HSC Belfast Health and
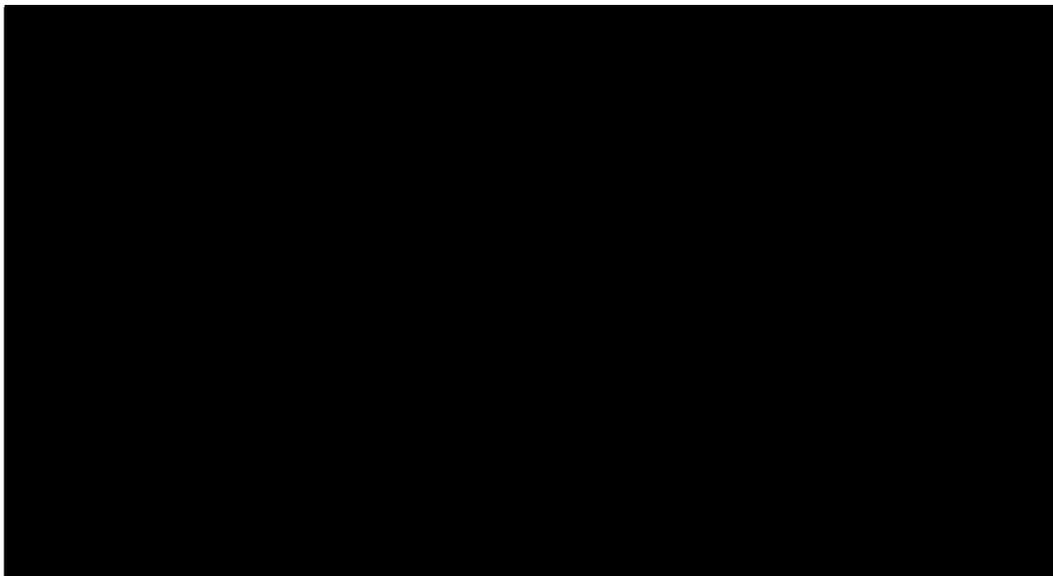Social Care Trust

caring supporting improving together

Risk & Governance

Amalgamated Assurance Report

July 2023

Incorporating:

Trust Incident & SAI Quarterly Report:
Q1: 01 April 2023 to 30 June 2023

Belfast Health and Social Care Trust

caring supporting improving together

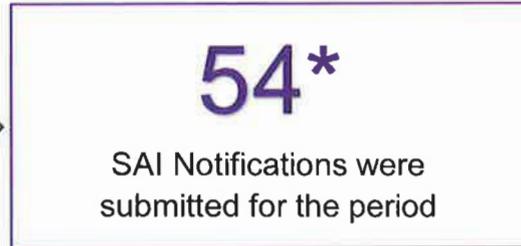# Trust Adverse Incidents and Serious Adverse Incidents Report

For reporting period 01 April 2023 to 30 June 2023 (as at 03 July 2023)

EXECUTIVE SUMMARY

## Adverse Incidents

10,859[1]

Reported Incidents occurred Trust-wide

Serious Adverse Incidents

54*

SAI Notifications were submitted for the period

excludes 1 SAI Notification that has since been withdrawn

⬆ **6.4%**

Increase in Incidents from same period in the previous year (10,210 incidents).

When incident data is compared to 2017/2018 period there had been 7,261 (49.6% increase)

Note: This report does not include Incidents reported by Independent Sector Providers. (2,291 incidents)

4% ⬆

Slight increase in SAIs compared to the same period in the previous year which had 52* SAI Notifications.
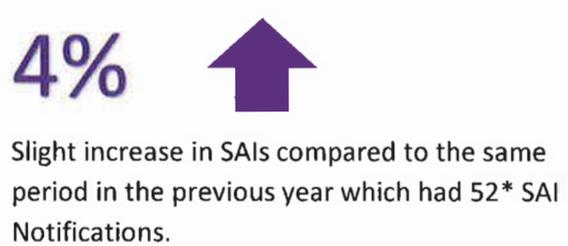
excludes 5 SAI Notifications that were later withdrawn

When SAI data is compared to 2017/2018 period there had been 19 (184% increase)
excludes ■ SAI Notification that was later withdrawn

Breakdown of level of review:

50 Level 1 SEAs
■ Level 2 RCAs

These 54 SAIs include:

■ Never Events
7 linked to Complaints
18 linked to Coroners
5 linked to Early Alerts

At 30 June 2023 there were 304 SAI reviews identified as being outstanding with SPPG. 14 SAI reports were submitted to SPPG during this reporting period.

Adverse Incidents by Severity

Trends in relation to severity remain largely unchanged for insignificant or minor severity incidents.

95.3%

Incidents were recorded as insignificant (no harm) or minor severity
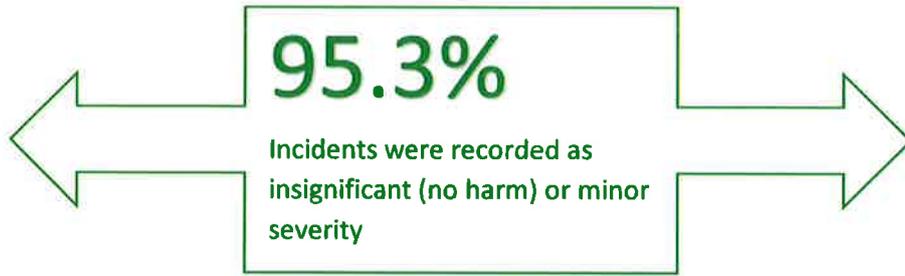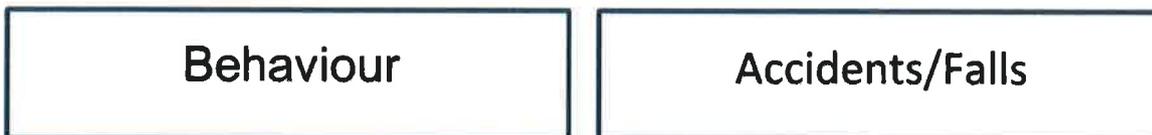
Catastrophic severity incidents have increased from 0.2% in the same period of the previous year. This is due mainly to the increased reporting of overcrowding/ongoing pressures in the Emergency Departments (with a Catastrophic Severity)

1.59%

Incidents were recorded as catastrophic severity
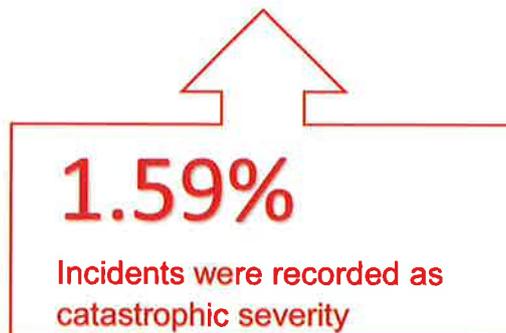
Adverse Incidents by Type

The most commonly reported types of incidents for this reporting period were:

Behaviour	Accidents/Falls

Incident data is used to support a wide range of Quality Improvement projects.

Serious Adverse Incidents with a Catastrophic Severity

18 (33%)

Serious Adverse Incidents were recorded as
catastrophic severity
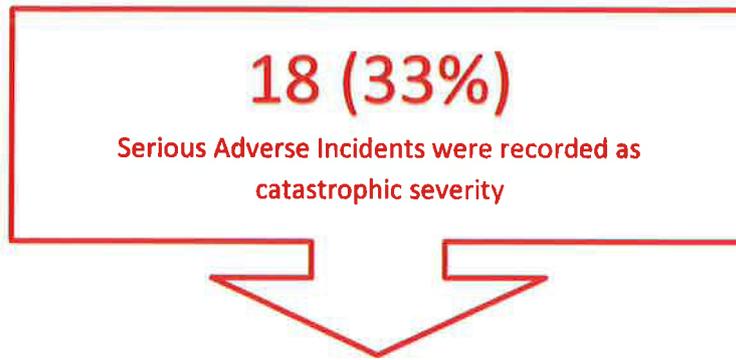
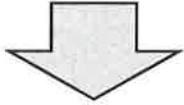| Type Tier One	Count
Behaviour (Including Violence and Aggression)	7
Diagnostic Processes/Procedures	
Medication/Biologics/Fluids	
Patient Accidents/Falls	
Unexpected Deaths or Severe Harm	5
Grand Total	**18**

Serious Adverse Incidents by Type (Tier 1)

The most commonly reported types of incidents for this reporting period were:

Behaviour

11 (20%)

SAI Notifications

Breakdown by Type Tier 3	Count
Other	
Physical contact (actual assault)	
Sexual (including indecent exposure)	
Suicide (actual)	
Grand Total	**11**

Diagnostic Processes / Procedures

10 (19%)

SAI Notifications

| Breakdown by Type Tier 3	Count
Delayed	
Delayed diagnosis	
Failure/insufficient response to significant change in patient status	
Failure/insufficient/incomplete monitoring	
Incorrect/insufficient triage in emergency situations	
Insufficient/incomplete/incorrectly performed	
Interpretation of investigation insufficient/incorrect/incomplete	
Interpretation of investigation not performed	
Specimen missing	
Grand Total	**10**

1.   INTRODUCTION

1.1.   All Adverse Incidents

During the period between 01 April and 30 June 2023 a total of 10,859[1] reported incidents occurred Trust-wide. In comparison, during the period from 01 April and 30 Jun 2022, a total of 10,210 reported incidents occurred. This represents a 6.4% increase.

In addition, there were 2,291 incidents reported by Independent Sector providers inputted onto Datix during this reporting period. These incidents are not included in the following graphs and statistics. They are separately monitored and reported on by the Trust's Quality & Support Team and/or Contracts office.

Fig. 1
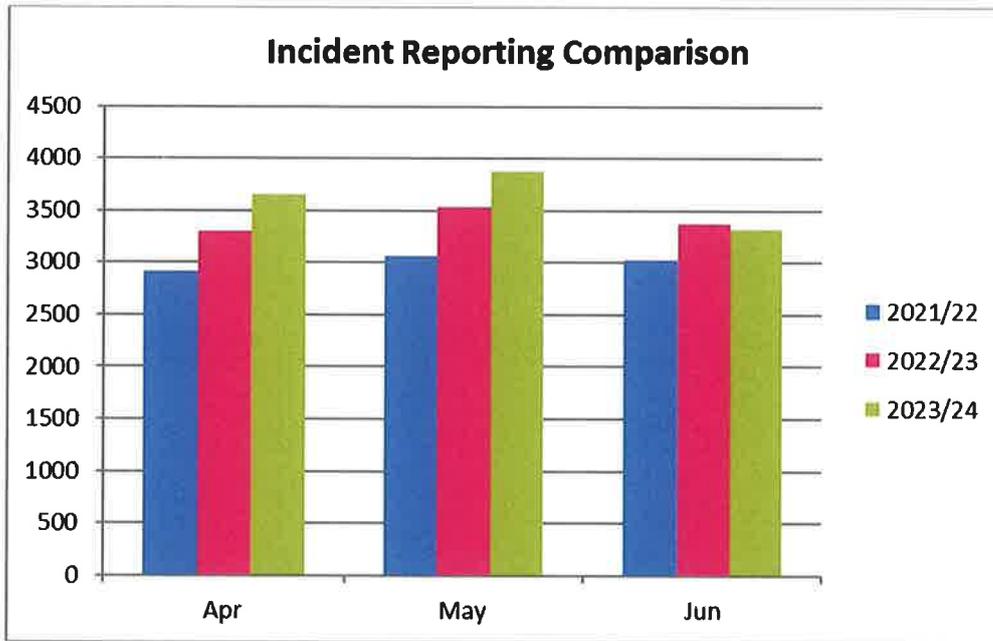
The 2020/21 period was during the height of the COVID-19 pandemic when there was a general downturn in incident reporting. Reporting levels have generally steadily increased since.

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[1] *It should be noted that quality assurance of data is ongoing, therefore statistics throughout this report are presented subject to alteration.*

1.2. Serious Adverse Incidents (SAIs)

1.2.1 New SAI Notifications

During the period between 01 April 2023 and 30 June 2023 a total of 54 new SAI notifications were submitted to the Strategic Planning & Performance Group (SPPG).

Of these SAIs, ▮ occurred in the Trust's Emergency Departments compared to ▮ or the same period in the previous year.

Fig. 2

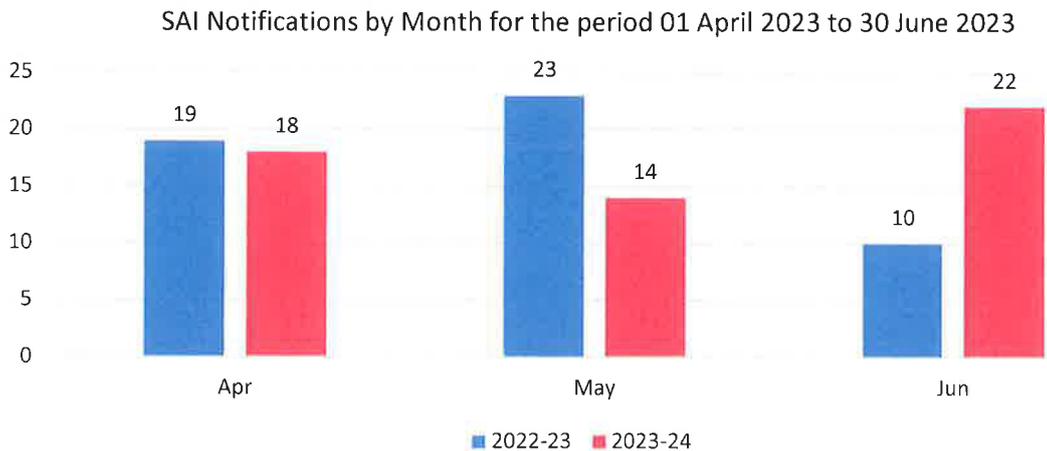SAI Notifications by Month for the period 01 April 2023 to 30 June 2023

Figure 2 above shows the monthly comparison of new SAI notifications between the two periods in 01 April 2022 to 30 June 2022 and 01 April 2023 to 30 June 2023.

Fig.2a

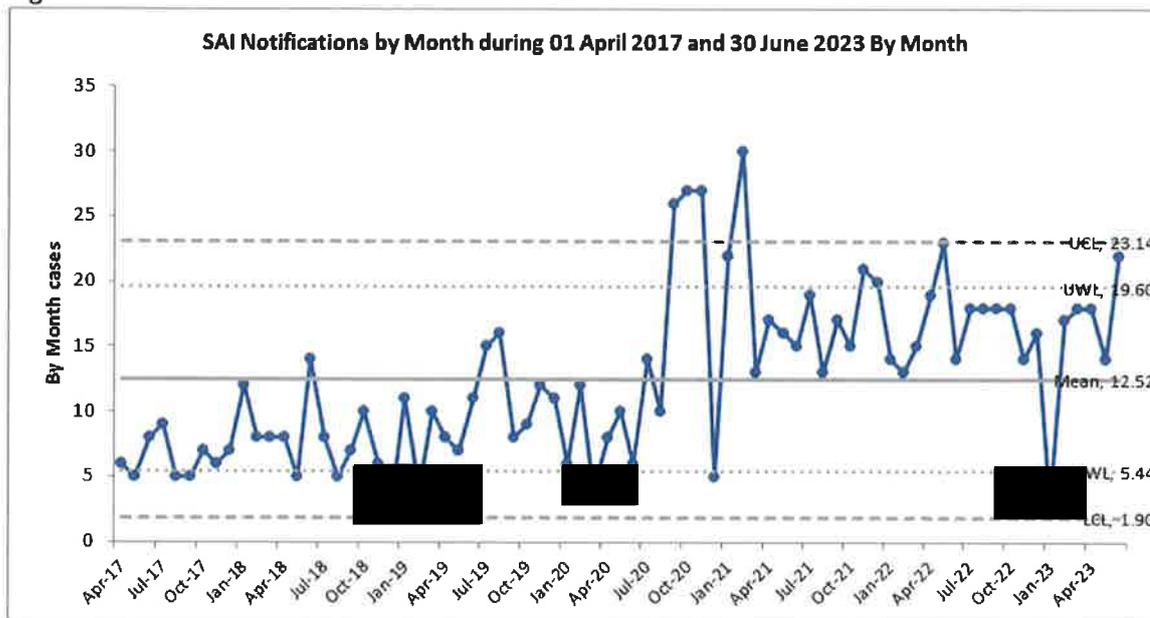SAI Notifications by Month during 01 April 2017 and 30 June 2023 By Month

Figure 2a provides a breakdown of SAI notifications by month from 01 April 2017 to 30 June 2023. The SPC chart shows that there has been a general increase in SAI notifications especially over the last 3 years which has been more significant since September 2020 onwards

Fig. 2b

SAI Notifications by Level of Review for the period 01 April 2023 to 30 June 2023

Figure 2b shows a breakdown of new SAI notifications for the period by Directorate and SAI Review Level.

50 (93%) new SAI notifications were for Level 1 SEA review while 4 (7%) were for Level 2 RCA. There were no Level 3 notifications for the reporting period.

[For the same period in previous year, 45 (87%) new SAI notifications were for Level 1 SEA review and 7 (13%) were Level 2 RCA reviews. There were no Level 3 notifications for the reporting period.]

Level 3 SAIs are reviews that are considered particularly complex involving multiple organisations, have a degree of technical complexity that require independent expert advice; and/or are very high profile and attracting a high level of both public and media attention.

For level 2 and 3 reviews, terms of reference would be submitted to the SPPG for their review/approval, in advance of the review commencing.

Fig.3a

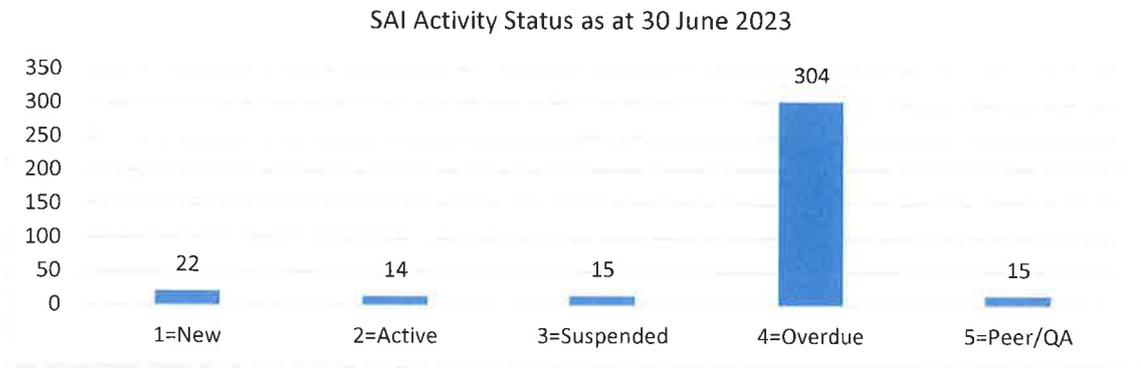### SAI Activity Status as at 30 June 2023

Figure 3a provides a breakdown of SAI activity as at 30 June 2023.

There are 36 SAI reviews underway that are still within SPPG timelines (i.e. have not yet reached their date of report due date to become overdue); 15 SAI reviews suspended due to ongoing PSNI investigations; and 304 SAI reviews overdue (i.e. date report due has past SPPG timelines and the report has not yet been submitted to Corporate Governance for peer/QA review), with 15 of these overdue reviews having a report submitted for QA/Peer review. This is a process to quality check reports for consistency, accuracy and completeness before submission to SPPG.

Fig.3b

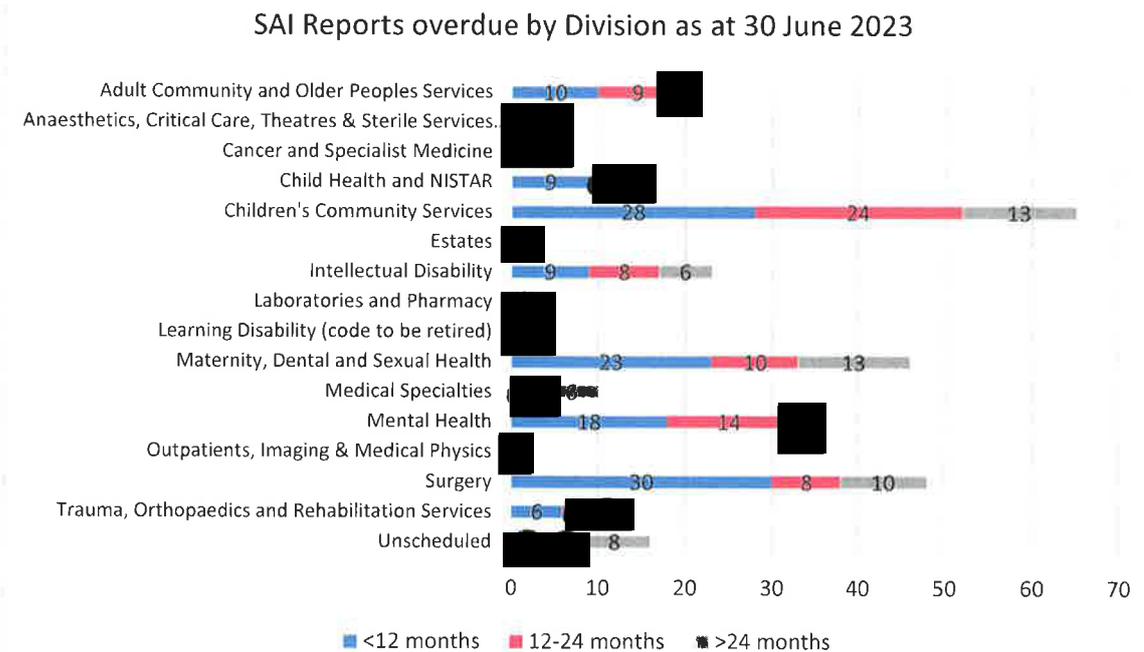### SAI Reports overdue by Division as at 30 June 2023

Figure 3b provides a breakdown of SAI reports overdue as at 30 June 2023 by Directorate and how long overdue (i.e. number of months past report due date)

1.2.3   SAI Reports Completed

A total of 23 SAI reports were submitted to SPPG during the period 01 April 2023 and 30 June 2023, compared to 26 reports submitted for the same period in the previous year.

Fig.4

SAI Reports submitted by Division for the period 01 April 2023 to 30 June 2023
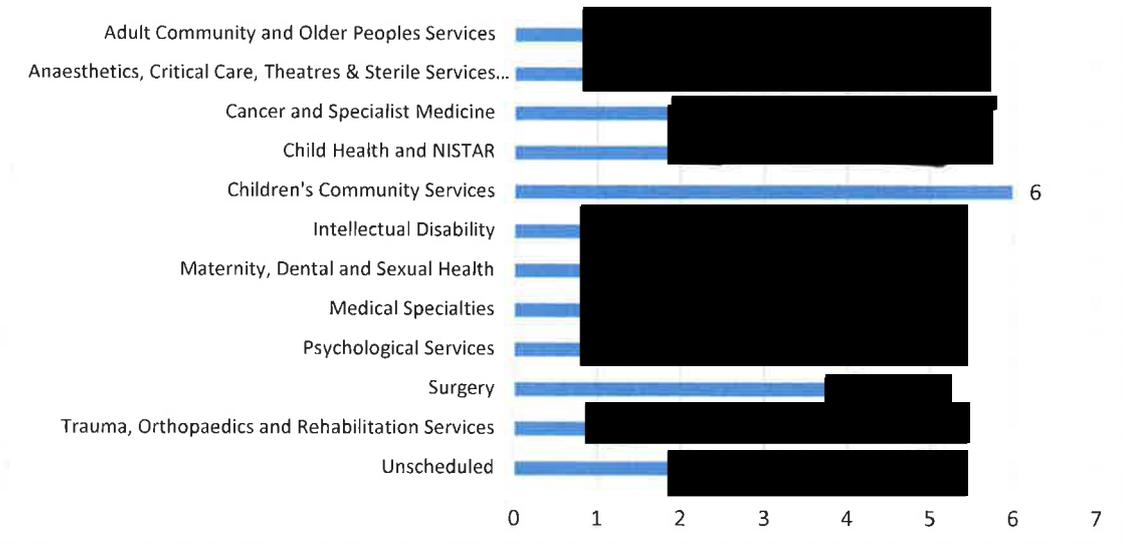
Over the last year there have been regular performance meetings with SPPG and BHSCT, with the most recent meeting occurring on the 28th June 2023. Concerns continue to be raised regarding high number of SAI reviews still not concluded and learning shared with SPPG.

From March 2023 individual meetings have been set up with Senior Leadership teams to discuss SAI data for each Division. This has included reviewing the number of SAI reviews outstanding, SAI Action Plans to be submitted for previously submitted SAIs and SAI Action Plans still to be closed.

Further escalation emails have been issued on behalf of the Medical Director to Director colleagues on the 30th June 2023 highlighting outstanding SAI reviews. This will be monitored closely by Risk & Governance and the Medical Director updated at regular intervals.

2. INCIDENTS BY DIVISION

2.1 All Adverse Incidents

Fig. 5

All Incidents by Division (Apr - Jun 23)
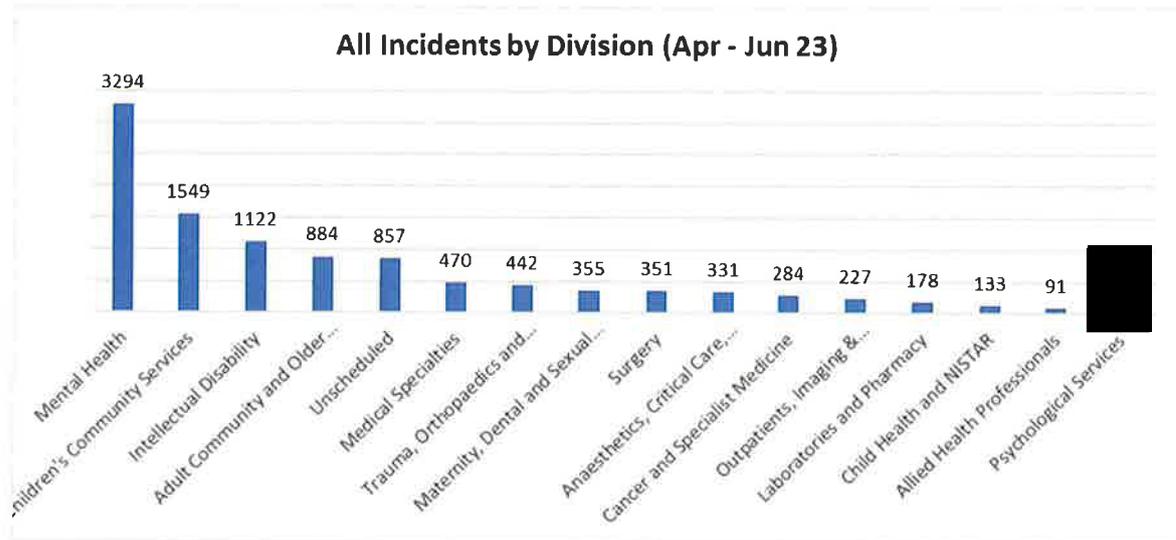
Figure 5 shows that the Division with the most reported incidents is Mental Health with 3294 (31.17%) incidents. Children's Community Services reported the second highest number of incidents with 1549 (14.66%) incidents.

2.2 Serious Adverse Incidents (SAIs)

Figure 7 shows the breakdown of SAI notifications by Directorate for the period 01 April 2023 to 30 June 2023.

Fig. 7

SAI Notifications by Directorate for the period 01 April 2023 to 30 June 2023
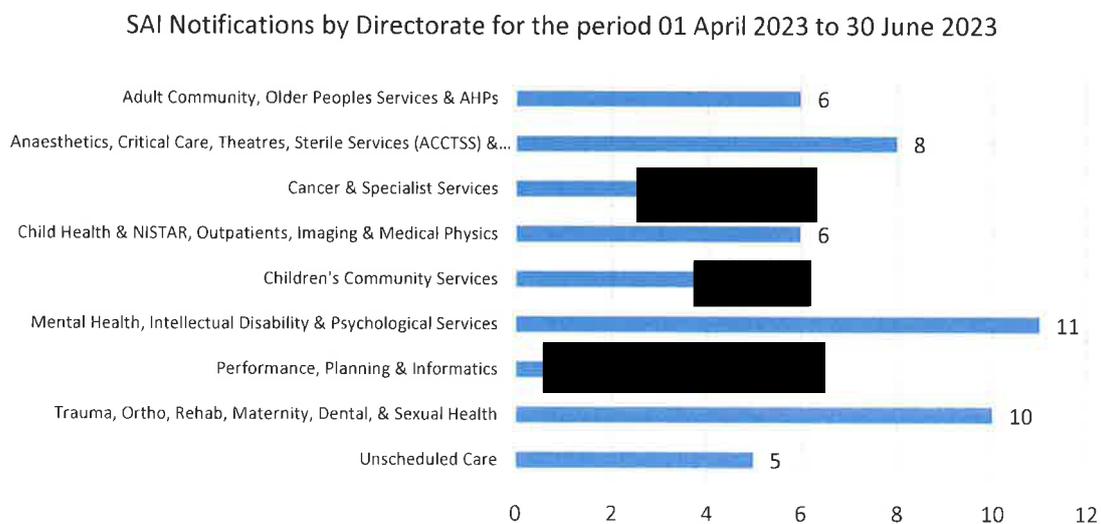
Figure 8 provides a further illustration of SAI Notification submitted by Division for the period.

Fig. 8

The 10 SAI Notifications raised by the Mental Health Division relate to ▮▮▮▮▮▮▮ and ▮▮▮▮▮▮▮▮▮▮ resulting in patient death.

3. INCIDENTS BY SEVERITY

3.1 All Adverse Incidents

Fig. 9

All Incidents by Severity (Apr - Jun 23)

Insignificant	Minor	Moderate	Major	Catastrophic
7806	2548	292	44	173

3.2 Serious Adverse Incidents (SAIs) by Severity

Fig. 12

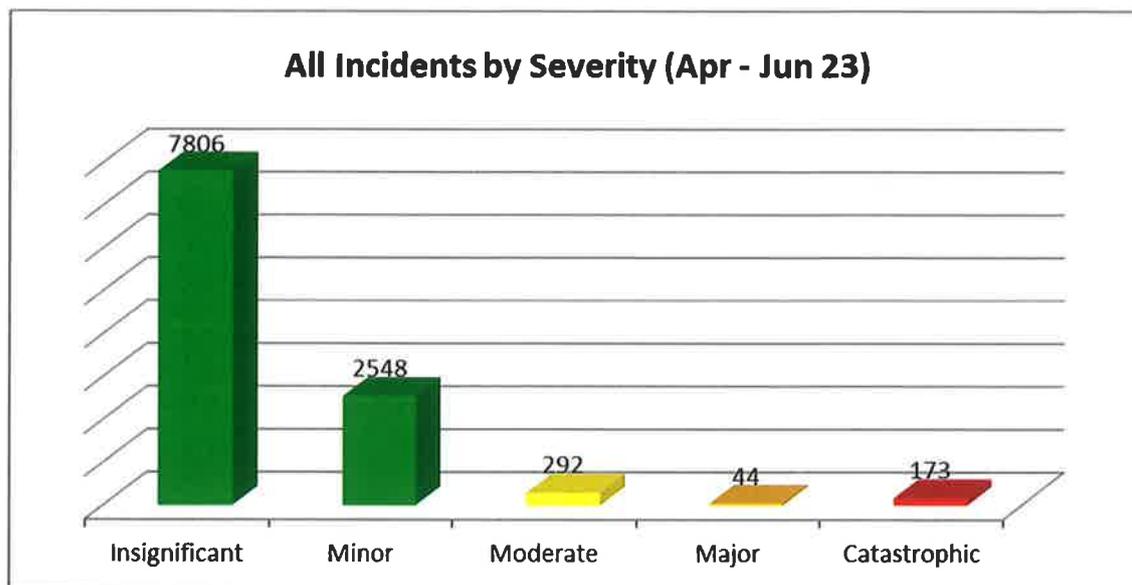SAI Notifications by Severity for the period 01 April 2023 and 30 June 2023
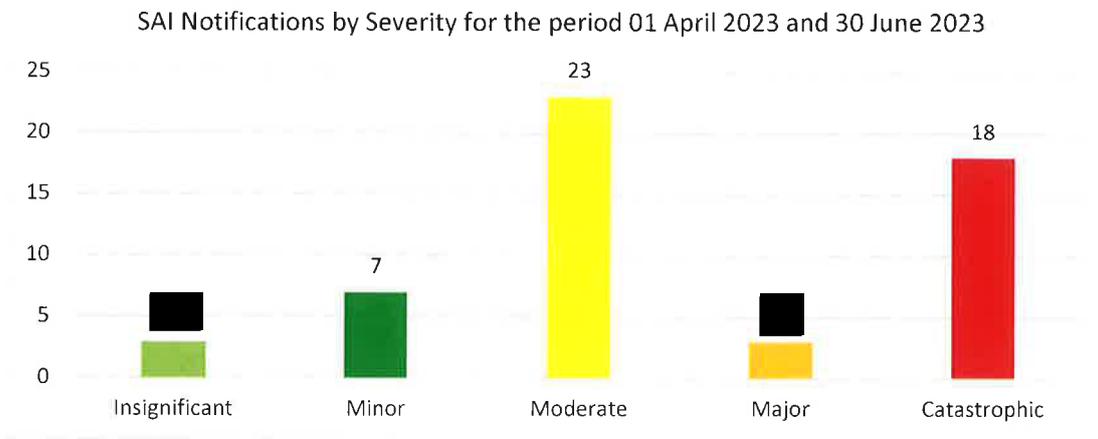
Fig12a

SAI Notifications By Division & Catastrophic Severity	Count
Adult Community and Older Peoples Services	
Unexpected death of service user (suspected suicide)	
Unexpected death of nursing home resident	
Unexpected death of service user who had fallen at home	
Children's Community Services	
Unexpected child death	
Mental Health	10
Choking incident resulting in patient death	
Death of a patient known to Mental Health Services (Suicide)	9
Surgery	
Medication Error (Incorrect Medication/fluid)	
Unscheduled	
Unexpected death of patient who attended ED from a nursing home with a history of falls and head injury.	
Inpatient death following unwitnessed fall	
Grand Total	18

Figure 12a provided a breakdown of Catastrophic severity by Division.

4.1 All Adverse Incidents by Type

Fig. 13

Incidents by Type Tier One - Top 10 (Apr - Jun 23)

Type	Value
Behaviour	5550
Accidents/Falls	1262
Medication/Biologics/Fluids	944
Other	618
Service Disruptions (environment, infrastructure, human resources)	384
Pressure Ulcers	293
Diagnostic Processes/Procedures	266
Documentation	226
Communication	216
Medical Devices, Equipment, Supplies	189
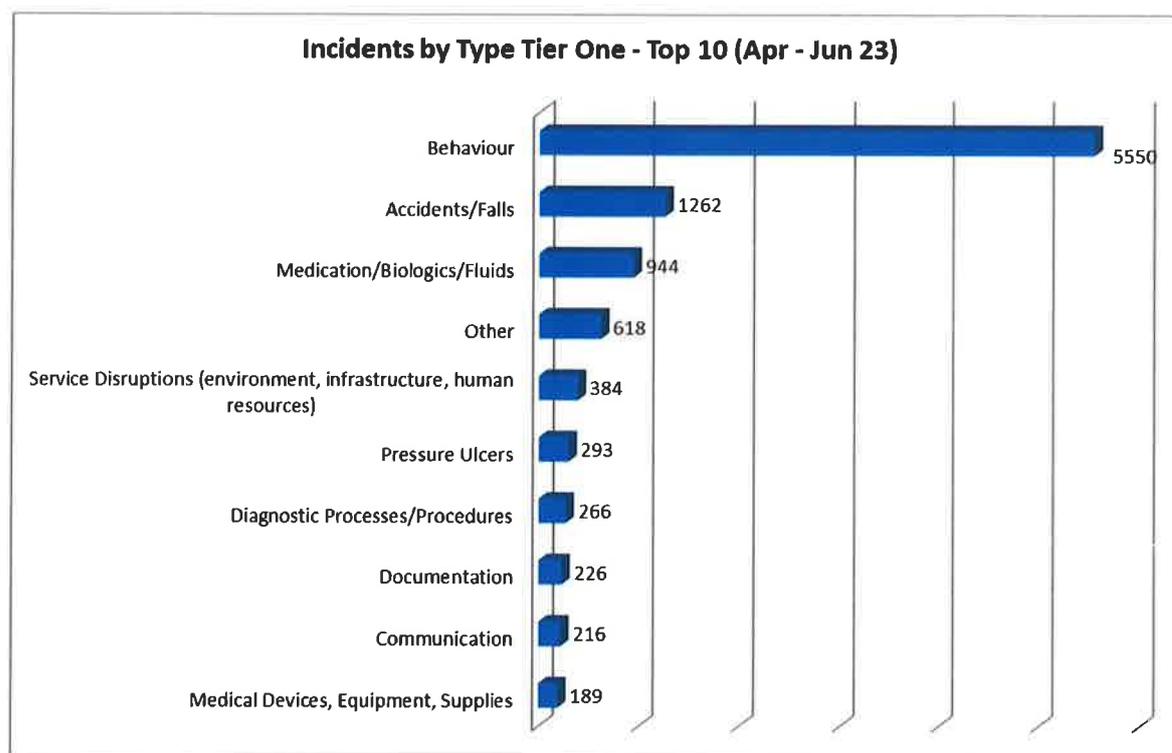
The top 2 types are displayed by Division in figures 14 and 15 below.

Fig. 14
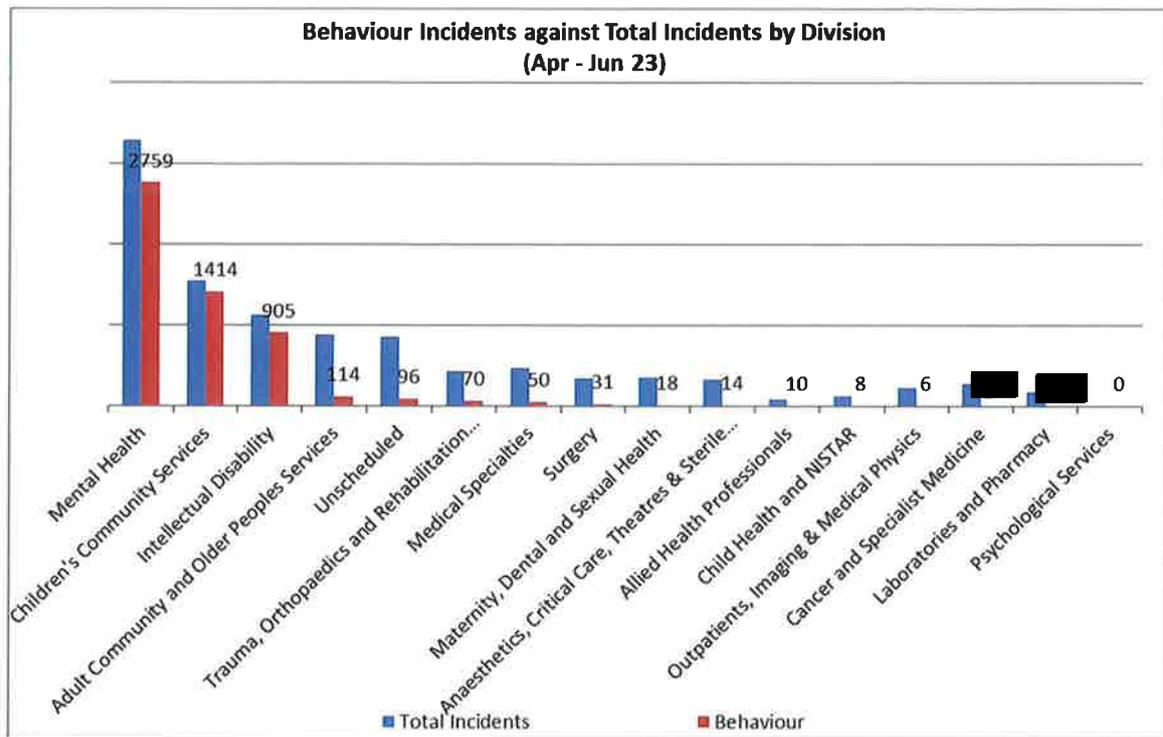
Fig. 15
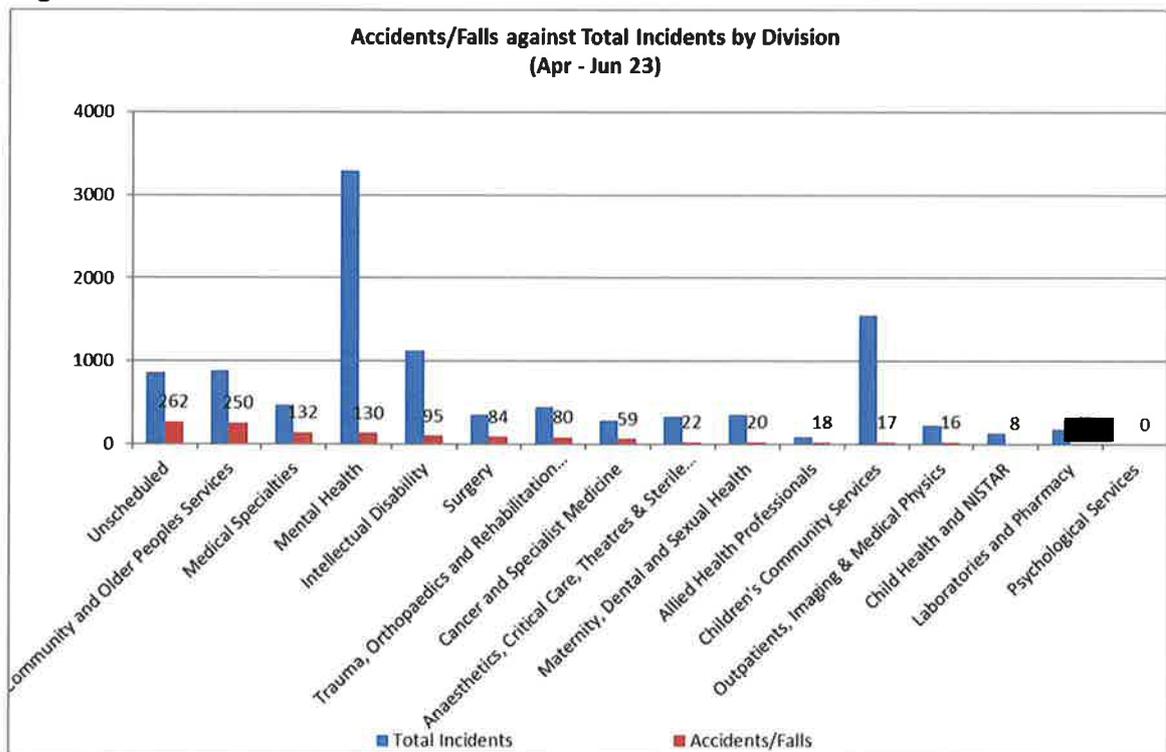
Individual run charts for the top 2 incident types for the last 2 years are shown in figures 16 and 17 below:

Fig.16
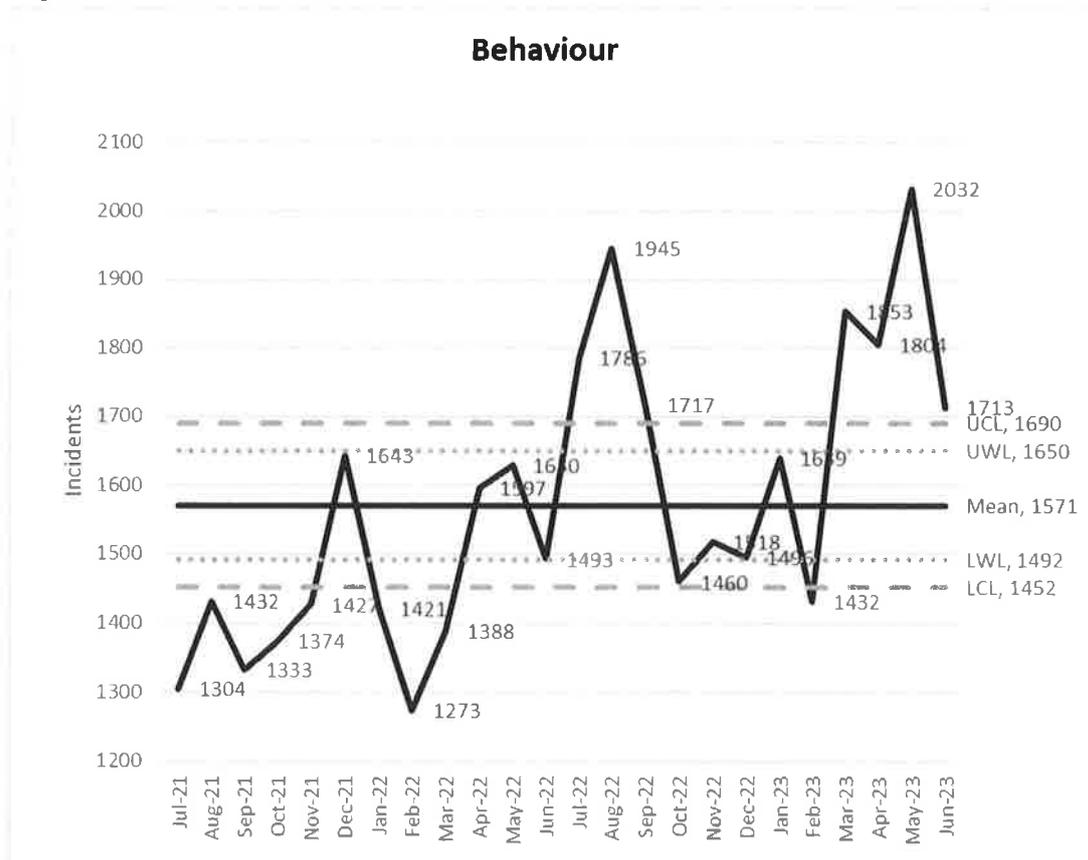
Behaviour

Fig. 17
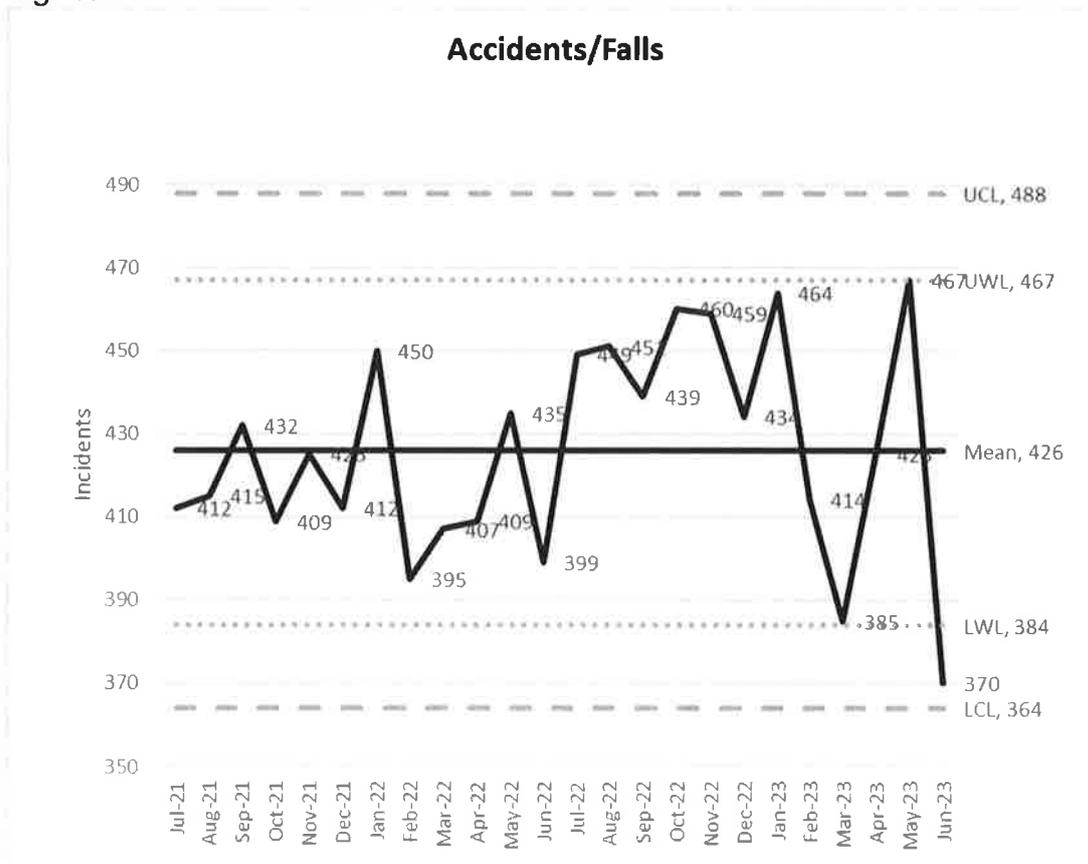
Accidents/Falls

4.2.1 'Behaviour' Incidents by Division (Top 3)

The data in figure 16 has been further broken down by the top 3 Divisions in figures 18 to 20 below. Figure 14 shows that, during this reporting period, the top 3 Divisions for Behaviour incidents were Mental Health, Children's Community Services and Intellectual Disability .

Fig. 18

Division: Mental Health
Behaviour

Fig. 19

**Division: Children's Community Services
Behaviour**

UCL, 404
UWL, 386
Mean, 348
LWL, 311
LCL, 292

Fig. 20

**Division: Intellectual Disability
Behaviour**

UCL, 391
UWL, 372
Mean, 336
LWL, 299
LCL, 281
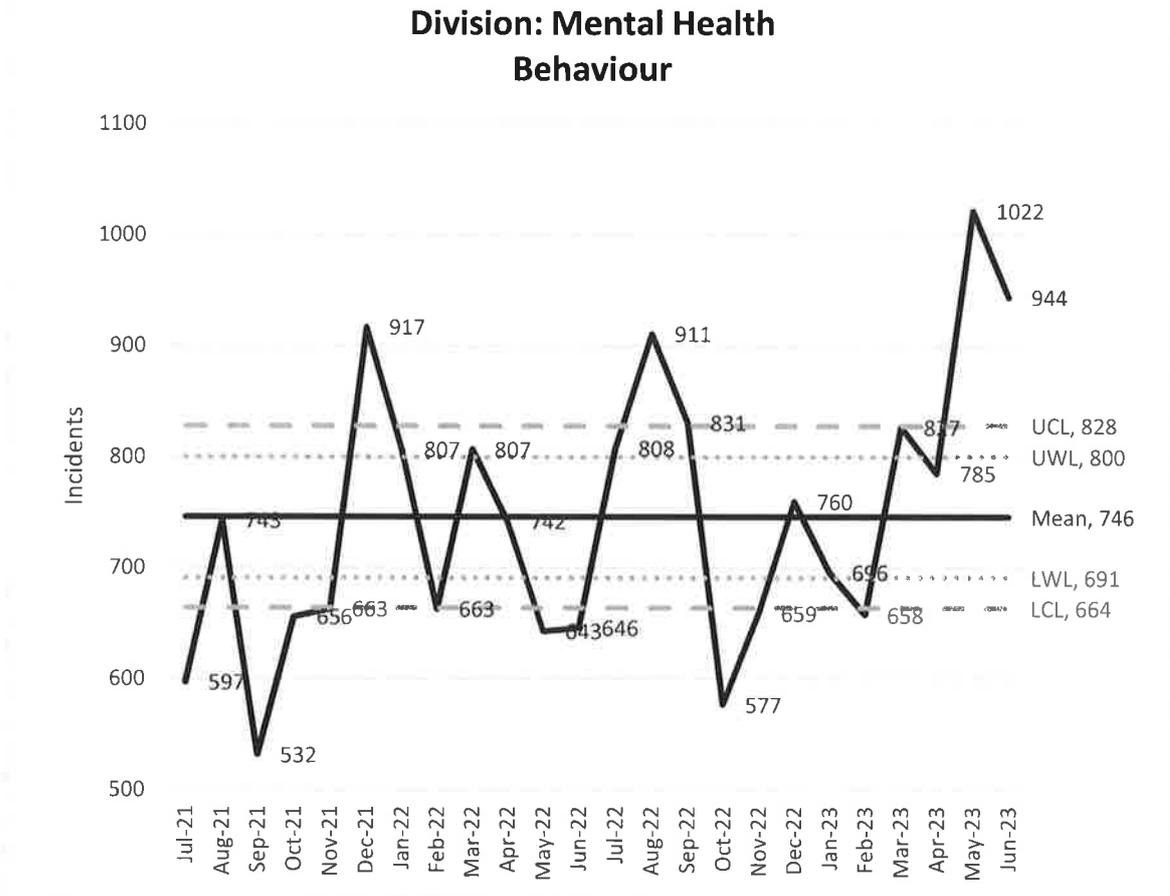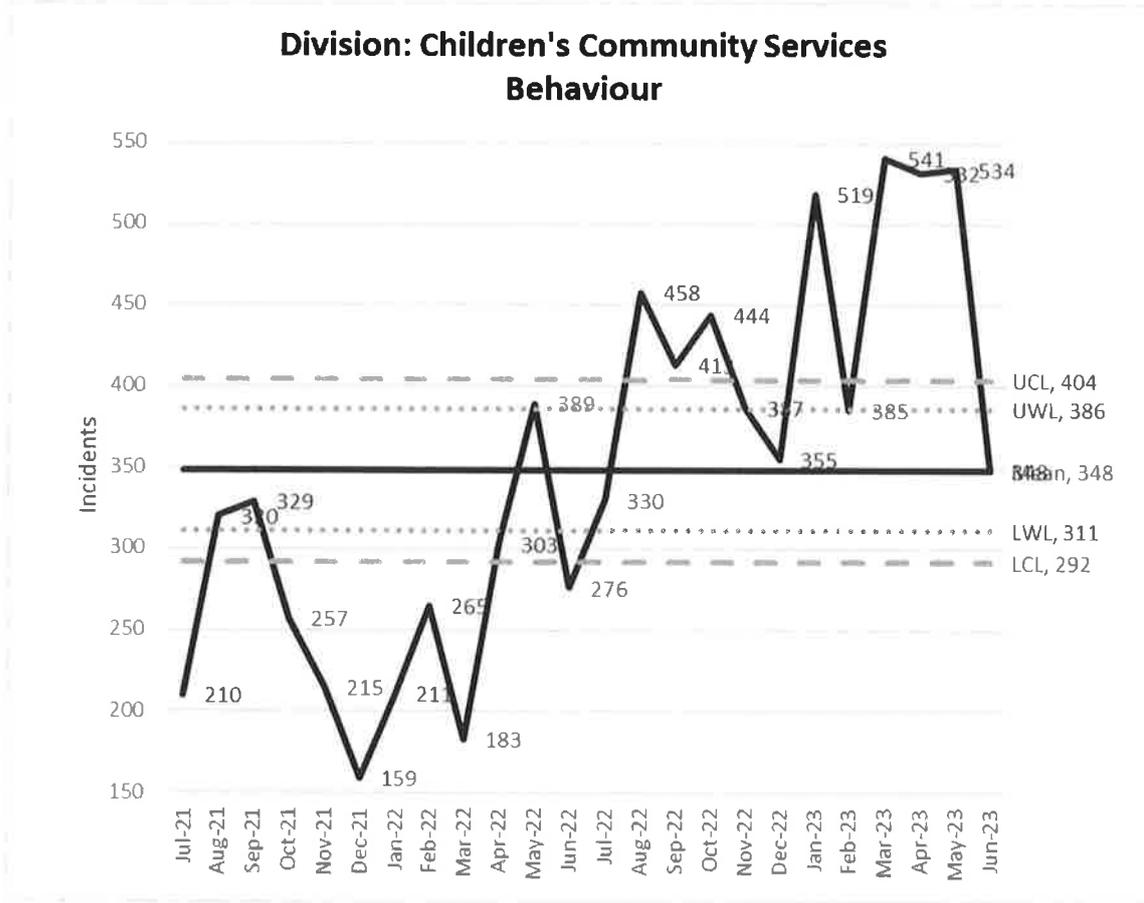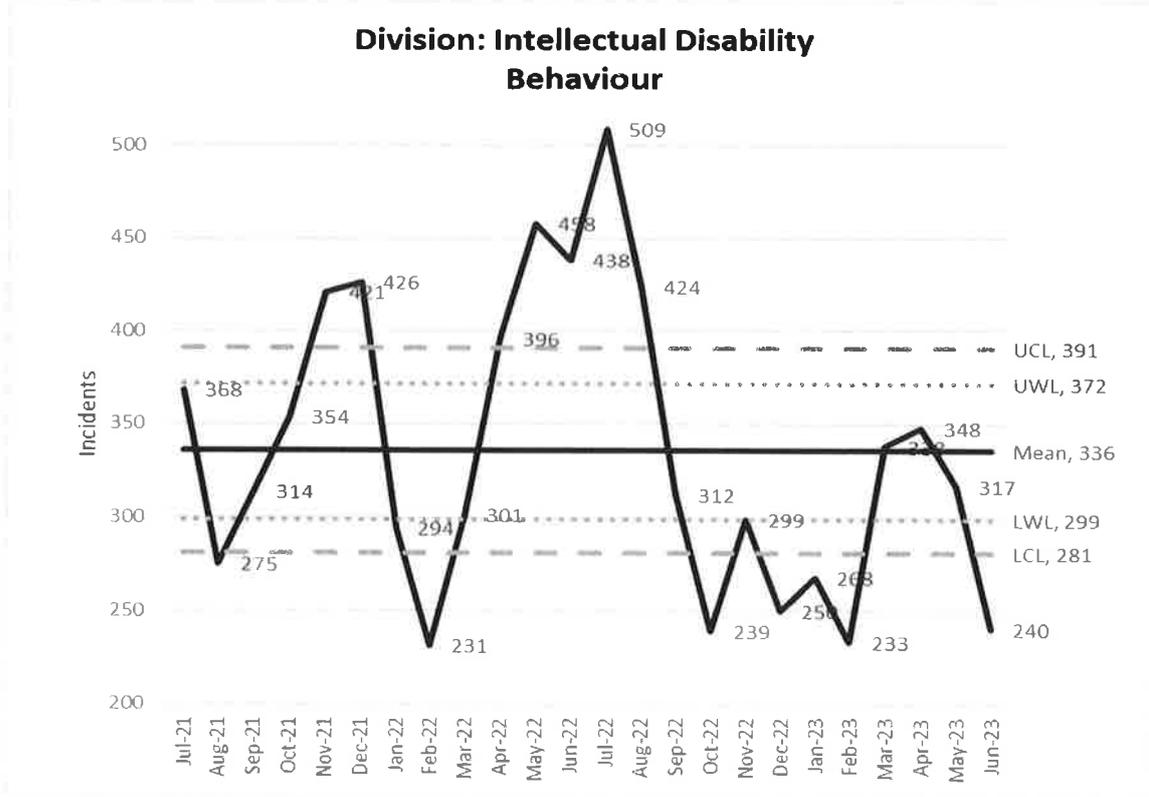
There has been a marked decrease in behaviour incidents within Intellectual Disability over the last two quarters. This can be at least partly explained by Positive Behavioural Support (PBS) training that has been made available to all staff bolstering the ongoing work of the Positive

Behavioural Support Therapists throughout the ID services. This enables staff to recognise, and understand, situations which may trigger challenging behaviours in our patients and service users and ultimately prevent it from becoming an adverse incident.

The service would hope that the number of incidents continues to consistently decrease, however is mindful that 1 service user or patient in crisis may increase this figure albeit temporarily. PBS training has raised the confidence of all the staff groups with the hope that the service users and patients feel more understood by the staff caring for them. The Division has confirmed this will be gauged through direct service user or patient feedback and continuing staff training and updates.

4.2.2 'Behaviour' incidents by Severity

Fig. 21

'Behaviour' Incidents by Severity (Apr - Jun 23)

Fig. 22

Behaviour Incidents by Type Tier 2 (Apr - Jun 23)

Category	Value
Self-harming Behaviour	1408
Inappropriate/Aggressive Behaviour towards Staff by a Patient	1289
Inappropriate/Aggressive Behaviour towards a Patient by a Patient	689
Patient refusal of diagnostic/therapeutic recommendations/Interventions	576
Uncooperative/Stubborn patient Behaviour	503
Missing Patient (absconded/abducted patient)	413
Inappropriate/Aggressive Behaviour by a Patient towards an Object/Structure (Not self harm)	364
Use/Possession of Prohibited/Stolen Goods	113
Other	59
Inappropriate/Aggressive Behaviour towards a Patient by a Visitor/Other	40
Inappropriate/Aggressive Behaviour towards a Patient by Staff	35
Inappropriate/Aggressive Behaviour towards Visitor by a Patient	21
Inappropriate/Aggressive Behaviour towards Staff by a Visitor	21
Inappropriate/Aggressive Behaviour towards Staff by Staff	13
Persons Performing Unauthorised Acts	5
Inappropriate/Aggressive Behaviour towards Visitor by Staff	
Inappropriate/Aggressive Behaviour towards a Visitor by a Visitor	

The data in figure 15 has been further broken down by the top 3 Divisions in figures 23 to 25 below. Figure 15 shows that, during this reporting period, the top 3 Divisions for accidents/falls were Adult Community & Older People Services, Unscheduled and Medical Specialties.

Fig. 23

Division: Adult Community & Older People Accidents/Falls

Fig. 24

Division: Unscheduled Accidents/Falls
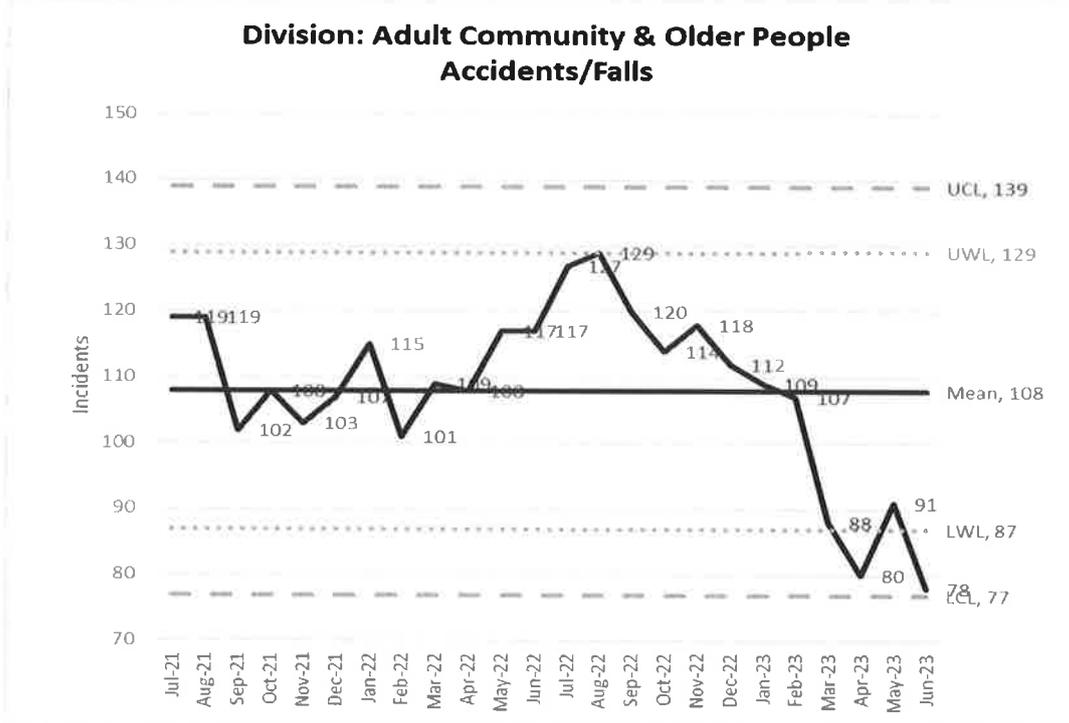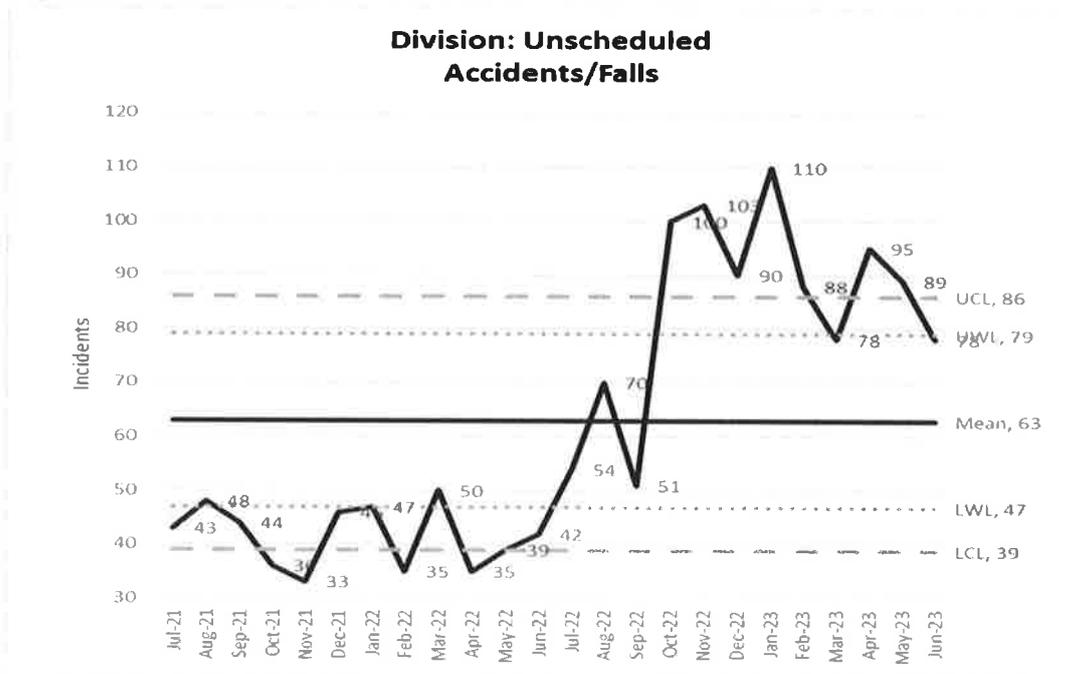
Fig. 25

Division: Medical Specialties
Accidents/Falls
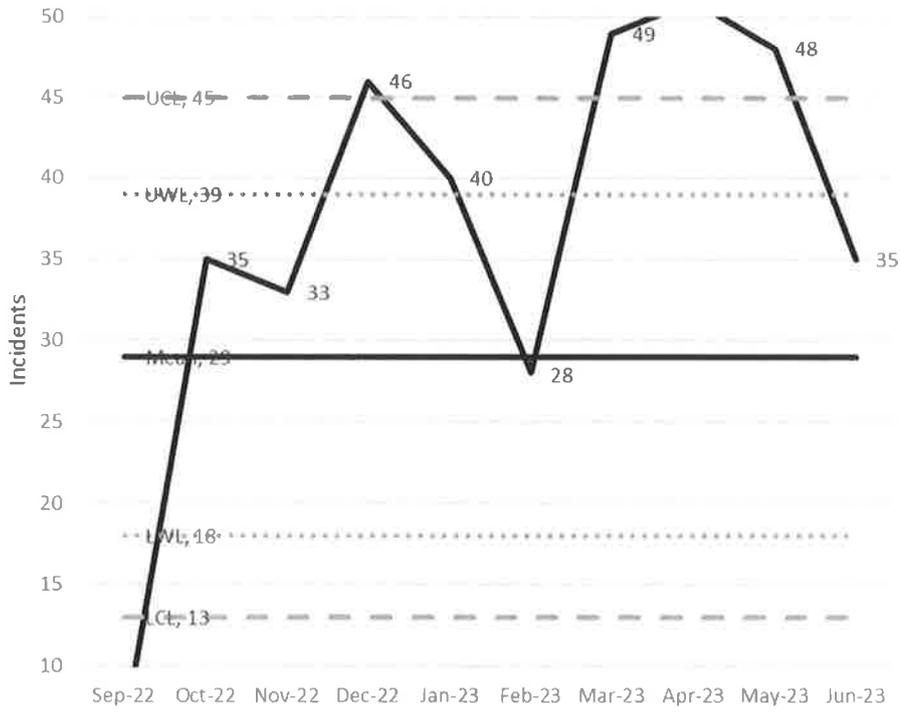
Please note for Figure 25, the data only goes back to September 2022 as this was a new Division updated on Datix from this time.

Fig. 26

Accidents/Falls by Severity (Apr - Jun 23)

799
428
27
7

Insignificant | Minor | Moderate | Major | Catastrophic
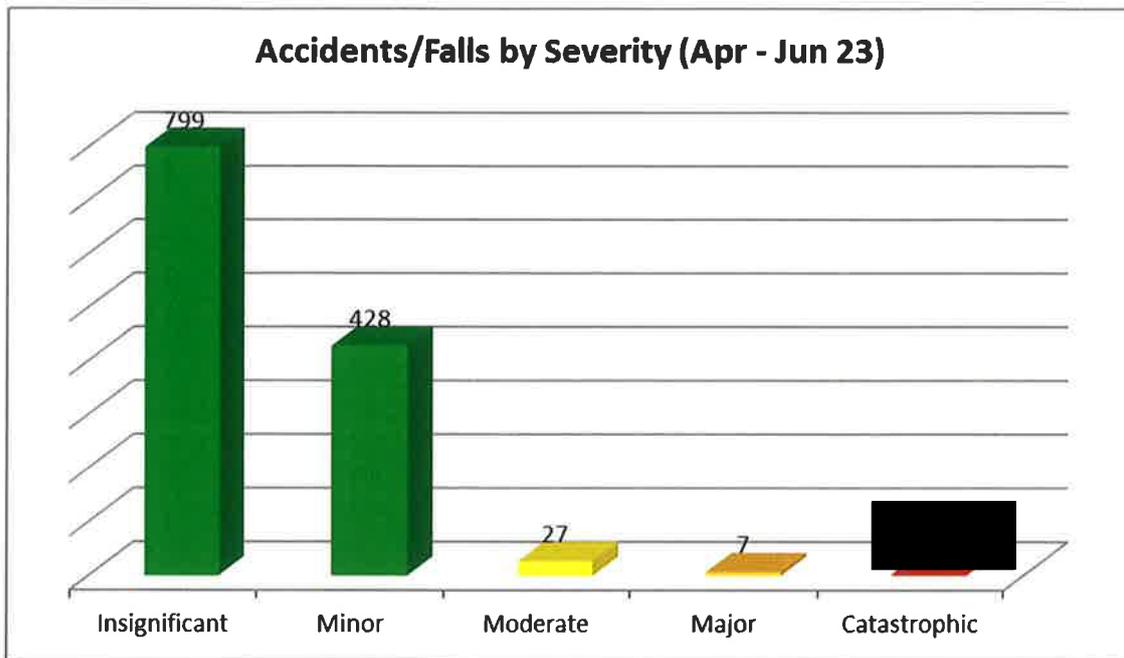
4.2.6 'Accidents/Falls' Incidents by Type Tier Two

Fig 27

Accidents/Falls by Type Tier 2 (Apr -Jun 23)

Witnessed Slips/Trips/Falls (includes faints)	346
Contact/Collision with Objects (not sharps)	88
Other	53
Contact with Sharps	37
Lifting/Manual handling	21
Choking/Inhalation/Aspiration	20
Entrapment	7
Contact with Potentially Infectious Materials	
Strangulation/Suffocation/Hanging	
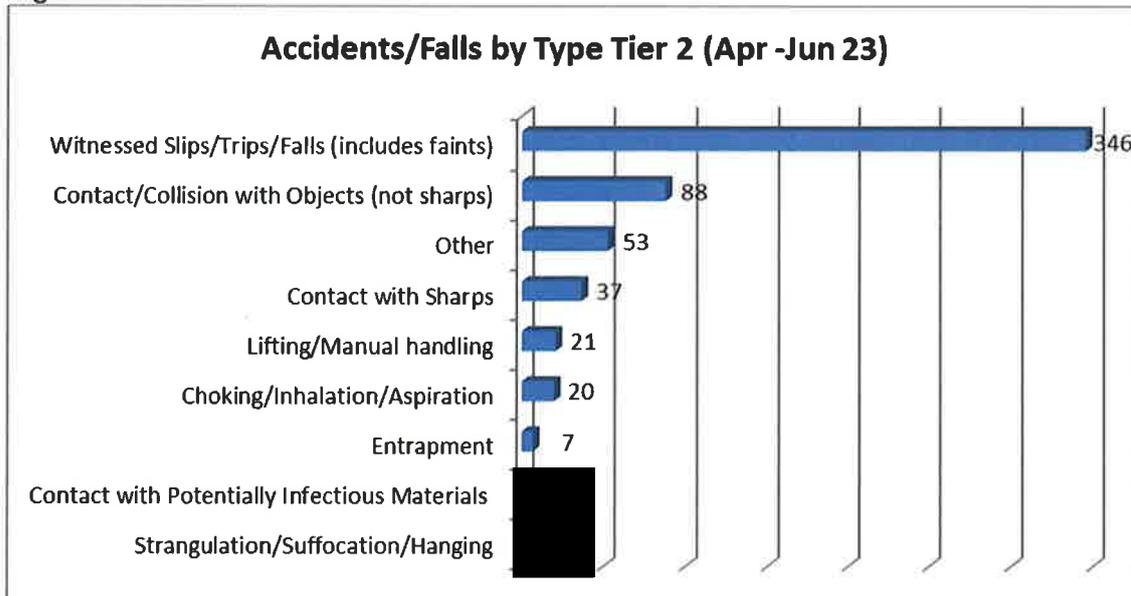
4.3 Serious Adverse Incidents by Incident Type / Criteria

4.3.1 SAIs by Type Tier 1
Fig.28

SAI Notifications by Type Tier 1 for the period 01 April 2023 to 30 June 2023
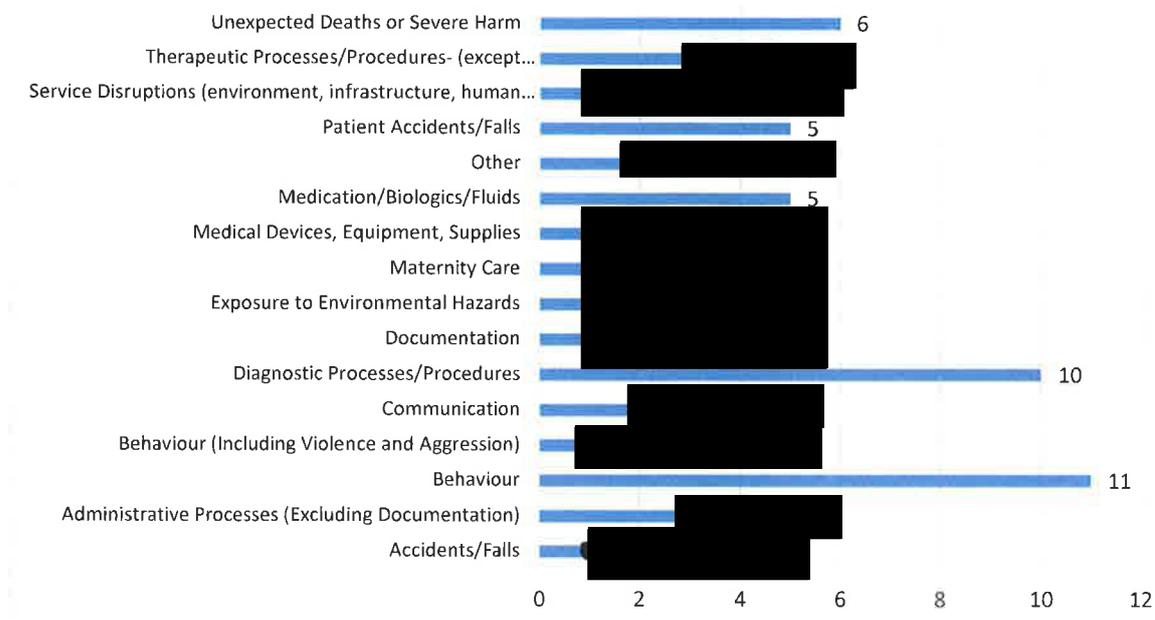
4.3.2 SAIs by Criteria

Fig. 29

SAI Notifications by SAI Criteria for the period 01 April 2023 to 30 June 2023
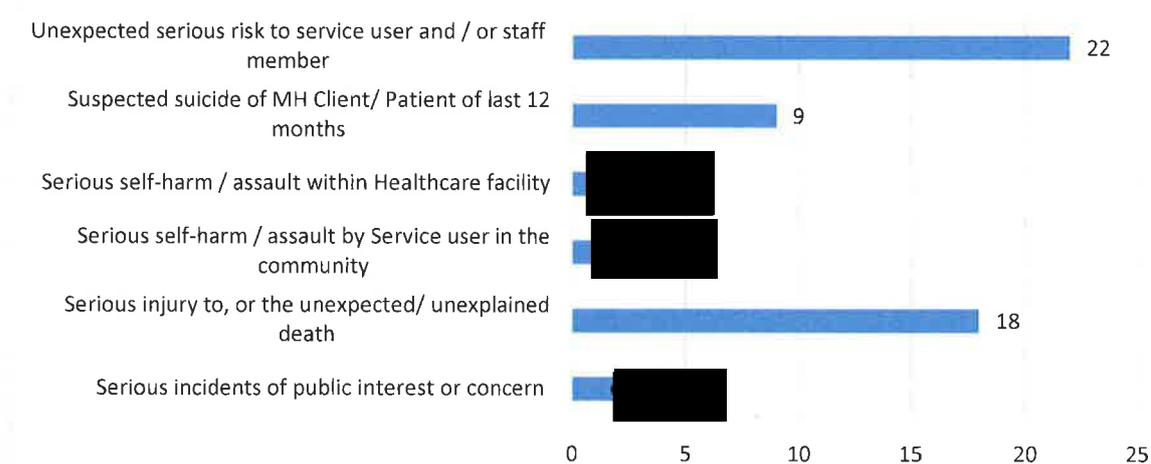
Criteria: 'serious injury to, or unexpected/unexplained death' includes 1 child deaths for Children's Community Services Directorate

Figure 29 shows a breakdown of SAIs by Criteria

5. SAIs REPORTED TO OTHER ORGANISATIONS

5.1 Regulation & Quality Improvement Authority

The Regulation & Quality Improvement Authority (RQIA) continues to require incidents to be reported to it in accordance with its statutory responsibilities. All mental health and learning disability SAIs are reportable to RQIA under Article 86.2 of the Mental Health (NI) Order 1986 AND any SAI that occurs within the regulated sector (whether statutory or independent) for a service that has been commissioned/funded by a HSC organisation.

5.2 Northern Ireland Adverse Incident Centre (NIAIC)

The Northern Ireland Adverse Incident Centre (NIAIC), part of Health Estates, exists to record and review reported adverse incidents involving medical devices, non-medical equipment, plant and building items used in HPSS and to issue warning notices and guidance to help prevent recurrence and avert patient, staff, client or user injury.

There were no SAIs for the reporting period reported also to NIAIC.

5.3 Health & Safety Executive (HSE)

The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1997 (RIDDOR) require employers and others to report accidents and some diseases that arise out of or in connection with work. These reports enable the enforcing authorities to identify where and how risks arise and to review serious accidents.

There was ▇ AI which met the requirement for reporting to Health & Safety Executive (HSE) under RIDDOR for this period. This relates to ▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇▇ ▇▇▇▇ (*Immediate learning was identified and shared across the Trust)

5.4 Interface Incidents

Interface incidents are incidents that have occurred in another organisation, which may be reportable as SAIs.

There were 10 interface notifications submitted to SPPG from BHSCT during the period 01 April 2023 and 30 June 2023.

Of the 10 interface notifications, ▇ have been closed by SPPG ▇ has had an SAI Notification submitted, ▇ s been confirmed by SPPG as not requiring a SAI and ▇ has had submission for rationale not to submit a SAI by the other Trust). A further 7 remain open under review.

In addition there have been ▇ erface notifications received by the Trust from SPPG (*these are managed under the External Interface process*).

Al ▇ xternal Interface Incidents remain open under review.

6. EARLY ALERTS

During this reporting period the Trust submitted 58 Early Alerts; 8 of these were also reported as SAIs. During the same period in the previous year 42 Early Alerts have been submitted. This is an increase of 38%.

Figure 30 below shows the breakdown by Directorate for the reporting period.

Fig30

New Early Alerts by Directorate submitted to DoH during the period 01 April 2023 and 30 June 2023

Directorate	Value
Adult Community, Older Peoples Services & AHPs	5
Children's Community Services	17
Mental Health, Intellectual Disability & Psychological Services	18
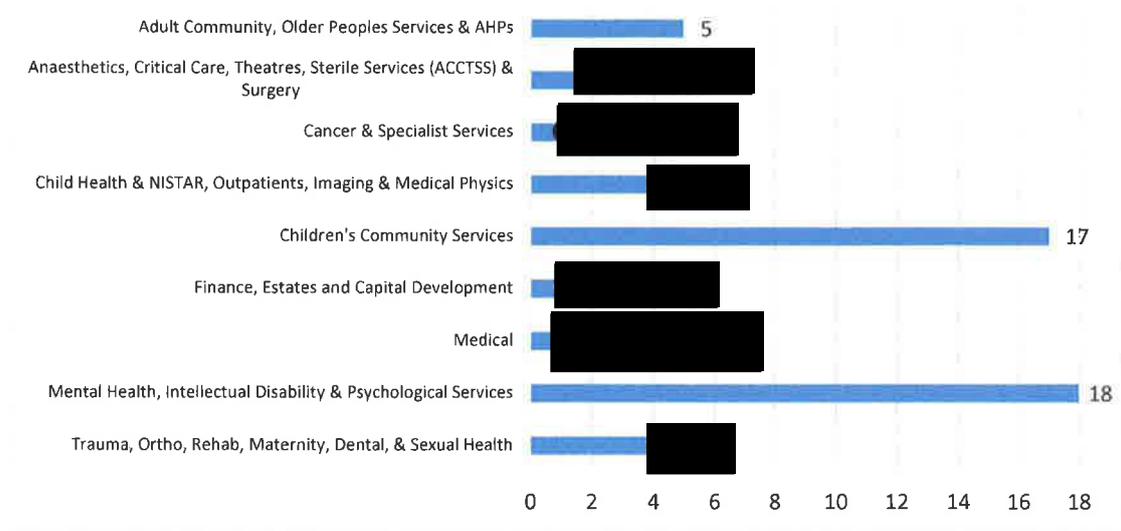
7. NEVER EVENTS

Never events are currently included as part of the Serious Adverse Incident (SAI) Notification process.

During this reporting period there were ██ AI notifications submitted to SPPG relating to Never Events.

Division	SAI Review Level	Never Event Criteria
Surgery	Level 1 SEA	██████████████████
Medical Specialties	Level 1 SEA	
Medical Specialties	Level 1 SEA	
Outpatients, Imaging & Medical Physics	Level 1 SEA	

8. SERVICE USER / FAMILY ENGAGEMENT

As part of the procedure for reporting and follow-up of Serious Adverse Incidents (SAIs) the Trust service users, families and/or carers should be made aware of an incident that has been reported as an SAI.

Fig 31a shows a breakdown of engagement status for the period 01 April 2023 and 30 June 2023, as per Datix.

Fig. 31a

SAI Engagement Status for the period 01 April 2023 to 30 June 2023 as at 30/06/2023
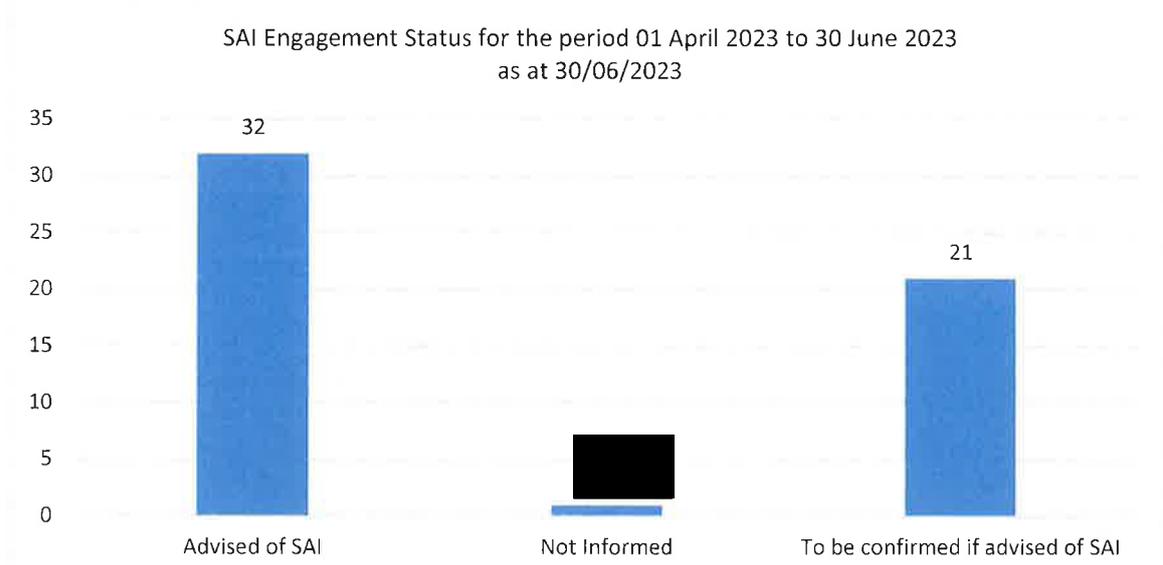
The figures for 'TBC if advised of SAI' in figure 31a above are displayed by Division in figure 31b below.

Fig. 31b

Division	Count
Adult Community and Older Peoples Services	
Cancer and Specialist Medicine	
Child Health and NISTAR	
Children's Community Services	
Maternity, Dental and Sexual Health	
Medical Specialties	
Mental Health	10
Outpatient, Imaging and Medical Physics	
Surgery	
Unscheduled	
Grand Total	**21**

9. ACTIONS AND LEARNING

9.1 Examples of Actions from Incident Trend Data

Top Two Categories

Behaviour

The highest level of Behaviour (including self-harming) incidents are usually in Acute Mental Health units, Beechcroft Child and Adolescent Unit and Learning Disability inpatient wards.

The last Learning Disability update confirmed the following:

Live Governance Meetings (which cover both Inpatient and Community ID services) are held weekly and attended by all Senior Management or their Deputies. Each service speaks to their incidents, in particular, those categorised as Behavioural focusing on Physical Intervention and all associated actions and learning for the service. If there is specific learning for staff in Learning Disability a Local Learning Letter is shared at all service huddles.

When there are particular issues e.g. an increase in incidents with an individual patient or service user, this instigates a review of treatment and medication. Immediately post-significant incident a Hot Debrief takes place, formulated to support staff and extrapolate immediate learning and action. There may be a review using SEA methodology required.

Learning disability services are currently working with both children and adults who are delayed discharge: these individuals are being supported in facilities which do not adequately fit their support needs. There has been extensive work carried out in MAH around resettlement for all remaining patients as they are all in an unsuitable environment. There is a focus on resettlement.

Self-injurious behaviours may be a maladaptive means of communicating needs; treatment aims to provide the patient with a means of communicating needs in a safer way. However, it is likely these behaviours are chronic in nature, developed over many years, and as such may never be eradicated. Psychology and TSS are supporting the services to sustain the service user. The aim being a reduction of instances of self-injurious/suicidal behaviours, and reduction in the frequency and intensity of these behaviours.

A change in routine or circumstance increases patient and staff anxiety. The Resettlement program has resulted in an increased impact in both. Prompted by this, Safety Intervention (SI) training has evolved to provide greater support to both staff and patients. This training is inclusive of the Positive Behavioural Support team. They explain to staff the importance and function of "behaviours that challenge" for our inpatients, and ultimately what staff can learn from this.

The Adult Safeguarding Team (ASG) also participate explaining staff roles and responsibilities during SI. Clarification and clear guidance given on what may constitute a Safeguarding referral with the purpose of increasing staff confidence.

The service also introduced a "Lived Experience of Restrictive Practice" element to the SI training, delivered to staff by a past inpatient. This Unique perspective is invaluable, aiding staff's understanding of the impact restraint can have on an individual.

The service intention is for a holistic approach to restraint practices and a reduction in behavioural incidents. The service wish to increase staff confidence in dealing with behaviours that challenge and reduce patient anxiety potentially reducing escalation to restraint practices by staff. The overarching intention being increasing service safety, improving quality and experience for Inpatients and Staff alike.

Separate interventions contributing to a reduction in behavioural incidents for some inpatients is the clear increase in PBS staffing onsite, and the stabilisation of their medication regime.

The Service is aiming to reduce reactive behaviours, which may manifest as self-injurious/suicidal behaviours through a QI project currently in progress.

Accidents/Falls

The Trust continues to implement actions for falls incidents as follows:

- Learning from fall incidents when a contributing factor to a fall incident relates to the assessment of enhanced care and the lack of assessment tools to aid staff with this assessment within the BHSCT. The development of an **Enhanced Patient Care and Observation (EPCO)** by a Regional Working Group provides staff with an assessment tool which should be commenced for any adult in-patient, who requires assessment and monitoring of distressed behaviours, which may increase the risk of harm to themselves and /or others. EPCO is not designed to be used in isolation and should be part of a person centred management plan, to promote safety, while identify the cause of and reducing distress. This assessment tool is currently being piloted within a number of ward areas within the BHSCT.
- Regional Shared Learning from SAI. The Regional Inpatient Falls Prevention Group have developed an amended version of the *Falls Assistive Technologies* guideline for inpatient settings. The purpose of this document is to provide key information on Falls Assistive Technologies, which will support staff in ensuring safe and effective use of falls prevention equipment, which may be available in the inpatient setting. The amendment to this document was as a result of learning identified from a Serious Adverse Incident, and highlights the importance of daily monitoring of any assistive technology that is in use.
- The Falls Forum resumed their monthly meetings in September 2022. The steering group is a multidisciplinary environment to ensure that a reduction in harm from falls is represented as an integral part of the Trusts quality improvement plan. A report giving an overview of the monthly moderate and above falls is discussed, focusing on themes and trends with a view to addressing arising issues.
- Learning from moderate and above falls (across acute in-patient wards)- all falls coded moderate and above continue to have a Minimum Data Set for Post Fall Review completed within 10 days of the incident. It is the Ward Managers responsibility to complete an action plan to reflect the learning from the incident reviewed and share this effectively with the MDT. The learning from these incidents are reported quarterly to the Public Health Agency.
- A report of all moderate and above falls is presented to the Senior Nursing and Midwifery monthly team meeting. The themes and trends of the fall incidents reviewed are highlighted within this report.
- The FallSafe Coordinator continues to support ward areas with falls quality improvement work and FallSafe Awareness sessions.

9.2 Learning from Adverse Incidents

Incidents are reviewed locally and learning is shared with teams and across the Trust if applicable. Service areas can run their own incident reports. Quarterly

and monthly reports are also provided routinely to Directorates to enable identification of trends and to inform improvement work.

Datixweb Incident Dashboards are well established and provide easy access to local trend information.

A dataset is available for adult in-patient wards and will be issued each month via Qlik software. Ward/unit level datasets are produced manually for ICU, Children's Community Services and Mental Health. Work continues to have datasets provided for all services electronically. Divisional datasets are provided each month to every Division. Specialty level datasets are being developed at present. Datasets triangulate safety and quality data with activity information and nurse staffing levels. Patient feedback is included for those 48 wards where real time feedback is collected every two weeks. Reports also include governance information on incidents, SAIs and complaints.

A number of quality improvement projects have made use of incident data to inform their work.

(Note: Directorate structures on Datix were last updated 30th September 2022).

9.3 Learning from Serious Adverse Incidents (SAIs)

During the period 01 April 2023 and 30 June 2023 a total of 23 SAI Reports were completed and submitted to SPPG.

Table below (Fig 32) shows Learning themes by Directorate and Division.

SAI Learning Themes by Directorate and Division for the period 01 April 2023 to 20 June 2023	Count
Adult Community, Older Peoples Services & AHPs	
Adult Community and Older Peoples Services	
D1: Failure to act on or recognise deterioration (including escalation)	
P10: Other (specify)	
Anaesthetics, Critical Care, Theatres, Sterile Services (ACCTSS) & Surgery	7
Anaesthetics, Critical Care, Theatres & Sterile Services (ACCTSS)	
C5: Risk management failure	
C8: Failings/ errors in documentation	
P10: Other (specify)	
Surgery	
E2: Necessary equipment misused or misread by practitioner	
P10: Other (specify)	
Cancer & Specialist Services	
Cancer and Specialist Medicine	
C2: Misinterpretation or mishandling of test results	
C4: Wrong - site/ implant/ procedure/ patient	
C8: Failings/ errors in documentation	
Child Health & NISTAR, Outpatients, Imaging & Medical Physics	8

	Count
Child Health and NISTAR	8
C6: Staff training not up to date	
I1: Failure to address engagement difficulties with family/ carers	
C4: Wrong - site/ implant/ procedure/ patient	
C7: Related to checking aids e.g. tick box	
C8: Failings/ errors in documentation	
E2: Necessary equipment misused or misread by practitioner	
P10: Other (specify)	
Children's Community Services	10
Children's Community Services	10
F2: Poor/ inadequate handover	
I1: Failure to address engagement difficulties with family/ carers	
C5: Risk management failure	
C7: Related to checking aids e.g. tick box	
C8: Failings/ errors in documentation	
Learning Themes TBC	
P7: Staff training/ skills deficiency	
P9: Failure to prevent self-harm or assault or homicide	
Z1: Closed with no learning	
Mental Health, Intellectual Disability & Psychological Services	5
Intellectual Disability	
D1: Failure to act on or recognise deterioration (including escalation)	
I1: Failure to address engagement difficulties with family/ carers	
C5: Risk management failure	
Psychological Services	
P7: Staff training/ skills deficiency	
P9: Failure to prevent self-harm or assault or homicide	
Trauma, Ortho, Rehab, Maternity, Dental, & Sexual Health	6
Maternity, Dental and Sexual Health	
C8: Failings/ errors in documentation	
Trauma, Orthopaedics and Rehabilitation Services	5
D1: Failure to act on or recognise deterioration (including escalation)	
D2: Failure to give ordered treatment/ support in a timely way	
F2: Poor/ inadequate handover	
I1: Failure to address engagement difficulties with family/ carers	
C2: Misinterpretation or mishandling of test results	
Unscheduled Care	9
Medical Specialties	
C5: Risk management failure	
P10: Other (specify)	
Unscheduled	7
C6: Staff training not up to date	
C2: Misinterpretation or mishandling of test results	
C8: Failings/ errors in documentation	
F1: Inappropriate discharge	
P7: Staff training/ skills deficiency	
Grand Total	50

9.4 Shared Learning

Shared learning is available on the Trust's Loop via the following link:
https://bhsct.sharepoint.com/sites/medical/SitePages/Shared-Learning.aspx

Figure 33 shows a breakdown of shared learning letters issued on the LOOP Library from Adverse Incidents/SAIs for the period 01 April 2023 to 30 June 2023.

Fig. 33

Shared Learning Letters Issued on the LOOP Library during the period 01 April 2023 to 30 June 2023		
Ref No	**Details**	**Date Issued**
███████	████████████████████	04 May 2023
	For the attention of all SACT prescribers	09 May 2023
	Infection status must be completed at time of admission to ward	11 May 2023
	Steroid induced Hyperglycaemia	31 May 2023
	Post procedural instructions should be clearly documented and recorded for relevant patients	30 June 2023

In addition to this the Trust would continue to receive external learning from the SPPG that has arisen from SAI reviews completed across HSC Trusts. Any learning relating to SAIs would be formally shared and noted at the next SAI Group.
Shared learning outside the SAI process is also considered for reporting through as per regional procedure for raising important learning through to PHA / SPPG for their consideration.

9.5 Other sources for sharing learning in the Trust

Safety Message of the week is also considered as part of the established governance arrangements, such as the weekly governance call or the Shared Learning Review Group, in addition to any learning to be presented in a learning template. Figure 34 shows a breakdown of SMOTW issued on the LOOP Library from Adverse Incidents/SAIs for the period 01 April 2023 to 30 June 2023.

Fig. 34

Safety Message of the Week (SMOTW) Issued on the LOOP Library during the period 01 April 2023 to 30 June 2023		
Ref No	**Details**	**Date Issued**
████████	POD System must not be used for TB specimens	21 June 2023