Belfast Health and Social Care Trust
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Risk & Governance

Amalgamated Assurance Report

May 2024

Incorporating:

Trust Incident & SAI Annual Report:
April 2023 – March 2024

BHSCT Incident and SAI Report for reporting period 01 April 2023 to 31 March 2024 (as at 17 April 2024)

for inclusion within the combined Risk & Governance Assurance report.

Adverse Incidents (AIs & SAIs)

45,861[1] Incidents reported

[1]This report does not include incidents reported by Independent Sector Providers (ISP).
For this period there were also 10,555 ISP Incidents.

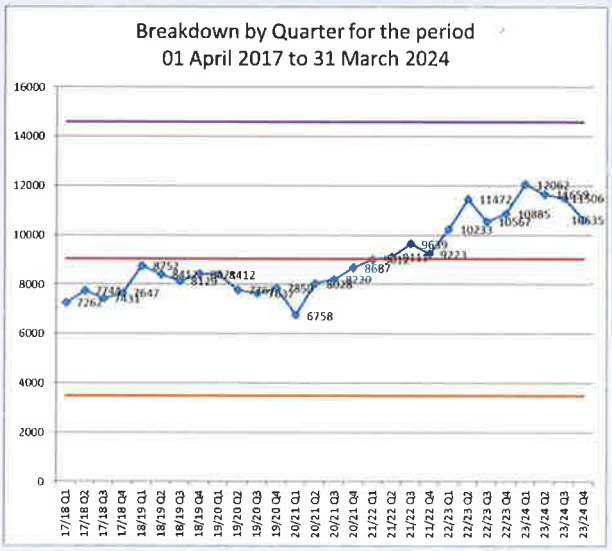
↑ **6.3%** Increase from previous year

Trust Adverse Incident definition:

'Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation arising during the course of the business of a HSC organisation/Special Agency or commissioned service.'

As incidents in some cases can experience some delays prior approval, approved incident data will change from time. *This reports reflects incident data extracted at 16 Apr 2024*

AIs & SAIs



Incident Severity (AIs & SAIs)

Serious Adverse Incidents (SAIs)

171* SAI Notifications were submitted

*Excludes [redacted] SAI Notifications that were subsequently withdrawn following further consideration

↓ **14%** Decrease from previous year

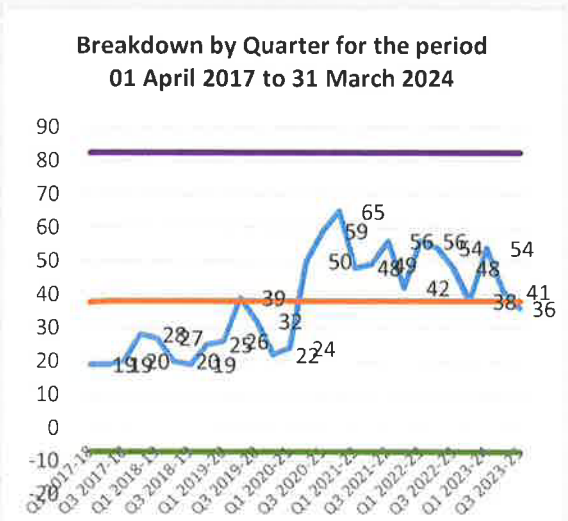
Summary SAI Review Level:
Level 1 SEA = 157
Level 2 RCA = 13
Level 3 RCA = [redacted]

Summary Linked Events:
SAI Never Events = 9
New SAIs currently linked to Complaints =23
(For this reporting period there were also [redacted] complaints raised in relation to SAI processes of reviews still ongoing)
SAI linked to Coroner's = 43
SAI currently linked to Claims = [redacted]
SAI linked to Early Alerts = 17

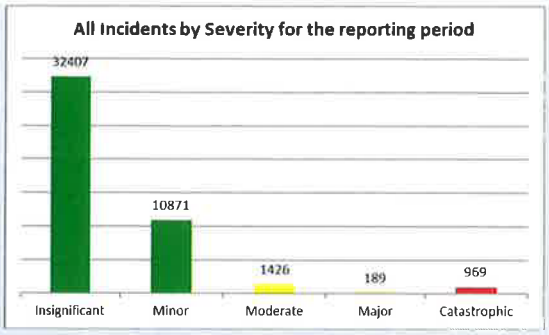
Summary SAI Reports:
As at 31 March 224 there were 227 SAI reports outstanding with SPPG.

216 SAI reports were submitted to SPPG during this reporting period

SAIs



[1]Trends in relation to severity remain largely unchanged for insignificant or minor severity incidents. <u>However</u> [1]Catastrophic severity incidents have increased from 365 (0.99%) for the same reporting period in 2022/23 to 969 (2.1%). This is mainly due to the increased reporting of



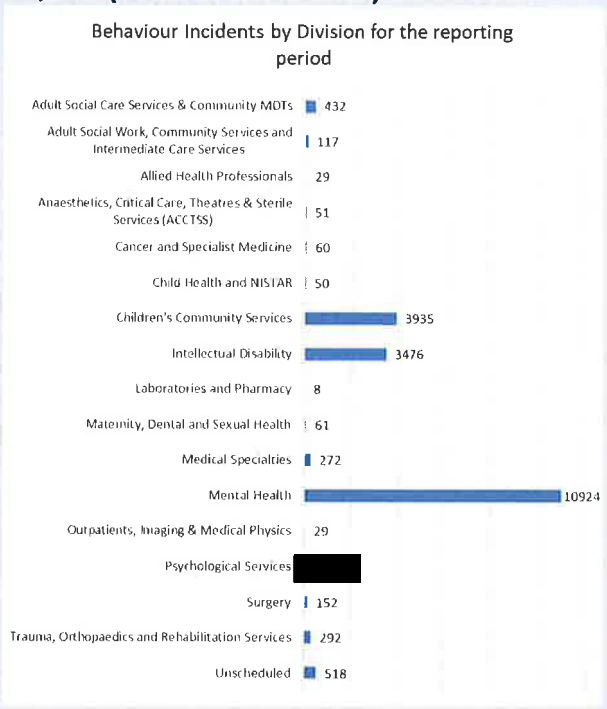
94%[1] recorded as insignificant (no harm) or minor severity, while **2.1%[1]** Incidents recorded as Catastrophic severity

overcrowding / ongoing pressures in the Emergency Departments.

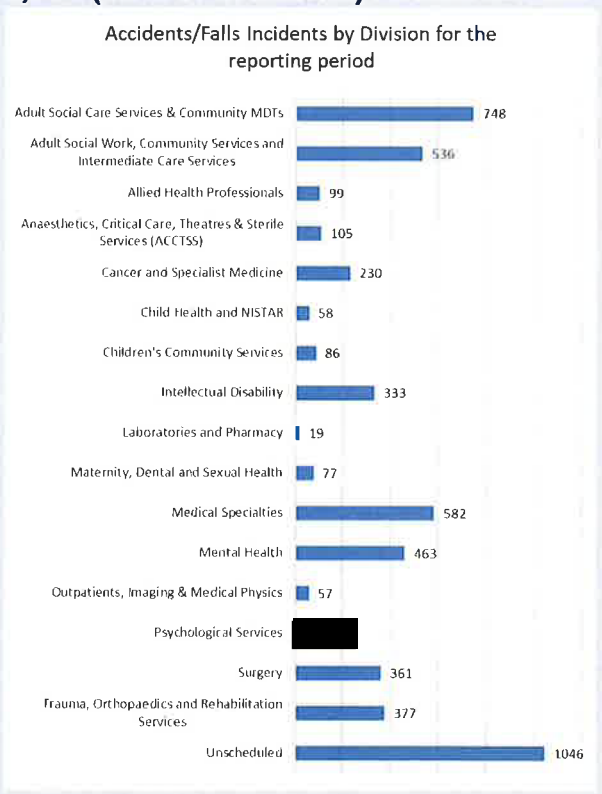
For this reporting period, 792 out of the 969 Catastrophic incidents were reported under Adult Emergency Departments. Of these, 767 were coded as Type Tier One 'Service Disruptions (environment, infrastructure, human resources)'.

Incident Type Tier – most commonly reported types for this reporting period have remain unchanged

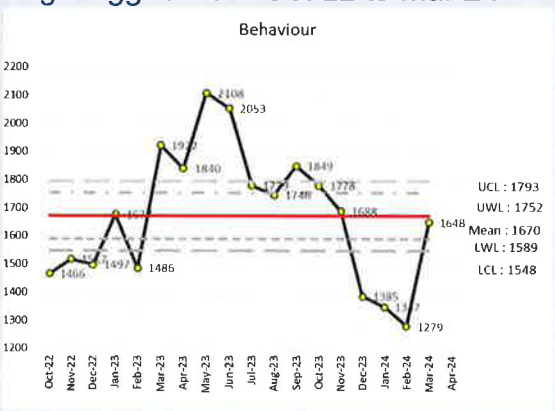
20,500 (45% of incidents) Behaviour



5,393 (12% of incidents) Accidents/Falls

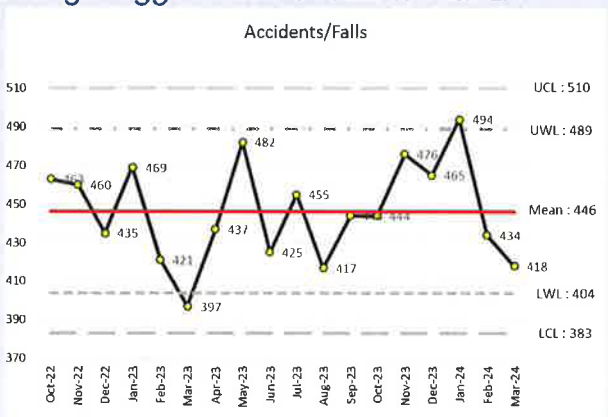


Change logged from Oct 22 to Mar 24



Had reduced significantly, until recently

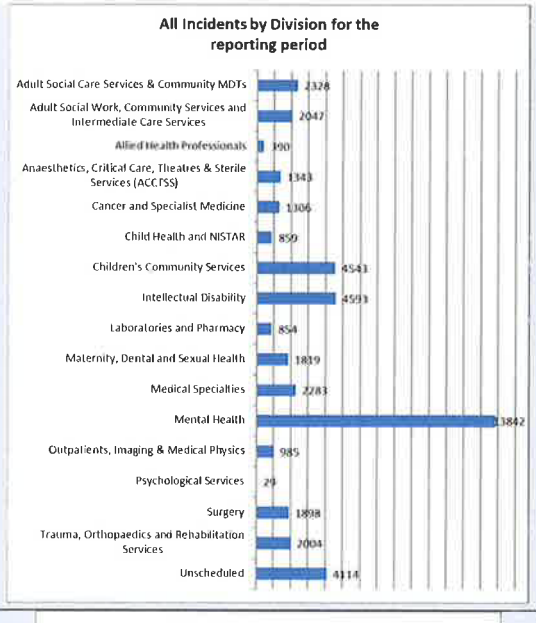
Change logged from Oct 22 to Mar 24

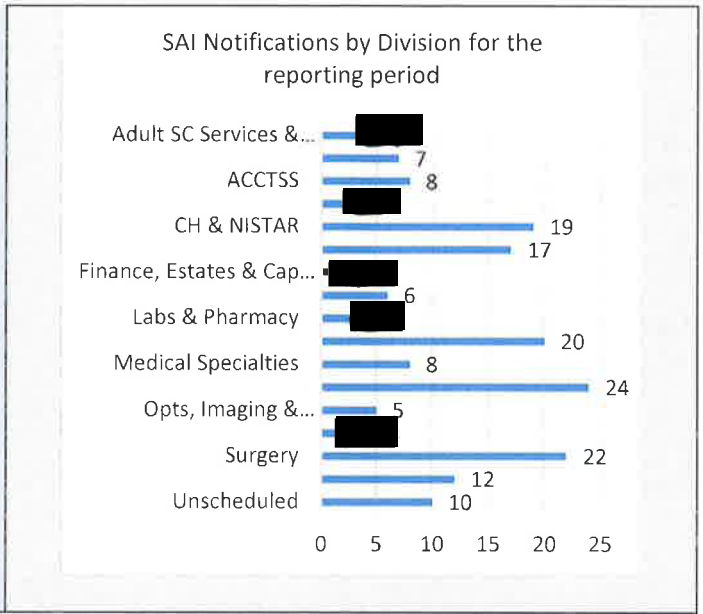


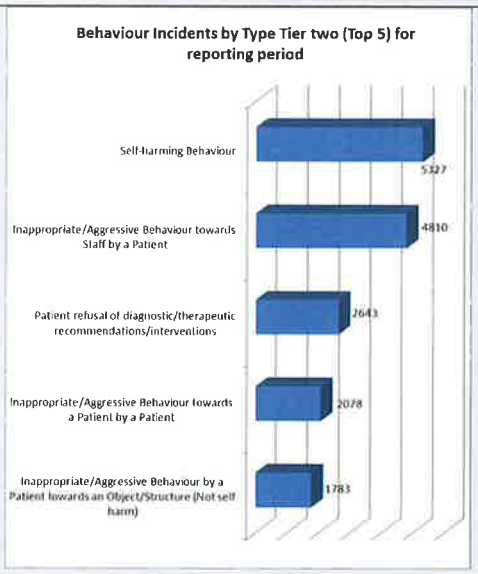
Falls data reviewed as per Falls Forum

AI (inc SAIs) Reporting by Division

SAI Reporting by Division

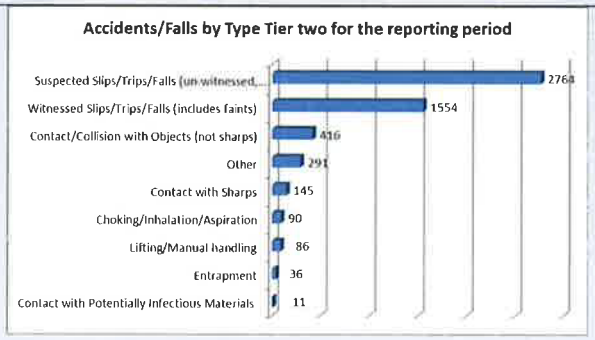






In addition to the top 5, there were 156 incidents of 'Inappropriate/Aggressive Behaviour towards a Patient by Staff'. Where the investigation is still ongoing at time of this report being generated, these incidents are shared with Directorate teams for their information and triangulation with their existing information.

There were also 45 incidents of 'Inappropriate/Aggressive Behaviour towards Staff by Staff'. These are shared with the HR Department on a quarterly basis. HR has confirmed this information is shared via the Director with the HR Co-Directors with a request to follow-up with relevant Business Partners in order that they can support the service area if required.



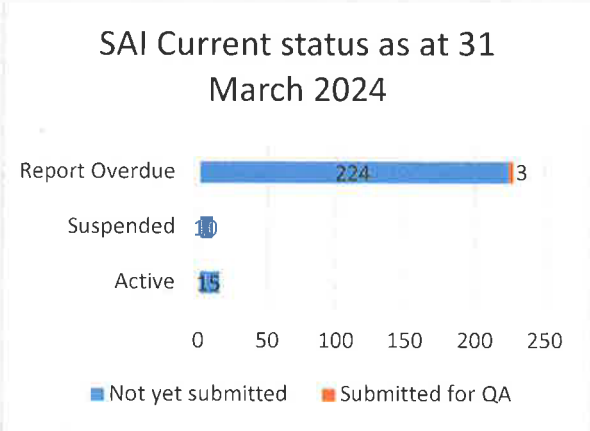
Of these accidents/falls, 77 (60 staff, 16 service user, [redacted] visitor) were reported to the Health & Safety Executive (NI) under RIDDOR Regulations as follows:

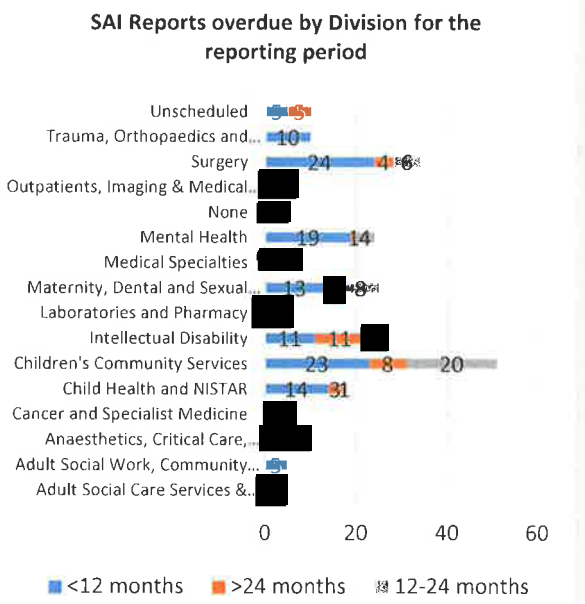
- Injury preventing work for more than 3 days – 46
- Major injury or condition – 22
- Dangerous occurrence – 5
- Fatality - [redacted]

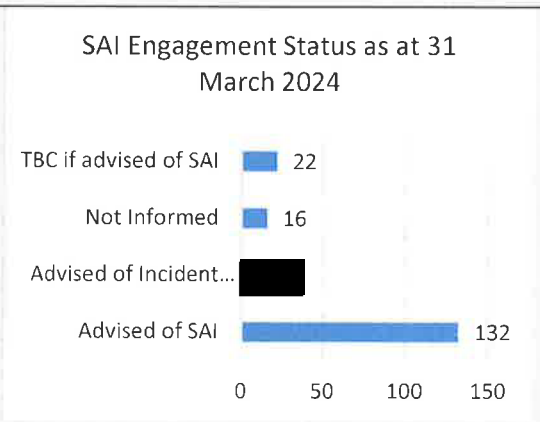
Injury to member of public resulting in being taken to hospital

SAI Reports.

There remains a high number of SAI reviews outstanding for the Trust







Ongoing follow-up with Directorates is completed to confirm status of engagement.

Within this reporting period there has been [redacted] complaints received in relation to the SAI review process including engagement.

Other Points to note in relation to AIs & SAIs

At 16 Apr 2024 996 **incidents** (excluding Independent Sector) awaiting approval for this reporting period. There is an established escalation protocol to notify services of incidents overdue for approval.

- SAI data is presented through the existing Trust QMS arrangements and is now also brought to the Executive team on a monthly basis. This information is used by Divisional teams for sense making and is monitored by the Executive Director Group.
- Additional meetings have been organised with the majority of the Senior Leadership teams across the different Divisions. At these meetings (facilitated by the Co Director for Risk & Governance and Deputy Medical Director) the number of SAI reviews outstanding along with outstanding SAI Action Plans are discussed to try and identify any additional assistance required or potential solutions. This remains under close scrutiny.
- Trust Serious Adverse Incident Group (SAIG) continues to seek to identify important learning as early as possible and where appropriate prior to a SAI review concluding. This supports learning being appropriately escalated and assurance provided. A Corporate Risk in relation to the delay in completing an appropriate review, identifying learning, sharing and acting is logged on Datix and continues to be regularly updated and presented at this group.

- A weekly governance call supports early identification of important governance information including new SAIs and immediate learning. This is considered weekly by Executive Safety Huddle and is routinely shared with Senior Leadership Teams, Directors and Non-exec Directors. This is well established.
- Additional email correspondence is escalated to Director level as and when required. (This could be on the back of received SPPG correspondence, or a delay in meeting additional SPPG Targets). This will be monitored closely by Risk & Governance and updated at regular intervals.
- Regular Assurance updates from SAIG are provided into the Clinical & Social Care Governance Steering Group Meeting (as per Assurance Framework arrangements)

Additional Reporting in relation to SAIs *(and Interface queries)*

39 SAI Notifications also submitted to RQIA during the period (as per reporting requirement)
[redacted]SAI Notification also submitted to NIAIC during the period
5 SAI Notifications also submitted to HSE during the period

42 Interface Incidents raised by BHSCT and submitted to SPPG during the period

Current Status	Count
Closed by SPPG	31
Open & Under Review	11

12 Interface Incidents received by BHSCT from SPPG during the period

Current Status	Count
Closed by SPPG	[redacted]
Open & Under Review	9

Learning Activity

In addition to the work undertaken by the established Assurance groups outlined as part of the Integrated Assurance Framework of the Trust in the review of specific incidents and SAIs there has been:
15 Shared Learning letters issued in relation to learning identified by Incidents
30 Shared Learning letters issued in relation to learning identified by SAIs
[redacted]Safety Message of the Weeks also issued during this time period

Incidents, SAIs and Risks - At year-end there were four risks on risk registers linked to incident reporting. This includes a Corporate Risk (Ref MDCG10). This risk currently outlines '*If there is a failure to escalate and appropriately review incidents and there is subsequent delay in completing an appropriate review, identifying learning, sharing and acting on this, there is a risk service users and/or staff could experience preventable harm.*' This risk would be reviewed and updated on at least a quarterly basis

Audit - Divisions on an ongoing basis audit incident data to identify trends or areas were further discussion or action may be required. In addition to this Internal Audit (external to the Trust) would also at least annually complete at least one audit that has a specific focus on incident reporting. For this period an audit was undertaken in November 2023 with a focus on Violence and Aggression incidents. Internal Audit findings from this audit were 'satisfactory'.

Going forward –
New Learning Strategy is currently being considered for issue late 2024
Work is underway across the region to assist in the testing of new review methodology in advance of new Guidance being agreed and issued to replace the existing Regional SAI Guidance last issued in 2016.

Note: Data outlined below has been extracted from the annual Incident and SAI report. A similar trend in incident and SAI data presentation to that previously made available to Assurance Committee was seen during the preparation of this report.

In Summary - Incident reporting continues to steadily rise. SAI reporting has fallen back slightly. Incident severity remains largely unchanged with the exception being incidents noted with a Catastrophic Severity largely due to the incidents being logged in an ED setting primarily linked to 'Gross failure to meet external/ national standards'
The same top types of incidents are being reported through with Behaviour 45 % followed by Accident Falls.
In relation to SAIs, the continued ongoing challenge is to clear the high number of SAI reviews outstanding.