To:	**Renfrewshire Integration Joint Board Audit, Risk and Scrutiny Committee**
On:	**10 September 2021**
Report by:	**Head of Health and Social Care**
Heading:	**Update on Safety – covering incident management, reporting and investigation**

1. Summary

1.1 This paper provides an update on incident management, reporting and investigation being progressed by the HSCP to the Audit, Risk and Scrutiny Committee. The report covers the period 1 April 2020 to 31 March 2021.

2. Recommendations

It is recommended that the Audit, Risk and Scrutiny Committee:

- Note the content of this paper.

3. Background

3.1 Health and Safety reporting previously formed part of the Non-Financial Governance Report to the IJB and continues to form part of the HSCP Annual Clinical Governance Report to the IJB. To refine this it was agreed by the Chair and Co-chair of the IJB and the Chair of the Audit, Risk and Scrutiny Committee to provide the Audit, Risk and Scrutiny Committee with a specific report on incident reporting and continue to present annually on incident management, reporting and investigation within the Annual Governance Report to the IJB.

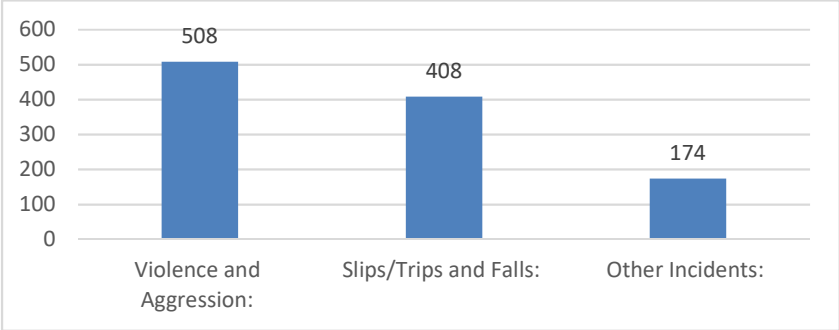
4. Safety (incident Management, Reporting and Investigation)

4.1 All incidents, regardless of the severity require reporting to review, action and share learning where appropriate. Within the HSCP incident reports are produced and discussed on a regular basis at the relevant governance groups. There are various systems currently used within Renfrewshire HSCP for incident reporting and management.

4.2 The DATIX Incident Reporting System is used within health to provide a clear reporting structure to record clinical incidents, near misses and complaints. From 1 April 2020 – 31 March 2021 there were **1821** incidents reported on DATIX, compared to **1921 (-100)** in the previous report.

The highest reported categories relate to:

Highest Incident Categories



4.3 The Incident Reporting Database which allows users within social work services to record incidents/accidents electronically has changed.

The undernoted provides data on accidents/incidents now reported on Business World during the period 1 April 2020 – 31 March 2021. Please note there may be a slight variation with this data due to the accident reporting function within Business World. This has been escalated and Renfrewshire Council are currently reviewing the system.

A total of **371** accidents and incidents were reported.

4.3.1 Breakdown includes:

Non-Employee Accidents/Incidents:

A total of 333 accidents/incidents were reported during 2020-2021, 324 involved service users.

The highest reported types of accidents were:

- 251 slips, trips and falls (246 occurred within older people residential services)
- 33 fall from height e.g. from a chair/WC (32 occurred within older people residential services)
- 7 medication incidents (6 occurred within residential premises).

Employee Accidents/Incidents:

A total of 38 were reported, the highest types of accidents were 9 slips, trips or falls and 7 violence and aggression.

4.3.2

In comparison with service user accidents/incidents reported during 2019-2020, 412 were slips, trips and falls. 359 occurred within residential premises (353 in older people and 6 in learning disabilities respite). 37 were reported within day services which have either been closed or operating at reduced capacity during the Covid-19 pandemic. 58 falls from height were reported during 2019-2020. The majority 46 occurred within older people services. 42 in residential premises and 4 in day services.

4.4 **Actions in place to address the highest reported incident categories include:**

- **Violence and Aggression:** Training and refresher training are in place for staff and an e-learning module is available. The Violence Reduction service is also available for staff to provide advice and support around violence reduction and de-escalation strategies.
- **Slips/Trips and Falls:** All accidents/incidents are investigated locally. Follow up actions are identified, risk assessments are reviewed and care plans updated.
- **Other incidents:** Work continues with Service Managers to ensure that appropriate categories are used for incidents and in order to avoid using the "other" category if appropriate. This will enable better analysis and action planning of known incidents.

5. Serious Adverse Events (SAEs)

5.1 Serious Adverse Events (SAEs) are those events that have or, could have significant or catastrophic impact and may adversely affect the organisation and its staff and have potential for wider learning (i.e. learning that can be gained for future care delivery). The purpose of an SAE investigation is to determine whether there are any learning points for the partnership and wider organisation. All SAEs must have a Briefing Note Template completed.

5.2 Renfrewshire HSCP Social Work services adopt the "Rapid Alert/Briefing Note" template used within health for serious incidents to ensure consistency in approach within the HSCP. All incidents reported are appropriately investigated to minimise the risk of recurrence through learning.

5.3 From April 2020 – March 2021 a total of **9** SCIs/SAEs have been commissioned within Renfrewshire HSCP. This compared to **5** SCIs **(+4)** in the previous report. Description of these incidents varied between attempted and actual suicides and pressure ulcer care. All staff involved in commissioning/conducting SCIs/SAEs investigations must adhere to a series of principles and key requirements. During this period there were also **2** incidents that will go through an Incident Case Review process through the Child Protection Committee. During COVID-19 a number of SCIs/SAEs investigations continued to be progressed however, others were suspended due to the restrictions imposed by the Scottish Government in limiting face to face contact and prioritising urgent duties.

5.4 **Examples of incident management/investigation/reporting improvements include:**

- Learning from SCI/SAEs is shared at various meetings.
- A process is in place to share learning across HSCP Governance Groups and NHS Greater Glasgow & Clyde Primary Care & Community Clinical Governance Forum.

6. Large-Scale Investigations

6.1 Three Large-Scale Investigations (LSIs) were initiated in 2020. These LSIs involved two independent sector care homes for older people and an independent sector home for adults with learning disabilities. Contributions to these LSIs during the reporting period came from colleagues across the health service, Police Scotland, the Care Inspectorate, Scottish Fire and Rescue Services, commissioning staff, social work services and the third sector, leading to holistic assessment of risks and

strengths within these care settings. The coordinated response to shared concerns enhanced the efficiency and efficacy of safeguarding measures undertaken.

7. RIDDOR

7.1 Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR) regulations require organisations to report certain incidents to the Health & Safety Executive (HSE) that occur as a result of, or in connection with the work that is undertaken. If an incident meets the criteria stipulated in the regulations then it must be reported under RIDDOR within a set timescale.

7.2 There is now a requirement from NHS GG&C Health and Safety Department to complete a Falls Severity 4/5 template and Non-Staff Incident Summary Sheet for every fall incident to establish if the fracture sustained by the patient is RIDDOR reportable.

7.3 From April 2020 – March 2021 a total of 8 incidents were investigated as RIDDORs within health and social work services, this was a slight reduction **(-3)** from the number of 11 incidents in the previous reporting period.

Breakdown includes:

Area	**Categories**	**Number of incidents investigated as RIDDOR**
Mental Health Inpatient Services	Violence and Aggression – Patient Physical Assault on Staff.	4
Localities	Covid-19 related after using hand gel and Slips/Trips and Falls.	2
Social Work	Slip/Trips and Falls.	2

7.4 **Examples of recommendations and actions from a Violence and Aggression incident include:**

Recommendation	**Action(s)**
• Post incident de-briefs carried out for all significant incidents as soon as possible following the incident.	Staff reminded to carry out post incident de-briefs and they are being carried out.
• Violence Reduction refresher training to be arranged for the injured person as soon as possible following the incident	Appropriate training to be arranged and undertaken prior to staff's training timescales lapsing within the ward.
• Review of the Violence and Aggression Risk Assessment in light of this incident	The Risk Assessment is reviewed following every significant incident but no changes are required.
• Management referral or staff self-referral to Occupational Health (OT) to be considered following incidents.	Referrals to OT are always considered as part of the process.

Implications of the Report

1. **Financial –** No direct implications from this report
2. **HR & Organisational Development –** No direct implications from this report
3. **Community Planning –** No direct implications from this report

4. **Legal –** No direct implications from this report
5. **Property/Assets –** No direct implications from this report
6. **Information Technology –** Managing information and making information available may require ICT input.
7. **Equality & Human Rights –** No direct implications from this report
8. **Health & Safety –** No direct implications from this report
9. **Procurement –** No direct implications from this report
10. **Risk –** No direct implications from this report
11. **Privacy Impact** – None.

List of Background Papers

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