The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
13 April 2023

Agenda item		041/23		
Report Title		Incident Overview Report		
Executive Lead		Hayley Flavell, Director of Nursing		
Report Author		Peter Jeffries, Patient Safety Specialist		
CQC Domain:		**Link to Strategic Goal:**		**Link to BAF / risk:**
Safe	√	Our patients and community	√	BAF1, BAF2, BAF4, BAF7, BAF8, BAF9
Effective		Our people		
Caring		Our service delivery		**Trust Risk Register id:**
Responsive		Our governance	√	328/1353
Well Led		Our partners		
Consultation Communication		Quality Operational Committee – 21 March 2023 Quality and Safety Assurance Committee – 29 March 2023		
Executive summary:		1. The Board's attention is drawn to section: **6** – relating to overdue incident reports which have shown improvement **8 and 9** – outlining the themes and trend identified from serious incidents raised and closed in February 2023		
Recommendations for the Board:		The Board is asked to: **Note** the issues highlighted, particularly with regard to the cluster of incidents related to testicular torsion and take **assurance** from the mitigations being put in place to reduce the risk of further incidents.		
Appendices:		N/A		

1. Introduction

This report highlights the patient safety development and forthcoming actions for March/April 2023 for oversight. It will then give an overview of the top 5 reported incidents during February 2023. Serious Incident reporting for February 2023 and also rates year to date are highlighted. Further detail of the number and themes of newly reported Serious Incidents and those closed during February 2023 are included along with lessons learned and action taken.

2. Patient Safety Development and Actions planned for March/April 2022/23

- Continue to 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.

3. Analysis of February 2022 Patient Safety Incident Reporting

The top 5 patient safety concerns reported via Datix for February 2023 are listed below. Any deviation in reporting, outside that which could be reasonably be expected, is analysed to provide early identification of a potential issue or assurance that any risks are appropriately mitigated.

3.1 Review of Top 5 Patient Safety Incidents

During February 2023, 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. Significant work is beginning undertaken under the banner of the Trust's Flow programme to improve flow through and movement of patients from the ED setting. The Acute Floor configuration is in place at RSH to support flow and timely review of medical patients.
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 February 2023

There were 10 serious incidents reported during February 2023, See Table 2. 1 of the serious incidents related to Maternity.

Table 2

Clinical Area	**Incident 1**
Classification	Serious Incident
Incident ref. no.	2023/2458
Incident Summary	Delay in treatment – ENT
Immediate Actions Taken	No immediate actions identified
Duty of Candour Met	First stage DOC: Yes – by clinical team with patient and family
Impact on Patient/Family	Potential further surgical intervention
Family involved in investigation	Yes

Clinical Area	**Incident 2**
Classification	Serious Incident
Incident ref. no.	2023/2606
Incident Summary	Maternity Obstetric affecting mother
Immediate Actions Taken	Learning on escalation fed into safety huddles
Duty of Candour Met	First stage DOC: Yes – by clinical team with mother and follow up meeting to confirm investigation
Impact on Patient/Family	Distress caused – support given
Family involved in investigation	Yes – patient involved

Clinical Area	**Incident 3**
Classification	Serious Incident
Incident ref. no.	2023/2769

Incident Summary	Fall Head Injury
Immediate Actions Taken	Feedback via ward huddle
Duty of Candour Met	First stage DOC: Yes – by clinical team with patient
Impact on Patient/Family	Distress and further imaging investigation
Family involved in investigation	Patient/family have declined further involvement

Clinical Area	**Incident 4**
Classification	Serious Incident
Incident ref. no.	2023/2947
Incident Summary	Cat 3 pressure ulcer
Immediate Actions Taken	Confirmed with ward staff how to obtain spinal bed Huddles utilised to emphasise repositioning frequency
Duty of Candour Met	First stage DOC: Yes – by ward manager with patient and family
Impact on Patient/Family	Distress -support given
Family involved in investigation	Yes- patient and daughter have requested ongoing updates

Clinical Area	**Incident 5**
Classification	Serious Incident
Incident ref. no.	2023/3153
Incident Summary	Fall fractured NOF
Immediate Actions Taken	Risk assessment updated for patient Quality matron has reminded medical team of need for CT head post falls
Duty of Candour Met	First stage DOC: Yes – by ward manager with family
Impact on Patient/Family	Distress – patient received full support
Family involved in investigation	Yes – family has asked to receive final report

Clinical Area	**Incident 6**
Classification	Serious Incident
Incident ref. no.	2023/3484
Incident Summary	Delay in diagnosis and treatment
Immediate Actions Taken	No actions identified (pending further investigation)
Duty of Candour Met	Yes – First stage DOC undertaken with family
Impact on Patient/Family	Patient passed away; support offered to family via consultant.

Family involved in investigation	Meeting with family being held first week in April to agree level of involvement.

Clinical Area	**Incident 7**
Classification	Serious Incident
Incident ref. no.	2023/3442
Incident Summary	Fall with head injury
Immediate Actions Taken	None immediately identified
Duty of Candour Met	Yes – clinical team with patient but will be reattempted pending full capacity.
Impact on Patient/Family	Patient support, transfer to rehabilitation following head injury
Family involved in investigation	No identified NOK

Clinical Area	**Incident 8**
Classification	Serious Incident
Incident ref. no.	2023/3790
Incident Summary	Cat 3 pressure ulcer
Immediate Actions Taken	Immediate escalation of pressure area care with support of TVN
Duty of Candour Met	First stage DOC: Yes – by quality governance team with family
Impact on Patient/Family	Distress support offered
Family involved in investigation	Family has asked to be kept informed of progress of investigation.

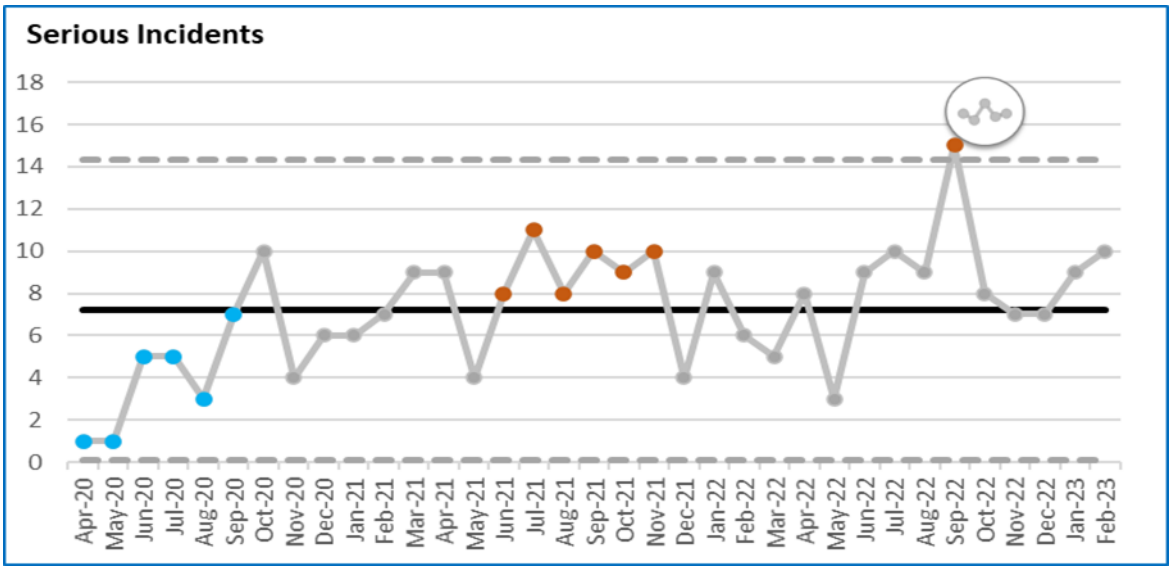
Clinical Area	**Incident 9**
Classification	Serious Incident
Incident ref. no.	2023/3964
Incident Summary	Delay in diagnosis of testicular torsion
Immediate Actions Taken	Work being undertaken to clarify torsion pathway/ongoing educational work to inform identification of potential torsion/referral from triage to surgical team initiated based on suspicion of torsion.
Duty of Candour Met	First stage DOC: Yes – by ward manager with family
Impact on Patient/Family	Distress -support offered
Family involved in investigation	Yes

Clinical Area	**Incident 10**
Classification	Serious Incident
Incident ref. no.	2023/4147
Incident Summary	Delay in diagnosis of testicular torsion
Immediate Actions Taken	Work being undertaken to clarify torsion pathway/ongoing educational work to inform identification of potential torsion/referral from triage to surgical team initiated based on suspicion of torsion.
Duty of Candour Met	First stage DOC: Yes – by quality governance team with family
Impact on Patient/Family	Distress -support given
Family involved in investigation	Yes – ongoing contact agreed

4.4 Serious Incident Reporting Year to Date

At the end of February 2023, the Trust had reported 95 serious incidents. After special cause variation in September 2022, serious incidents have returned to common cause variation.

SPC Chart 1



5. Never Events

There have been no Never Events reported in February 2023.

6. Overdue Datix

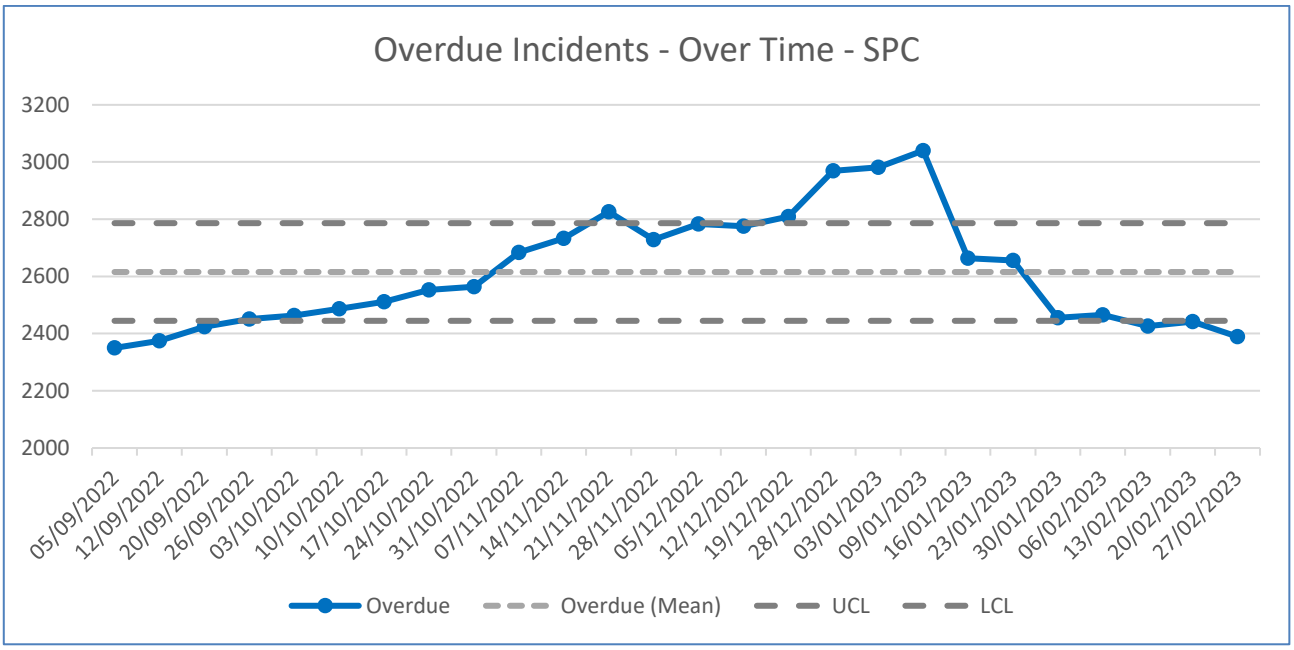
SPC 2 shows that concentrated work within the emergency and neonatal centres particularly had begun to reduce numbers of overdue datix reports. Work is on-going to continue to review the overdue datix by the Division and supported by the Quality Governance team.

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 February 2023 - Lessons Learned and Action taken

There was 1 Serious Incident closed in February 2023. A synopsis of the incident and learning is identified below in Table 3.

Table 3

Clinical Area	**Incident 1**
Classification	Serious Incident
Incident ref. no.	2022/11678
Incident Summary	Category 3 Pressure Ulcer
Immediate Actions Taken	Review of plan of care Review staff compliance with skin management TVN involvement with planned wound care support
Duty of Candour Met	Yes, all stages completed, and report shared
Impact on patient/family	Extended length of stay
Investigations findings/actions	• Staffing challenges noted (up to 50% backfill with temporary staff) impacting effective communication • Challenges with staff able to access relevant training linked to above • Lack of understanding of the use of the skin assessment booklet rather than using the nursing notes **Actions taken** • Ward development and engagement with Stop the Pressure to support Learning Made Simple (skin module) • Increase base level of training target 100% within identified timescale (increase from 10% to 45% by

	the time the report was completed). SSKIN booklets to be available to all staff and encouraged to utilise. • Additional face to face training providing skin assessment and management • Handover being monitored by Ward Manager and Band 6's to ensure effective communication maintained • Block booking of staff encouraged to promote improved communication. • Staff recruitment and retention is being supported/ managed corporately

8. Themes identified from closed serious incidents

Themes from the closed SI relating to a pressure ulcer have been incorporated into ongoing improvement work supported by TVN and the Quality Matron teams.

9. Themes identified by serious incidents raised in February 2023

Themes identified by the serious incidents raised in February 2023 include:

Management of emergency presentation of torsion of the testes: Four serious incidents have now been raised relating to torsion of the testes. Three relate to the emergency pathway and as this report was being written work was nearing completion on a revised torsion pathway based on the learning from the incidents previously investigated. Initial educational work to support nursing and junior medical staff to explore torsion as a potential diagnosis when children/young men present with abdominal pain has been undertaken. Once all four investigations have been completed a grouped review will take place to ensure all appropriate actions have been identified.

Falls: Learning from falls continues to inform the overarching Trust falls improvement plan

Deterioration: Serious incidents relating to deterioration are being reviewed at the Deteriorating Patient Committee and used to inform the deteriorating patient action plan.