Board of Directors' Meeting
12 October 2023

Agenda item		130/23		
Report Title		Incident Overview Report		
Executive Lead		Hayley Flavell, Executive Director of Nursing Dr John Jones, Executive Medical Director		
Report Author		Kath Preece, Assistant Director of Nursing, Quality Governance		
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 – 19th September 2023 Quality and Safety Assurance Committee – 27th September 2023		
Executive summary:		1. The Board's attention is drawn to sections: **6** – relating to overdue incident reports which continue to show improvement **8 and 9** – outlining the themes and trend identified from serious incidents raised and closed in July and August 2023		
Recommendations for the Board:		For Assurance		
Appendices:		N/A		

1. Introduction

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

2. Patient Safety Development and Actions planned for October/November 2023/24

- Move toward PSIRF implementation.

3. 2023 Patient Safety Incident Reporting

The top five patient safety concerns reported via Datix for July and August 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 July and August 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. Overall falls numbers continue to see improvement during July and August. 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 July and August 2023

There were 12 serious incidents reported in July 2023, including 1 reported Never Event, see table 2.

There was 1 new maternity HSIB reportable serious incidents during July 2023.

Table 2

Incident 1	
Classification	Delayed Diagnosis
Incident ref. no.	2023/12819
Incident Summary	Delayed transfer to specialist centre
Immediate Actions Taken	Full review of episode of care
Duty of Candour Met	Yes
Impact on Patient/Family	Distress and anxiety caused. Full support provided.
Patient/Family involved in investigation	Yes, family questions and concerns are included have been investigation.

Incident 2	
Classification	Environmental Incident
Incident ref. no.	2023/12832
Incident Summary	Power Outage W&C Centre
Immediate Actions Taken	Several immediate actions were taken as part of a critical incident.
Duty of Candour Met	Yes, where appropriate
Impact on Patient/Family	Various
Patient/Family involved in investigation	Contact made with all families who were impacted.

Incident 3	
Classification	Return to Theatre
Incident ref. no.	2023/13459
Incident Summary	Return to theatre for realignment of bone
Immediate Actions Taken	Review of surgery and physiotherapy provided
Duty of Candour Met	Yes
Impact on Patient/Family	Anxiety and pain caused. Family and patient supported.
Patient/Family involved in investigation	Mother involved in the investigation, with questions and concerns included.

Incident 4	
Classification	Never Event, wrong site surgery
Incident ref. no.	2023/13491
Incident Summary	Two separate lesions identified for removal in outpatient setting. Plan for one lesion to be removed, marked, and photographed. Incorrect lesion removed.
Immediate Actions Taken	Plan made for patient to return to have the correct lesion removed.
Duty of Candour Met	Yes full apology given.
Impact on Patient/Family	Patient a little anxious but understood that lesions did need to be removed. Patient supported.
Patient/Family involved in investigation	Yes patient involved with questions to be included in the investigation.

Incident 5	
Classification	Medication Error - Pharmacy
Incident ref. no.	2023/13625
Incident Summary	Incorrect labelling of medication which led to dispensing of incorrect mediation to take home.
Immediate Actions Taken	Treatment plan reviewed and blood monitoring. Additional steps taken at Pharmacy and ward level when dispensing medication.
Duty of Candour Met	Yes
Impact on Patient/Family	Distress caused to patient and staff. Patient and staff supported.
Patient/Family involved in investigation	Yes

Incident 6	
Classification	Fall resulting in fractured neck of femur
Incident ref. no.	2023/13617
Incident Summary	Unwitnessed fall next to bedside
Immediate Actions Taken	Full support and falls review undertaken
Duty of Candour Met	Yes
Impact on Patient/Family	Pain and distress caused, patient and family supported.
Patient/Family involved in investigation	Yes family questions are included in the investigation

Incident 7	
Classification	Delayed diagnosis and treatment
Incident ref. no.	2023/13687
Incident Summary	Suboptimal care and treatment
Immediate Actions Taken	Full immediate review undertaken
Duty of Candour Met	Yes
Impact on Patient/Family	Significant distress caused to family. Family supported.
Patient/Family involved in investigation	Yes various meeting with family and questions all included in the investigation.

Incident 8	
Classification	Fall resulting fractured neck of femur
Incident ref. no.	2023/13767
Incident Summary	Unwitnessed fall whilst mobilising to bathroom, door swung back and knocked patient off feet.
Immediate Actions Taken	Review of door by Estates and all other bathroom doors.
Duty of Candour Met	Yes
Impact on Patient/Family	Distress and pain caused.
Patient/Family involved in investigation	Yes questions included in the investigation.

Incident 9	
Classification	Maternity obstetric affecting baby - HSIB
Incident ref. no.	2023/13751
Incident Summary	Therapeutic cooling for baby
Immediate Actions Taken	Full review of care
Duty of Candour Met	Yes

Impact on Patient/Family	Anxiety and distress, support provided
Patient/Family involved in investigation	Yes, via HSIB.

Incident 10	
Classification	Category 3 Pressure Ulcer
Incident ref. no.	2023/13792
Incident Summary	Hospital acquired category 3 pressure ulcer
Immediate Actions Taken	Full review undertaken
Duty of Candour Met	Yes
Impact on Patient/Family	Anxiety and distress. Patient and family supported and discharged to a community hospital
Patient/Family involved in investigation	Family offered opportunity to be involved with investigation, however have declined.

Incident 11	
Classification	Fall resulting in fractured pubic rami
Incident ref. no.	2023/13925
Incident Summary	Unwitnessed fall in ED.
Immediate Actions Taken	Full review of falls protocol.
Duty of Candour Met	Yes
Impact on Patient/Family	Anxiety and pain caused due to fracture. Support provided.
Patient/Family involved in investigation	Yes family questions included in the investigation.

Incident 12	
Classification	Fall resulting in fractured neck of femur
Incident ref. no.	2023/13978
Incident Summary	Unwitnessed fall by the bedside
Immediate Actions Taken	Full falls review undertaken.
Duty of Candour Met	Yes
Impact on Patient/Family	Anxiety and pain caused. Support provided
Patient/Family involved in investigation	Family questions included.

There were 8 serious incidents reported during August 2023, See Table 3.

There were no HSIB reportable serious incidents reported during August 2023. There was 1 reportable maternity serious incident, see table 3.

Table 3

Incident 1	
Classification	Fall resulting in head injury
Incident ref. no.	2023/15281
Incident Summary	Unwitnessed fall from bed to floor
Immediate Actions Taken	Full falls review undertaken
Duty of Candour Met	Yes
Impact on Patient/Family	Pain and distress caused. Patient and family supported.
Patient/Family involved in investigation	Yes family questions included

Incident 2	
Classification	Missed opportunity to identify psychosis
Incident ref. no.	2023/15328
Incident Summary	Delay in obtaining mental health assessment, impacting on appropriate care
Immediate Actions Taken	Once identified full assessment by mental health teams and appropriate care put in place
Duty of Candour Met	Yes
Impact on Patient/Family	Distress to both patient, family and staff
Patient/Family involved in investigation	Family have declined to be involved with the investigation.

Incident 3	
Classification	Delayed diagnosis and treatment
Incident ref. no.	2023/15355
Incident Summary	Multiple concerns regarding care and treatment
Immediate Actions Taken	Full review undertaken
Duty of Candour Met	Yes
Impact on Patient/Family	Anxiety and distress caused, support provided
Patient/Family involved in investigation	Yes family fully involved with investigation and questions included.

Incident 4	
Classification	Maternity obstetric affecting baby - neonatal
Incident ref. no.	2023/15772
Incident Summary	Concerns relating to prematurity and intubation, care withdrawn
Immediate Actions Taken	Full review of care undertaken

Duty of Candour Met	Yes
Impact on Patient/Family	Distress caused. Support provided
Patient/Family involved in investigation	Yes

Incident 5	
Classification	Delayed diagnosis and psychological harm
Incident ref. no.	2023/15780
Incident Summary	Suboptimal care during and after invasive procedure
Immediate Actions Taken	Full review of service provided
Duty of Candour Met	Yes
Impact on Patient/Family	Significant distress caused. Full support provided.
Family involved in investigation	Yes all questions and concerns included in the investigation

Incident 6	
Classification	Deteriorating patient
Incident ref. no.	2023/16236
Incident Summary	Deteriorating patient in waiting room in ED
Immediate Actions Taken	Full review of process of escalation
Duty of Candour Met	Yes
Impact on Patient/Family	Distress caused. Support provided.
Patient/Family involved in investigation	Yes

Incident 7	
Classification	Medication Error
Incident ref. no.	2023/16243
Incident Summary	Dual antibiotic use resulting in toxicity
Immediate Actions Taken	Medication immediately stopped and changed. Learning shared regarding dual use of these antibiotics
Duty of Candour Met	Yes
Impact on Patient/Family	Distress caused. Support provided.
Patient/Family involved in investigation	Yes questions included in the investigation.

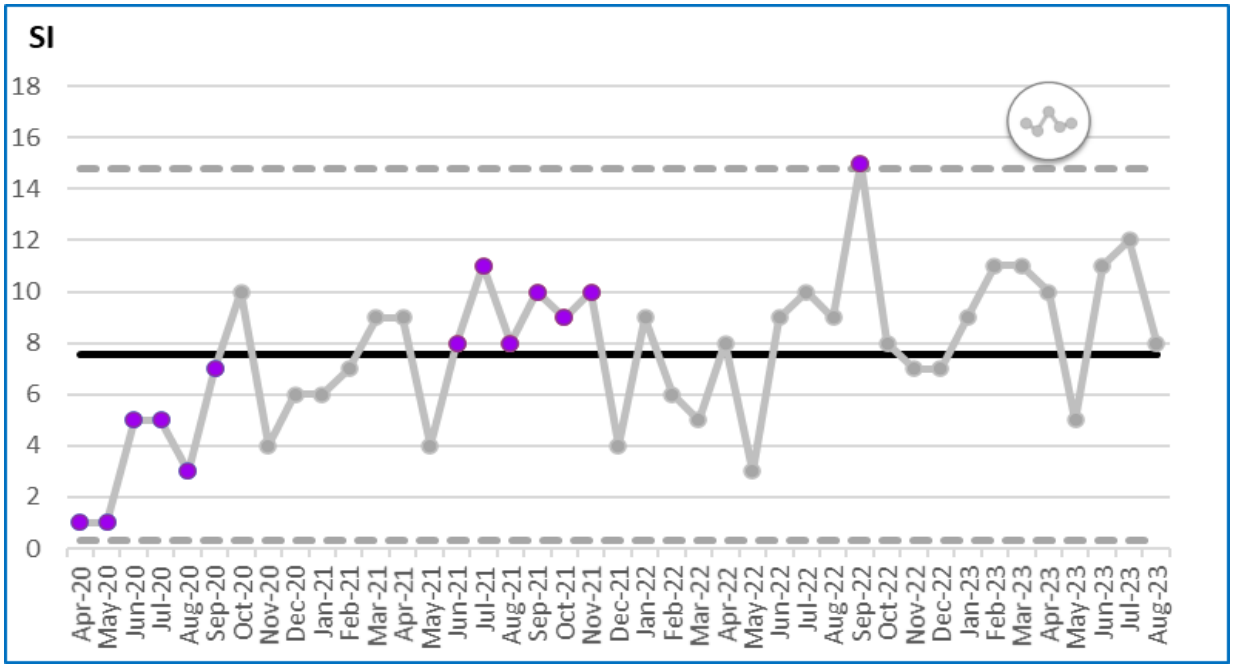
Incident 8	
Classification	Delay in recognition and treatment

Incident ref. no.	2023/16252
Incident Summary	Delay in recognition and treatment for ovarian torsion
Immediate Actions Taken	Full review of care undertaken
Duty of Candour Met	Yes
Impact on Patient/Family	Anxiety, pain and distress. Support provided
Patient/Family involved in investigation	Yes involved in investigation

4.4 Serious Incident Reporting Year to Date

At the end of August 2023/24, the Trust had reported 46 Serious Incidents. SPC 1 shows the serious incident reporting rate over time to August 2023, which demonstrates common cause variation, with a spike in September 2022 above the upper control limit.

SPC Chart 1



5. Never Events

There has been one Never Events reported in July 2023, see Table 2.

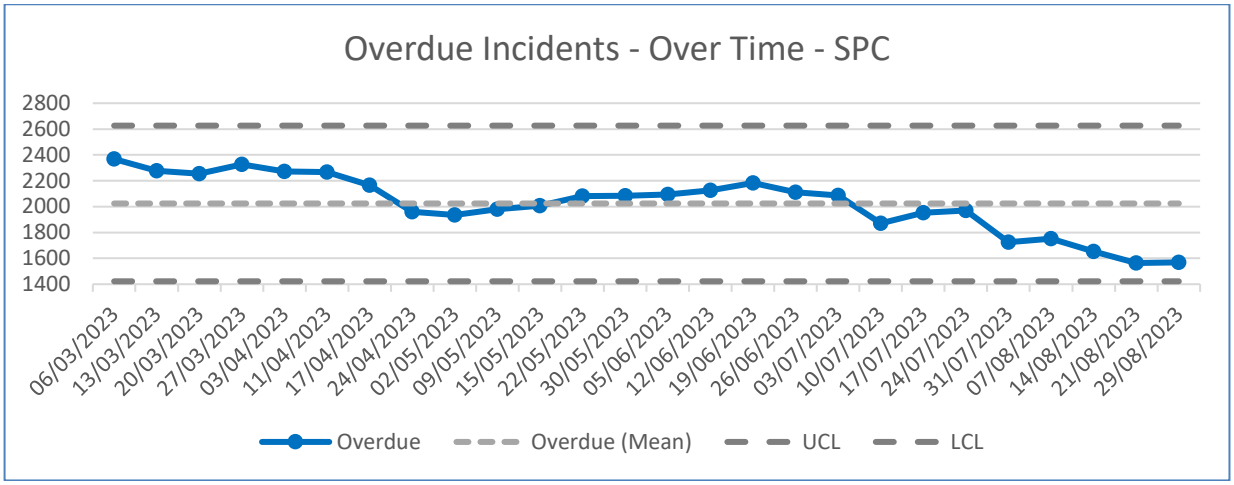
6. Overdue Datix

SPC 2 shows that concentrated work within the emergency 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 July and August 2023 - Lessons Learned and Action taken

There were 11 Serious Incidents closed in July 2023. A synopsis of the incident and learning is identified below in Table 4

There were no maternity or HSIB reportable incidents closed during July 2023.

Table 4

Incident 1	
Classification	Serious Incident
Incident ref. no.	2022/447
Incident Summary	Paediatric Deteriorating Patient
Duty of Candour Met	Yes all aspects fully met
Impact on patient/family	Support provided to family through TRIM network
Investigations findings/actions	• An MDT has already been introduced for complex cases. Continue to ensure these are documented on a portal or similar system. • All children over the age of 5 years who are seen in the asthma outpatient clinics will have a spirometry test completed. • All children over the age of 5 years who attend the asthma outpatient clinics will have their results documented on the central database so all clinicians are able to access results.

Incident 2	
Classification	Serious Incident
Incident ref. no.	2022/6195
Incident Summary	Delayed Treatment.
Duty of Candour Met	Yes all aspects met
Impact on patient/family	Pain and distress caused. Support provided.
Investigations findings/actions	1. An urgent review carried out of all patients on the pessary clinic with a pessary in place that is potentially overdue for follow up who may have been missed.

	2. Urgent review of all Patients who have pessaries put in by consultants who may not have been referred to the pessary clinic. 3. Development of pessary information leaflet containing information for patients on the importance of regular changes and how to seek advice and support. 4. Clinical Audit to be carried out against the standards within the trust guidelines for vault prolapse management to ensure that patients are followed up in accordance with these guidelines and that alternatives to pessaries are discussed and offered where applicable. 5. Review of the process for booking follow up appointments for inpatients who are being discharged. 6. A clear pathway is to be created to guide the bookings team regarding who to contact if a patient cancels/declines further appointments.

Incident 3	
Classification	Serious Incident
Incident ref. no.	2022/9029
Incident Summary	Deteriorating patient/Escalation (part of paediatric thematic review)
Duty of Candour Met	Yes
Impact on patient/family	Support provided.
Investigations findings/actions	• There were occasions when the vital sign observations were late and the PEWS score was incorrectly calculated which impacted on the required frequency of observation and possible earlier intervention • No overview of all blood results/trends in one place to support review of care and treatment plans, blood chemistry was complex and required comprehensive overview. • Challenges with the fluid balance chart design • System for handover of the acutely unwell patient to be improved. • Need to ensure parents/carers views are sought on their perception of a child's condition. • Improvements to be made to the process of referral to BCH and KIDS.

	All recommendations and actions are part of the Paediatric Transformation Programme.

Incident 4	
Classification	Serious Incident
Incident ref. no.	2022/18829
Incident Summary	Deteriorating patient/escalation (part of paediatric thematic review)
Duty of Candour Met	Yes
Impact on patient/family	Support provided
Investigations findings/actions	• There were inconsistencies with how the childs acuity was described and resulting actions. • There were inconsistencies with frequency of observation monitoring. • PEWS scores calculated incorrectly. • Review of SOP for escalating deteriorating patient • Concerns relating to Level 2/3 care in a Level 1 setting. All recommendations and actions are part of the Paediatric Transformation Programme.

Incident 5	
Classification	Serious Incident
Incident ref. no.	2022/23669
Incident Summary	Deteriorating patient/escalation (part of paediatric thematic review)
Duty of Candour Met	Yes
Impact on patient/family	Support provided
Investigations findings/actions	• Issues raised regarding communication/data sharing between hospital and community settings • There is uncertainty in the optimum routes for very unwell paediatric patients and a lack of cohesion between ED and CAU. PEWS scores calculated incorrectly and inconsistencies with observation frequency. • Issues with systematically recording blood results in one place to allow observation of trends. • Issues relating to paediatric and neonatal rota. All recommendations and actions are part of the Paediatric Transformation Programme

Incident 6	
Classification	Serious Incident
Incident ref. no.	2022/16630
Incident Summary	Suboptimal care of the deteriorating patient

Duty of Candour Met	Yes
Impact on patient/family	Full support provided
Investigations findings/actions	• Patients notes show no decision points around the care plan – discussions were had but no decisions made or documented which led to delay in insertion of NG tube and increased length of time without nutrition • If a patient is NBM and there is a delay in waiting for SALT then Dietetics should be contacted for advice and guidance. • Staff to escalate in timely manner if delay in SALT review and patient is still NBM. • Nursing/medical to ensure pharmacy are informed if patient unable to swallow prescribed medication. • Explore the possibility of the new PSAG boards having capability of identifying patients who have been NBM, length of time they have been with ability of dietitian team to access oversight across the trust. • Improved safety huddles on the ward.

Incident 7	
Classification	Serious Incident
Incident ref. no.	2022/26230
Incident Summary	Delay in escalation of deteriorating patient
Duty of Candour Met	Yes
Impact on patient/family	Significant distress – support provided
Investigations findings/actions	• The alcohol detox pathway was not commenced. • Appropriate detox medication was not commenced as per regime or detox pathway. This could have led to an increase in confusion and heart rate. • The investigation identified inaccuracies in the NEWS recordings due to some clinical information not recorded on VitalPac. Such inaccuracies led. to a false NEWS score, which was lower than what the actual NEWs score would have been, if all parameters had been recorded. This led to missed opportunity for recognising the deteriorating patient, escalation for a senior review, and a change in observation intervals changed to increase monitoring. • Antibiotic Gentamicin levels were not taken as per policy. The policy was not followed when a decision was made to omit the second gentamycin dose. • Hospital escalation process for managing the deterioration patient was not followed when

	there were changes in clinical condition. This led to missed opportunities for clinical assessment and escalation to senior clinicians. • Patient clinical observations were observed & reviewed by clinical staff in isolation to previous results, leading to a missed opportunity to recognise a deterioration in patient condition over time.

Incident 8	
Classification	Serious Incident
Incident ref. no.	2022/26193
Incident Summary	Airway Difficulties/Tracheostomy Care
Duty of Candour Met	Yes
Impact on patient/family	Patient recovered well and supported throughout
Investigations findings/actions	• The procedure went as foreseen, and staff were completing final checks where it was identified that the cuff on the tracheostomy tube was leaking. This can happen due to a small leak in the balloon/cuff. The cuff is checked before entering the body during the process. On identification of this, the consultant removed the tracheostomy tube to replace, this is when it was identified that there was a bleeding vein from the stoma site. • All staff involved in the procedure have completed training and experienced staff in this procedure. Tracheostomy are performed in ITU and theatre with the appropriately skilled, experience staff.

Incident 9	
Classification	Serious Incident
Incident ref. no.	2023/814
Incident Summary	Delayed Treatment
Duty of Candour Met	Yes
Impact on patient/family	Anxiety caused due to delay; support provided.
Investigations findings/actions	• The issue in this case was that the appointment was missed. An appointment was documented to be made for follow up in 4 weeks, then changed to 3-4 months. However, neither were made the patient represented at 6 months. The original review and diagnosis were thought to be clinically sound. • Improve passed max waits for appointments.

	• Business plan to improve waits and decrease number of patients waiting to be seen. • Exploring options to support our general past max waits by looking at insourcing companies.

Incident 10	
Classification	Serious Incident
Incident ref. no.	2023/5116
Incident Summary	Delayed Diagnosis
Duty of Candour Met	Yes
Impact on patient/family	Family fully supported
Investigations findings/actions	• The Trust has a policy on the criteria for accepting patients into AMA, which was followed. • There is a clear protocol in place for patients with suspected Acute Coronary Syndrome, and a copy is included in the booklet used for all admitted patients, for staff to refer to. It is not clear why this was not followed and staff involved in the care do not recollect details of the decision-making • The ACS pathway makes reference to the need for serial ECGs, but also does not give clear definition as to what is meant by this.

Incident 11	
Classification	Serious Incident
Incident ref. no.	2023/8344
Incident Summary	Fall resulting in fractured neck of femur
Duty of Candour Met	Yes
Impact on patient/family	Pain and distress caused. Patient and family supported.
Investigations findings/actions	• ECS staff for bed 1 was used for additional supervision making the staff member 1:2 supervision. not in accordance with hospital policy (ECS) 1:1 supervision. • Removal of crash mat to accommodate a chair

There were 8 serious incidents closed in August 2023. A synopsis of the incident and learning is identified below in Table 5.

There were no maternity or HSIB reportable incidents closed during August 2023

Table 5

Incident 1	
Classification	Serious Incident
Incident ref. no.	2023/9566
Incident Summary	Delayed Diagnosis due to no follow up plan
Duty of Candour Met	Yes

Impact on patient/family	Anxiety and distress caused; patient supported throughout
Investigations findings/actions	• The NICE, Trust and BSG guidelines should be followed. • Training on the criteria of 2-week rule referral. • Examinations should be thorough, and the documentation should be more detailed. • Further investigations must be requested to ensure a cause of the symptoms and therefore a diagnosis can be made prior to discharging patients. • Discharge letter should contain more detail and be of a higher standard, they should also advise the GP re specific follow ups i.e. the referral to gastro. • The GP practice to hold a round table meeting to establish and share learning, to include SATH.

Incident 2	
Classification	Serious Incident
Incident ref. no.	2023/9206
Incident Summary	Fall resulting in Subarachnoid haemorrhage
Duty of Candour Met	Yes
Impact on patient/family	Distress and anxiety caused. Support provided.
Investigations findings/actions	• There were no care service delivery problems were identified during the investigation. • The patient was not supervised for mobilizing, however she would not of been supervised whilst in the toilet **Good practice identified** • Prompt escalation from the ward staff to medics once the incident was raised. • Followed falls policy assessments completed. • Falls compliance training was 89% • Falls sticker in notes completed. • Family communicated in timely manner and received further updates

Incident 3	
Classification	Serious Incident
Incident ref. no.	2023/8109
Incident Summary	Delay in polyp surveillance - Endoscopy
Duty of Candour Met	Yes
Impact on patient/family	Distress caused, supported through the investigation, patient involved in the investigation with key questions
Investigations findings/actions	The most significant causal factor in the delay in colonoscopy being the significant backlog of

	endoscopy investigations created by standing services down in line with national Covid guidance. The impact of the backlog was compounded by the existing context of ongoing and increasing demand for endoscopy investigations and organisational challenges in terms of staffing and capacity. Attempts to follow guidance suggesting alternative ways of assessing the risk of patients who were subject to delayed surveillance investigations such as FIT testing (an investigation to look for traces of blood in faeces) were also problematic. A specific issue in this case related to the potential use of video capsule endoscopy which due to his existing medical conditions became closed as an option. All these factors combined to produce the two-year delay experienced by this patient. The scope of this investigation whilst acknowledging the standing down of services in the Covid 19 pandemic as being a key causal factor does not attempt to question the basis of these decisions nationally which will fall under the overview of the national Covid inquiry.

Incident 4	
Classification	Serious Incident
Incident ref. no.	2023/7319
Incident Summary	Psychological Harm
Duty of Candour Met	Yes
Impact on patient/family	Significant psychological harm caused. Support provided throughout investigation and involvement with identifying specific questions
Investigations findings/actions	• The patient was poorly prepared to undergo a one-stop hysteroscopy. • The consent process for hysteroscopy is currently suboptimal. • The provision of analgesia in the hysteroscopy suite is currently inadequate. • There is no agreed procedure for the withdrawal of consent in the hysteroscopy suite. • Recording of hysteroscopy in the clinical record is currently inadequate. • All patients attending a one-stop hysteroscopy clinic should be provided with written information regarding the procedure in advance of the clinic. • All patients having hysteroscopy should be offered appropriate types of anaesthetic including local anaesthetic, spinal anaesthetic, inhalational analgesia, general anaesthetic and

	IV sedation and that this is documented in the patient record. • All patients should be offered a paracervical block prior to hysteroscopy whether diagnostic or therapeutic. • All clinicians undertaking hysteroscopy should undergo training in safe IV sedation with a plan to provide this as a routine by December 2023 • The airflow in the hysteroscopy suite should be assessed and uprated to allow the safe use of Entonox within the area by December 2023. • Audit of pain scores of patients having outpatient hysteroscopy should be undertaken and ensure that there is regular feedback to gynaecologists performing hysteroscopy. The results of the audit should be presented to the Quality Operational Committee as part of the Divisional report. • There should be a Standard Operating Procedure for patients who withdraw consent during outpatient hysteroscopy. The model suggested by the British Society of Gastroenterology for withdrawal of consent during GI endoscopy should serve as a template for this work. • The team should review the working practices of hysteroscopy clinics to reduce the demands on the hysteroscopists who is significantly overburdened compared to other members of the team. This could include delegating consent to another member of the team.

Incident 5	
Classification	Serious Incident
Incident ref. no.	2023/5119
Incident Summary	Delay in sepsis treatment
Duty of Candour Met	Yes
Impact on patient/family	Support provided throughout the investigation process

Investigations findings/actions	• SATH and WMAS to discuss ways of ensuring ambulances can be made available for the transfer of critically ill patients to other trusts during times of peak demand. • Consideration should be given to the core role of CAU and there should be a scoping exercise to see if some of the work currently undertaken there e.g. blood tests, returns for review can be moved to other areas to ensure that emergency patients presenting to CAU do not experience delays in assessment and initiation of treatment. Also, to consider ways in ensuring that ACPs are not called to other areas for tasks such as cannulation, phlebotomy etc. • Teamworking exercises to be considered to explore ways of ensuring delegation of tasks does not lead to delays in the treatment of acutely unwell patients. • Review of staffing levels and processes to provide cover for unexpected staff sickness to ensure safe staffing levels for both CAU and the ward. • The trust to consider replacement of the bleep system and consider use of baton phones to improve referrals and communication between teams. • Review of medications stocked on CAU and the inpatient ward to see if there are any medications not there that need to be stocked routinely, even if they are only needed occasionally for time-critical interventions. This investigation has also considered the recommendations and action following the Paediatric Thematic Review.

Incident 6	
Classification	Serious Incident
Incident ref. no.	2023/5111
Incident Summary	Delayed Diagnosis
Duty of Candour Met	Yes
Impact on patient/family	Significant distress caused. Support provided throughout the investigation process allowing the family to ensure their questions were included in the investigation
Investigations findings/actions	Several key concerns arose from this incident. Firstly, the communication between Acute Medical Assessment (AMA) and Emergency Department (ED) was suboptimal, resulting in confusion and possible misdirection of patient care. Secondly, the internal

	processes within AMA did not meet the expected standards of care, specifically in prioritising patients and allocating resources. Lastly, a significant delay occurred in the clinical assessment of the patient. This prolonged wait might have played a pivotal role in the patient's rapid deterioration, underscoring the critical importance of timely medical evaluation in emergency care. It was recommended that the Emergency pathways, the processes in the AMA seated area and the on-call medical staffing arrangements should be reviewed.

Incident 7	
Classification	Serious Incident
Incident ref. no.	2023/4654
Incident Summary	Inappropriate Transfer
Duty of Candour Met	Yes
Impact on patient/family	Full support provided to the family to enable them to ask all of their questions in relation to care
Investigations findings/actions	• Remove access to out-of-date inter-hospital transfer forms and MCA documentation. • To raise awareness of the importance of completing Best Interests paperwork when a patient lacks capacity and contacting the next of kin at this stage to support with decision making (the new MCA documentation is an MCA and BI combined). • When a new confusion is identified, this must result in a score of 3 on the patient's National Early Warning Score, a sepsis screen and the associated escalation. • This report to be shared with the quality matron to feed into the new hospital transfer policy to include a clear escalation model to support staff from the transferring wards, when they are unable to connect with the receiving ward. Doctor-to-doctor handovers to be included in the interhospital transfer policy. A checklist to be included in the interhospital transfer policy documentation. • Staff who were directly involved in the management and handover of care to complete a piece of reflection and reflective discussion regarding their role in her care not following the plan of care and poor communication. • To use her story and this report to highlight to the contributions that overcrowding, and lack of staffing have on human factors and specifically on this patient's management.

Incident 8	
Classification	Serious Incident
Incident ref. no.	2022/16348
Incident Summary	Delayed Diagnosis
Duty of Candour Met	Yes
Impact on patient/family	Anxiety and distress caused by the delay. Support provided throughout the investigation process and patient's questions included in the investigation
Investigations findings/actions	• To ensure all Consultant Gynaecologists who are involved in the triage of gynaeclogy referrals are fully conversant with national and local guidelines for the management of women with ongoing menstrual symptoms. This will safeguard women being sign posted to the correct clinic to meet their individual symptoms and needs. • To continue to work to meet the NHS Constitution 18 week waiting time target. • To consider undertaking an audit of a cross section of gynaecology referrals to establish if or how many patients are triaged to an incorrect clinic.

8. Themes identified from closed serious incidents in July and August 2023

Themes identified from the serious incidents closed in July and August include:
Incidents across the emergency pathway: a wider theme 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.

Paediatric deterioration and escalation. Each case has undergone an individual serious incident investigation, in addition to a thematic review of the themes and trends across all of the reported cases. Paediatric Transformation Programme now in place to monitor actions and improvements.

Management, escalation, and care of the deteriorating Adult. This is a key quality priority for the Trust and will be reflected as a priority in the new Patient Safety Incident Response Plan for PSIRF.

9. Themes identified by serious incidents raised in July and August 2023

Themes identified by the serious incidents raised in July and August 2023 include:

Although there are a few new serious incidents relating to delayed diagnosis there is no clear theme within this group.

Unwitnessed falls – there have been a few unwitnessed falls resulting in injury during this period and although the overall number of falls have reduced the witnessed falls are under review as part of the ongoing falls prevention programme.

Incidents across the emergency pathway: a wider them has been noted of incidents across the emergency pathway, including a couple of falls. 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.