The Shrewsbury and Telford Hospital NHS Trust

Board of Directors' Meeting
14 March 2024

Agenda item		049/24		
Report Title		Incident Overview Report		
Executive Lead		Hayley Flavell, Executive Director of Nursing John Jones, 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 – February 2024 Quality and Safety Assurance Committee – February 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 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 March/April 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 January 2024 are included. Lessons learned and action taken are reported, in detail, through Quality and Safety Committee.

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

- Embed PSIRF
- Focus on Trust priorities.
- Develop the Trust overarching Patient Safety Strategy
- Commence recruitment of Patient Safety Partners.

3. Patient Safety Incident Response Framework (PSIRF)

PSIRF was implemented on the 1st 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 Incidents Closed during January 2024

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

There were 5 Serious Incidents closed in January 2024. A synopsis of the incident and action/learning is identified below in Table 1.

There were no Maternity reportable incidents closed during January 2024.

Table 1

Clinical Area	**Incident 1**
Classification	Serious Incident
Incident Ref number	2023/17673
Incident Summary	**Category 3 Pressure Ulcer** Hospital acquired category 3 Pressure Ulcer All actions are included in the overarching pressure ulcer prevention plan
Duty of Candour Met	Yes
Impact on patient/family	Distress caused, patient and family supported
Clinical Area	**Incident 2**
Classification	Serious Incident
Incident ref. no.	2023/13792
Incident Summary	**Category 3 Pressure Ulcer** Hospital acquired category 3 pressure ulcer. All actions are included in the overarching pressure ulcer prevention plan
Duty of Candour Met	Yes
Impact on patient/family	Pain and distress caused
Clinical Area	**Incident 3**
Classification	Serious Incident
Incident ref. no.	2023/13617
Incident Summary	**Fall with fractured neck of femur** Unwitnessed fall resulting in fracture neck of femur All actions are included in the overarching falls prevention plan
Duty of Candour Met	Yes
Impact on patient/family	Pain and distress caused, patient and family supported.

Clinical Area	**Incident 4 and Incident 5**
Classification	Serious Incident
Incident ref. no.	2023/9239/2023/7923
Incident Summary	**Fall resulting in fractured neck of femur and Category 3 Pressure Ulcer** Unwitnessed fall resulting in fracture neck of femur and then developed hospital acquired category 3 pressure ulcer. All actions are included in the overarching falls and pressure ulcer prevention plans.
Duty of Candour Met	Yes
Impact on patient/family	Pain and distress caused – support provided

5.0 Patient Safety Incident Investigations (PSII) commissioned during January 2024

A summary of the Patient Safety Incident Investigations (PSII) reported in January 2024 is contained Table 2.

Table 2

PSII
2024/149 HIE Therapeutic hypothermia treatment – **MNSI -** Maternity
2024/1032 Incorrect diagnosis and treatment PRH ED/AMU

A summary of the After-Action Reviews commissioned in January 2024 is contained Table 3.

Table 3

After Action Review (AAR)	**Number Reported**
Failure to monitor AAA surveillance	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.

The top four are issues from January were known themes, the rest are issues that have been emerging themes from IROG.

Known Themes
Delayed appointments
Delated treatment (ED- often related to ambulance offload delays)

Admission issues (availability of beds, acceptance by specialities)
Omitted doses of time critical medication (known Trust priority)

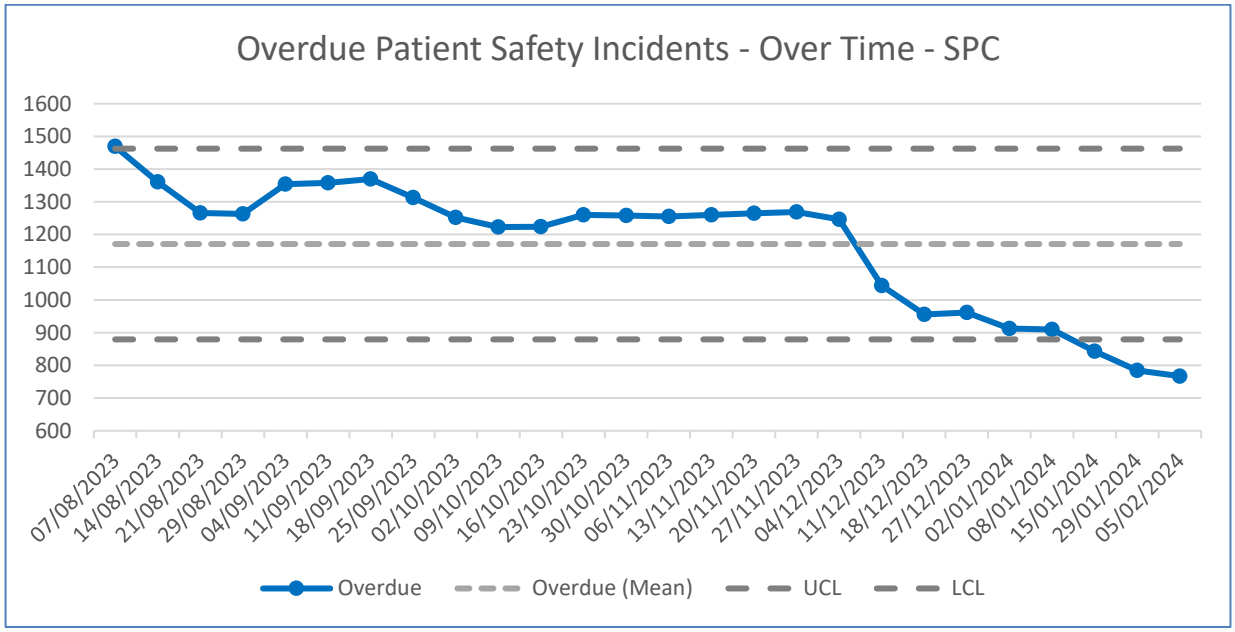
New Emerging Themes
Overcrowding/inappropriate patients in AMA seated area
IPC concerns not handed over on admission
AAA missed surveillance (having AAR)
Cluster of OHSS cases in fertility (reviewed and all cases managed appropriately)
Delayed treatment of low potassium
Inaccurate handovers (on admission and between wards)

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 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

7.1 12 hour breach harm reviews

Harm reviews have been completed for the longest 12-hour breach patients during December. A total of 40 harm reviews have been completed, 20 for RSH and 20 for PRH.

1 patient was identified as low harm, which was due to issues around sepsis identification and commencement of appropriate treatment plan.

The remaining patients had no delay in their care, although it is acknowledged that patient experience would be poor.

7.2 Ambulance offload delay harm reviews

Ambulance offload delay harm reviews have been completed for every patient reported to have been held in the ambulance for over 6 hours.

A total of 47 patients underwent harm review between 28th and 31st January.

- Patients had identified low harm due to a delay in administration of IV antibiotics for the treatment of sepsis. Once offloaded they were treated and continued with their care with no further concerns.
- 1 patient identified low harm due to a delay in referral to Stoke for further care
- 8 of the patients were living with dementia
- 95% of the patients were reviewed in the ambulance in line with the SOP
- 2 of the patients, who remained in the ambulance for 10 hours were brought in from nursing homes for the management of hypoglycaemia and catheter management and were discharged from the ED soon after offload. The ICB are monitoring for themes and trends to support work in the community, for admission avoidance

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