The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
8 February 2024

Agenda item		022/24		
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 – December 2023 and January 2024 Quality and Safety Assurance Committee – December 2023 and January 2024		
Executive summary:		1. The Board's attention is drawn to sections: **6** – relating to overdue incident reports which continue to show improvement **3 and 5** outlining new PSIRF incident management processes and cases		
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 February/March 2024 for oversight. It will provide an overview of the new Patient Safety Incident Response Framework (PSIRF). Detail of the number and themes of closed serious incidents during November and December are included. Lessons learned and action taken are reported, in detail, through Quality and Safety Committee.

2. Patient Safety Development and Actions planned for February/March 2023/24

- Embed PSIRF
- Focus on Trust Patient Safety Priorities.
- Develop the Trust overarching Patient Safety Strategy

3. Patient Safety Incident Response Framework (PSIRF)

PSIRF was implemented on 1 December 2023, which replaces the Serious Incident Framework. PSIRF is a key element of the overall National Patient Safety Strategy

The four key principles of PSIRF are:

1. Compassionate engagement and involvement of those affected by patient safety incidents

2. Application of a range of system-based approaches to learning from patient safety incidents

3.Considered and proportionate responses to patient safety incidents

4. Supportive oversight focused on strengthening response system functioning and improvement

A summary of learning responses and patient safety incident investigations, that have been commissioned at Incident Review Oversight Group (IROG) and RALIG will form part of this Incident Overview Report.

The incident management process within PSIRF consists of the following:

- Daily Datix Triage – identifying cases to be further reviewed at IROG
- IROG – full weekly MDT review of incidents, commissioning of learning responses and escalation to RALIG.
- Peer Review Group – weekly quality assurance review of cases, which have been identified at IROG to be presented to RALIG.
- Duty of Candour Group – monthly assurance group for assurance.
- Monthly Safety Triangulation Group will be set up to triangulate themes and trends from all sources

Processes are undergoing PDSA cycles and will continue to develop over the next 12 months.

This incident management report will develop over time as we progress further with PSIRF and will incorporate outcomes from both PSII and AAR, along with themes/trends/learning and improvements evidenced.

4. Incident Management

4.1 Serious Incident Reported in November 2023 (prior to the commencement of PSIRF)

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

There were no new maternity MNSI reportable serious incidents during November 2023.

Table 2

Incident 1	
Classification	Serious Incident
Incident ref. no.	2023/20237
Incident Summary	Delayed diagnosis and treatment - Gynaecology
Immediate Actions Taken	Clinical validation sessions put in place in an attempt to reduce waiting time
Duty of Candour Met	Yes
Impact on Patient/Family	Distress caused to patient and family.
Patient/Family involved in investigation	Yes, patient and family questions included.
Incident 2	
Classification	Serious Incident
Incident ref. no.	2023/20341
Incident Summary	Fall resulting in Head Injury
Immediate Actions Taken	Full falls review undertaken
Duty of Candour Met	Yes
Impact on Patient/Family	Distress and pain caused
Patient/Family involved in investigation	Family and patient questions included in the investigation
Incident 3	
Classification	Serious Incident
Incident ref. no.	2023/20518
Incident Summary	Medication toxicity
Immediate Actions Taken	Review of processes undertaken
Duty of Candour Met	Yes
Impact on Patient/Family	Anxiety caused.
Patient/Family involved in investigation	Yes, family questions included

Incident 4	
Classification	Serious Incident
Incident ref. no.	2023/20547
Incident Summary	Missed diagnosis - Emergency
Immediate Actions Taken	Initial review of care undertaken
Duty of Candour Met	Yes
Impact on Patient/Family	Pain and distress caused.
Patient/Family involved in investigation	Yes, patient questions included
Incident 5	
Classification	Serious Incident
Incident ref. no.	2023/20717
Incident Summary	Delayed diagnosis - Medicine
Immediate Actions Taken	Review of escalation processes
Duty of Candour Met	Yes
Impact on Patient/Family	Distress caused to family
Patient/Family involved in investigation	Yes, family questions included
Incident 6	
Classification	Serious Incident
Incident ref. no.	2023/21022
Incident Summary	Delayed diagnosis - Medicine
Immediate Actions Taken	Initial review of care undertaken
Duty of Candour Met	Yes
Impact on Patient/Family	Anxiety caused to patient and family
Patient/Family involved in investigation	Yes, Patient and family questions included
Incident 7	
Classification	Serious Incident
Incident ref. no.	2023/21297
Incident Summary	Fall resulting in fractured neck of femur
Immediate Actions Taken	Falls review undertaken

Duty of Candour Met	Yes
Impact on Patient/Family	Pain and distress caused
Patient/Family involved in investigation	Yes, family questions included
Incident 8	
Classification	Serious Incident
Incident ref. no.	2023/21399
Incident Summary	Delayed diagnosis - Emergency
Immediate Actions Taken	Initial review completed
Duty of Candour Met	Yes
Impact on Patient/Family	Anxiety caused
Patient/Family involved in investigation	Family included in investigation
Incident 9	
Classification	Serious Incident
Incident ref. no.	2023/21646
Incident Summary	Delayed diagnosis - Emergency
Immediate Actions Taken	System wide work ongoing to improve flow, to support a reduction in ambulance offloads
Duty of Candour Met	Yes
Impact on Patient/Family	Anxiety and distress caused
Patient/Family involved in investigation	Yes, family involved
Incident 10	
Classification	Serious Incident
Incident ref. no.	2023/21642
Incident Summary	Category 3 Pressure Ulcer
Immediate Actions Taken	Review of care
Duty of Candour Met	Yes
Impact on Patient/Family	Anxiety and pain caused
Patient/Family involved in investigation	Yes family involved
Incident 11	

Classification	Serious Incident
Incident ref. no.	2023/21383
Incident Summary	Delayed diagnosis - Gynaecology
Immediate Actions Taken	Initial review of care completed
Duty of Candour Met	Yes
Impact on Patient/Family	Anxiety caused
Patient/Family involved in investigation	Yes family involved

4.2 Serious Incidents Closed during November and December 2023

Lessons Learned and Action taken are reported, in detail, through Quality and Safety Committee.

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

There were no Maternity reportable incidents closed during November 2023.

Table 4

Incident 1	
Classification	Serious Incident
Incident ref. no.	2023/15281
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	Pain and distress caused. Full support provided.
Incident 2	
Classification	Serious Incident
Incident ref. no.	2023/13925
Incident Summary	**Fall resulting in fractured pubic rami – Key finding** All actions included in overarching fall 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.	2023/13625
Incident Summary	**Medication Error – Key findings** Two medications were next to each other on the shelf, as they follow each other alphabetically, with similar names. Further separation of medications have been undertaken to reduce the risk of this occurring in the future and improved processes for checking in the clinical areas established.
Duty of Candour Met	Yes
Impact on patient/family	Anxiety and distress caused. Full Support provided.

Incident 4	
Classification	Serious Incident
Incident ref. no.	2023/11060
Incident Summary	**Fall resulting in fracture – Key findings** All actions included in the overarching falls prevention plan
Duty of Candour Met	Yes
Impact on patient/family	Pain and anxiety caused. Support provided

There were 9 serious incidents closed in December 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 December 2023

Table 5

Incident 1	
Classification	Serious Incident
Incident ref. no.	2023/13767
Incident Summary	**Fall resulting in fracture neck of femur – Key finding** All actions contained within the overarching falls prevention plan
Duty of Candour Met	Yes
Impact on patient/family	Distress caused. Support given.
Incident 2	
Classification	Serious Incident
Incident ref. no.	2023/13491
Incident Summary	**Never Event – wrong site surgery/outpatient – Key finding** Clinical photographs not uploaded in order that they were taken. Full description not included on the booking form.
Duty of Candour Met	Yes
Impact on patient/family	Distress caused as patient required additional procedure
Incident 3	
Classification	Serious Incident
Incident ref. no.	2023/13459
Incident Summary	**Return to Theatre – Key findings** Error made in repairing fracture, return to theatre required to ensure correct repair
Duty of Candour Met	Yes
Impact on patient/family	Distress and additional pain caused. support provided.
Incident 4	
Classification	Serious Incident
Incident ref. no.	2023/12291
Incident Summary	**Fall resulting in fractured neck of femur – Key findings** All actions included in the overarching falls prevention plan
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.	2023/12191
Incident Summary	**Potential delayed diagnosis – Key finding**

	Following investigation, it is recorded that appropriate and timely assessment and care was provided however this was a very rare condition which may have benefitted from an earlier referral to speciality.
Duty of Candour Met	Yes
Impact on patient/family	Distress caused. Family supported.
Incident 6	
Classification	Serious Incident
Incident ref. no.	2023/11719
Incident Summary	**Delayed diagnosis – Key Findings** Missed opportunity to identify areas of concern on a CT scan.
Duty of Candour Met	Yes
Impact on patient/family	Patient and family supported.
Incident 7	
Classification	Serious Incident
Incident ref. no.	2023/11684
Incident Summary	**Delayed diagnosis – Key findings** Multi agency review of care pathway. System learning identified and shared.
Duty of Candour Met	Yes
Impact on patient/family	Anxiety caused – support provided.
Incident 8	
Classification	Serious Incident
Incident ref. no.	2023/11688
Incident Summary	**Delayed diagnosis – Key findings** Delay in requesting appropriate imaging which would have affected the management plan and improved care
Duty of Candour Met	Yes
Impact on patient/family	Pain and distress caused
Incident 9	
Classification	Serious Incident
Incident ref. no.	2023/10932
Incident Summary	**Delayed diagnosis – key findings** Delays in management and treatment identified.
Duty of Candour Met	Yes
Impact on patient/family	Support provided

5.0 Patient Safety Incident Investigations (PSII) commissioned during December 2023

A summary of the Patient Safety Incident Investigations (PSII) reported in December is contained Table 1.

Table 1

PSII	Number Reported
2023/22460 Diagnosis delay/treatment – SAC	1
Total	1

A summary of the After-Action Reviews commissioned in December is contained Table 2.

Table 2

After Action Review (AAR)	Number Reported
Datix 263881 Omitted medication - Paediatrics	1
Total	1

5.3 IROG – initial update/themes

IROG, previously corporate rapid review meeting, is working well and is undergoing PDSA.

Each month, themes identified through IROG will be presented in this Incident Management Report.

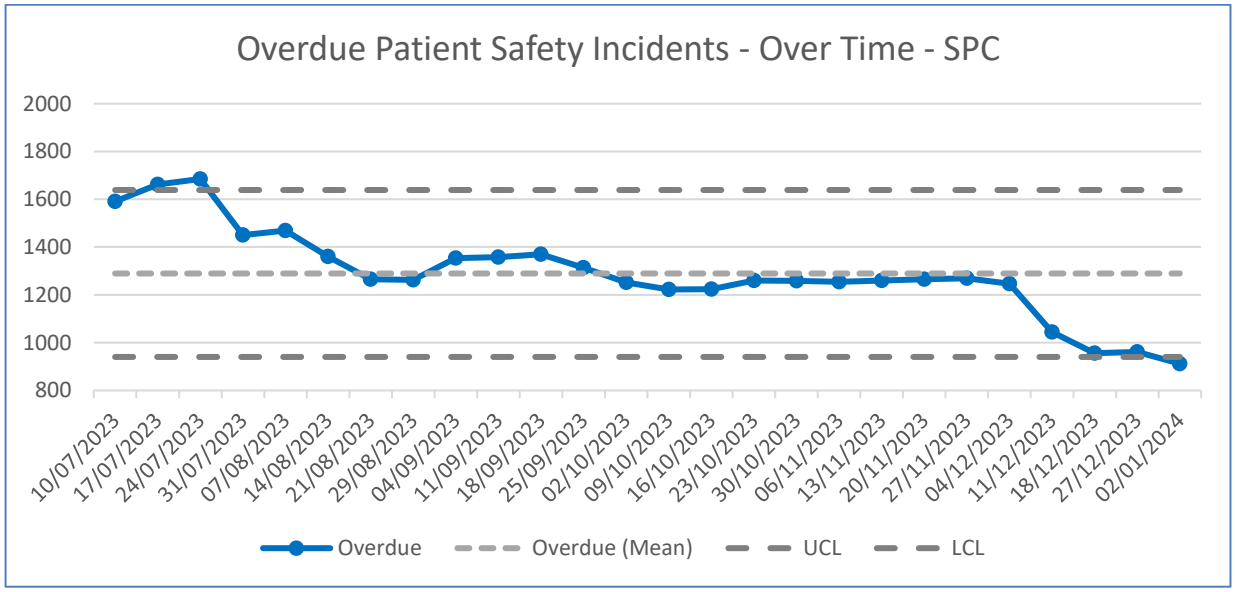
6.0 Overdue Datix

SPC 1 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's are reviewed daily by the patient safety team who filter out those Datix that require immediate actions. Datix triage is now in place since the 1st December 2023. 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 1



7.0 Themes identified from closed serious incidents November and December 2023

Themes identified from the serious incidents closed in November and December 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.

8.0 Emergency Department Harm Reviews

A new process has been agreed, with appropriate contracts amended for ED 12-hour breach harm reviews and Ambulance offload delay harm reviews.

9.1 12-hour breach harm reviews

Harm reviews will be completed for 12-hour breaches on the following basis:

- 5 longest breaches, per week, per site
- New electronic proforma
- Retrospective reviews for the previous month, sent monthly to the Quality Team at the ICB for assurance.

9.2 Ambulance offload delay harm reviews

- Every patient in an ambulance offload delay over 6 hours will have a harm review.
- New electronic proforma
- Retrospective reviews from the previous week, sent weekly to the Quality Team at the ICB.
- Weekly meeting to discuss any concerns relating to the harm reviews.

Themes/Learning will be shared as part of this incident management overview report.