The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
14 December 2023

Agenda item		163/23		
Report Title		Incident Overview Report		
Executive Lead		Hayley Flavell, Executive Director of Nursing		
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 – 21st November 2023 Quality and Safety Assurance Committee – 29th November 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 September and October 2023		
Recommendations for the Board:		The Board of Directors is asked to take assurance from this report in relation to incident management.		
Appendices:		N/A		

1. Introduction

This report highlights the patient safety development and forthcoming actions for December/January 2023/24 for oversight. It will then give an overview of the top five reported incidents during September and October 2023. Serious Incident reporting for September and October 2023 and rates year to date are highlighted. Further detail of the number and themes of newly reported Serious Incidents and those closed during September and October 2023 are included. Lessons learned and action taken are reported, in detail, through Quality and Safety Committee.

2. Patient Safety Development and Actions planned for December/January 2023/24

- Patient Safety Incident Response Framework (PSIRF) will commence on the 1st December 2023 and will replace the current Serious Incident Framework.

3. 2023 Patient Safety Incident Reporting

The top five patient safety concerns reported via Datix for September and October 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 September and October 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 September and October. 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 September and October 2023

There were 6 serious incidents reported in September 2023, see table 2.

There was 1 new maternity HSIB reportable serious incident during September 2023.

Table 2

Incident 1, Incident 2 and Incident 3	
Classification	Category 3 Pressure Ulcers
Incident ref. no.	2023/16760 - 2023/16788 – 2023/17673
Incident Summary	Hospital Acquired Category 3 Pressure Ulcers
Immediate Actions Taken	Full review 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 in the investigation.
Incident 4	
Classification	Delay in Diagnosis
Incident ref. no.	2023/17444
Incident Summary	Delay in diagnosis of cancer
Immediate Actions Taken	Full review of care.
Duty of Candour Met	Yes
Impact on Patient/Family	Significant distress caused. Support provided.
Patient/Family involved in investigation	Patient questions form the basis of the investigation.

Incident 5	
Classification	Maternity Obstetric affecting baby - HSIB
Incident ref. no.	2023/17559
Incident Summary	HSIB criteria met and accepted for HSIB Investigation - Therapeutic cooling
Immediate Actions Taken	Full review of care (72-hour review)
Duty of Candour Met	Yes
Impact on Patient/Family	Support provided to family
Patient/Family involved in investigation	HSIB will involve the family in the investigation as standard practice.
Incident 6	
Classification	Treatment Delay
Incident ref. no.	2023/18290
Incident Summary	Delays in treatment and suboptimal care
Immediate Actions Taken	Full review of care
Duty of Candour Met	Yes
Impact on Patient/Family	Significant distress caused. Support provided
Patient/Family involved in investigation	Family involved with investigation – family questions included

There were 9 serious incidents reported during October 2023, See Table 3.

As of 1 October 2023, Maternity and Newborn Safety Investigations (MNSI) is hosted by the CQC. The transition from Healthcare Safety Investigation Branch (HSIB) to the Care Quality Commission (CQC) MNSI, is complete. There will be no interruption to ongoing investigations. The new MNSI is now fully operational and focused on delivering high-quality, independent, and family- centred maternity investigations.

There were no MNSI (formerly HSIB) reportable serious incidents reported during October 2023. There were no reportable maternity serious incidents, see table 3.

Table 3

Incident 1 and Incident 2	
Classification	Fall resulting in fracture neck of femur
Incident ref. no.	2023/18971 and 2023/19691
Incident Summary	Unwitnessed fall
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 in investigation

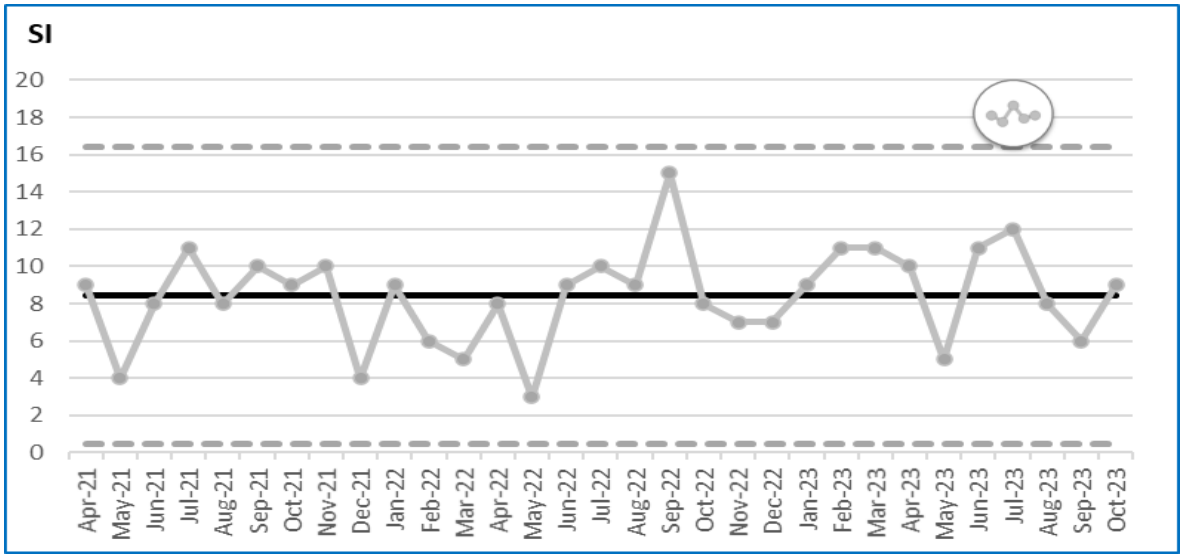
Incident 3	
Classification	Delay in treatment
Incident ref. no.	2023/19077
Incident Summary	Delay in diagnosis and treatment, results not actioned.
Immediate Actions Taken	Full review of care
Duty of Candour Met	Yes
Impact on Patient/Family	Significant distress caused. Family supported
Patient/Family involved in investigation	Family questions included in the investigation
Incident 4	
Classification	Category 3 Pressure Ulcer
Incident ref. no.	2023/19169
Incident Summary	Pressure ulcer prevention actions not consistently followed.
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 5	
Classification	Delay in CPR
Incident ref. no.	2023/19385
Incident Summary	Delay in initiating CPR following collapse
Immediate Actions Taken	Full review undertaken
Duty of Candour Met	Yes
Impact on Patient/Family	Distress caused. Support provided
Patient/Family involved in investigation	Yes, family questions included in the investigation
Incident 6	
Classification	Delay in diagnosis/Treatment
Incident ref. no.	2023/19386
Incident Summary	Delay in acting on adverse symptoms/deteriorating patient
Immediate Actions Taken	Full review of care provided
Duty of Candour Met	Yes
Impact on Patient/Family	Distress caused. Full support provided.
Family involved in investigation	Yes all questions and concerns included in the investigation
Incident 7	

Classification	Suboptimal monitoring of patient condition
Incident ref. no.	2023/19827
Incident Summary	Delayed response to a disconnected non invasive ventilation device
Immediate Actions Taken	Full review of care and medical equipment
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	Hospital Acquired Infection
Incident ref. no.	2023/19809
Incident Summary	Hospital acquired Serratia Marcescens
Immediate Actions Taken	Full review undertaken
Duty of Candour Met	Yes
Impact on Patient/Family	Distress caused. Support provided
Patient/Family involved in investigation	Yes, involved in investigation
Incident 9	
Classification	Fall resulting in c-spine injury
Incident ref. no.	2023/19974
Incident Summary	Unwitnessed fall, including 2 falls prior to admission
Immediate Actions Taken	Full falls review undertaken
Duty of Candour Met	Yes
Impact on Patient/Family	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 October 2023/24, the Trust had reported 61 Serious Incidents. SPC 1 shows the serious incident reporting rate over time to October 2023, which demonstrates common cause variation

SPC Chart 1



5. Never Events

There have been no Never Events reported in during September and October 2023.

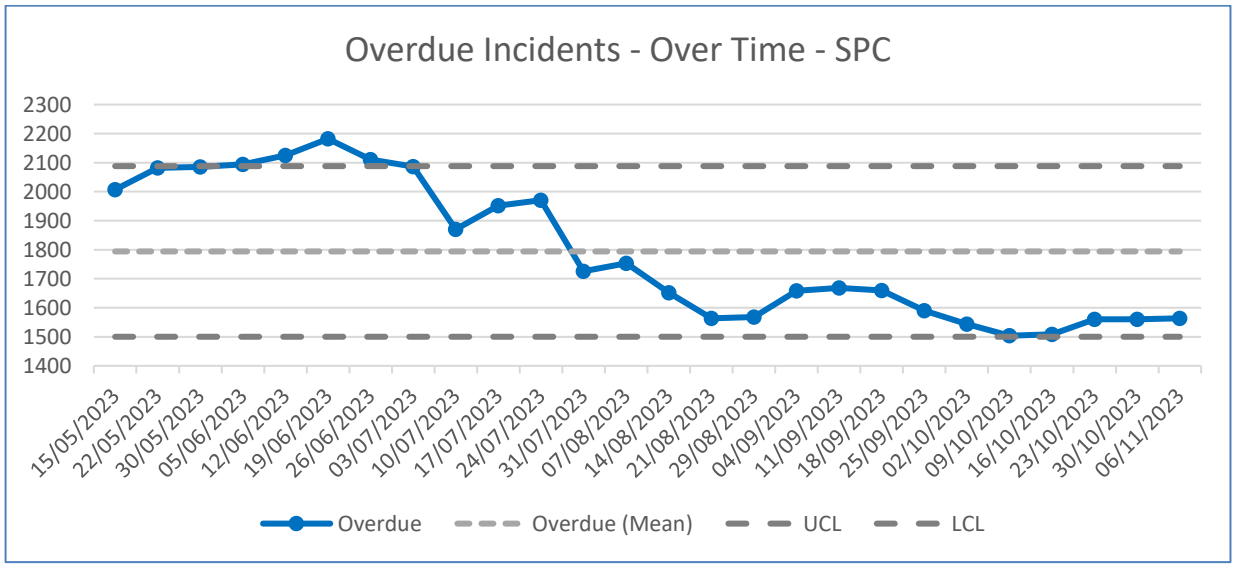
6. Overdue Datix

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 September and October 2023 - Lessons Learned and Action taken are reported, in detail, through Quality and Safety Committee.

There were 8 Serious Incidents closed in September 2023. A synopsis of the incident and action/learning is identified below in Table 4

There were 2 Maternity HSIB reportable incidents closed during September 2023.

Table 4

Incident 1	
Classification	Serious Incident
Incident ref. no.	2022/12287
Incident Summary	**Fall resulting in head injury – Key finding** All actions included in the overarching falls prevention plan.
Duty of Candour Met	Yes all aspects fully met
Impact on patient/family	The patient made good progress on the Ward and was discharged to a Care Home.
Incident 2	
Classification	Serious Incident
Incident ref. no.	2023/11999
Incident Summary	**Category 3 Pressure Ulcer – Key finding** Improved recording of patients who are admitted with splints is required. Added to overarching pressure ulcer prevention plan
Duty of Candour Met	Yes all aspects met
Impact on patient/family	Pain and distress caused. Support provided.
Incident 3	
Classification	Serious Incident
Incident ref. no.	2023/8112
Incident Summary	**Delayed screening Endoscopy – Key finding** The most significant causal factor in the delay to the colonoscopy being the significant backlog of endoscopy investigations created by standing services down in line with national Covid guidance.
Duty of Candour Met	Yes
Impact on patient/family	Support provided.
Incident 4	
Classification	Serious Incident
Incident ref. no.	2023/3484
Incident Summary	**Delayed diagnosis – Key finding** investigation identified that a faster diagnosis of cardiac failure due to ACS could have taken place.
Duty of Candour Met	Yes
Impact on patient/family	Distress and anxiety caused. Support provided
Incident 5	
Classification	Serious Incident
Incident ref. no.	2022/24772
Incident Summary	**Intrapartum Stillbirth HSIB Findings** The Mother's routine antenatal care pathway was in line with guidance. On attendance at the triage unit the Baby's heartrate could not be heard. This led to an urgent referral for obstetric review; an ultrasound scan confirmed the

	death of the Baby. The Trust's bereavement care was in line with the national bereavement care pathway 2020. There were no safety recommendations identified.
Duty of Candour Met	Yes
Impact on patient/family	Full support provided through bereavement service
Incident 6	
Classification	Serious Incident
Incident ref. no.	2022/19583
Incident Summary	**Intrapartum Stillbirth HSIB Findings** The Mother's antenatal risks were assessed, and antenatal care was provided in line with local and national guidance (NICE, 2021). The Baby's birthweight was below the expected range on the 7th centile, and this was within the error margin. When the mother attended in labour, the Baby's heart rate could not be heard. An USS was undertaken which showed the Baby had died. The Trust's bereavement care was in line with the national bereavement care pathway 2020. There were no safety recommendations identified.
Duty of Candour Met	Yes
Impact on patient/family	Bereavement support provided.
Incident 7	
Classification	Serious Incident
Incident ref. no.	2022/17839
Incident Summary	**Blood Transfusion Incident. Key findings** Important to Ensure the new LIMS system is implemented as soon as possible. Consider the introduction of remote blood issue (On Demand). The incident has been reported under SABRE (Serious Adverse Blood Reactions and Events) and SHOT (Serious Hazards of Transfusion) where MHRA (Medicines & Healthcare products Regulatory Agency) have oversight.
Duty of Candour Met	Yes
Impact on patient/family	Anxiety caused, support provided
Incident 8	
Classification	Serious Incident
Incident ref. no.	2021/17275
Incident Summary	**Hospital Acquired Infection – Trust wide COVID 19 Response** Shared through Quality Operational Committee and Quality and Safety Committee
Duty of Candour Met	Full duty of candour met for all appropriate families
Impact on patient/family	Anxiety and distress

There were 11 serious incidents closed in October 2023. A synopsis of the incident is identified below in Table 5, full synopsis of learning is shared at Quality and Safety Committee.

There were no maternity or MNSI (formerly HSIB) reportable incidents closed during October 2023

Table 5

Incident 1	
Classification	Serious Incident
Incident ref. no.	2023/8754
Incident Summary	**Fall resulting in fracture neck of femur – Key finding** It is essential that clinical staff keep oversight of patients being monitored by security officers
Duty of Candour Met	Yes
Impact on patient/family	Distress caused. Support given throughout investigation
Incident 2	
Classification	Serious Incident
Incident ref. no.	2023/8375
Incident Summary	**Fall resulting in head injury – Key finding.** All falls, witnessed and unwitnessed, should be handed over via SBAR documentation when patients are transferred between wards. All actions are included in the overarching falls prevention plan.
Duty of Candour Met	Yes
Impact on patient/family	The injury contributed to increased pain, a lengthy stay and extensive rehabilitation.
Incident 3	
Classification	Serious Incident
Incident ref. no.	2023/9112
Incident Summary	**Fall resulting in head injury – Key findings.** Appropriate risk assessments and prevention plans in place.
Duty of Candour Met	Yes
Impact on patient/family	Distress caused, support provided.
Incident 4	
Classification	Serious Incident
Incident ref. no.	2023/6433
Incident Summary	**Hospital Acquired Category 3 Pressure Ulcer – Key finding** pressure ulcer prevention plan was not consistently followed.
Duty of Candour Met	Yes
Impact on patient/family	Pain and distress caused, support provided to patient and family.
Incident 5	
Classification	Serious Incident
Incident ref. no.	2023/6200
Incident Summary	**Delayed diagnosis and treatment of sepsis – Key finding** Sepsis was not considered despite red flags. If sepsis screening had been completed earlier review and treatment could have been initiated.

	Learning is captured in the deteriorating patient improvement plan.
Duty of Candour Met	Yes
Impact on patient/family	Significant distress caused. Family supported.
Incident 6	
Classification	Serious Incident
Incident ref. no.	2023/3442
Incident Summary	**Fall with head injury – Key finding** Lack of documentation from initial assessment. Delay in transferring for CT head. It was not possible to identify if the head injury was sustained in the fall prior to admission or within the hospital setting. Learning included in overarching falls prevention plan.
Duty of Candour Met	Yes
Impact on patient/family	Patient supported.
Incident 7	
Classification	Serious Incident
Incident ref. no.	2023/2769
Incident Summary	**Fall with head injury – Key finding.** Patient unsteady on feet following long length of stay in ICU, element of deconditioning. Learning included in overarching falls prevention plan.
Duty of Candour Met	Yes
Impact on patient/family	Anxiety when mobilising – support provided.
Incident 8	
Classification	Serious Incident
Incident ref. no.	2022/22981
Incident Summary	**Delay in diagnosis of bowel obstruction. Key finding** The suspected bowel obstruction was missed on transfer to the ward. Improvements in handover to be put in place, including electronic white boards.
Duty of Candour Met	Yes
Impact on patient/family	Patient and family supported. Family involved in investigation.
Incident 9	
Classification	Serious Incident
Incident ref. no.	2022/21007
Incident Summary	**Delay in diagnosis of a deteriorating patient. Key finding** The escalation of clinical condition appropriate was not in line with the trust's deteriorating patient policy. Learning included in the deteriorating patient improvement plan.
Duty of Candour Met	Yes
Impact on patient/family	Support provided during hospital stay and through investigation
Incident 10	
Classification	Serious Incident
Incident ref. no.	2022/20378

Incident Summary	**Delay in diagnosis and treatment – Key finding** Review of abnormal blood results were not fully explored and lack of escalation to correct abnormal physiology.
Duty of Candour Met	Yes
Impact on patient/family	Distress caused. Family support provided.
Incident 11	
Classification	Serious Incident
Incident ref. no.	2022/16236
Incident Summary	**Delay in treatment/Delay in transfer – Key finding** Urgent need for transfer to another hospital was not escalated in line with standard operating procedure. Learning had been shared both within the Trust and to the wider system.
Duty of Candour Met	Yes
Impact on patient/family	Anxiety and distress caused, support provided

8. Themes identified from closed serious incidents September and October 2023

Themes identified from the serious incidents closed in September and October 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.

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 September and October 2023

Themes identified by the serious incidents raised in September and October 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.