Belfast Health and Social Care Trust
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Risk & Governance

Amalgamated Assurance Report

February 2024

Incorporating:

Trust Incident & SAI Quarterly Report:
April 2023 – December 2023

[redacted]

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TRUST ADVERSE INCIDENTS AND SERIOUS ADVERSE INCIDENTS REPORT

For reporting period 01 April 2023 to 31 December 2023 (as at 25 January 2024)

EXECUTIVE SUMMARY

Adverse Incidents

34,712[1]
Incidents were reported across the Trust for the period

[1]Approved incidents as at date of report completion. This report does not include incidents reported by Independent Sector Providers (ISP). For this reporting period there were 7,943 ISP Incidents.

↑ 7.6%
Increase in incidents from the same period in the previous year (32,256 incidents)

For this time period, using estimated ratios, there were 267 incidents for every SAI. For the same time period last year there were 205 incidents per SAI.

When incident data is compared to 2017/18 period there had been 22,436 (54.7% increase)

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 25 Jan 2024

Serious Adverse Incidents (SAIs)

130*
SAI Notifications were submitted for the period

*Excludes 2 SAI Notifications that were subsequently withdrawn following further consideration

↓ 9%
Decrease in SAIs compared to same period in previous year (143*)

*Excludes 17 SAI Notifications that were subsequently withdrawn following further consideration.

When SAI data is compared to 2017/18 period there had been 58 (180% increase)

*Excludes 2 SAI Notifications that were subsequently withdrawn following further consideration

Summary SAI Review Level:
Level 1 SEA = 120
Level 2 RCA =10
Summary Linked Events:
SAI Never Events = 8
New SAIs currently linked to Complaints =15
(*For this reporting period there were also* [redacted] *complaints raised in relation to SAI processes of reviews still ongoing*)
SAI linked to Coroner's = 26
SAI currently linked to Claims = [redacted]
SAI linked to Early Alerts = 11
Summary SAI Reports:
As at 31 December 2023 there were 238 SAI reports outstanding with SPPG.

165 SAI reports were submitted to SPPG during this reporting period.

INCIDENT SEVERITY

Adverse Incidents

Serious Adverse Incidents (SAIs)

INSIGNIFICANT OR MINOR

94%[1]
Incidents recorded as insignificant (no harm) or minor severity

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

16%*
Incidents recorded as insignificant (no harm) or minor severity

*84% SAIs have a moderate severity or above

CATASTROPHIC

2.0%[1]
Incidents were recorded as Catastrophic severity

[1]Catastrophic severity incidents have increased from 227 (0.8%) for the same reporting period in 2021/22 to 698 (2.0%). This is mainly due to the increased reporting of overcrowding / ongoing pressures in the Emergency Departments.

For this reporting period, 564 out of the 698 Catastrophic incidents were reported under Adult Emergency Departments. Of these, 544 were coded as Type Tier One 'Service Disruptions (environment, infrastructure, human resources)'.

40 (31%)
SAI Notifications were recorded as Catastrophic severity

Breakdown by Type Tier 1:

Type Tier 1	Count
Administrative Processes (excluding Documentation)	[redacted]
Behaviour	12
Diagnostic Processes/Procedures	8
Injury of unknown origin	[redacted]
Medication/Biologics/Fluids	[redacted]
Other	[redacted]
Patient Accidents/Falls	6
Unexpected Deaths or Severe Harm	10

INCIDENT TYPE TIER

Adverse Incidents

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

16,037 (46%)
Behaviour

3,999 (12%)
Accidents/Falls

Serious Adverse Incidents (SAIs)

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

31 (24%)
Behaviour

30 (23%)
Diagnostic Processes/ Procedures

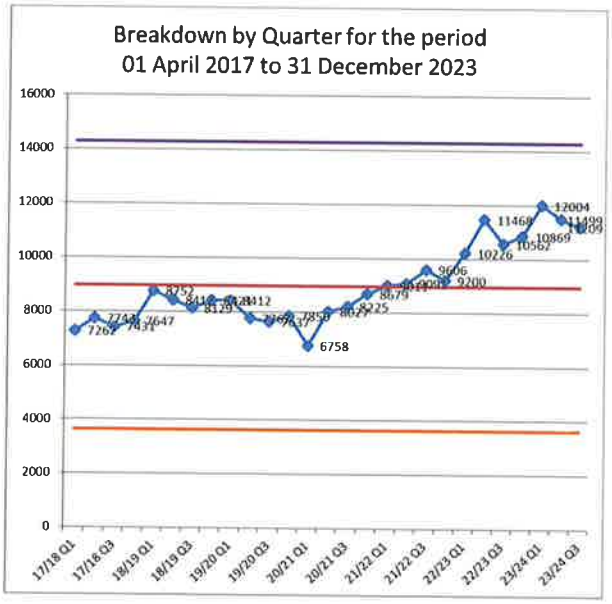
SECTION 1: INTRODUCTION

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.'

1.1 Incident Breakdown by Quarter

Adverse Incidents

Fig 1



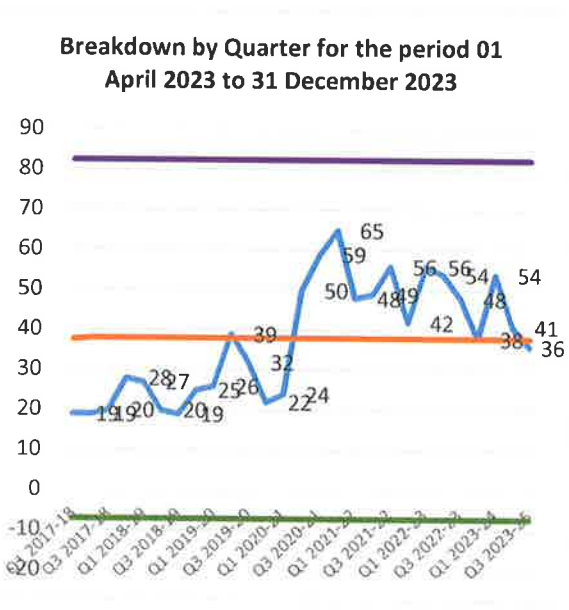
During this reporting period a total of 34,712 were reported and approved Trust-wide. In comparison, during the same period in the previous year, there were 21,671 incidents. This represents a 7.6% increase.

In addition, there were 7,943 incidents reported by Independent Sector providers inputted onto Datix during this reporting period. These incidents are not included in this report. They are separately monitored and reported on by the Trust's Quality & Support Team and/or Contracts office. (Incident information would be summarised and presented back through the Clinical & Social Care Governance Steering Group as per the Board Assurance Framework)

At 19 Jan there were 847 incidents (excluding Independent Sector) awaiting approval for this reporting period. There is an established escalation protocol to notify

Serious Adverse Incidents (SAIs)

Fig 2



During this reporting period a total of 130 SAI notifications were submitted to the Strategic Planning & Performance Group (SPPG).

Of these SAIs, 7 occurred in the Trust's Emergency Departments compared to 6 for the same period in the previous year.

Figure 2 shows the shift in the volume of SAI Notifications over the last 6 years. The average number of SAI notifications raised during the period Q1 2017-18 to Q1 2020-21 was 24, while the average number of notifications for the period Q2 2020-21 to Q3 2023-24 was 47.

At the 31 Dec 2023 based on the incidents approved at this time, it is estimated for every 267 incidents approved there had been 1 SAI. For the same period the previous year it had been 205 incidents for every SAI. This indicates that even though overall incident

services of incidents overdue for approval. (From Jan 2024 a summary report outlining the overall numbers of unapproved incidents per Service are also brought to a quarterly meeting of the Trust's Governance Forum)

numbers have been steadily increasing year on year especially over the last couple of years, the proportion of these being reported as SAIs has fallen.

1.2 Incident Breakdown by Method of Review / Investigation

Adverse Incidents

Fig 3

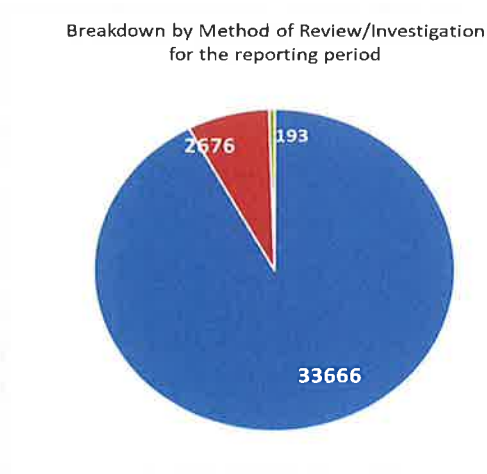


Figure 3 shows the breakdown of the 'Method of Review/Investigation' for incidents within the reporting period as follows:
Local Informal Review – 33,666
Other Methodologies – 2,676
Review Methodology still to be agreed - 193

Other Methodologies include:

- Significant Event Audit (SEA)
- Root Cause Analysis (RCA)
- Patient Safety & Clinical Governance Meeting (incorporating M&M)
- Structured Judgement Review (SJR)
- Post Fall Review
- Post Pressure Ulcer Review
- Adult Safeguarding Review (ASR)
- Child Safeguarding Review (CSR)
- Perinatal Mortality Review Tool (PMRT formerly SCOR)
- Case Management Review (CMR)
- Joint Protocol Investigation
- Covid Death Review
- Independent External Review (e.g.Royal College)

Serious Adverse Incidents (SAIs)

Fig 4

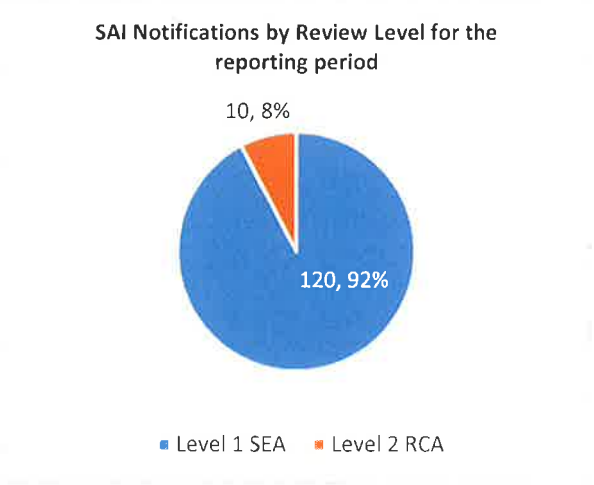


Figure 4 shows a breakdown of Level of Review with

- 92% of SAI Notifications for the period 01 April 2023 to 31 December 2023 as Level 1 reviews (using SEA methodology) and
- 8% Level 2 reviews (using RCA methodology).
- There were no Level 3 notifications for the reporting period.

For the same period in the previous year, 98 (89%) SAI Notifications were Level 1 reviews and 11 (11%) were Level 2 reviews. There were no Level 3 notificaitons.
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.

1.3 Incident Breakdown by Directorate / Division

Adverse Incidents

Fig 5a

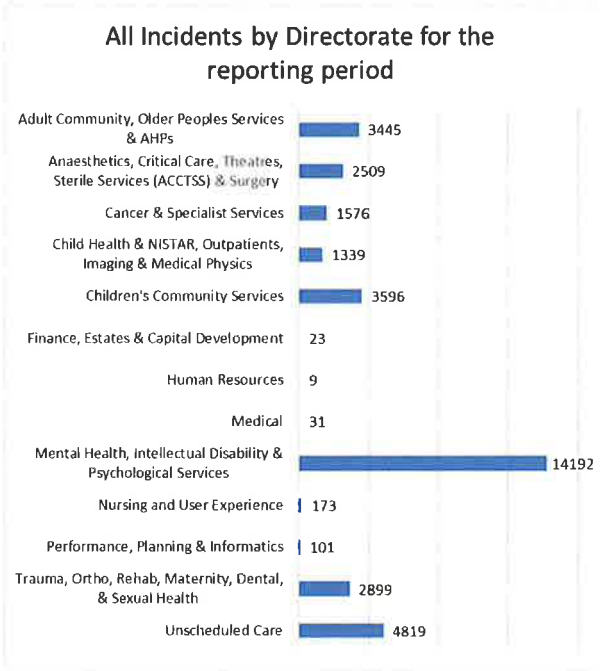


Fig 5b

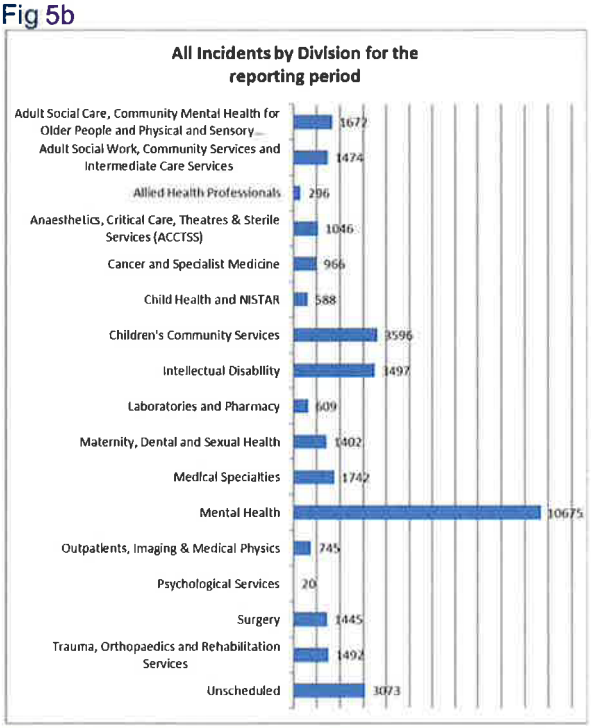


Figure 5b shows that the Division with the most reported incidents is Mental Health with 10,675 (31.09%) incidents. Children's Community Services reported the second highest number of incidents with 3,596 (10.47%) incidents.

Serious Adverse Incidents (SAIs)

Fig 6a

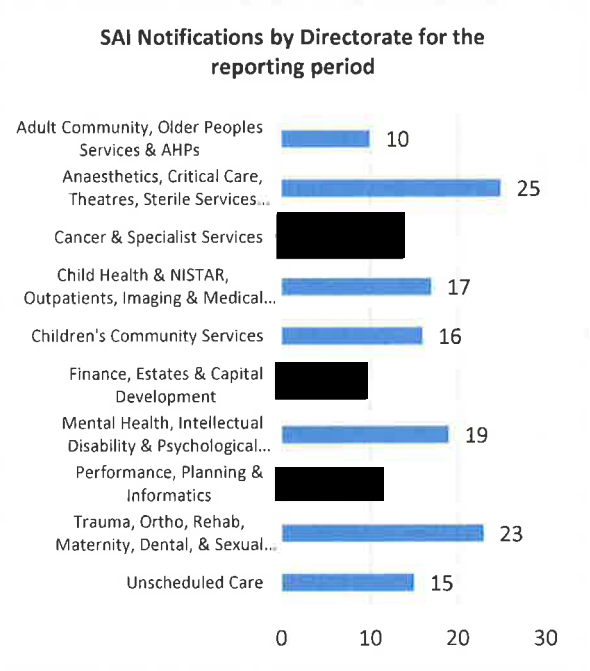


Fig 6b

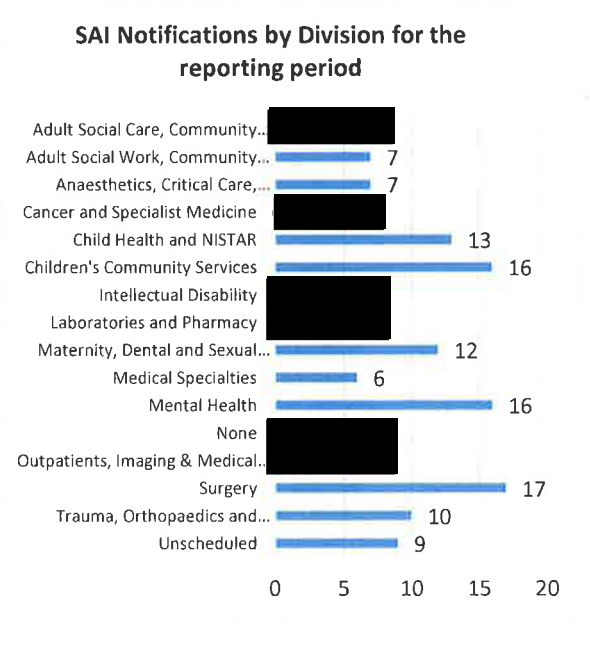


Figure 6b shows that the Division with the most reported SAIs is Surgery. The 16 SAI Notifications raised by the Mental Health Division relate to 14 suicides, [redacted] choking incident resulting in patient death.

1.4 Incident Breakdown by Severity

Adverse Incidents

Fig 7

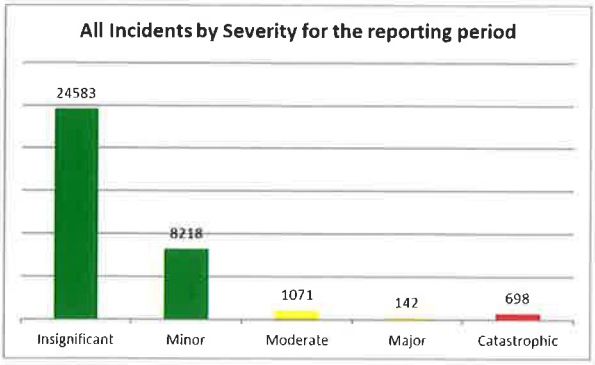


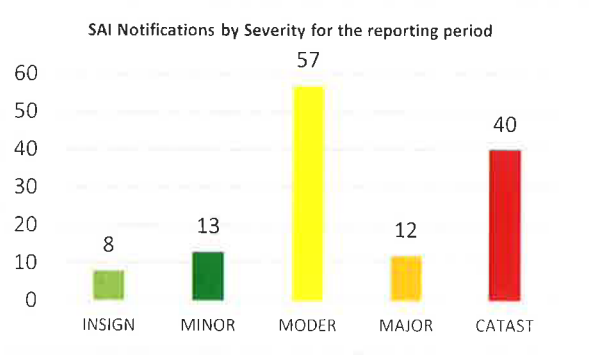
Figure 7 indicates that 32,801 (94%) of incidents were assessed as having a severity rating of insignificant or minor while 698 (2.0%) were rated as catastrophic. The severity rating indicates actual harm or damage as a result of the incident rather than potential risk.

Service Directorates review major or catastrophic severity incidents to ensure appropriate grading and follow-up. All catastrophic severity and extreme risk incidents are also discussed at the weekly Governance teleconference.

For this reporting period, 564 out of the 698 Catastrophic incidents were reported under Adult Emergency Departments. Of these, 544 were coded as Type Tier One '*Service Disruptions (environment, infrastructure, human resources)*'.

Serious Adverse Incidents (SAIs)

Fig 8

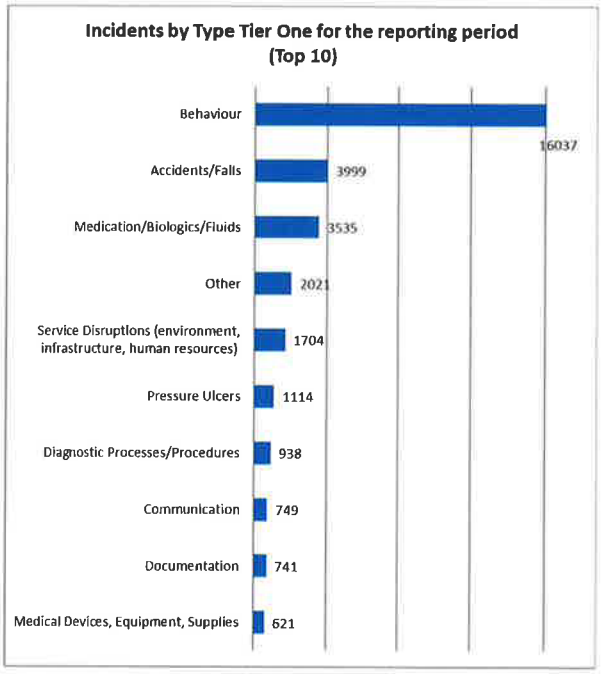


Catastrophic Severity by Division & Descriptor	Count
Adult SC, Community MH for OPS and P&DS	
Unexpected death of nursing home resident	
Adult SW, Community Services & ICS	
Unexpected death of service user (suspected suicide)	
Unexpected death of nursing home resident	
Unexpected death of service user who had fallen at home	
Child Health & NISTAR	
Unexpected child death	
Children's Community Services	
Unexpected child death	
Medical Specialties	
Delayed follow-up	
Unexpected inpatient death	
Mental Health	**15**
Choking incident resulting in patient death	
Death of a patient known to MHS (Suicide)	14
Outpatients, Imaging and Medical Physics	
Delayed Diagnosis	
Interpretation of investigation insufficient/ incorrect/ incomplete	
Surgery	
Medication Error (Incorrect Medication/fluid)	
TOR and MDS	
Unexpected patient death	
Unscheduled	**7**
Unexpected death of patient who attended ED from a nursing home with a history of falls and head injury.	
Inpatient death following unwitnessed fall	
Unexpected service user death at home post discharge	
Unexpected death of patient (missed diagnosis)	
Unexpected death of service user brought to ED but due to no space remained in the ambulance for 3 hours.	
Unexpected death of patient who presented to ED following a mixed overdose. Prescription medications found on her person belonging to a member of the public.	

1.5 Incident Breakdown by Type Tier One

Adverse Incidents

Fig 9a



The top 2 types are displayed by Division in figures 9b and 9c below.

Fig 9b

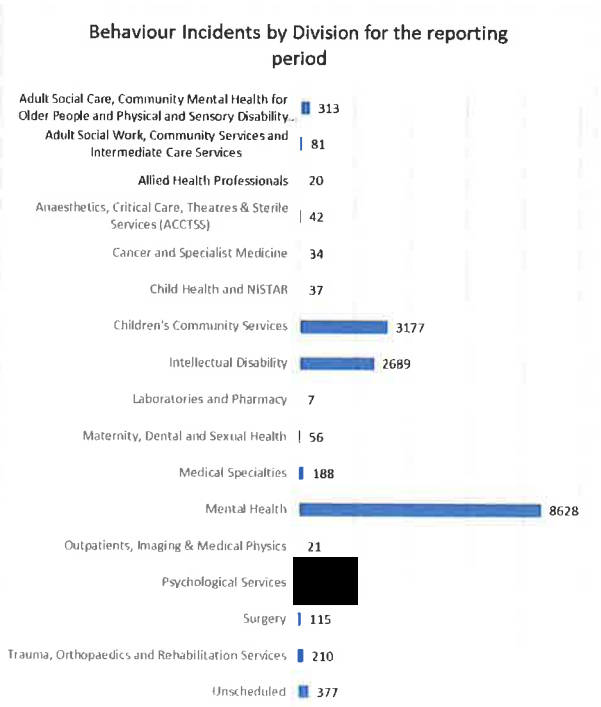
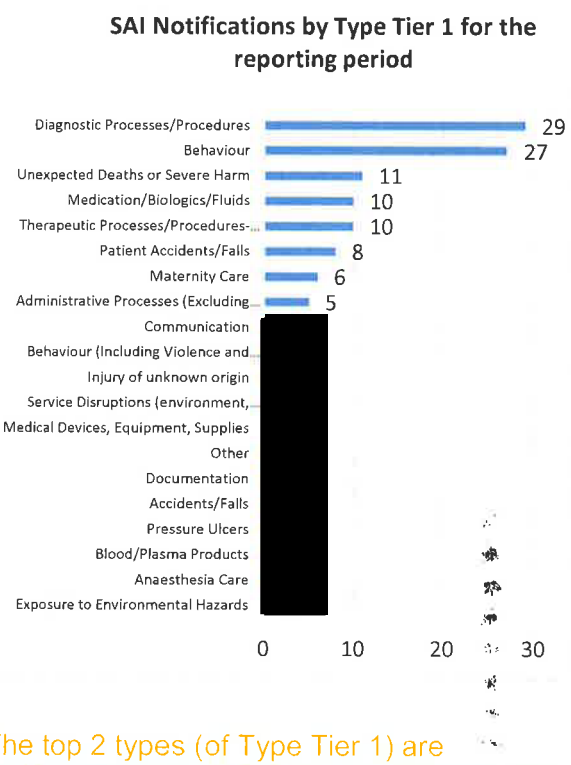


Fig 9c

Serious Adverse Incidents (SAIs)

Fig 10a



The top 2 types (of Type Tier 1) are displayed by Division in figures 10b and 10c below:

Fig 10b

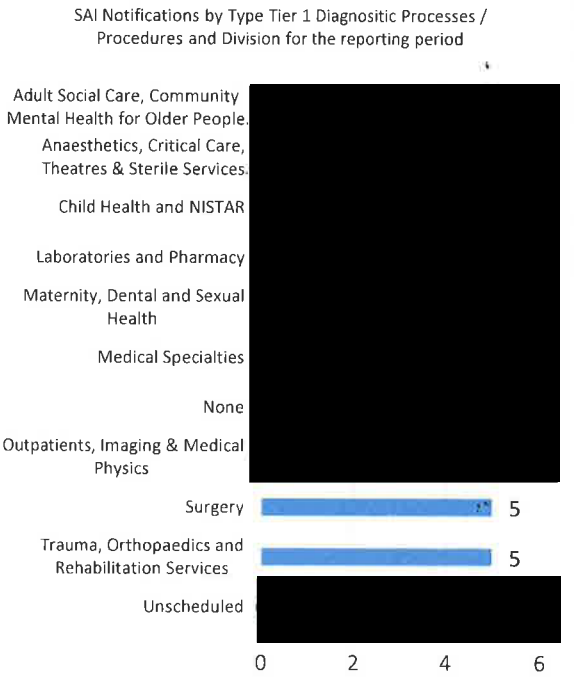
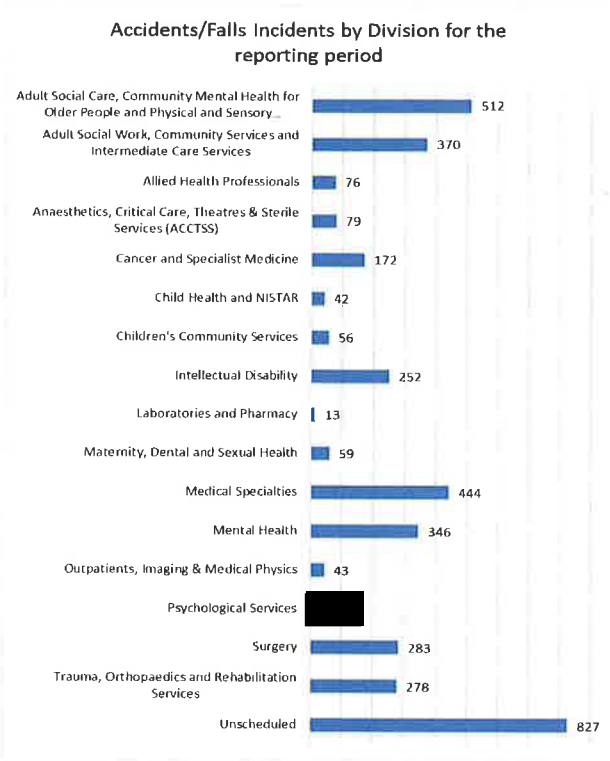
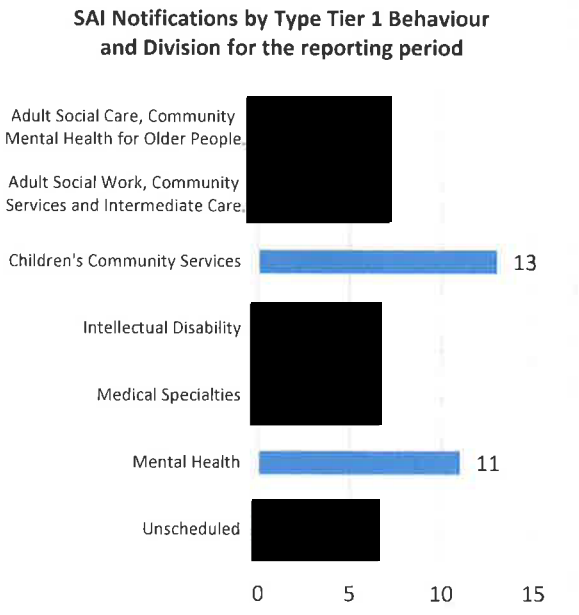


Fig10c





Individual run charts for the top 2 incident types for the last 12 months are shown in figures 9d and 9e below:

Fig 9d

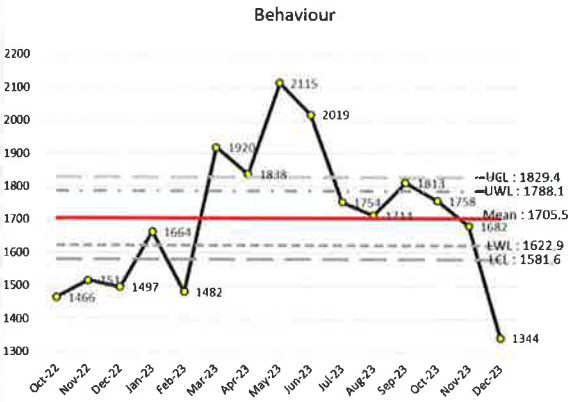
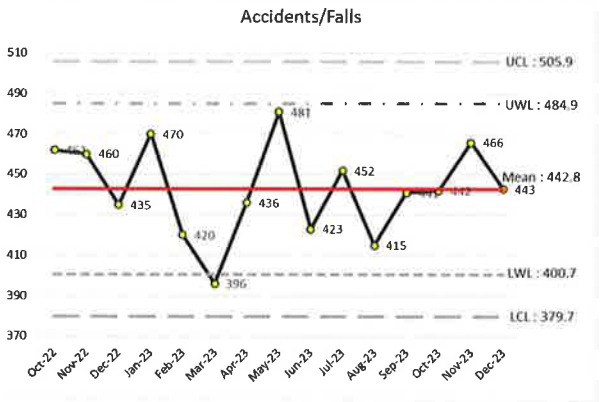


Fig9e



SECTION 2: INCIDENT BREAKDOWN OF TOP 2 TYPES

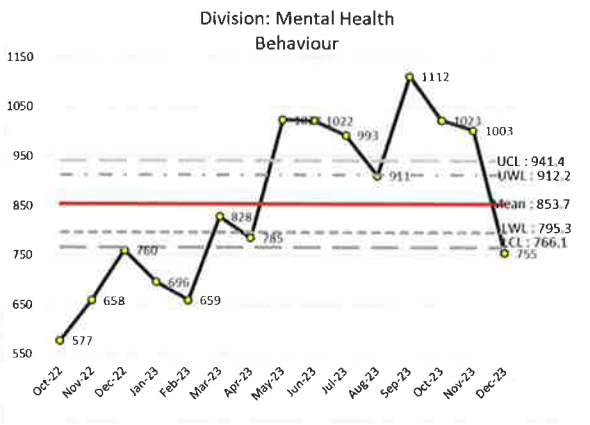
2.1 'Behaviour' Incidents by Division (Top 3)

Adverse Incidents

Figure 9b above shows that, during this reporting period, the top 3 Divisions for Behaviour incidents were Mental Health, Children's Community Services and Intellectual Disability. Run charts for the last 12 months are shown in figures 11 to 13.

There has been a marked decrease in behaviour incidents across all of these 3 Divisions.

Fig 11



This in part can be explained by the following

Mental Health.

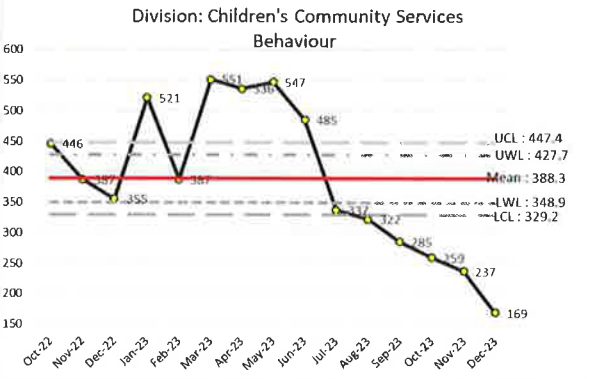
- The drop in incidents during December 2023 for CAMHS/ Beechcroft and AMHIC was due to a combination of factors including:
  - a number of patients being on pass over Christmas period and New Year period (some of those who would require Naso Gastric feeding)
  - a number of discharges during the month of December [redacted]
  - Some empty beds in AMHIC during this reporting period.

Children's Community Services.

The reduction in incidents over the last period can be evidenced clearly in residential services and specifically across 3 homes. (This data has also been presented as part of the Directorate governance meeting).

- In relation to one home that is the short term assessment home and has a high turnover of young people, some of who are new to care or emergency admissions. This can be, quite traumatic and often can manifests itself in behavioural incidents. Also, due to the short term nature of stays, relationships with staff take time to establish and this is very important in helping to moderate a young person's behaviour. The pattern is that there would be a higher number of incidents during the initial period of admission. [redacted] Of note, the home is also involved in piloting a framework of reflective governance which utilises data from DATIX to understand trends and patterns in relation to the young people. The framework whilst it is early days for this pilot, it does appear to be effective and the service are moving to roll this out across all homes.
- In relation to another home there was reduction of incidents in July 2023, [redacted]

Fig 12



- In relation to the third home, [redacted]

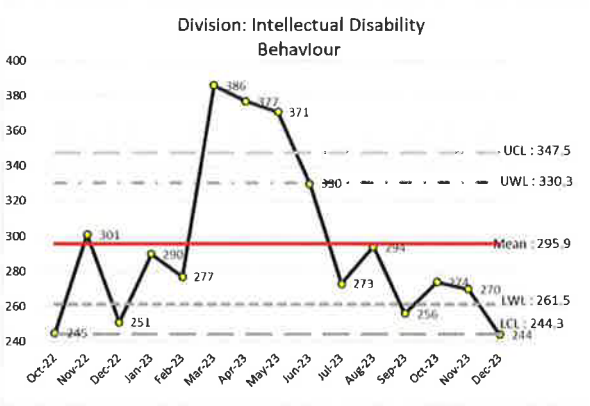


Fig 13

Intellectual Disability.

-Data with Inpatient data has been significantly impacted by resettlement during this reporting period.

Positive Behavioural Support (PBS) training has been made available to all staff bolstering the ongoing work of the Positive Behavioural Support Therapists throughout the ID services has also been a factor for this recent change. (*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*).

In addition to this the service note that maintaining a further reduction can be impacted even by one service user or patient in crisis, albeit temporarily.

2.2 'Behaviour' Incidents by Severity

Adverse Incidents

Fig 14

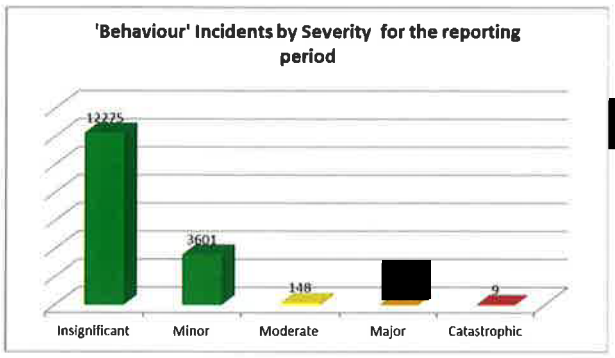


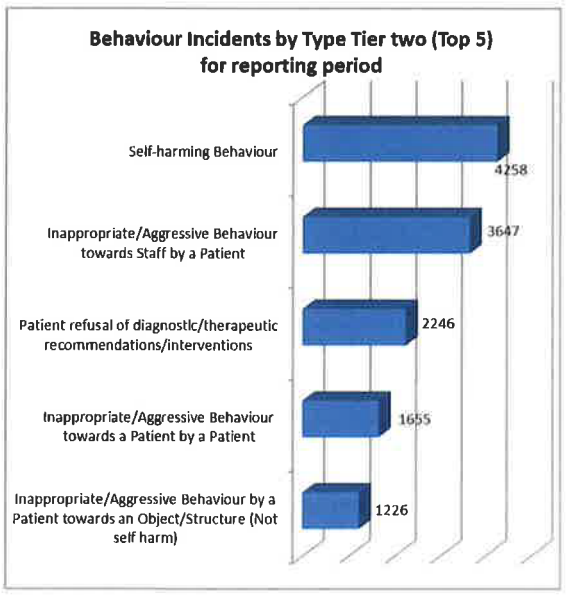
Figure 14 shows that the majority of incidents in this type (15,876 or 99%) were of insignificant or minor severity. [redacted] graded as major and 9 (0.06%) graded as catastrophic.

Of the total number of behavioural incidents, 414 had Safeguarding Review recorded as the Method of Review/Investigation.

2.3 'Behaviour' Incidents by Type Tier Two

Adverse Incidents

Fig 15



In addition to the top 5, there were 119 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.

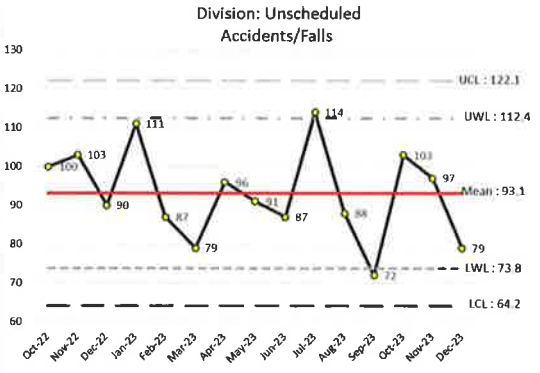
There were also 35 incidents of 'Inappropriate/Aggressive Behaviour towards Staff by Staff'. These are shared with the HR Department on a quarterly basis. HR has confirmed this information is shared via the Director with the HR Co-Directors with a request to follow-up with relevant Business Partners in order that they can support the service area if required.

2.4 'Accidents/Falls' Incidents by Division

Adverse Incidents

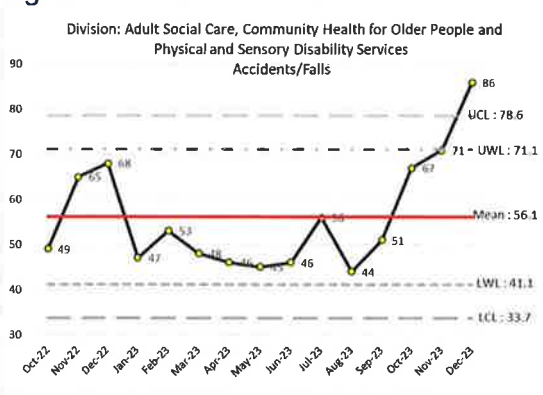
Figure 9c shows that, during this reporting period, the top 3 Divisions for accidents/falls were Unscheduled, Adult Social Care, Community Health for Older People and Physical and Sensory Disability Services, and Medical Specialties. Run charts for the last 12 months are shown in figures 16 to 18. There has been a marked increase across 2 of the 3 Divisions, while Unscheduled did show a recent decrease. The data below includes both patient and staff incidents. For Accidents/ falls, further information on the current assurance processes can be found in Section 5.1 later in this report.

Fig 16



For Unscheduled there was no obvious explananation for the latest data. Incident data continues to be reviewed as part of the established Falls Forum that meets monthly and any key learning fed back to Divisional teams.

Fig 17



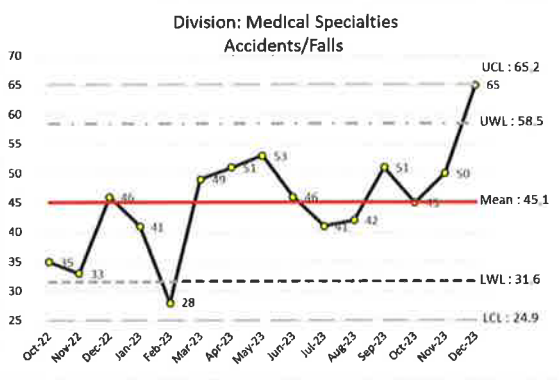
For ACOPS the breach of the upper control limit was correlated to the number of falls within the four Residential homes within Community Mental Health for Older Peoples Services (CMHOPS).The Service has identified three causal factors which have directly contributed to the increase in falls in December 2023.

1. Currently a high number of residents requiring nursing care – this has been escalated to Co-Director level and is being reviewed by a Task & Finish Group
2. Covid-19 outbreaks in 3x Residential Homes and 2x Noravirus outbreaks.
3. The majority of falls within the Residential Homes for December 2023 were unwitnessed.

In addition to above ACOPS provided an outline of current assurance processes that includes:

- Regional falls pathway has been implemented and embedded within the Service Area.
- All falls checklists are completed and uploaded to Datix – audited routinely (currently 100% compliance).
- Falls implementation group monthly meets where trends, patterns and themes are reviewed and discussed.
- Monthly Divisional Governance meeting and weekly Live Governance meeting in place were all incidents (incl. falls) are discussed.
- Service Area is currently exploring assisted technology for falls.

Fig 18



For Medical Specialities there was a marked increase in December.
Increased number of patients being boarded, patient acuity, and management of patients in undesignated bed spaces may be contributory factors.
Incident data continues to be reviewed as part of the established Falls Forum that meets monthly and any key learning fed back to Divisional teams.

2.5 'Accidents/Falls' Incidents by Severity

Adverse Incidents

Fig 19

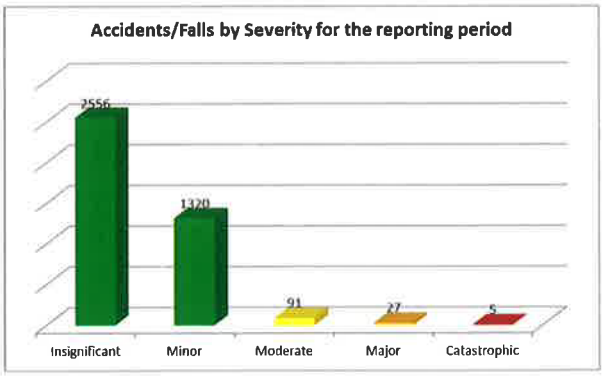
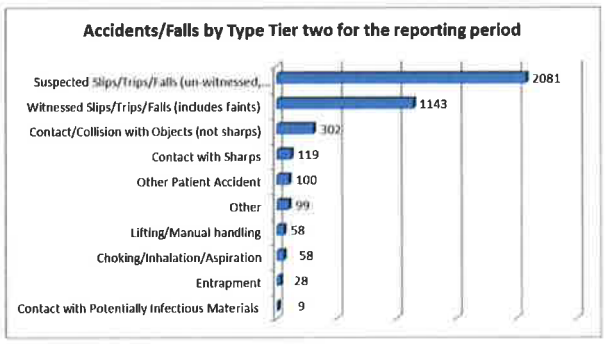


Figure 19 shows that the majority of incidents in this category (3,876 or 97%) were of insignificant or minor severity. There were 27 (0.7%) graded as major and 5 (0.1%) graded as catastrophic.

2.6 'Accidents/Falls' Incidents by Type Tier Two

Adverse Incidents

Fig 20



Of these accidents/falls, 61 (48 staff, 13 service user) were reported to the Health & Safety Executive (NI) under RIDDOR Regulations as follows:

- Injury preventing work for more than 3 days – 39
- Major injury or condition – 16
- Dangerous occurrence – [redacted]
- Fatality - [redacted]

SECTION 3: SUMMARY OF SAI ACTIVITY

3.1 Breakdown of SAI Current Status

Figure 21 shows activity status of open SAI reviews as at 31 December 2023. (*Open SAI reviews are reviews that have not closed and there is no reason currently for the SAI review to be de-escalated / put on hold (suspended). A SAI review might be put on hold if PSNI still were actively investigating the original incident*)

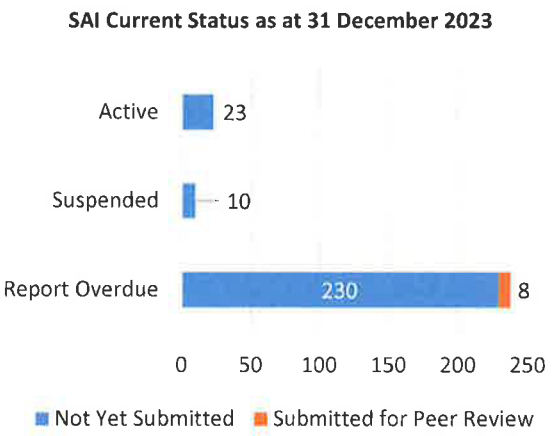
[redacted]SAI Notifications linked to Case Management Reviews (CMRs).

23 SAIs have not yet reached their report due date; 10 SAIs are suspended due to ongoing PSNI investigations; and 238 SAIs have reports overdue, with 8 undertaking final QA review prior to submission to SPPG (a process to quality check reports for consistency, accuracy and completeness).

Monthly updates of SAI status is fed into the Trust QMS system

Serious Adverse Incidents (SAIs)

Fig 21

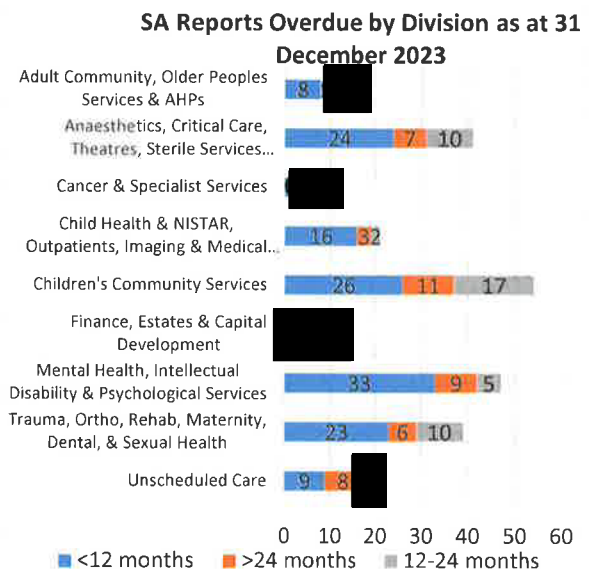


3.2 Breakdown of SAI Reports Overdue

Serious Adverse Incidents (SAIs)

Fig 22

Figure 22 provides a breakdown of 238 SAI reports overdue as at 31 December 2023 by Division and how long overdue i.e. number of months past report due date.



3.3 Breakdown of SAI Report Submitted

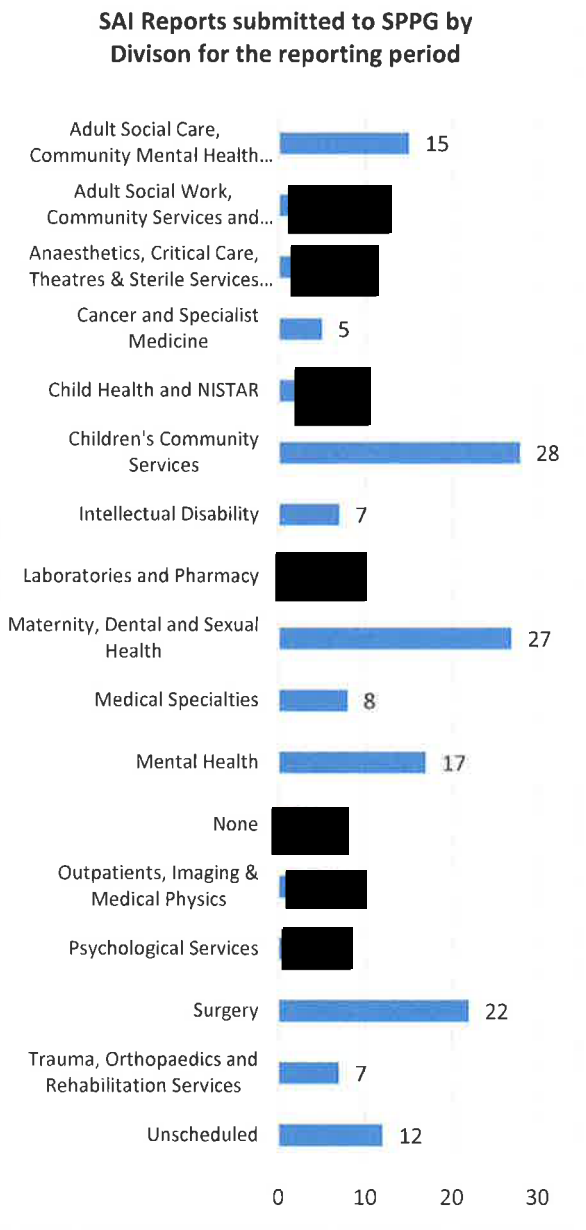
A total of 165 SAI reports were submitted to SPPG during the period 01 April 2023 to 31 December 2023, compared to 146 reports submitted for the same period in the previous year.

Over the last year there have been regular performance meetings with SPPG and BHSCT, with the most recent meeting occurring on the 18th Dec 2023. SPPG wrote to the Trust in November 2023 outlining *They consider the current position to be unacceptable* and requested the SAI reviews that fall within the final stage category were given urgent attention and submitted no later than 29 December 2023; with those remaining reports outstanding beyond 12 months to be submitted by 31 January 2024. At the 31 December less than 20% had been submitted. ***Ref Section re Assurance and escalation processes***.

(Prior to 31 December approximately 50 BHSCT SAI reviews had been also identified for external support from an organisation identified by SPPG).

Serious Adverse Incidents (SAIs)

Fig 23



3.4 Breakdown of SAI Never Events

Never Events are SAIs that are wholly preventable, as guidance or safety recommendations that provide strong systemic protective barriers are already available at a national level and should have been implemented by all health care providers. Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event

During this reporting period there were 8 Level 1 SAI notifications submitted to SPPG relating to Never Events.
Immediate learning/actions are discussed at the weekly governance teleconference and update shared with the Safety Huddle.

As per weekly governance and SAIG arrangements it has been noted that there had been other Never events relating to specifically retained swabs especially over the last couple of years. *(Further work has been completed in January 2024 with a presentation also planned for Feb 2024 SAIG in relation to retained swabs).*
For this period there had bee[redacted]SAI reviews finalised and submitted in the period April 2023-Dec 2023 that had involved Never events (specifically covering retained swabs) that had occurred in a previous reporting period.

Serious Adverse Incidents (SAIs)

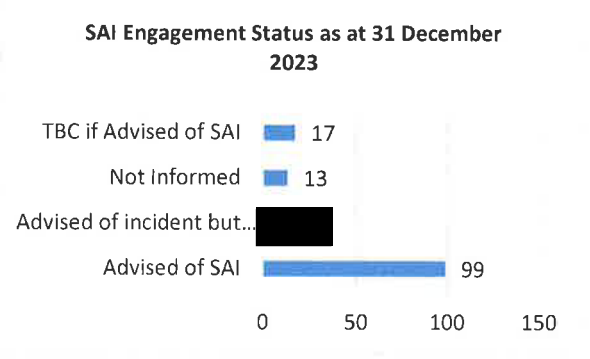
Fig 24

Division	Never Event Criteria	Immediate Learning
ACCTSS	[redacted]	
CH & NISTAR		
Opts, Imaging & MP		
Surgery		

3.5 Breakdown of SAI Service User / Family Engagement

Serious Adverse Incidents (SAIs)

Fig 25



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

Figure 25 shows a breakdown of engagement status for the period 01 April 2023 and 30 September 2023.

There were 15 new SAI notification raised during this reporting period linked to Complaints.

Some Directorates have reported difficulties in being able to fully meet / manage expectations regarding level of engagement. (There were [redacted] formal complaints raised in relation to the SAI process in this reporting period).

The table provides a further breakdown by Division of SAIs where engagement is TBC (as at 31 December 2023).

Division	Count
ACCTSS	[redacted]
Child Health and NISTAR	7
Children's Community Services	[redacted]
Maternity, Dental and Sexual Health	
Mental Health	
Surgery	
Trauma, Orthopaedics and Rehab Services	
Total	**17**

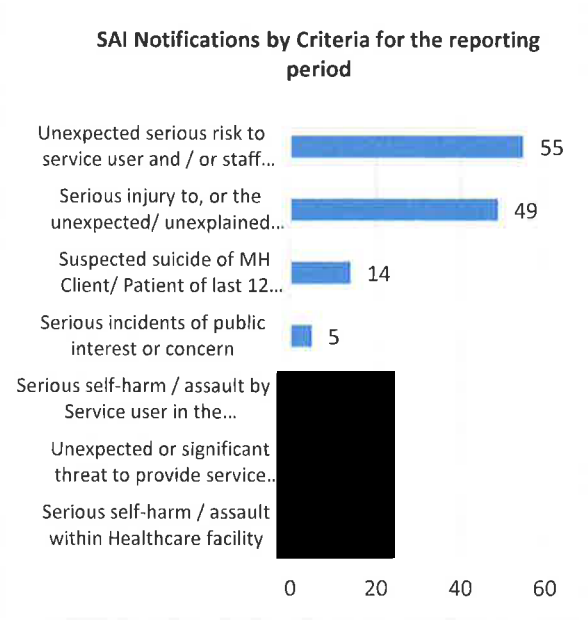
3.6 Breakdown of SAI Notifications by Criteria

Serious Adverse Incidents (SAIs)

Fig 26

Figure 26 shows a breakdown of SAI notifications for the reporting period by SAI Criteria.

42% were reported under Unexpected Serious Risk and 38% were reported under Serious Injury or Unexplained/Unexpected Death.



3.7 Breakdown of SAI Notification by Type Tier

Serious Adverse Incidents (SAIs)

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

31 (24%)
Behaviour

Breakdown by Type Tier 3 below:

Type Tier 3	Count
Actual self harm	[redacted]
Diagnostic recommendations/interventions	
Other	
Physical contact (actual assault)	8
Sexual (including indecent exposure)	6
Suicide (actual)	12

30 (23%)
Diagnostic Processes/ Procedures

Breakdown by Type Tier 3 below:

Type Tier 3	Count
Delayed	[redacted]
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	
Investigation delayed	
Investigation not clinically indicated	
Investigation not performed	
Missed diagnosis/failure to diagnose	
Specimen insufficient/incorrect/incomplete	
Specimen missing	

3.8 Assurance and Escalation processes (relating to SAIs)

SAI data (New SAI notifications and SAI recommendations from recently completed reports) are fed into Weekly Governance Report and shared with Executive team as part of the established weekly Safety Huddle. A copy of which is also shared in turn with the Non-Executive Directors. Important learning identified at time of SAI notification is covered as part of weekly governance call by the relevant Directorates.

Monthly Serious Adverse Incident Group (SAIG) requires regular updates to be provided by Directorates that covers any additional risks or important learning identified from SAI reviews ongoing / recently concluded.

SAI data is updated on a monthly basis and provided back by via the established Trust QMS arrangements.

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.

Meetings supported by Co Director for R&G and Deputy medical Director for R&G organised with Senior Divisional Leadership. These meeting were set up from March 2023. These meetings include reviewing the number of SAI reports outstanding, SAI Action Plans to be submitted for previously submitted SAIs and SAI Action Plans still to be closed.

Regular Assurance updates from SAIG are provided into the Clinical & Social Care Governance Steering Group Meeting (as per Assurance Framework arrangements)

SECTION 4: EXTERNAL REPORTING

4.1 Regulation & Quality Improvement Authority (RQIA)

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 intellectual 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.

Serious Adverse Incidents (SAIs)

28*

SAI Notifications submitted to RQIA during the period

*Data includes [redacted]

For those SAI notifications previously shared with RQIA, on completion of the SAI review a copy of the final SAI report is also shared with RQIA

4.2 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.

Serious Adverse Incidents (SAIs)

1

SAI Notification submitted to NIAIC during the period

4.3 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.

For this reporting period HSENI requested visibility of one BHSCT Shared Learning letter linked to a SAI. (This had been in relation to the use and management of a cleaning agent)

Serious Adverse Incidents (SAIs)

5*

SAI Notifications submitted to HSE during the period

*relates [redacted]

4.4 Interface Incidents

Interface incidents are incidents that have occurred in another organisation, which may be reportable as SAIs. These Interface Incidents have been raised by BHSCT against incidents in other organisations.

Raised by BHSCT

34

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

The table provides a breakdown of the current status of each of the interface incidents as at 31 December 2023.

Current Status	Count
Closed by SPPG	**13**
SAI Notification Submitted	9
SAI Notification not required (as per SPPG)	[redacted]
SAI Notification not required rationale submitted	
Open & Under Review	**21**

Received by BHSCT

These Interface Incidents have been raised by other organisations against incident in BHSCT and require review to determine if an SAI notification is required.

8

Interface Incidents received by BHSCT from SPPG during the period

The table provides a breakdown of the current status of each of the interface incidents as at 31 December 2023

Current Status	Count
Closed by SPPG	[redacted]
SAI Notification Submitted by BHSCT	
Open & Under Review	**7**

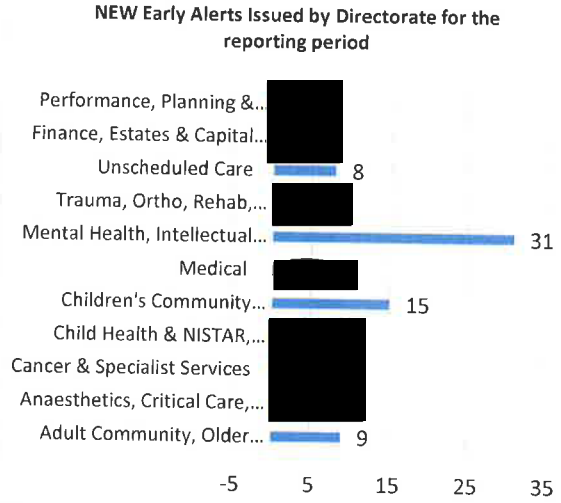
4.5 DoH Early Alerts

Fig 27

Figure 27 provides a breakdown by Division of Early Alerts (EAs) submitted during the reporting period. There was a total of 82 new Early Alerts; 6 of these were also reported as SAIs.

Compared to the same period in the previous year there has been a decrease.

This data does not include the many updates that can be submitted also for EAs



SECTION 5: LEARNING FROM INCIDENTS

5.1 Examples of Actions from Incident /trend Data

Following on from the detail already covered in Sections 2.1 & 2.4 for **behaviour** (including self-harming) incidents are most commonly reported by Acute Mental Health units, Beechcroft Child and Adolescent Unit, and Intellectual Disability inpatient wards.

Mental Health:
Behaviour incidents continue to remain one of the highest for reporting of Adverse Incidents within Mental Health Services – particularly within the Acute Mental Health Inpatient Centre (AMHIC) and Beechcroft Child and Adolescent Unit.

Within Acute MH this tends to be in the early stages of admission to acute settings for adults. Within AMHIC, there are a growing number of patients (Intellectual Disability) who have been placed there, as there is no other inpatient facility for them at this time (due to MAH being closed to admissions). AMHIC is a mental health unit and not an appropriate setting for such patients. There are a number of projects ongoing within AMHIC to try and reduce incidents of violence and aggression.

As part of the weekly governance call arrangements, the Mental Health team confirmed a risk is in place within their risk register in relation to demand for beds exceeding capacity within AMHIC.

Incidents continue to be monitored on a regular basis on the wards, in team meetings, and at Operational/ Patient Safety Meetings. Collective Leadership Team (CLT) have oversight of all incidents recorded (once approved) as Moderate or above severity and incidents graded as Moderate or above consequence. CLT also review the weekly Physical Interventions report which outlines the occurrence of Intermuscular (IM) / Prone/ Supine restraints on inpatients. If there is a particular area of concern, further investigation will be requested.

Within Beechcroft Child and Adolescent Unit, the majority of self-harming incidents are down to a small number of patients. CLT have been meeting with the senior management team in Beechcroft on a weekly basis to review the current situation for both assurances and support. This work remains ongoing.

Mental Health provide a trend analysis report for monthly governance meetings which also assists with local governance meetings.

Intellectual Disability:
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 Intellectual 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.

Intellectual 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.

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.

Currently with the exception of ID Services when an incident is reported that includes the use of safety interventions, this allows member of Corporate Safety Intervention team to get visibility of the incident at time of approval. This information is reviewed by a Trust advisor to establish if learning or support for the service is required. If learning or support is identified this is updated on Datix and made available to the relevant service.

For ID the process outlined immediately above this is provided from within the service via a Service manager.

This is separate to the discussions undertaken as part of the established Governance huddle arrangements established within each Division.

Accidents / Falls

The Falls Forum continues to meet regularly. 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.

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

- The FallSafe Coordinator works collaboratively with service groups and other stakeholders to develop, improve and facilitate services to try and reduce the incidence of falls within the Belfast Trust, through a planned programme of risk assessment, health promotion and evidence based treatment interventions and person-centred care. The FallSafe Coordinator delivers on the requirements of the FallSafe Project within the BHSCT, is responsible for the delivery of training programmes to the multi-disciplinary

team and provides specialist input with respect to investigations into moderate to catastrophic falls.

- From April '23 –Dec '23, a total number of 57 patients experienced an injurious fall and a 'minimum data set for post fall incident review' was completed. There have been [redacted] catastrophic fall incidents recorded in this time period.
- Comparing Quarter (3) 2022 with Quarter (3) 2023 the BHSCT experienced a 21% reduction in moderate and above, injurious falls.
- A report of all moderate and above falls is presented at the Senior Nursing and Midwifery team meeting. The themes and trends of the fall incidents reviewed are highlighted within this report along and the completed post fall review is embedded within the report.
- The shared learning from each review is completed and reported each month to the Public Health Agency. A 'Learning from Falls' newsletter was published in September 2023. The purpose of this newsletter, is to share information and key learning derived from adverse incidents of inpatient falls across HSC Trusts, which have been identified from post fall reviews.

The FallSafe Coordinator continues to support ward areas with falls quality improvement work and FallSafe Awareness sessions.

5.2 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.

Every week all new approved incidents with a Catastrophic severity or Extreme risk grade are presented at the Trust Weekly Governance call. Any immediate learning identified by the relevant Directorate would be discussed as part of this call.

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

A ward governance dataset is provided for acute adult in-patient wards via Business Intelligence software (Qlik). Indicators are provided for a range of safety and quality issues including C.Difficile rates, deaths, incidents, SAIs and complaints. Patient feedback is also included for selected wards where real time feedback is collected. These reports are also produced at aggregate specialty and Division level. Ward/unit level datasets are produced manually for ICU, Children's Community Services and Mental Health. These datasets aim to triangulate safety and quality data with activity information and nurse staffing levels.

Additionally, new QMS Divisional level datasets and dashboards are provided each month covering a broader range of performance indicators for efficiency, effectiveness and aggregate safety and quality indicators.

A number of current quality improvement projects are making use of incident data to inform their work.

5.3 Learning from Serious Adverse Incidents (SAIs)

Similar to above with incidents every week all new SAI notifications and SAI recommendations from completed reviews are presented at the Trust Weekly Governance call. Any learning (including immediate) identified by the relevant Directorate would be discussed as part of this call.

Learning is also a specific focus on Directorate reports tabled at the monthly SAIG meeting. A summary of Learning Themes from completed SAI reviews would be brought at least every 6 months to this meeting. (*This was last discussed in detail at SAIG that occurred in 21 November 2023*)

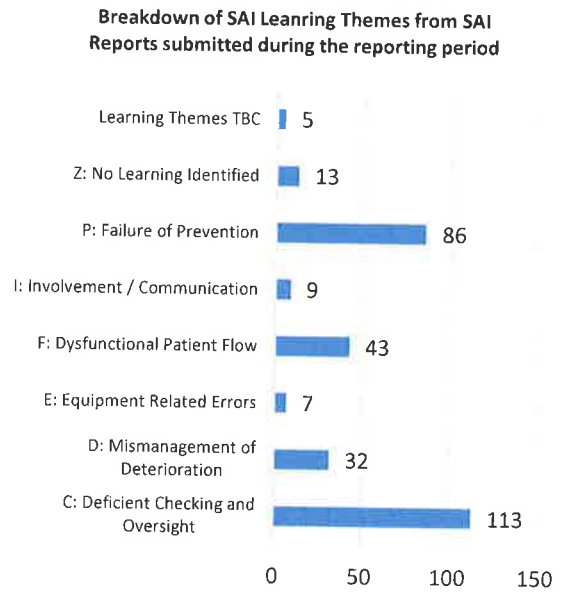
Serious Adverse Incidents (SAIs)

Fig 28

During the period 01 April 2023 and 31 December 2023 a total of 165 SAI reports were completed and submitted to SPPG.

Figure 28 provides a breakdown of learning themes from these SAI reports.

Of the 165 reports submitted, 160 had learning themes confirmed as at 31 December 2023 with a total of 290 learning themes across the 165 reports.



The table provides a breakdown of sub-group learning themes for the top 2 groups, i.e. C: Deficient Checking & Oversight (113) and P: Failure of Prevention (86).

Work is underway to potentially add some additional learning themes to the current list to assist some services accurately capturing their key themes, for example Social Work.

Learning Theme	Count
C: Deficient Checking & Oversight	**113**
C1: Medication error	6
C2: Misinterpretation/mishandling of test results	12
C3 Unexpected perioperative death (within 24hrs)	0
C4: Wrong - site/implant/procedure/patient	7
C5: Risk management failure	23
C6: Staff Training not up to date	6
C7: Related to checking aids e.g. tick box	10
C8: Failings/errors in documentation	49
P: Failure of Prevention	**86**
P1: Inpatient falls	[redacted]
P2: Healthcare-associated infections	6
P3: Pressure sores/decubitus ulcers	[redacted]
P4: Suicides	18
P5: VTE/pulmonary embolus	[redacted]
P6: Cardiac / respiratory arrests	
P7: Staff Training/ skills deficiency	13
P8: Infant/Child Death	0
P9: Failure to prevent self-harm/assault/homicide	[redacted]
P10: Other (specify)	40

SECTION 6: SHARING LEARNING

6.1 Shared Learning Letters

Adverse Incidents

Fig 29

Ref	Details	Date Issued
[redacted]	Steroid induced Hyperglycaemia	31 May 2023
	Staff must not email patient related data to their unsecure personal emails or use non-Trust approved devices when dealing with patient data	27 July 2023
	Skin bundle commencement and use of interpreting service to communicate with patients at risk of pressure damage	28 July 2023
	NISCC Registration Checks	08 August 2023
	Temporary Storage for Filing Cabinets containing Documentation	08 August 2023
	Patients with urgent conditions who decline admission should be highlighted to Surgery WL Office	13 October 2023
	HCP requesting test results are responsible for review and communication of results	13 October 2023
	SACT Prescriber Checks	17 October 2023
	Advice on management of complex STIs	07 November 2023

Serious Adverse Incidents (SAIs)

Fig 30

Ref	Details	Date Issued
[redacted]	[redacted]	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
	Post procedural instructions should be clearly documented and recorded for relevant patients	30 June 2023
	Incidental Findings	21 July 2023
	Transfer Directive Order (TDO) from Prison Services	24 July 2023
	DVT D-Dimer and further investigations	07 August 2023
	Communication and documentation of Patient Journey	08 August 2023
	Retinal Imaging Suspected Wet Age Related Macular Degeneration (AMD)	08 August 2023
	MRI Brain Reporting to include Vasculature Changes	30 August 2023
	Ensure Correct email address is used	13 October 2023
	Diabetic Patients with NCVH should have B-Scan	13 October 2023
	Patients with muscle invasive bladder cancer must be fast tracked	17 October 2023
	Patients with potential obstruction or recurrent infections	30 October 2023
	Patient notes must record decisions re patient management	30 October 2023

[redacted]	Communication with Lifeline re Sudden Deaths	10 November 2023
	Patient on Warfarin & Enoxaparin re INR checks	17 November 2023 (Re-Issued)
	Raised Troponin Levels require Cardiology Review before Discharge	22 December 2023

Access to Shared Learning Letters issued is available on the Trust's LOOP Learning Library via the following link:

https://bhsct.sharepoint.com/sites/medical/SitePages/Shared-Learning.aspx

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.

Work is underway in the review of current ways learning is presented on the Loop to identify any improvements with further changes expected to be completed by Spring 2024.

6.2 Safety Message of the Week (SMOTW)

Adverse Incidents

Fig 31

Ref	Details	Date Issued
[redacted]	POD System must not be used for TB specimens	06 July 2023
Multiple Incidents	Data Breaches	13 September 2023
[redacted]	Safe Prescribing of Gentamicin	21 December 2023

Safety Message of the Week (SMOTW) 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.

6.3 Incident Reporting (inc SAIs) and Risk

As at 25 Jan 2024 there were three risks on risk registers linked to incident reporting. This includes a Corporate Risk (Ref [redacted] that was recorded on the 22 March 2021. 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.

6.4 Incident Reporting and Audit

Divisions would on an ongoing basis audit incident data to identify trends or areas were further discussion or action may be required.

In addition to internal audit processes Internal Audit (that is 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.

As at 31 Dec 2023 draft report was still be compiled for sharing with the Trust.