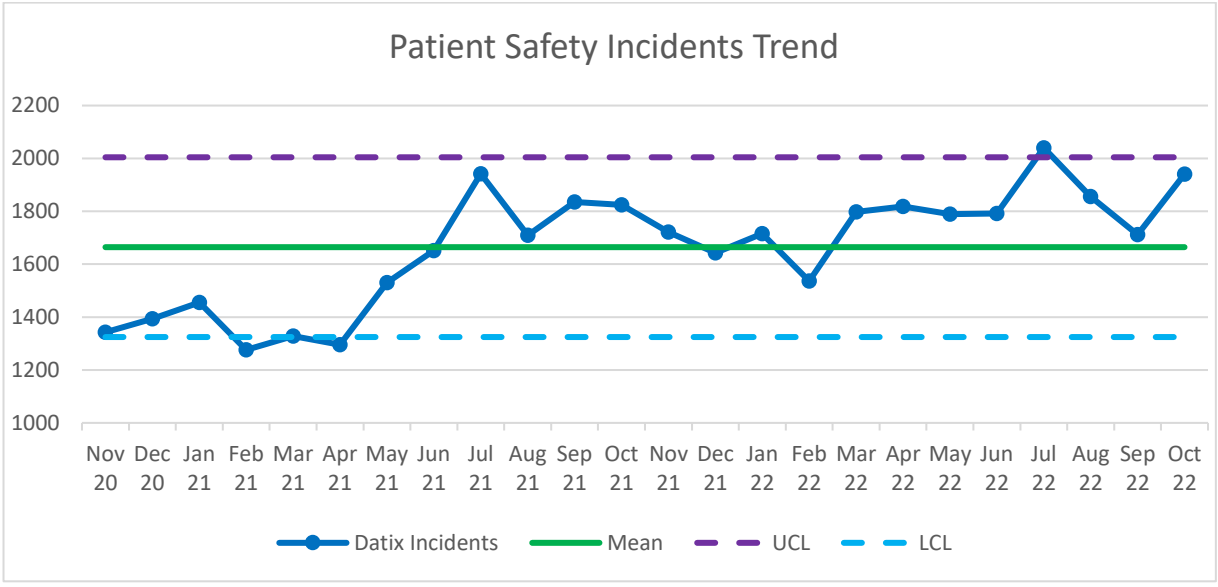
2. Patient Safety Development and Actions planned for December/January 2022/23

- 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. Analysis of October 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 October there were 1940 Patient Safety Incidents reported which were classified as incidents attributable to Shrewsbury and Telford Hospitals. The top 5 reported incidents account for 33% of the reported incidents during October 2022 – see Table 1. There has been an increase in capacity related incidents reported which reflects the capacity and patient flow challenges faced by the Trust.

The top 5 reported incidents are explored in more details below, along with a review of improvement work underway in each section.

Table 1

Top 5 Patient Safety Incidents	Totals
Admission of patient	207
Bed shortage	122
Staffing problems	110
Inpatient Falls	104
Care/monitoring/review delay	98
Total	641

3.2 Admission of patients

October has seen an increase in the number of incidents reported categorised as difficulties with the admission of patients. 11% of all reported incidents during October (207) 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 demonstrates increased harm caused to patients who are waiting for admission. 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 an upward trend of reporting demonstrating special cause variation and reflects the significant and ongoing pressure within the Emergency Department and capacity concerns within the Trust.

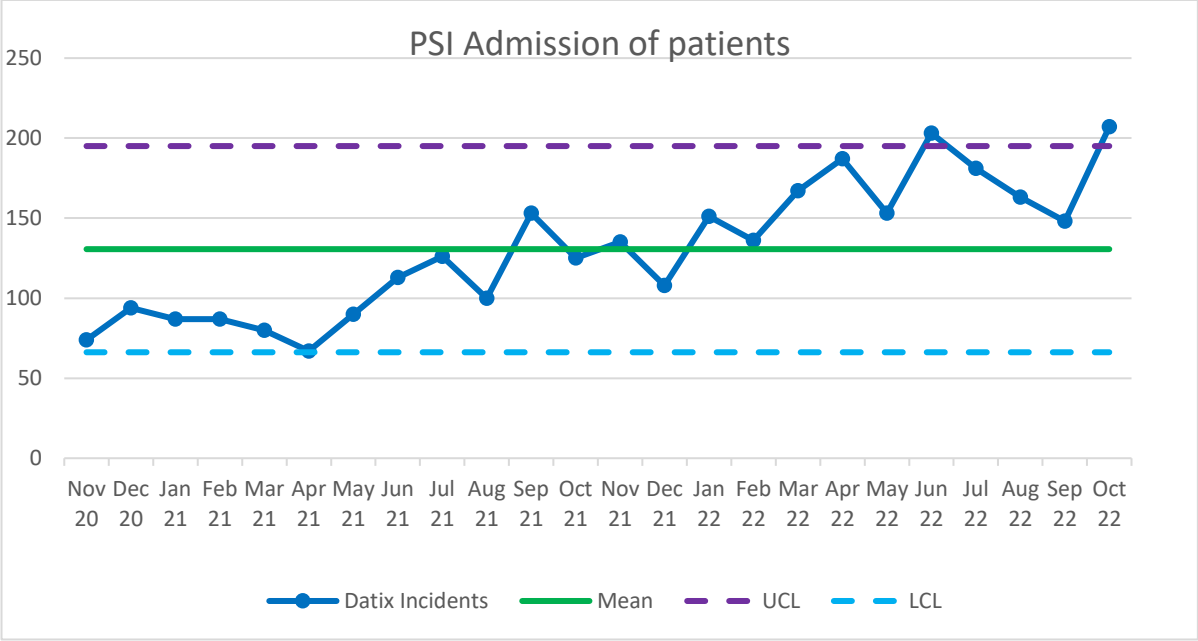
Improvement work is ongoing both internally within the Trust and also with System partners. The Trust has implemented an initiative called **"Next Patient"**, which allows a release of capacity in our Emergency Departments and assessment portals (AMU, SAU) throughout the day enabling an earlier release of ambulance crews and response to 999 calls. This model originated in North Bristol NHS Trust and has been implemented in several Trusts with the most delays.

Over the last month the **"Next Patient"** approach has been piloted at both sites.

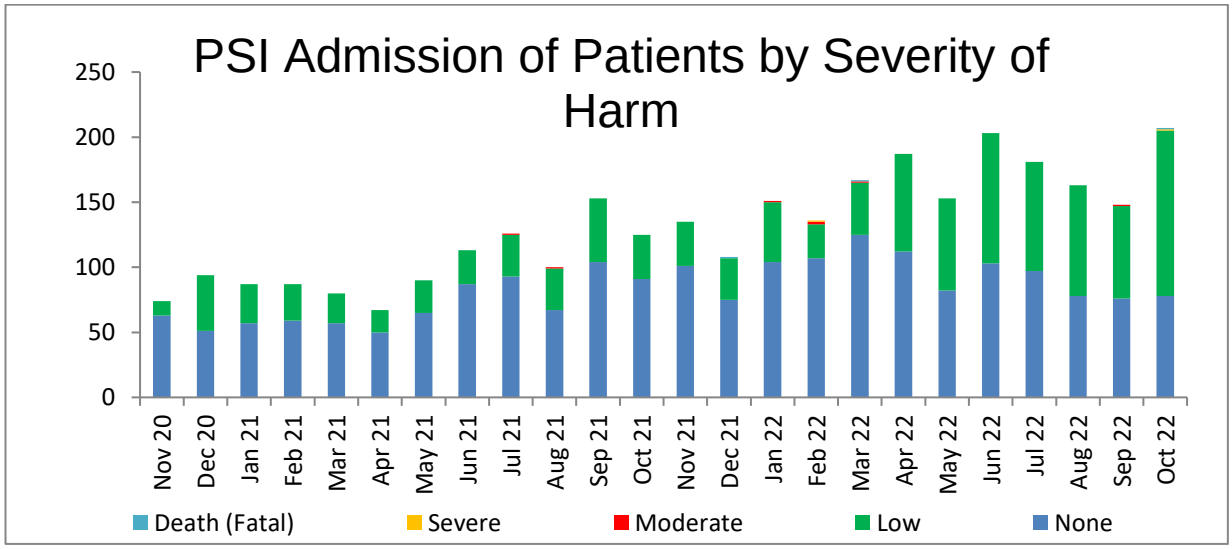
The **"Next Patient"** approach has been adopted from 8am to 8pm Monday to Friday, to enable us to decongest our Emergency Departments and release crews. Each hour, patients will move, predominantly from AMU, but also ED where appropriate to our wards, the numbers of patients moved corelated to the medical take. The moves happen automatically with support from the Divisional leadership teams. There has been an increased use of the discharge lounge during this month and an increase in discharges before 12 noon, which supports the early patient flow.

Graph 1 demonstrates the level of harm identified with delays in admission of patients following review of the incident reported. The graph identifies that the number of patients where harm has been identified has increased over time, however the level of patient harm remains low with more than 50% of the patients experiencing low harm such as a delay in antibiotics, pain relief or access to diagnostics.

SPC Chart 2



Graph 1 – Severity of Harm Admission of Patients



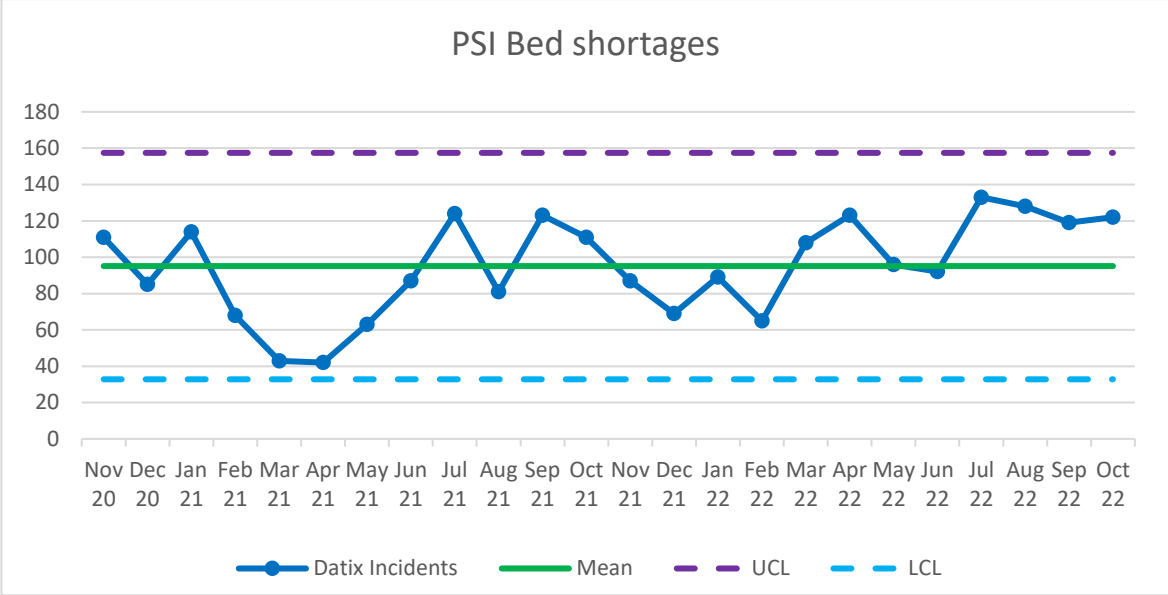
3.3 Bed Shortage

6% of all reported incidents during October (122) 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.

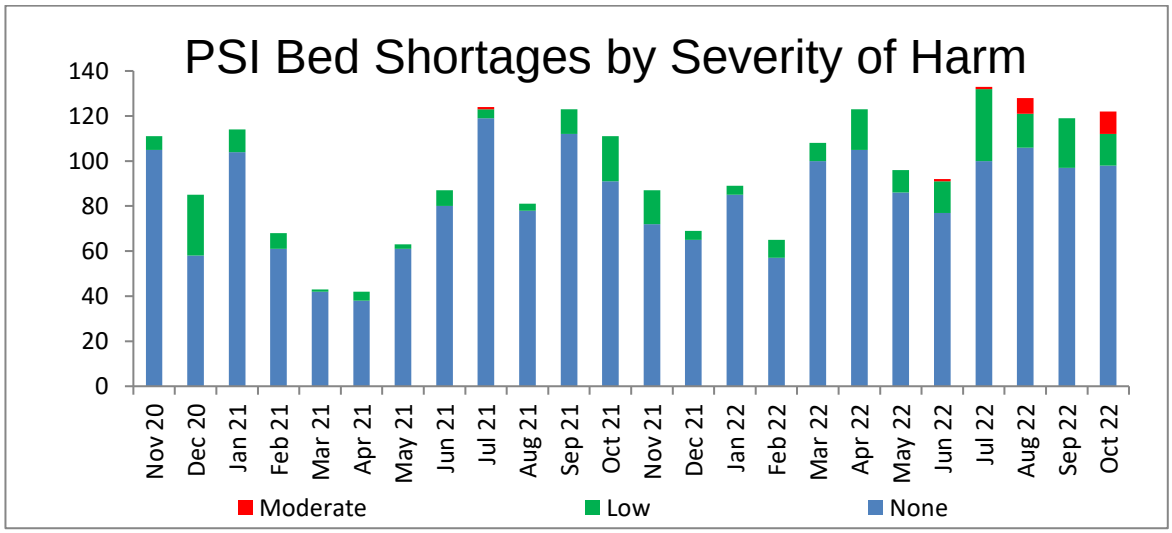
SPC Chart 3 demonstrates common cause variation and remains within the control limits.

Graph 2 identifies that 80% of bed shortage incidents were reviewed as no harm, with 20% low/moderate harm. The improvement work noted in the section 3.2 aims to have a positive impact on this category.

SPC Chart 3



Graph 2 Severity of Harm Bed Shortages



3.4 Staffing

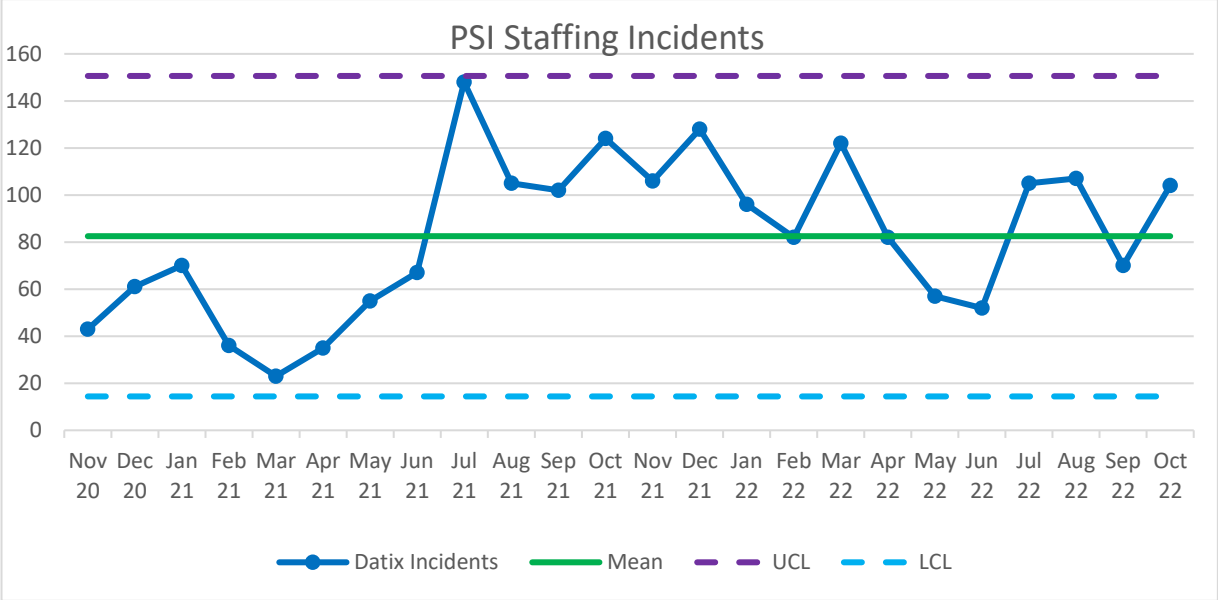
6% of all reported incidents during October (110) were categorised as Staffing Problems.

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.

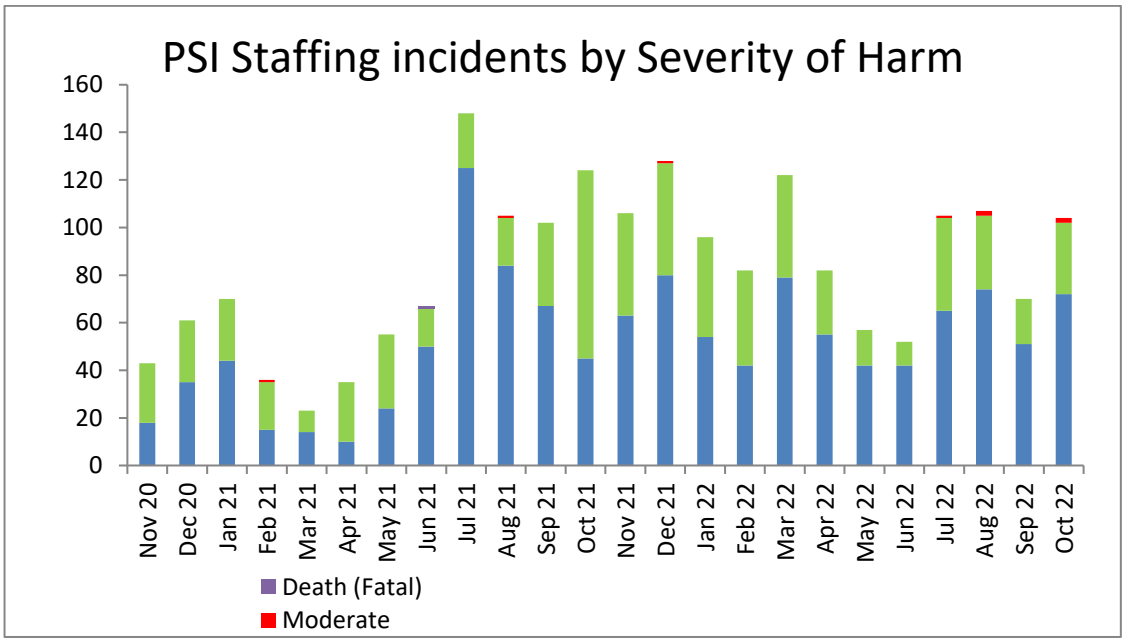
SPC Chart 4 demonstrates common cause variation with level of reporting and has around the mean.

Graph 3 identifies that 65% of the staffing problems resulted in no harm for patients with 27% resulting in low harm such as delays to administration of medication, timeliness of care. Two of the incidents resulted in moderate harm.

SPC Chart 4



Graph 3 – Severity of harm staffing problems



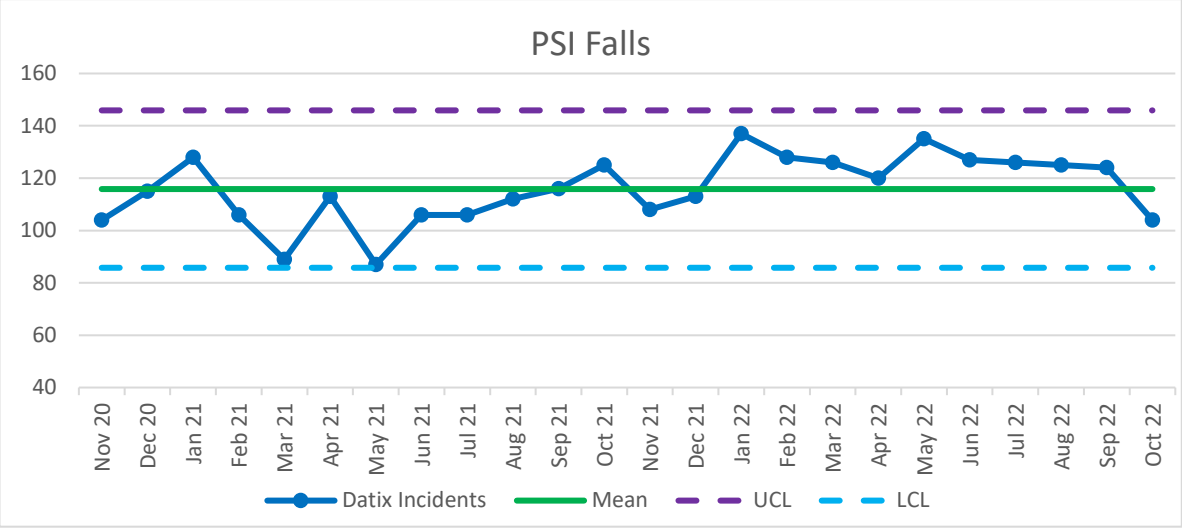
3.5 Inpatient Falls

5% of all reported incidents during October (104) were categorised as a Fall. Of these, 2 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.

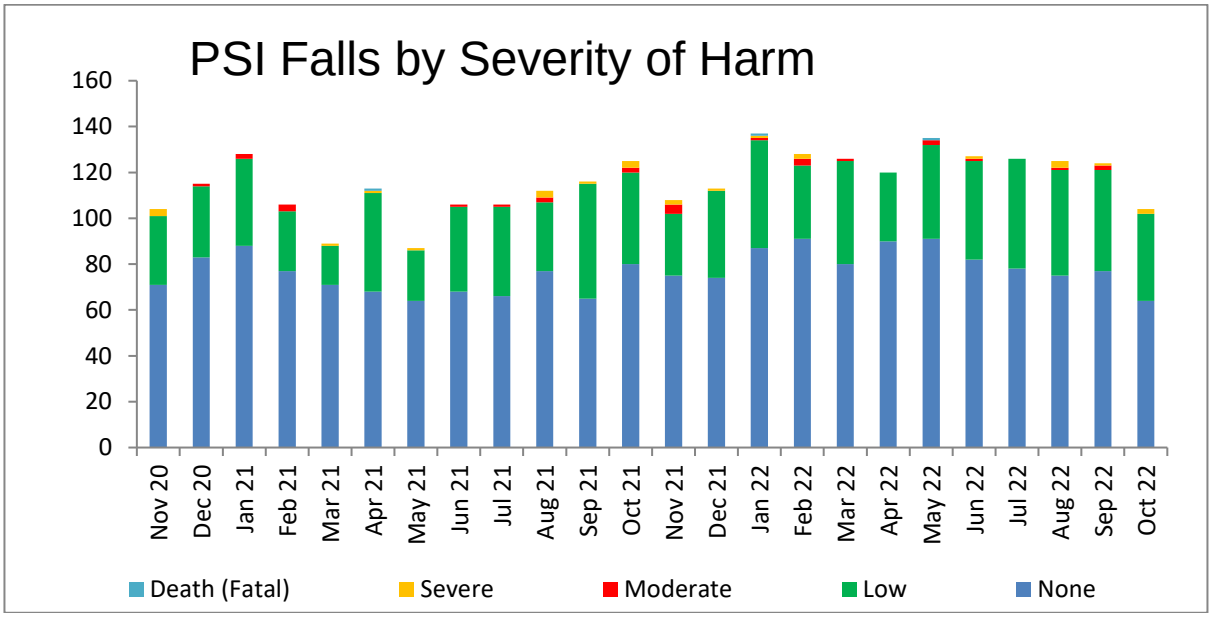
All inpatient falls are reviewed daily by the Quality Matrons and the Falls Lead Practitioner, identifying areas for improvement and shared learning.

SPC Chart 5 identifies that inpatient Falls reported is on a downward trend. The Trust is part of the Regional Falls Group working to share learning and falls prevention strategies.

SPC Chart 5



Graph 4

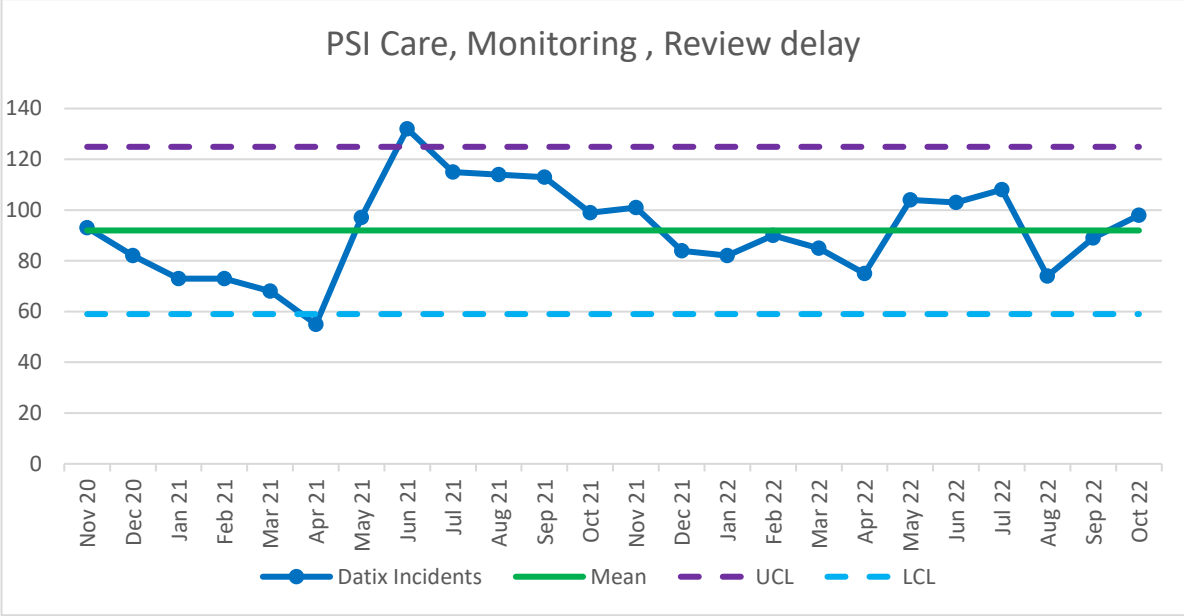


3.6 Care Monitoring Delay

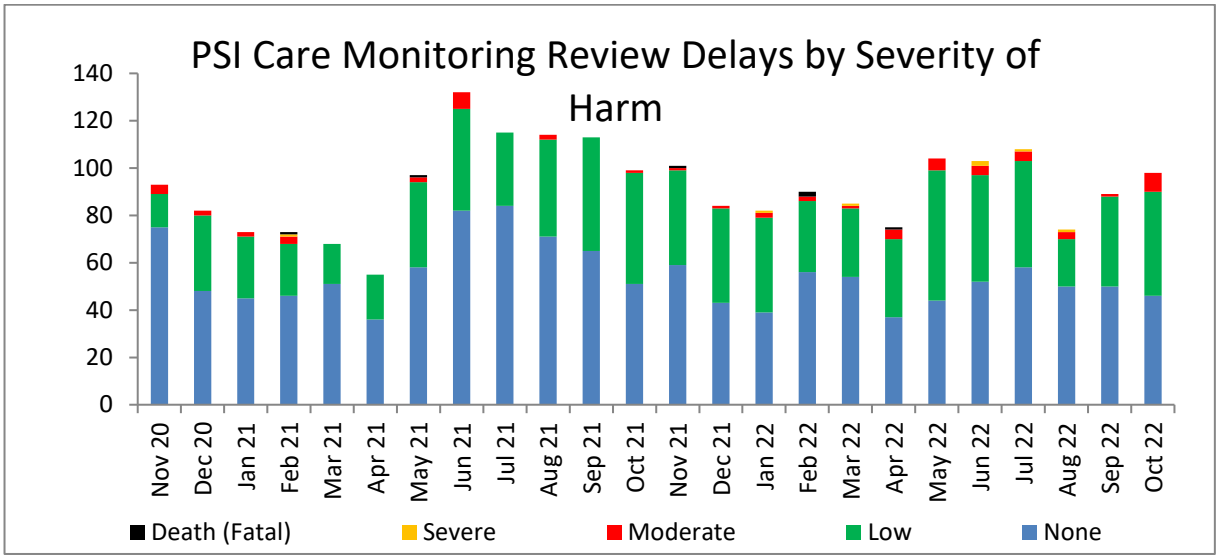
5% of all reported incidents in October (98) were categorised as Care Monitoring Delays. Analysis of this group of datix is complex and identifies a wide range of issues, which relate to delays due to staffing, delays due to lack of beds, delays in escalation, delays in observations. Ongoing work in relation capacity, flow and staffing should help to mitigate harm. SPC Chart 6 demonstrates common cause variation.

Graph 5 identifies 45% of incidents report resulted in low harm to our patients, the harm includes delays in medication, observations, escalation, medical review. In October, 8 incidents resulted in moderate harm and are under review.

SPC Chart 6



Graph 5



4. Incident Management including Serious Incident Management

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

12 new case assessments were reviewed by RALIG during October, Chaired by the Medical Director, resulting in 6 Serious Incident Investigations being commissioned (see appendix 1)

4.2 Nursing Incident Quality Review Meeting (NIQAM)

2 Serious Incident Investigations were commissioned during October relating to 2 falls severe harm (See appendix 1).

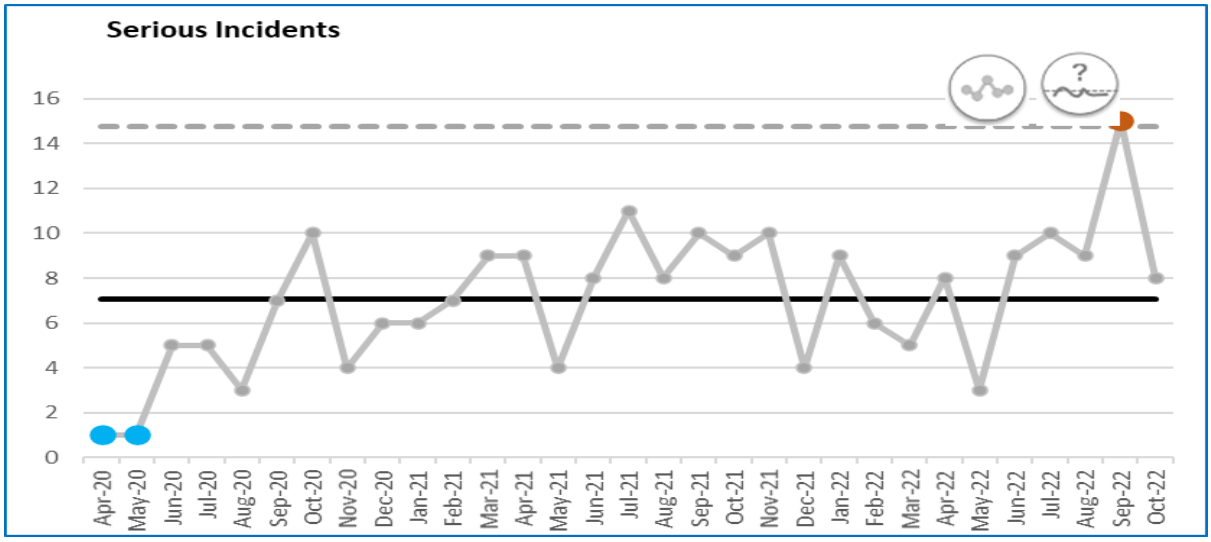
4.3 Maternity

There was 1 serious incident reported for Maternity during October (See appendix 1).

4.4 Serious Incident Reporting Year to Date

At the end of October 2022/2023, the Trust had reported 62 serious incidents.

SPC Chart 7



5. Never Events

There have been no Never Events reported in October 2022.

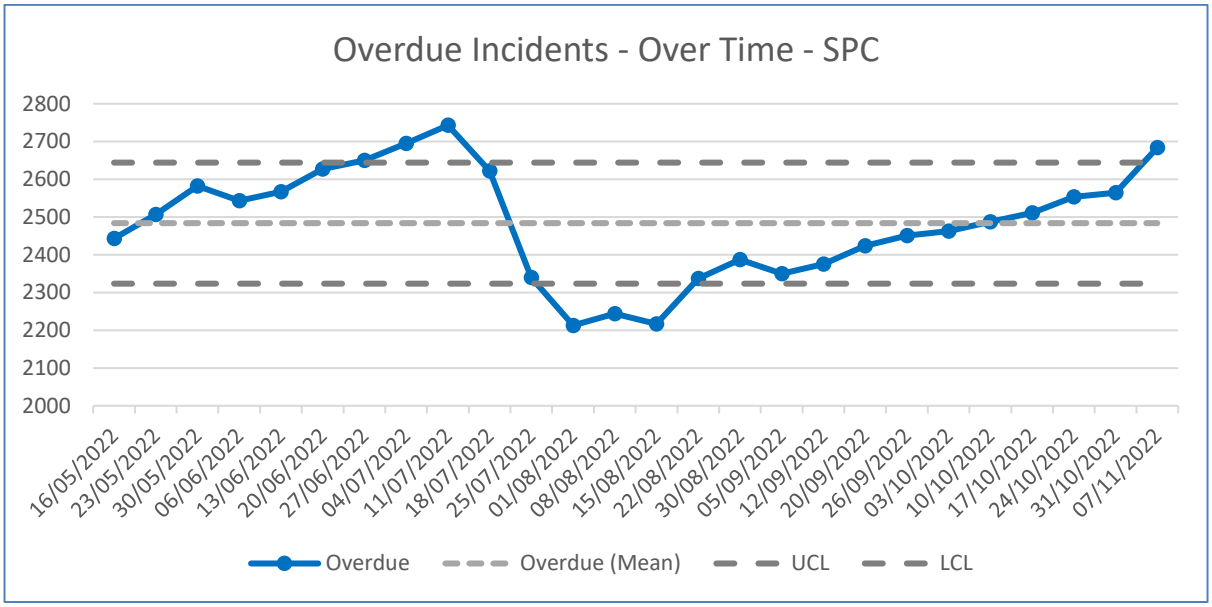
6. Overdue datix overtime

SPC 8 shows that the progress with overdue incidents had improved during July 2022 however the improvement has been difficult to sustain this is largely due to the high numbers of datix submitted within the Emergency Centre. In October the number of overdue datix has exceeded the upper control limit. Work is on-going to continue to review the overdue datix by the Divisions and supported by the Quality Governance team.

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

8. Duty of Candour

There have been no reported breaches in Duty of Candour during October. An internal audit of duty of candour is in progress.

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 - October 2022

A summary of the serious incidents reported in October 2022 is contained Table 1. There were 8 serious incidents reported in October 2022.

Table 1

SI reported October 2022	Number Reported
2022/21082 Fall fracture neck of femur	1
2022/21399 Misdiagnosis	1
2022/21791 Failure to act on CT scan findings	1
2022/22237 Fall fracture neck of femur	1
2022/22648 HIE HSIB	1
2022/22676 Delay in diagnosis	1
2022/22981 Delay in diagnosis	1
2022/22990 Delay in treatment	1
Total	8

3 Closed Serious Incident Investigations – October 2022

SI – Closed - October 2022
2022/13082 Fall Head Injury
2022/16850 Fall Fracture Neck of Femur
2021/21080 Never Event wrong site surgery

Appendix Two

Learning identified from closed incidents in October

Key themes:

• **Problem identified - Lack of one-to-one supervision** • Learning/Action - Review of Enhanced Supervision Policy underway. • Newly appointed Lead Nurse for Enhanced Supervision Team • Recruitment underway to new Enhanced Supervision Team • Further training and awareness of current Enhanced Supervision policy and risk assessment tool
• **Problem identified - Lack of consideration for a hi/lo bed and crash mats** • Learning/Action – review of availability of hi/lo bed completed • Awareness raised within ED for requirement consider hi/lo bed rather than hospital trolley whilst patient awaiting transfer to ward bed.
• **Problem identified – Delay in escalation to orthopaedic team to review x-ray** • Learning/Action - Post falls bundle updated to remind clinical teams to escalate to specialty doctors where the mechanism of injury is great enough to cause harm or the patient exhibits clinical symptoms which may speed up diagnosis and treatment plan.
• **Problem identified – No lifting equipment used to retrieve patient from the floor** • Learning/Action - Clinical teams to ensure they are up to date with the falls protocol in relation to lifting equipment – to be monitored through metric meetings
• **Problem identified – marking of operation site did not follow correct procedure** • Learning/Action - Marking of all sites must follow Trust policy and current NatSSIPS – audited in place and discussed in clinical governance
• **Problem identified – Issues at the start of the booking process** • Learning/Action - Electronic booking forms now amended and checking process now in place to check transcription from booking form to theatre list.

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.