The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
8 June 2023

Agenda item		073/23		
Report Title		Incident Overview Report		
Executive Lead		Hayley Flavell, Executive 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 – 16th May 2023 Quality and Safety Assurance Committee – 31st May 2023		
Executive summary:		1. The Board's attention is drawn to sections: **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 April 2023		
Recommendations for the Board:		The Board is asked to: **Note** the issues highlighted		
Appendices:		N/A		

1. Introduction

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

2. Patient Safety Development and Actions planned for May/June 2023/24

- Continue to work with the National and Regional teams 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. Information gathered in the diagnostic and discovery phase is being fed to three working groups (including external partners, patients and other community members) who will undertake further, more detailed planning, which will feed into the initial view of the Trusts Patient Safety Incident Response Plan.
- A plan is in place to co-ordinate the work to allow the Trust to be connected to the new Learning from Patient Safety Events system (via Datix our local incident reporting management system).During mid-May to early June an intensive series of workshops are being held to understand the impact of the new mandatory fields on the Datix form staff open when reporting an incident. This work will in turn inform a roll out and training plan to support implementation of the new system.

3. 2023 Patient Safety Incident Reporting

The top five patient safety concerns reported via Datix for March and April 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 March and April 2023, the top five reported patient safety incidents are outlined in Table 1. There has been an ongoing increase in capacity related incidents (as shown by the bed shortage and admission of patient's categories) reported which reflects the capacity and patient flow challenges faced by the Trust.

The top five 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
Pressure ulcer/skin damage
There is an overarching pressure ulcer prevention plan which includes actions from previous RCA/SI investigations, and this continues to be implemented across all divisions.
All RN staff are completing the mandatory tissue viability training and compliance with training is monitored via the monthly nursing quality metrics meetings.

Spot checks by ward managers and matrons are undertaken to ensure Waterlow assessments are accurately completed and that the prevention actions implemented via care plans continue to be implemented.

Targeted additional education and support is being provided by the tissue viability team for wards with increased numbers of pressure ulcers.

Inpatient Falls

A yellow falls blanket to highlight falls risk being trialled in ED. A Yellow tabard for co-horting being trialled on medical wards. Specific targeted support from the Falls Practitioner has been made available for ward 17 at PRH following an increase in falls in April.

Overall falls numbers have not significantly increased but number of falls with harm did increase during April with five serious incidents being raised relating to falls with fractures.

Work continues to deliver the ongoing falls improvement plan.

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.

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 and this reflects the significant and ongoing pressure within the Emergency Department and capacity concerns within the Trust.

Significant work is being 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.

Communication problem between staff, teams, depts

There is no clear trend or pattern across the incident reports which cover a wide variety of issues across the theme of communication between teams.

4. Incident Management including Serious Incident Management

4.1 Serious Incident Reporting March and April 2023

There were 11 serious incidents reported in March 2023, see table 2

Table 2

Incident 1	
Classification	Inappropriate transfer
Incident ref. no.	2022/4654
Incident Summary	Concerns around method of transport of a patient between PRH and RSH
Immediate Actions Taken	Nurses and co-ordinators to be reminded of Ezec threshold for patient transfers.

	Transport Policy to be urgently reviewed and monitored at RALIG
Duty of Candour Met	Yes
Impact on Patient/Family	Patient passed away
Patient/Family involved in investigation	Yes

Incident 2	
Classification	Delay in diagnosis and treatment
Incident ref. no.	2023/5111
Incident Summary	Delay in review and treatment after a GP referral for abnormal blood test results
Immediate Actions Taken	None
Duty of Candour Met	Yes
Impact on Patient/Family	Patient passed away
Patient/Family involved in investigation	Yes

Incident 3	
Classification	Delay in diagnosis and treatment
Incident ref. no.	2023/5116
Incident Summary	Delay in sending bloods and starting treatment
Immediate Actions Taken	Staffing and standard operating procedure for admission to area reviewed
Duty of Candour Met	Yes
Impact on Patient/Family	Patient passed away
Patient/Family involved in investigation	Yes

Incident 4	
Classification	Delay in sepsis treatment
Incident ref. no.	2023/5119
Incident Summary	Potential delay in sepsis treatment for a child admitted as an emergency
Immediate Actions Taken	
Duty of Candour Met	Yes
Impact on Patient/Family	Patient passed away

Patient/Family involved in investigation	Yes

Incident 5	
Classification	Fall
Incident ref. no.	2023/5220
Incident Summary	Fall with fractured neck of femur
Immediate Actions Taken	Ward manager reviewed bedrail usage with confused patients as per Trust policy in huddles and via email communication
Duty of Candour Met	Yes
Impact on Patient/Family	Conservative management of fracture
Patient/Family involved in investigation	Yes

Incident 6	
Classification	Fall
Incident ref. no.	2023/5664
Incident Summary	Fall with fractured neck of femur
Immediate Actions Taken	Lead clinical nurse specialist asked to inform all clinical nurse specialists of the process they must take following a fall
Duty of Candour Met	Yes
Impact on Patient/Family	Fracture requiring surgical intervention
Patient/Family involved in investigation	Yes

Incident 7	
Classification	Delay in treatment
Incident ref. no.	2023/5691
Incident Summary	Potential delay to treatment of rare condition for patient presenting as an emergency
Immediate Actions Taken	Support for staff Awareness raising with medical teams of this rare condition
Duty of Candour Met	Yes
Impact on Patient/Family	Patient passed away
Patient/Family involved in investigation	Yes

Incident 8	
Classification	Delay in diagnosis and treatment
Incident ref. no.	2023/5665
Incident Summary	Concerns relating to potential missed myocardial infarction
Immediate Actions Taken	ED message of the week focussed on process for review of electrocardiograms (ECG's)
Duty of Candour Met	Yes
Impact on Patient/Family	Patient passed away
Patient/Family involved in investigation	Yes

Incident 9	
Classification	Concerns relating to diagnosis and treatment
Incident ref. no.	2023/6200
Incident Summary	Potential delays to initiation of timely treatment for sepsis
Immediate Actions Taken	None
Duty of Candour Met	Yes
Impact on Patient/Family	Patient passed away
Patient/Family involved in investigation	Yes

Incident 10	
Classification	Delay in diagnosis and treatment
Incident ref. no.	2022/6272
Incident Summary	Potential missed spine fracture
Immediate Actions Taken	Patients seen by junior doctors who are being referred to frailty, must be reviewed by a senior clinician prior to referral
Duty of Candour Met	Yes
Impact on Patient/Family	Yes
Patient/Family involved in investigation	Yes

Incident 11	
Classification	Category 4 pressure ulcer
Incident ref. no.	2023/6433
Incident Summary	Category 4 pressure ulcer

Immediate Actions Taken	Actions relating to risk assessments, pressure prevention and correct reporting on the Datix system implemented
Duty of Candour Met	Yes
Impact on Patient/Family	Yes
Patient/Family involved in investigation	Yes

There were 10 serious incidents reported during April 2023, See Table 3.

Table 3

Incident 1	
Classification	Psychological harm
Incident ref. no.	2023/7319
Incident Summary	Psychological harm caused by a procedure including issues around pain control, preparation and consent
Immediate Actions Taken	Alternative analgesia for the procedure is being explored
Duty of Candour Met	Yes
Impact on Patient/Family	Impact on mental well being
Patient/Family involved in investigation	Yes

Incident 2	
Classification	Delay in diagnosis and treatment
Incident ref. no.	2023/7235
Incident Summary	Long wait for a procedure, this delay leading to harm
Immediate Actions Taken	Further review of waiting list and options for reducing wait times is being undertaken
Duty of Candour Met	Yes
Impact on Patient/Family	Long wait potentially added to the progress of disease
Patient/Family involved in investigation	Yes

Incident 3	
Classification	Fall with fractured neck of femur
Incident ref. no.	2023/7293
Incident Summary	Unwitnessed fall on ward as patient mobilised
Immediate Actions Taken	Feedback via ward huddles in relation to escalation of pain issues to medical team
Duty of Candour Met	Yes
Impact on Patient/Family	Fracture of femur requiring surgical intervention

Patient/Family involved in investigation	Yes

Incident 4	
Classification	Delay in surveillance investigation
Incident ref. no.	2023/8109
Incident Summary	Due to services being stood down during Covid a surveillance investigation was not undertaken within the requested timeframe. Potential to undergo earlier treatment for a tumour was lost.
Immediate Actions Taken	Ongoing development of a business case for additional resource to address current backlog.
Duty of Candour Met	Yes
Impact on Patient/Family	Distress/potential impact on overall prognosis
Patient/Family involved in investigation	Yes

Incident 5	
Classification	Delay in surveillance investigation
Incident ref. no.	2023/8112
Incident Summary	Due to services being stood down during Covid a surveillance investigation was not undertaken within the requested timeframe. Potential to undergo earlier treatment for a tumour was lost.
Immediate Actions Taken	Ongoing development of a business case for additional resource to address current backlog.
Duty of Candour Met	Yes
Impact on Patient/Family	Distress/potential impact on overall prognosis
Family involved in investigation	Yes

Incident 6	
Classification	Failure to recognise and react to abnormal test results
Incident ref. no.	2023/8167
Incident Summary	A blood result was missed in terms of medical review which could potentially have prompted more immediate treatment or changes in decisions on treatment.
Immediate Actions Taken	Process for oversight and sign off of results has been reviewed. Communication via staff huddles relating to blood results and highlighting to medical teams.
Duty of Candour Met	Yes

Impact on Patient/Family	Patient RIP
Patient/Family involved in investigation	Yes

Incident 7	
Classification	Fall with fractured neck of femur
Incident ref. no.	2023/8344
Incident Summary	Witnessed fall as patient mobilised
Immediate Actions Taken	Crash mats placed on both sides of bed
Duty of Candour Met	Yes
Impact on Patient/Family	Fracture requiring surgical intervention
Patient/Family involved in investigation	Yes

Incident 8	
Classification	Fall with fractured neck of femur
Incident ref. no.	2023/8375
Incident Summary	Unwitnessed fall when mobilising to bathroom
Immediate Actions Taken	Feedback on immediate escalation to medical team via ward huddles
Duty of Candour Met	Yes
Impact on Patient/Family	Fracture requiring surgical intervention after medical optimisation.
Patient/Family involved in investigation	Yes

Incident 9	
Classification	Fall with fractured neck of femur
Incident ref. no.	2023/8582
Incident Summary	Unwitnessed fall as patient climbed from bed
Immediate Actions Taken	Feedback to staff on Datix reporting process and involvement of quality team post falls. Head of Nursing scoping options for providing EPS in emergency settings.
Duty of Candour Met	Yes

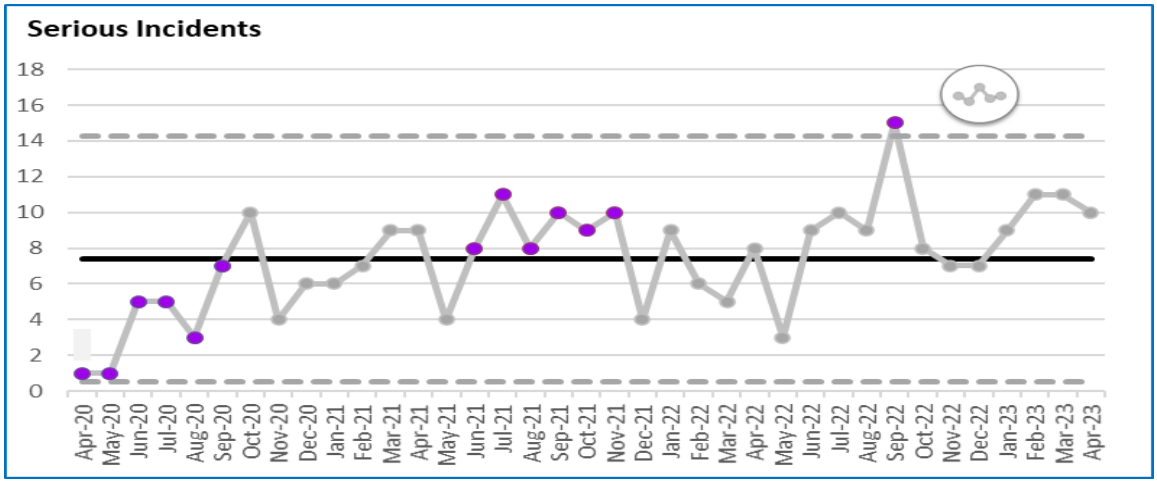
Impact on Patient/Family	Fracture requiring surgical intervention
Patient/Family involved in investigation	Yes

Incident 10	
Classification	Slip with fractured neck of femur
Incident ref. no.	2023/8754
Incident Summary	A patient who had been aggressive and violent and the security guards who were safe holding the patient sipped on a wet floor resulting in the patient fracturing their femur
Immediate Actions Taken	None identified
Duty of Candour Met	Yes
Impact on Patient/Family	Fracture requiring surgical intervention
Patient/Family involved in investigation	Patient currently not responding to attempts to contact

4.4 Serious Incident Reporting Year to Date

In March 2023 the Trust reported 11 serious incidents. At the end of April 2023, the Trust had reported 10 serious incidents for financial year 2023/24. 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 March and April 2023.

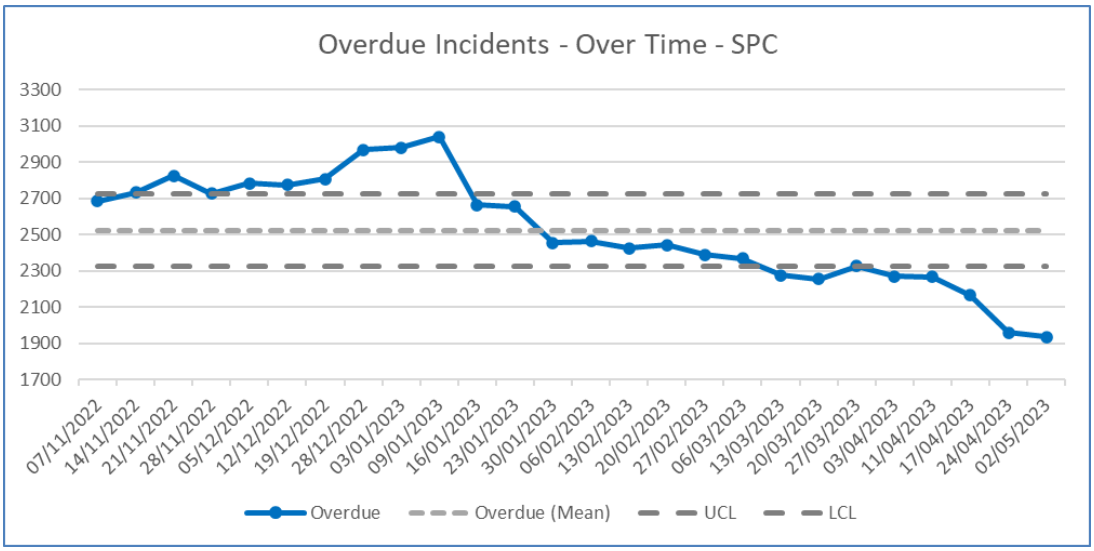
6. Overdue Datix

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, Emergency Department weekly incident review.

SPC Chart 2



7. Serious Incidents Closed during April 2023 - Lessons Learned and Action taken

There were nine Serious Incidents closed in March 2023. A synopsis of the incident and learning is identified below in Table 4

Three of the incidents ae linked to the paediatric thematic review. These have been grouped and the overarching recommendations and link to the paediatric transformation programme outlined.

Table 4

Incident 1	
Classification	Delayed diagnosis
Incident ref. no.	2022/12302
Incident Summary	Potential missed diagnosis of spinal fracture
Duty of Candour Met	Yes
Investigations findings/actions	**Findings:** A C-spine fracture was not missed in CT A T-12 fracture was missed on CT **Actions taken:** Trust wide communication to all clinical staff to remind them to keep their patients at the centre of decision-making process and informed of plans. Documentation -consider structured ward template with prompts to improve consistency.

	For a Trust wide lead to be appointed for ReSPECT. Trust wide communication regarding ReSPECT discussions and documentation. Review admission booklet regarding the volume of information/ paperwork Handover information has been further developed since this incident as part of the transfer process from ED to the ward. This should be re-communicated in huddles for ED across sites. Quality team to regularly highlight the importance of fluid balance charts being completed in full in the ED's. As part of induction training for new ED staff there is a session on fluid balance charts.

Incident 2	
Classification	Lost to follow up
Incident ref. no.	2022/26425
Incident Summary	Patient lost to follow up resulting in surgery not being undertaken in line with treatment plan
Duty of Candour Met	Yes
Investigations findings/actions	**Findings:** Patient was lost to follow up Patient was removed from the Somerset Cancer Database before he should have been. There was no mechanism for flagging when a scan is available to view that has come from a tertiary hospital at the time of the incident. The CT finding in December 2016 were not followed up **Actions taken:**

	Secretaries to email relevant specialties when referrals are made All Cancer Services Tracking Guides are being updated Establish launch date for CareFlow and check referral process

Incident 3	
Classification	Testicular Torsion
Incident ref. no.	2022/24214
Incident Summary	Pathway for testicular pain not followed appropriately
Duty of Candour Met	Yes
Investigations findings/actions	**Findings:** Appropriate questions were not asked at triage The existing Trust pathway for testicular pain was not followed Trust pathway for pain management was not followed appropriately **Actions:** Following MDT discussions, a new testicular pain pathway to be developed from ED triage. Torsion information to be shared in the RN huddle and weekly message to nursing staff. 1 hour teaching session for Junior ED Doctors on testicular torsion Create bite sized training videos to capture medics and put these on the intranet Appoint a GP lead within the ED Review adopting the RCEM best practice pain guideline at ED Clinical Governance.

Incident 4	
Classification	Screening incident
Incident ref. no.	2022/12527
Incident Summary	Multiple false positive test results

Duty of Candour Met	Yes
Investigations findings/actions	**Findings:** Procedures not following guidance, leading to contamination of samples High staff turnover impacted on the incident as a result of issues maintaining training **Actions:** The Gynaecology Department have made changes to their guidelines on the management of results. The Microbiology Department have updated their labelling to tubes and lids of the contents of tip boxes and staff have been updated and advised accordingly. The Pathology Centre now have a Quality and Health & Safety Manager in post New equipment has been brought in to improve the method of analysing chlamydia samples which reduces the risk of contamination.

Incident 5	
Classification	Never Event
Incident ref. no.	2022/24259
Incident Summary	Wrong side insertion of a chest drain
Duty of Candour Met	Yes
Investigations findings/actions	**Findings:** Primary beam markers not used to mark a chest x-ray X-ray incorrectly labelled with side markers Given the incorrectly marked x-ray I was very unlikely there were missed opportunities for the ED team to recognise they were inserting a chest drain on the wrong side **Actions:** Ongoing audit of the use of primary beam markers.

	Human factors review to assess ways of maintaining use of primary beam markers Chest drain packs available in ED include the checklist Ambulance information to available for ED team members (for review alongside other clinical information) Learning from this incident to be presented at Infection Prevention and Control Committee Discussion regarding current processes to review IPC Covid Guidance

Incident 6	
Classification	Never event
Incident ref. no.	2023/817
Incident Summary	Retained equipment following procedure
Duty of Candour Met	Yes
Investigations findings/actions	**Findings** When the piece of equipment was thought to be lost, the correct procedure, as per the Trust's theatre count policy, was not adhered to The specific part of the equipment can be manipulated by surgeons but is not expected to break User technique was not considered an issue in this case. **Actions** Review to be undertaken by manufacturers rep to ensure equipment is being used correctly by surgeons Alternative equipment to be trialled Further user and decontamination training to be put in place Communication, LMS training package and induction training relating to the 5 safer steps

Incidents forming the Paediatric Thematic Review:

Incident 7/8/9	
Classification	Inpatient child deaths
Incident ref. no.	2022/9029, 2022/18829, 2022/23669
Incident Summary	Safety concerns relating to three medically complex children cared for as inpatients.
Duty of Candour Met	Yes
Investigations findings/recommendations	All three incidents were subject to serious incident investigations with common key lines of enquiry and overarching safety recommendations across each report which in turn were outlined in the paediatric thematic review. The overarching findings and recommendations were focussed around the following areas: The care of looked after children The pathway for admission of unwell children through the emergency department and children's admission unit Recognition and management of the deteriorating child Management of blood test results to inform clinical care The frequency and process of clinical review (including the use of clinical information) Escalation pathways and communication with external teams (such as the KIDS service from Birmingham Women's and Children's hospital) Escalation of ward staffing and acuity Governance processes within paediatrics The Medical Director and Director of Nursing have agreed these recommendations will form the basis of the paediatric transformation programme which will be overseen by a committee (Paediatric Transformation Assurance Committee) chaired by the medical director. The paediatric transformation programme will be modelled on the existing maternity transformation programme and utilise the same agile programme methodology with reporting through Quality

	Operational Committee and Quality and Safety Assurance Committee to Board.

There were five Serious Incidents closed by in April 2023. A synopsis of the incident and learning is identified below in Table 5.

Table 5

Incident 1	
Classification	Discharge and medication issues
Incident ref. no.	2022/25724
Incident Summary	Unsafe discharge from ward with medication omitted
Duty of Candour Met	Yes, all stages completed, and report shared
Investigations findings/actions	**Findings:** Aspects of the discharge process were sub-optimal**.** **Actions taken:** Raise awareness of Transfer of Care Around Medicines (TCAMS) if it is felt a patient could require further support and counselling on the management of their medications following discharge. Carry out a review safety netting advice provided to patients being discharged from ward using existing examples in use at SATH. Awareness raising of the implication of the conditions this patient had with clinical teams Share learning re awareness that erratic blood sugars could indicate underlying sepsis, which in this case was due to bowel ischaemia Share case with lead anti-biotic pharmacist to highlight issues experienced by the patient that are potentially linked to him being given gentamicin, with a view to reviewing first line antibiotics and trust policy Ward to adopt Patient Status At a Glance process to streamline process for discharge medications.

Incident 2	
Classification	Transfusion incident
Incident ref. no.	2022/17839
Incident Summary	Specific phenotype units not transfused as required
Duty of Candour Met	Yes
Investigations findings/actions	**Findings:** Heavy reliance on paper forms alongside a dated IT system

	Analysers are subject to frequent breakdowns The ‘second check’ is brief and should be more robust Significant distractions for staff **Actions:** Review alerts on the system and explore ways of making changes to make them harder to dismiss without reading. Redesign the use of double-checking Consider the introduction of remote blood issue (On Demand). Review laboratory equipment including analysers to see how to reduce the cognitive workload of those working there. Consider mitigations to counter the effects of fatigue caused by sustained attention on tasks during the working day.

Incident 3	
Classification	HSIB maternity investigation
Incident ref. no.	MI-015202
Incident Summary	Death of a baby post-natal day 4 (presented to another hospital emergency department and passed away)
Duty of Candour Met	Yes
Investigations findings/actions	**Findings:** No significant findings for SaTH Issues with delay to ambulance (category 2) **Actions:** No recommendations made from SaTH

Incident 4	
Classification	Deteriorating patient
Incident ref. no.	2022/26230
Incident Summary	Patient passed away after being found unresponsive

	and following CPR. On initial review it was felt the death was potentially avoidable if earlier signs of deterioration had been acted upon promptly.
Duty of Candour Met	Yes
Investigations findings/actions	**Findings:** The alcohol detox pathway was not commenced Appropriate detox medication was not commenced as per regime or detox pathway The investigation identified inaccuracies in the NEWS recordings due to some clinical information not recorded on VitalPac. Hospital escalation process for managing the deterioration patient was not followed when there were changes in the patienst clinical condition. This led to missed opportunities for clinical assessment and escalation to senior clinicians. Patient clinical observations we observed & reviewed by clinical staff in isolation to previous results, leading to a missed opportunity to recognise a deterioration in patient condition over time. **Actions:** Registered and non-registered staff training (mandatory & non mandatory) should be reviewed to ensure staff have appropriate skills and knowledge in order to recognise and manage the deteriorating patient, using the vital pack systems, documentation and fluid balance, all in line with local policy and expected standards. Staff to be enabled to undertake the Deteriorating patient e-learning for health module. Clinical teams should have resources and ability to access ‘trend view’ for clinical observations. The Alcohol Liaison Service must be reviewed to ensure if can meet the service at SaTH should align with Alcohol Care Teams: Core Service Descriptor (November 2019)

Incident 5	
Classification	Mismanagement of red cell antibodies
Incident ref. no.	2022/26439
Incident Summary	Baby required treatment due to antibodies

Duty of Candour Met	Yes
Investigations findings/actions	**Findings:** The Royal College of Obstetricians and Gynaecologists (RCOG) Green-top guideline No. 65 – The Management of Women with Red Cell Antibodies was not available on the Trust Intranet. There was no local guidance in place for the management of women with red cell antibodies during pregnancy. There is no named Consultant/s with allocated time in their job plan/s to manage women with red cell antibodies with a reliance of the goodwill of a named Consultant to manage this group of women – single point of failure. At the time of the incident, there was a complete system failure. There was no pathway or electronic database in place for the management of women with red cell antibodies, There is no post registration education or training in place for midwives for the management of women with red cell antibodies. **Actions:** Add RCOG Green- top Guidance No 65 to the Trust Intranet Develop local guideline for the management of women with red cell antibodies To consider allocation of planned time within a consultant's job plan to manage women with red cell antibodies Review electronic database to ensure compliance with the RCOG guidance No. 65

8. Themes identified from closed serious incidents in March and April 2023

Themes from the incident relating to a deteriorating patient (SI:2022/26230) correlate with themes identified via an overall thematic review of the adult deteriorating patient.

There is an existing deterioration improvement plan. Further discussions have taken place with the Medical Director, Director of Nursing, Clinical Directors and Heads of Nursing focussing on the key themes outlined. A full day event is planned to further review these themes and outline a longer-term improvement strategy and plan relating to deterioration.

9. Themes identified by serious incidents raised in March and April 2023

Themes identified by the serious incidents raised in March and April 2023 include:

Falls: Themes across falls related to location of nursing staff at the time of falls and patient footwear. All learning will be incorporated into the existing falls improvement plan. Specific actions taken in relation to falls are noted in table 1.

Delays to surveillance colonoscopies due to the standing down of services during the Covid pandemic: two of the cases relate to this known (locally and nationally) and ongoing issue. Backlogs of patients for colonoscopy surveillance are further impacted by increasing year on year demand for endoscopy investigation and capacity is not currently meeting demand.

The Surgery, Anaesthetics and cancer division is currently developing a business case for additional resource to meet demand and national standard for DMO1.

Incidents across the emergency pathway: a wider them has been noted of incidents across the emergency pathway. This is thought to be related to pressures in the emergent department and the medical pathway. This relates to the priority for improvement of flow across the organisation.

Torsion of the testes: four serious incidents have been raised relating to torsion of the testes. A complete review has been undertaken of the emergency pathway and a revised pathway is due to be signed off and in place in May with a plan for ongoing audit of effectiveness.

Themes relating to the paediatric thematic review are outlined under section 3, table 3.