

Risk & Governance

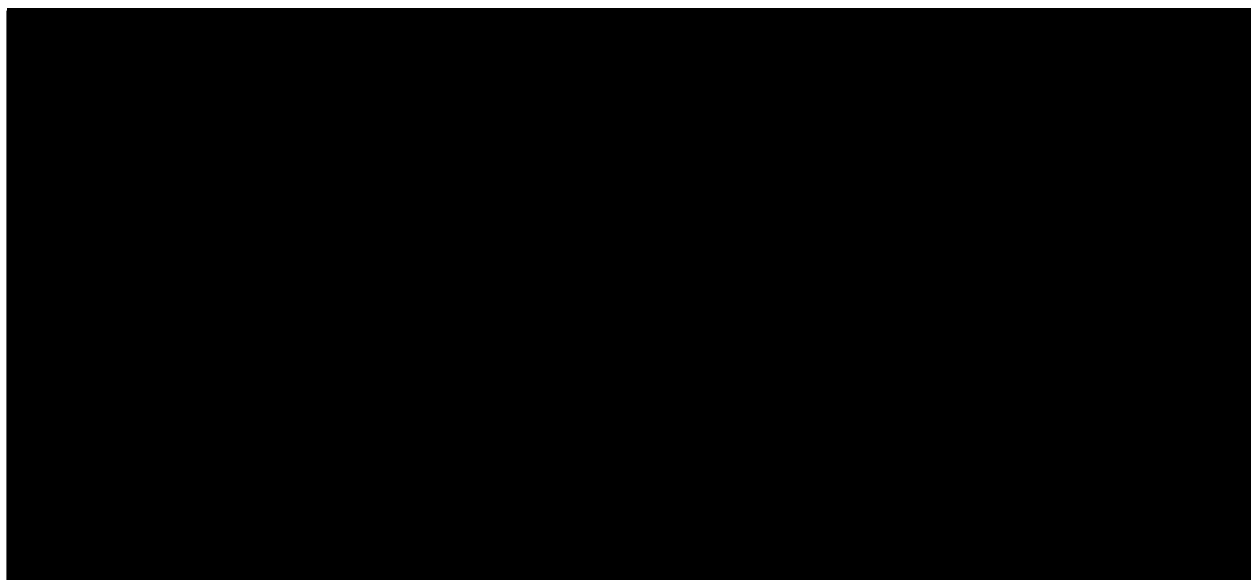
Amalgamated Assurance Report

November 2024

Incorporating:

[Trust Incident & SAI Annual Report:](#)

Q1 April 2024 – September 2024



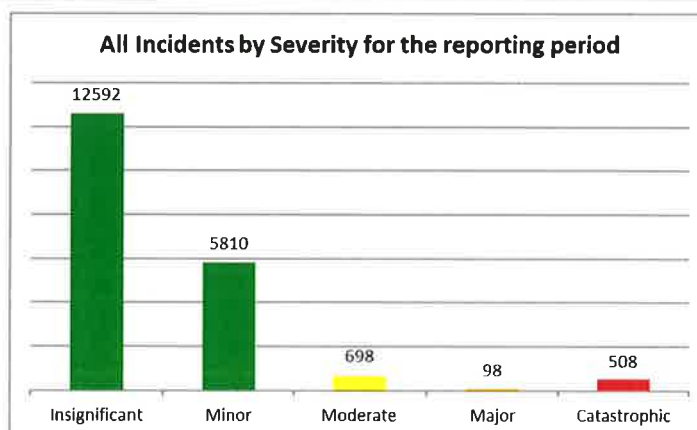
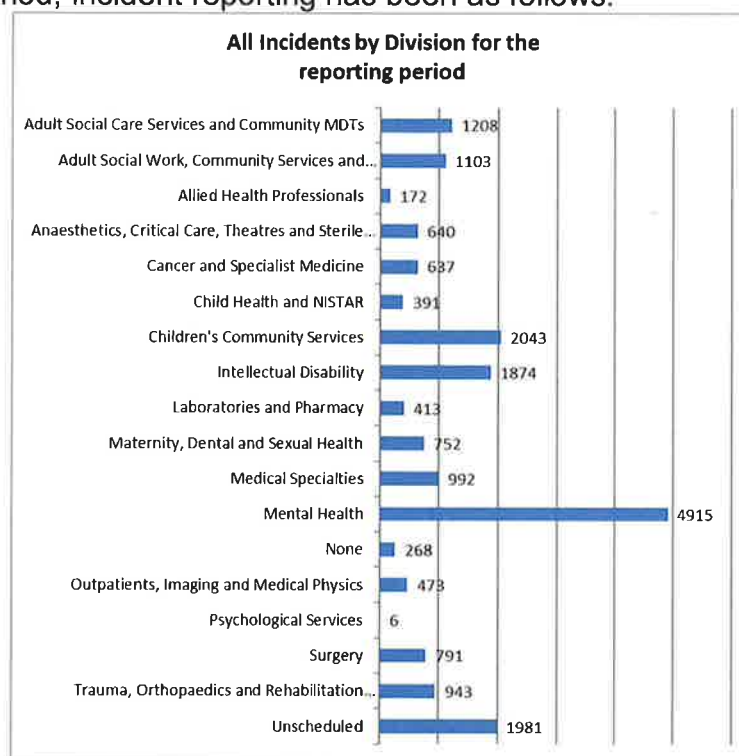
Incident & SAI high level summary report for reporting period 01 April 2024 to 30 September 2024 (as at 10 Oct 2024*)

Incidents

*Note: *Due to the proximity of the report being run to the end of reporting period, incident numbers will increase.*

- Total *approved incidents (excluding Independent Sector) = **19,706**
(For this reporting period there were also 5,169 incidents reported by ISP)
- **Decrease of 17%** from the same period in the previous year (23,815 incidents)

For this reporting period, incident reporting has been as follows:



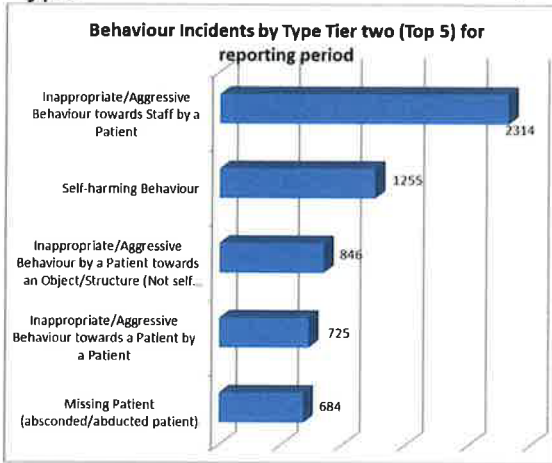
For this reporting period, **436 out of the 508 Catastrophic incidents were reported under Adult Emergency Departments**. Of these, 425 were coded as Type Tier One 'Service Disruptions (environment, infrastructure, human resources)'.

Incident Type Tier One (top two)

Behaviour = 7458. Currently **38%** *(For same period last year the percentage was 48%)*
Accidents/Falls = 2610. Currently **13%** *(For same period last year the percentage was 11%)*

There is no change to the top two Incident Types from the previous reporting period and year. However it is noted that there has been a 10 % decrease in 'behaviour' incidents.

Type Tier two behaviour breakdown.



In addition to the top 5 outlined, there were 64 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, support triangulation with their existing information and seek confirmation on action taken.

There were also 19 incidents of *'Inappropriate/Aggressive Behaviour towards Staff by Staff'*.

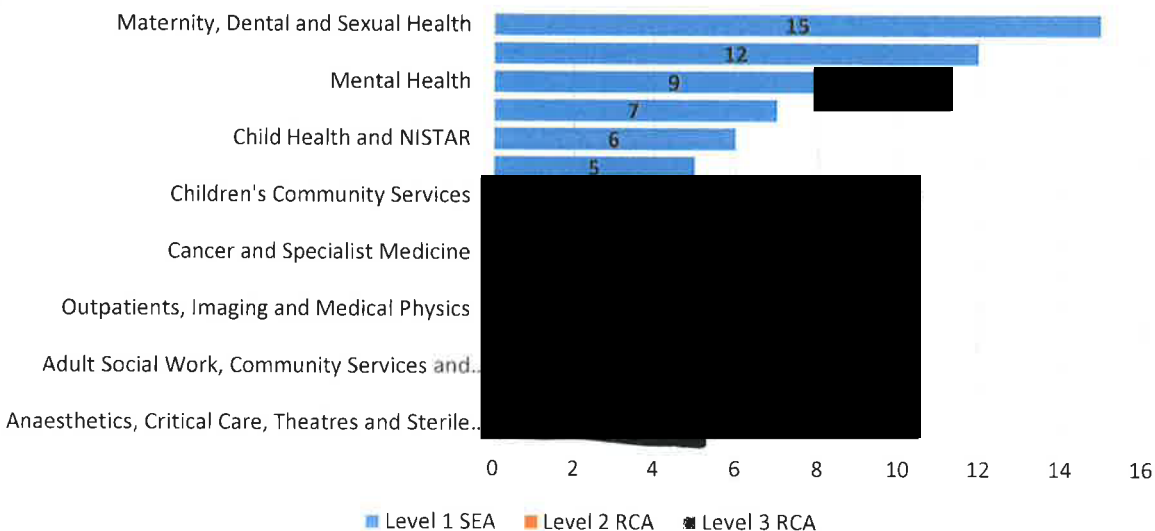
- These are shared with HR Department on a quarterly basis. HR has confirmed this information is shared via the Director with HR Co-Directors with a request to follow-up with relevant Business Partners in order that they can support the service area if required.

During June 2024 Encompass Go Live occurred. Prior to going live Datix was updated with additional fields to allow Incident reporters to record any incidents felt to have been directly linked to the Encompass system / implementation. At time of this report being run there were 839 incidents reported as being related to encompass/Epic. (788 of these are approved). This information is also shared with the Trust Digital Safety team for review. Initially during the first month of implementation of Encompass, the Trust seen an overall reduction in incident reporting (~25 % in incidents approved) to the same period the previous year. At time of this report, there is still >20 % reduction from the Encompass go live date to quarter end in incident numbers approved. At this stage it is still difficult in identifying specific trends and associated rationale for this change, but this will continue to be monitored. It has also been discussed at the Trust Digital Safety Committee and Encompass Stabilisation Group. Further more detailed analysis of the incident category and location showing the largest fluctuations planned.

Serious Adverse Incidents (SAIs)

For this reporting period there were 76 SAI Notifications submitted to SPPG.

SAI Notifications by Division and Level of Review for the period 01 April 2024 to 30 September 2024



Of these 76 SAI Notifications, 5 were Never Events**:

(**Note: Never Events are seen as serious incidents 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 healthcare providers. Details of what is deemed to be a never event is found in HSC(SQSD) 4/22)

Division	Never Event Criteria	Immediate Learning
ACCTSS		
MDS		
Surgery		

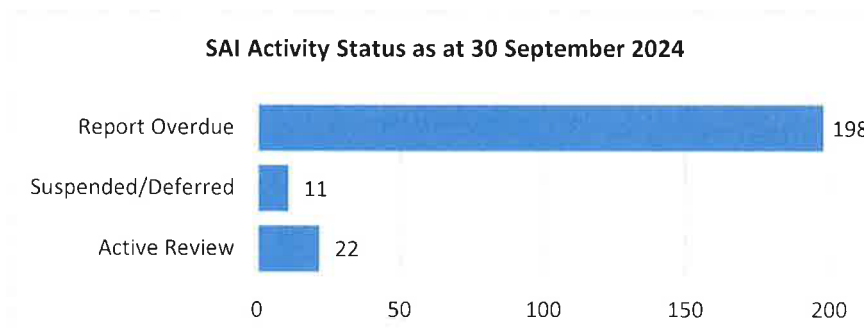
It was noted in the last reporting period there had been [redacted] never events reported as SAIs in relation to retained swabs. (As there has been [redacted] retained swab never events within BHSCT over the last three years, [redacted] of which have occurred within Maternity further work is underway to identify any additional learning required to reduce the risk of reoccurrence. This is being also monitored via the Trust SAIG).

SAI Activity Status

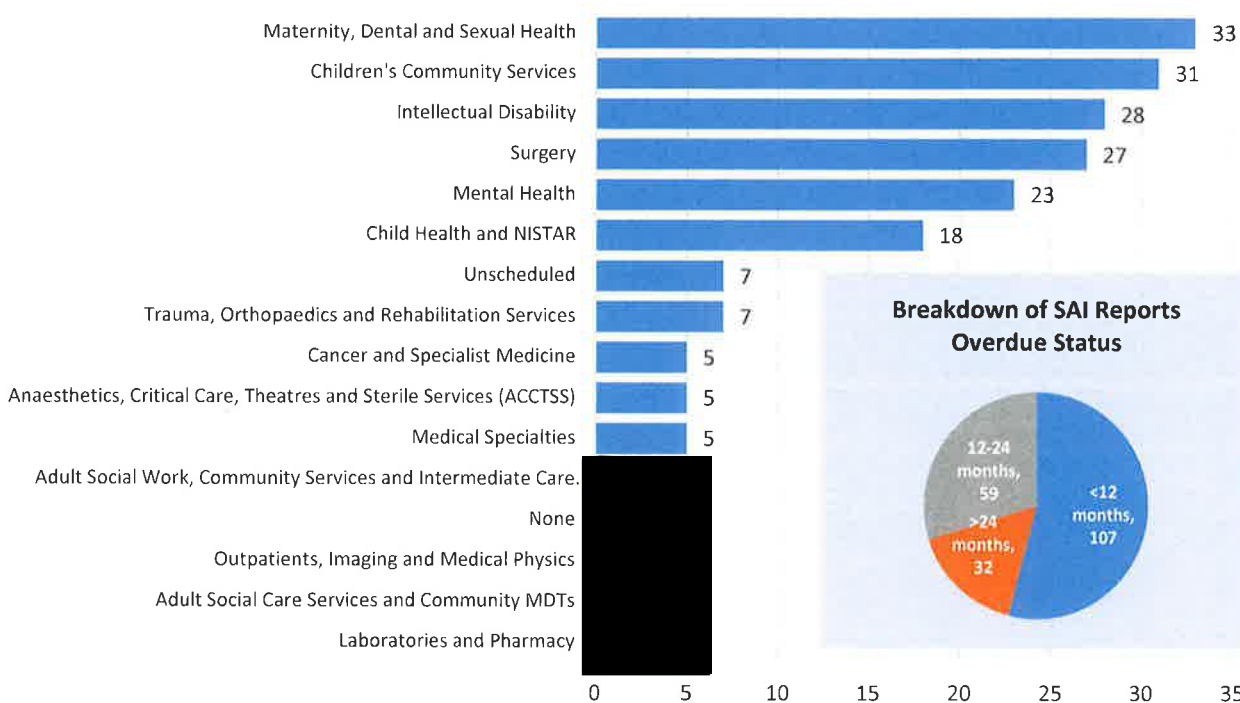
For this reporting period 90 SAI reports were submitted to SPPG.

At **30 September**, **198** SAI Reports are overdue.

(At the end of the previous quarter 31 March, this had been 227 SAI reviews outstanding)



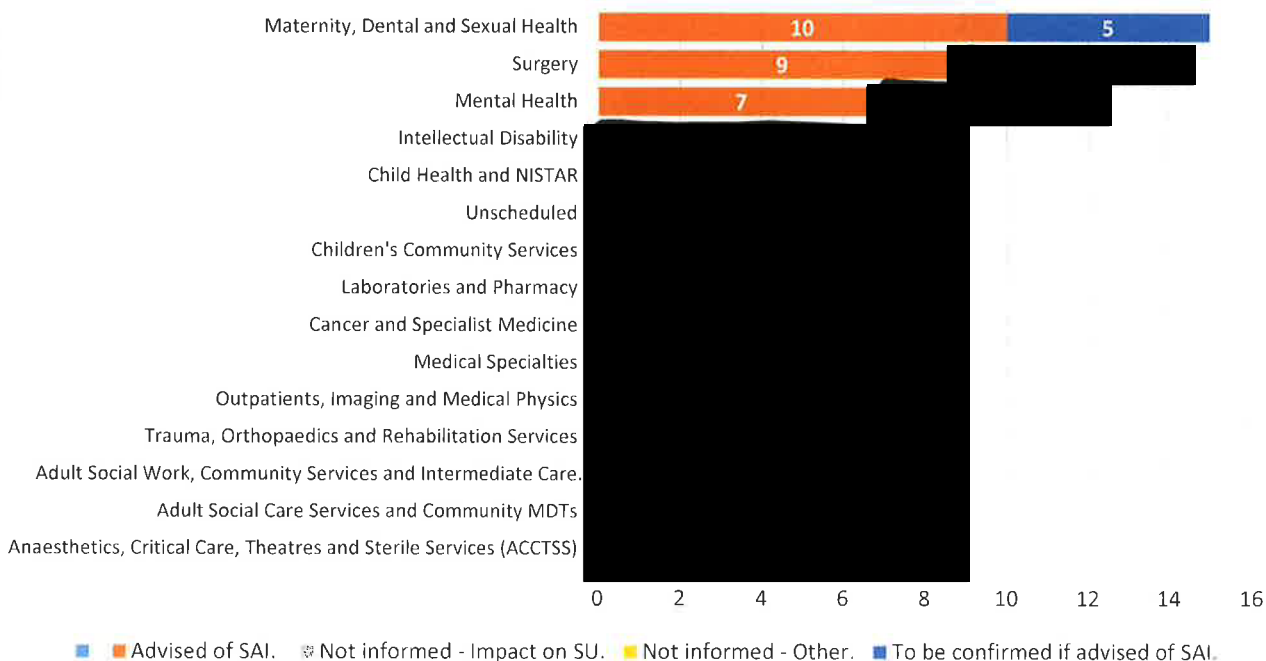
SAI Reports Ovedue by Division as at 30 September 2024



SAI data continues to be updated on a monthly basis and shared with Directors as part of the established QMS arrangements. A high level summary update (of SAI reviews outstanding) has been shared weekly (from the end of August 2024) with Executive team members. Meetings to discuss SAI data has been set up and completed with Divisional Senior Leadership Teams. Any outstanding meetings are in the process of being set up. The Trust continue to have bi-monthly Performance meetings with SPPG to discuss current arrangements. Last meeting with SPPG was 7th October 2024.

SAI Engagement Status

SAI Notification Engagement Status by Division for the period 01 April 2024 to 30 September 2024



For this reporting period the following formal learning was issued by the Trust:

- 11 Shared Learning Letters re Incidents
- 6 Shared Learning Letters re SAIs
- 8 Safety Messages of the Week (SMOTW)

In relation to Assurance processes the Trust Weekly Governance call continues to occur and new Incident & SAI information confirmed as being shared appropriately as well as any important learning. The Trust SAI Group continues to meet regularly with the last formal meeting occurring on the 17 September 2024.

SAI Redesign Update

Work is underway across the Region around the issue of new guidance to replace the existing SAI Guidance. Estimated date of issue of this new guidance is still Spring 2025. BHSCT has assisted the Region in testing a potential alternative review process – ‘After Action Review’. Comments have been submitted and initial findings presented back to Regional representatives. (As part of the current testing, the Trust are looking at piloting the presentation of findings back to the relevant Senior Leadership team immediately after completion of the AAR to try and enhance approval times).