Board of Directors' Meeting
9 February 2023

The Shrewsbury and Telford Hospital NHS Trust

Agenda item	015/23			
Report Title	Incident Overview Report – December 2022 data			
Executive Lead	Hayley Flavell, Director of Nursing and Dr John Jones Executive Medical Director			
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:				
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				
Executive Lead				

1. Introduction

This report highlights the patient safety development and forthcoming actions for February/March 2023 for oversight. It will then give an overview of the top 5 reported incidents during December 2022. Serious Incident reporting for December 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 December 2022 are included along with lessons learned and action taken.

2. Patient Safety Development and Actions planned for February/March 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 December 2022 Patient Safety Incident Reporting

The top 5 patient safety concerns reported via Datix for December are listed below. 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.

3.1 Review of Top 5 Patient Safety Incidents

During December the top 5 reported patient safety incidents are included in 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
Admission of patients The admission of patients remains the top reported incident across the Trust. The 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 and this 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 with System partners. The **"Next Patient"** approach is being utilised on 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 ambulance crews. Each hour, two patients move, predominantly from AMU, but also ED where appropriate to our wards. The moves happen automatically with support from the Divisional leadership teams. There has been an increased use of the discharge lounge during this month.
Bed shortage 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.
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
Inpatient Falls All inpatient falls are reviewed daily by the Quality Matrons and the Falls Lead Practitioner, identifying areas for improvement and shared learning.
Care/monitoring/review delay 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.

4. Incident Management including Serious Incident Management

4.1 Serious Incident Reporting December 2022

There were 7 serious incidents reported during December 2022, See Table 2. 1 of the serious incidents related to Maternity, this was the mismanagement of red blood cells incident detailed below.

Table 2

Clinical Area	**Incident 1**
Classification	Serious Incident
Incident ref. no.	2022/25724
Incident Summary	Omission of Discharge Medication
Immediate Actions Taken	Trust wide comms regarding anticoagulation on discharge summaries issued
Duty of Candour Met	First stage DOC – Yes with patient
Impact on Patient/Family	Readmission and distress caused – support provided
Family involved in investigation	Yes

Clinical Area	**Incident 2**
Classification	Serious Incident
Incident ref. no.	2022/26193
Incident Summary	Tracheostomy Insertion complications
Immediate Actions Taken	LOCSIP updated to include ‘STOP’ prompt
Duty of Candour Met	First stage DOC – Yes with patient and family
Impact on Patient/Family	Distress caused – patient and family supported
Family involved in investigation	Yes

Clinical Area	**Incident 3**
Classification	Serious Incident
Incident ref. no.	2022/26230
Incident Summary	Delayed Treatment deteriorating patient
Immediate Actions Taken	Review and support from the Sepsis Practitioner
Duty of Candour Met	First stage DOC - Y

Impact on Patient/Family	Support provided for the family
Family involved in investigation	Yes

Clinical Area	**Incident 4**
Classification	Serious Incident
Incident ref. no.	2022/26425
Incident Summary	Delayed Treatment
Immediate Actions Taken	Review underway
Duty of Candour Met	First stage DOC – Yes with the family
Impact on Patient/Family	Family supported
Family involved in investigation	Yes

Clinical Area	**Incident 5**
Classification	Serious Incident
Incident ref. no.	2022/26439
Incident Summary	Mismanagement of red cell antibodies
Immediate Actions Taken	Review of guidelines available/RCOG guidelines uploaded to intranet Learning to be shared
Duty of Candour Met	First stage DOC – Yes with the patient
Impact on Patient/Family	Patient supported
Family involved in investigation	Yes

Clinical Area	**Incident 6**
Classification	Serious Incident
Incident ref. no.	2022/26935
Incident Summary	Category 3 Pressure Ulcer
Immediate Actions Taken	Professional Development Nurse supporting with training/education
Duty of Candour Met	First stage DOC – Yes with the family
Impact on Patient/Family	Family happy with care and are supported
Family involved in investigation	Yes

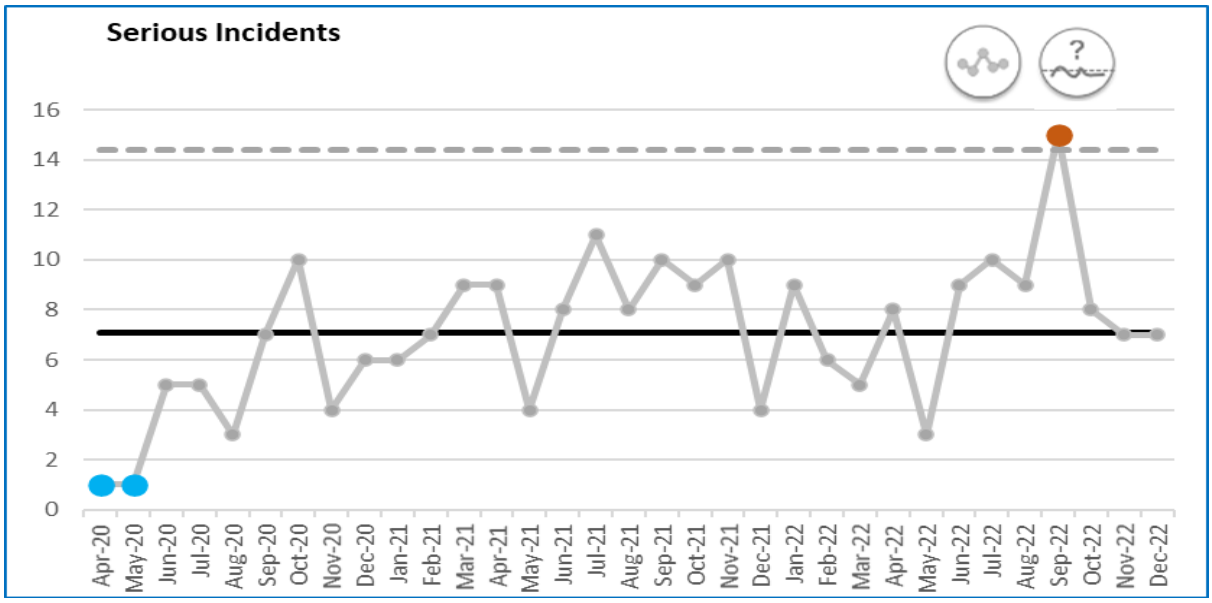
Clinical Area	**Incident 7**
Classification	Serious Incident
Incident ref. no.	2022/26975
Incident Summary	Delayed diagnosis - imaging
Immediate Actions Taken	Escalation lists reviewed. Site code amended.
Duty of Candour Met	First stage DOC – Yes with the patient

Impact on Patient/Family	Distress caused, patient and family supported
Family involved in investigation	Yes

4.4 Serious Incident Reporting Year to Date

At the end of December 2022/2023, the Trust had reported 76 serious incidents.

SPC Chart 1



5. Never Events

There have been no Never Events reported in December 2022.

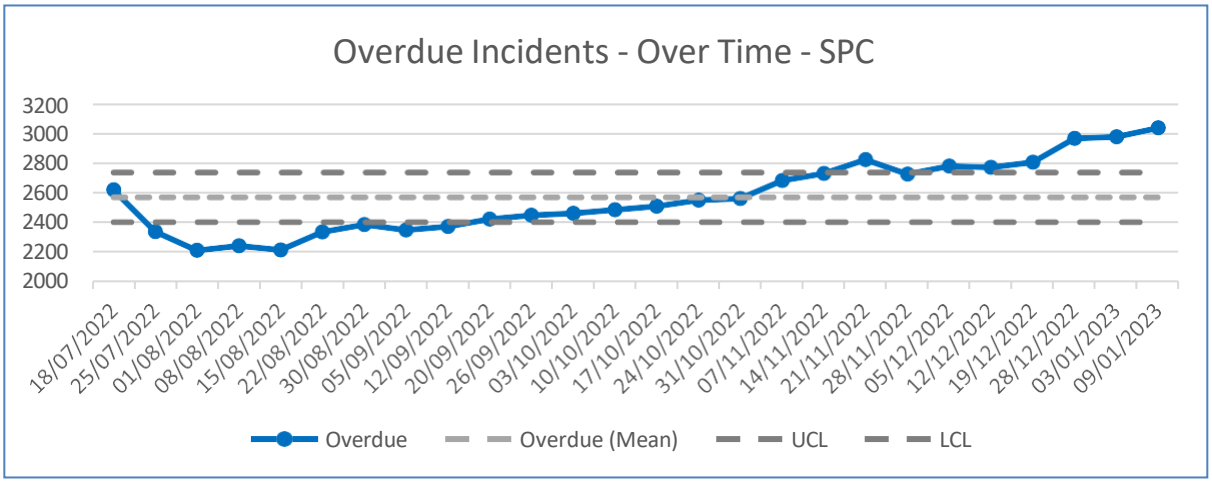
6. Overdue datix overtime

SPC 2 shows that the progress with overdue incidents has been difficult to sustain which is largely due to the high numbers of datix submitted within the Emergency Centre. Work is on-going to continue to review the overdue datix by the Division 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 2



7. Serious Incidents Closed during December - Lessons Learned and Action taken

There were 8 Serious Incidents closed in December. A synopsis of incident and learning is identified below in Table 3.

Table 3

Clinical Area	**Incident 1**
Classification	Serious Incident
Incident ref. no.	2022/20025
Incident Summary	Category 3 Pressure Ulcer
Immediate Actions Taken	Review of plan of care Review of staff compliance with pressure ulcer training Support from Tissue Viability Nurse
Duty of Candour Met	Yes – the family were noted to thank the staff for all the care provided and they had no additional questions.
Impact on patient/family	Prolonged length of stay Patient was very unwell on admission – support and care provided
Investigations findings/actions	• Fall at home resulted in fractured neck of femur which resulted in reduced mobility • general frailty and condition including previous poor skin integrity, history of falls and poor nutritional state meant a higher risk of developing a pressure ulcer. • Nurse staffing levels were variable • Inconsistent use of the assessment tool within the SSKIN booklet. **Actions taken** • Additional face to face training provided in recognising and management pressure ulcers • Monitoring process now in place for high-risk patients by the ward manager • Increased awareness of requirement to refer to Tissue Viability Service

Clinical Area	**Incident 2**
Classification	Serious Incident
Incident ref. no.	2022/19676
Incident Summary	Fall resulting in skull fracture
Immediate Actions Taken	Falls debrief/review undertaken
Duty of Candour Met	Y – all stages completed, and report shared.
Impact on patient/family	Conservative treatment provided. The patient experienced increased pain and discomfort because of the fall and a prolonged length of stay in hospital.
Investigations findings/actions	• The patient had intermittent leg weakness and fluctuating mobility • Risk assessments did not accurately assess the risk of falls due to fluctuating mobility **Action taken** • Additional falls prevention training and support provided and

	monitored through the quality team • High risk patients now noted in the safety huddle daily • Monitoring of risk assessment completion undertaken by ward manager and matron

Clinical Area	**Incident 3**
Classification	Serious Incident
Incident ref. no.	2022/16860
Incident Summary	Delay in Escalation of deterioration
Immediate Actions Taken	Review of process of escalation within the Division undertaken
Duty of Candour Met	Yes, all stages completed and report shared
Impact on patient/family	Support and care provided for patient and family
Investigations findings/actions	• There were missed opportunities to recognise deterioration and Sepsis • Issues with handover of care which had an impact on continuity of care **Action taken** • Escalation of care chart reviewed and amended making it easier to navigate • Transfer policy updated • Overarching review of deteriorating patient and handovers in progress supported by Human Factors Team

Clinical Area	**Incident 4**
Classification	Serious Incident
Incident ref. no.	2022/16687
Incident Summary	Delay in treatment
Immediate Actions Taken	Safety net put in place Additional training Triage process poster now in clinical room A review of all previous patients was undertaken to ensure this was an isolated case
Duty of Candour Met	Yes, all stages fully completed, and report shared.
Impact on patient/family	Due to delay in treatment, there was a rapid deterioration of the patient's vision.
Investigations findings/actions	• Referral appointment for treatment not made • Delay in treatment of 4months • Paper based system in use with no safety net • Incorrect triage code used • Referral sent to wrong bookings team **Action taken** • A referral template has been reviewed and amended

	• Electronic record for tracking referrals is now in place • SOP now in place to describe the process of referrals

Clinical Area	**Incident 5**
Classification	Serious Incident
Incident ref. no.	2022/12485
Incident Summary	Delayed Diagnosis
Immediate Actions Taken	Round table review of the case
Duty of Candour Met	Yes, all stages completed and report and outcome shared
Impact on patient/family	Potential delay in diagnosis resulting in pain and distress
Investigations findings/actions	• Delay in review • The investigation found that the delay was relatively short and subsequent care and management was appropriate therefore a downgrade from serious incident was agreed by the ICB Quality Team. Learning points were identified and action taken as below **Action taken** • Case to be used for teaching in relation to diagnosis of this rare condition

Clinical Area	**Incident 6**
Classification	Serious Incident
Incident ref. no.	2022/10684
Incident Summary	Diagnostic Incident
Immediate Actions Taken	All results and MDT referrals now communicated electronically. Tracking system now in place electronically as a safety net.
Duty of Candour Met	Yes, all stages met
Impact on patient/family	Distress caused due to a delay in identifying a progression of disease.
Investigations findings/actions	• Delay in surveillance scan due to COVID pandemic. • Failure of administrative systems – and complex mixture of paper based and electronic records. **Action taken** • Work ongoing to improve the safety and reliability of the Trust patient record systems which include the Digital Transformation Programme. • Patient Safety Specialist mapping the current complex and variable systems. • This case to be used as a patient story to share learning

Clinical Area	**Incident 7**
Classification	Serious Incident
Incident ref. no.	2022/8466
Incident Summary	Suboptimal care
Immediate Actions Taken	Fluid balance and escalation protocols immediately revisited.
Duty of Candour Met	Yes, all stages completed, and report shared.
Impact on patient/family	Patient and family supported
Investigations findings/actions	• Delay in escalation of deterioration **Action taken** • Review of understanding of fluid management and further training on fluid balance recording • Trigger point for escalation for patients for renal review shared.

Clinical Area	**Incident 8**
Classification	Serious Incident
Incident ref. no.	2022/5233

Incident Summary	Suboptimal Care
Immediate Actions Taken	Focused review of areas of concerns Sepsis screen now on vitalpac in line with the rest of the Trust
Duty of Candour Met	Yes, all stages met, and report shared.
Impact on patient/family	Support provided for the family
Investigations findings/actions	• There was a delay in recognition of sepsis • Delay in diagnosis resulted in a delay in treatment with antibiotics **Action taken** • Sepsis education and deteriorating patient recognition and escalation

8. Themes identified from closed serious incidents

- Identification and escalation of deteriorating patient
- Administrative processes – paper-based v electronic processes

The two themes identified are currently key priorities for the Trust with improvement work underway.

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 Division.