Oxford University Hospitals
NHS Foundation Trust

Cover Sheet

Trust Board Meeting in Public: Wednesday 9 November 2022

TB2022.099

Title:	**An Annual Review of the Serious Incidents Requiring Investigation and Never Events reported during Financial Year 2021/22**

Status:	**For Information**
History:	**Clinical Governance Committee 19 October 2022**

Board Lead:	**Chief Medical Officer**
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Confidential:	**No**
Key Purpose:	**Assurance**

Executive Summary

1. This report presents a review of the serious incidents requiring investigation (SIRI) during the financial year (FY) April 2021-March 2022. It considers trends over time in incident reporting and describes significant actions taken to prevent recurrence of adverse events and to support good practice.
2. 99 serious incidents requiring investigation (SIRI) were declared during the FY April 2021- March 2022. Twelve SIRIs were subsequently reclassified leaving 87 SIRIs for review in this report. *All data in this report is based on these 87 SIRIs*.
3. FY 2021/22 saw a mean of 2245 incidents reported per month. This is notably higher than the previous 4 years' data and is believed to be the result of improvements to the interface and workflow for reporting incidents, making the process more accessible and user-friendly to staff members.
4. Incidents of moderate or greater impact (IOMGI) rose in FY 2021/22. This is primarily because of a change in practice in Maternity, bringing incident grading in line with National Reporting & Learning System (NRLS) guidance.
5. Attendance at the SIRI Forum in FY 2021/22 rose 84% against the previous year. This is doubtless because of the move to virtual rather than physical meetings, coupled with staff now being more available than they were during the height of the COVID-19 pandemic.
6. Future plans relating to the implementation of the national Patient Safety Incident Response Framework are described.
7. **Recommendations**

   The Trust Board is asked to note the content of this report for information.

Contents

An Annual Review of the Serious Incidents Requiring Investigation and Never Events reported during Financial Year 2021/22

1. Purpose

1.1 The purpose of this paper is to inform Trust Board of the trends in reported Serious Incidents during FY April 2021-March 2022. The paper provides information to Trust Board on actions taken to prevent recurrence of these types of incident and ongoing work to further embed a culture of both safety and duty of candour across the Trust.

1.2 The Appendices have been used for additional information about the SIRI forum process, NHS survey and training. This report focuses on the trends and actions arising from the SIRIs in FY 2021/22.

2. Review of numbers of Incidents, SIRIs and Never Events

2.1 During FY 2021/22 99 SIRIs were declared by the Trust via the Strategic Executive Information System (STEIS), NHS England's web-based serious incident management system.

2.2 Twelve of these SIRIs were reclassified on STEIS (with agreement from the Integrated Care Board (ICB) (known during the period covered by this report as the Oxfordshire Clinical Commissioning Group), leaving 87 SIRIs in 2021/22. This is an increase of 31 from the previous financial year but is much closer to the 5-year mean (83). Fluctuations often occur year on year, but the FY 2020/21 figure was unusually low, reflecting the reduction in core activity during the height of the COVID-19 pandemic.

2.3 Nine of these investigations were reclassified to local investigations, and a Divisional investigation was completed for the remaining three.

Table 1: SIRIs by FY

FY	SIRIs excluding reclassifications
2017/18	91
2018/19	109
2019/20	71
2020/21	56
2021/22	87

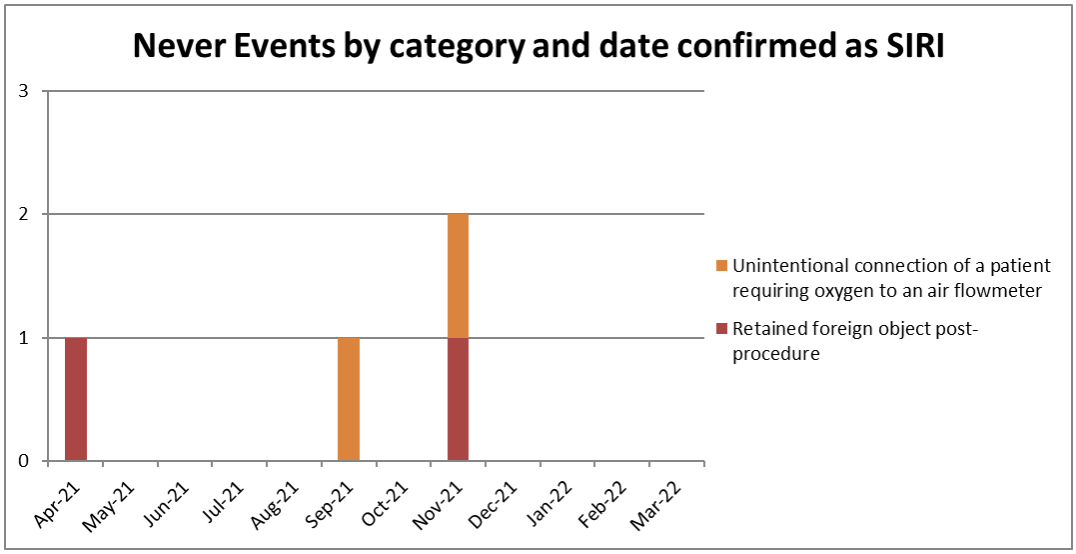
2.4 Four Never Events were identified in FY 2021/22:

a. A vaginal pack was unintentionally retained in Gynae-Oncology following surgery.

b. A swab was unintentionally retained in maternity whilst suturing following a vaginal delivery.

c. Two hypoxic patients requiring oxygen therapy were unintentionally connected to medical air. Although these occurred in different departments on different sites, they were identified within weeks of each other, and so were addressed by a single investigation, report and action plan.

Graph 1: Never Events declared in FY 2021/22



2.5 The primary improvements identified in the vaginal pack (VP) Never Event were:

a. Clarification of whose task it is to inform patients of the meaning of the “VP” sticker affixed to the patient’s hand when a vaginal pack is intentionally retained.

b. Creation of an ‘enhanced recovery after surgery’ pathway.

2.6 The primary improvements of the retained swab Never Events were

a. Creation of a separate retainable items local safety standard for invasive procedures (LocSSIP) relating specifically to Delivery Suite, and a perineal compress standard operating procedure.

b. A quality improvement plan to ensure all Delivery Suite staff have full knowledge of the LocSSIP and policy relating to swabs, needles, instruments and accountable Items, with an associated audit tool for future assurance.

c. Addition of training on counting swabs to the preceptee and new doctor induction programmes in Maternity.

2.7 The primary improvements identified in the medical air Never Events were

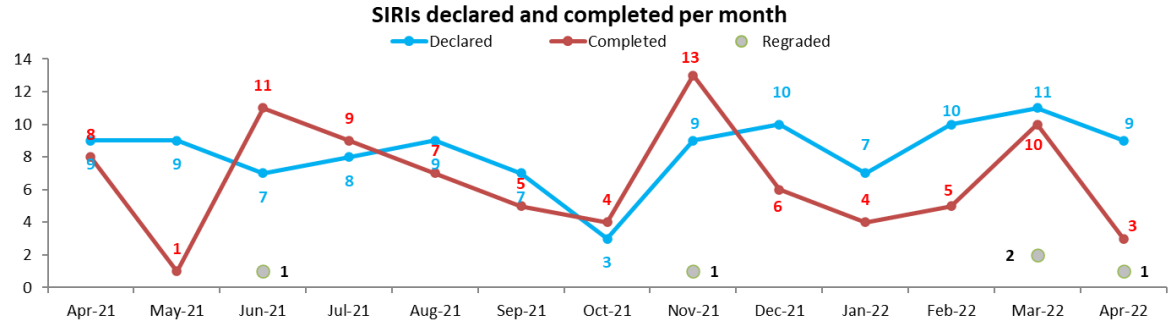
a. Ensuring that wall air plugs are closed with the correct caps.

b. Audit of air-driven nebuliser use on wards, and a review of Equipment Library stock to cover failures, plus training on use of the devices.

c. Reinstatement of mandatory training on oxygen management.

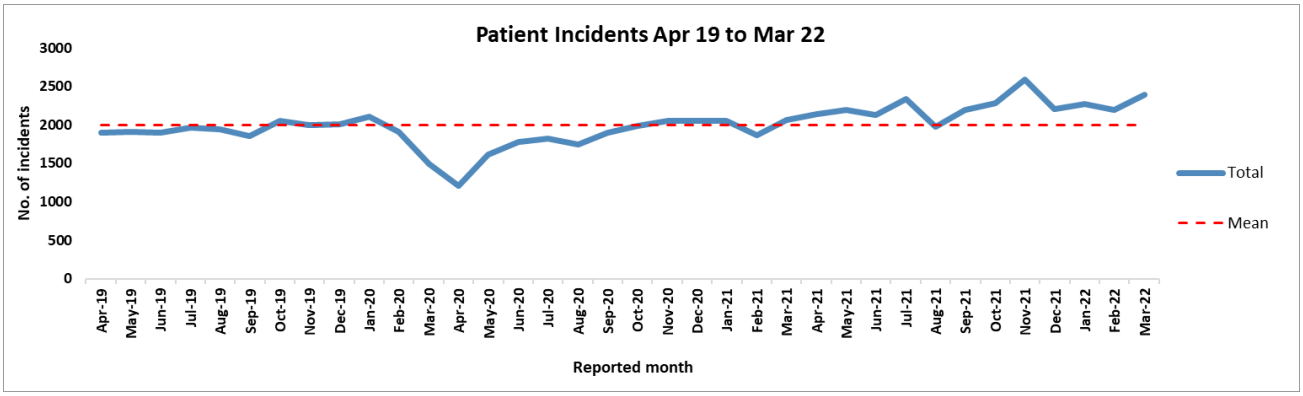
2.8 The graph below shows the number of SIRIs declared, completed, or reclassified per month. Please note that completion or reclassification generally takes place in alternative months to the declaration, so some of those figures will cover FY 2020/2 SIRIs.

Graph 2: SIRI management in FY 2021/22

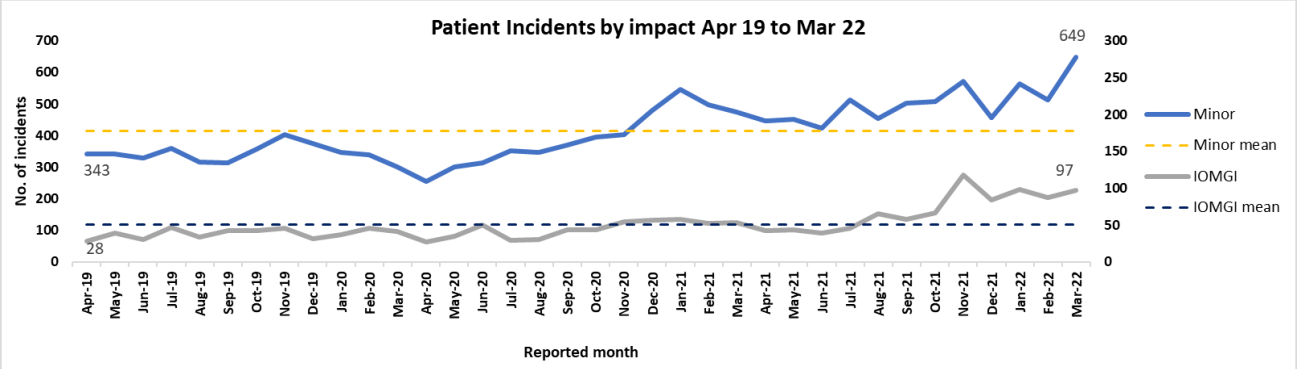


2.9 The graphs below show the number of patient incidents reported in FY 2021/22, and the two previous FYs, and the number reported with minor impact and IOMGI.

Graph 3: Patient incidents by month reported



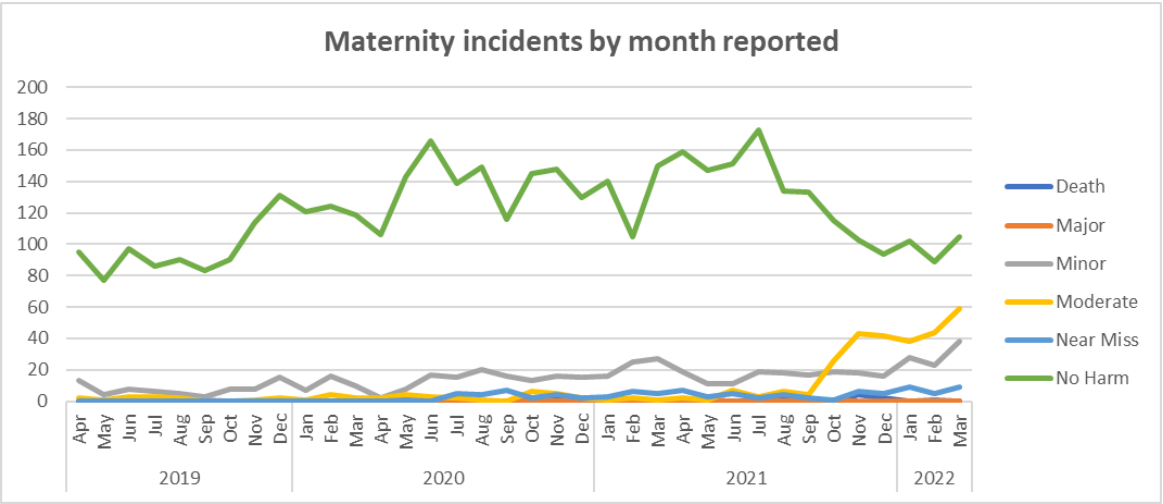
Graph 4: Patient incidents with impact by month reported



2.10 In FY 2021/22 3.1% of patient-related incidents involved moderate or greater impact, which is an increase on previous financial years (2020/21 2.4%, 2019/20 2.0%, 2018/19 0.9%, 2017/18 0.5%).

2.11 This increase is primarily associated with a change in approach to incident grading in Maternity. Previously incidents which might be considered incidental to childbirth, such as 3rd or 4th degree vaginal tears, obstetric haemorrhages above 1500ml and/or unexpected admission to the neonatal unit had been reported as entailing no harm, unless immediate concerns were evident. From October 2021, these incidents were all reported as entailing moderate impact, in line with Trust policy, which follows impact-grading guidance from NRLS. Graph 5 shows the changing trend in grading for this Directorate over the last 6 months of FY 2021/22.

Graph 5: Incidents reported by the Maternity Directorate



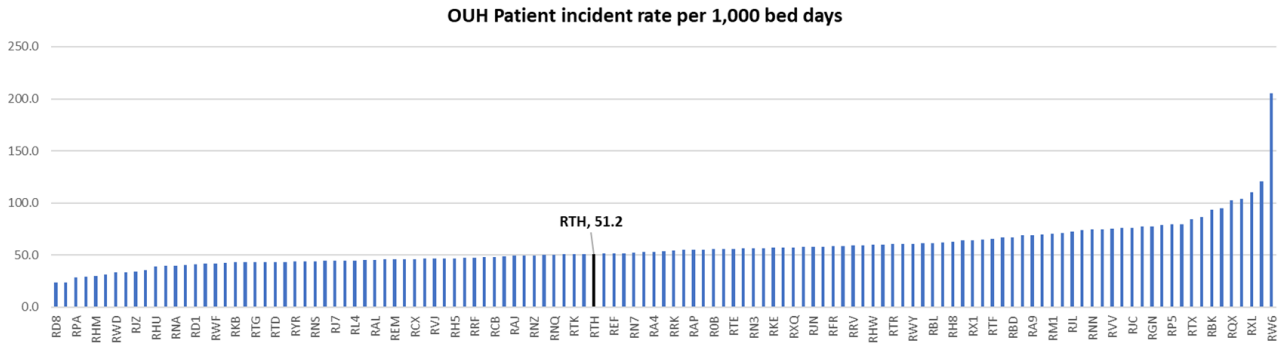
2.12 Table 2 shows the mean monthly incidents reported by financial year. The overall increase is attributable to ongoing work to improve the incident reporting process. Since the Trust replaced Datix with Ulysses as its incident management system in June 2020 there have been continual

efforts to streamline the reporting process, reducing the length of the core interface, with the creation of dedicated questionnaires for specific incident types to ensure that reporters are not asked to add irrelevant data.

Table 2: Average monthly reporting rates by financial year.

Financial Year	Mean number of patient incidents reported per month	Mean number of incidents reported per month
2017/18	1869	2220
2018/19	1875	2243
2019/20	1919	2318
2020/21	1841	2273
2021/22	2245	2819

Graph 6: The rate of incidents reported per 1,000 bed days between April 2020 and March 2021 by acute (non-specialist) organisations. Each vertical line is an acute provider. Oxford University Hospitals NHS Foundation Trust (OUH) is depicted by the black line.



2.13 Graph 6 shows that the rate the incidents reported per 1,000 bed days in 2021/22, 51.2, has risen from the previous year's figure, 50.1.

a. It should be noted that the final column is believed to be erroneous. This relates to a trust that was subsumed by another organisation during the year, and it is understood that the number of bed days has been under-reported.

2.14 Graph 2 and table 2 demonstrates reassuring data that the incident reporting rate (apart from during the COVID-19 pandemic peaks) has remained at a relatively constant rate or even slightly above the monthly mean.

2.15 In FY 2020/21 14,259 incidents were reported to NRLS, this is a decrease from 18,181 (3922 incidents) reported in FY 2019/20 but explanations

above provide a rationale for this and table 2 shows the live data on incident reporting within the Trust (sees section 2.7).

3. Selected SIRI actions undertaken in FY 2021/22 with significant impact

Please note that other actions were undertaken relating to specific findings in the following investigations, but only actions with significant or Trust wide impact have been summarised.

3.1. 2122-090, a patient's duodenal biopsy showing B cell lymphoma was not acted on and they later developed advanced disease. The investigation found that the biopsy request was sent on paper and consequently the result was not sent electronically; at the time of the incident, approximately 50% of all histopathology specimens were requested using paper-based systems.

a. The process for electronic requesting includes automatic notification to the requesting team's inbox, thus reducing the risk of loss to follow up of diagnostic test results. A task and finish group was set up in in FY 2021/22 in response to this and other incidents with the aim of addressing the many and complex reasons why clinicians continue to use paper-based requesting for diagnostic tests.

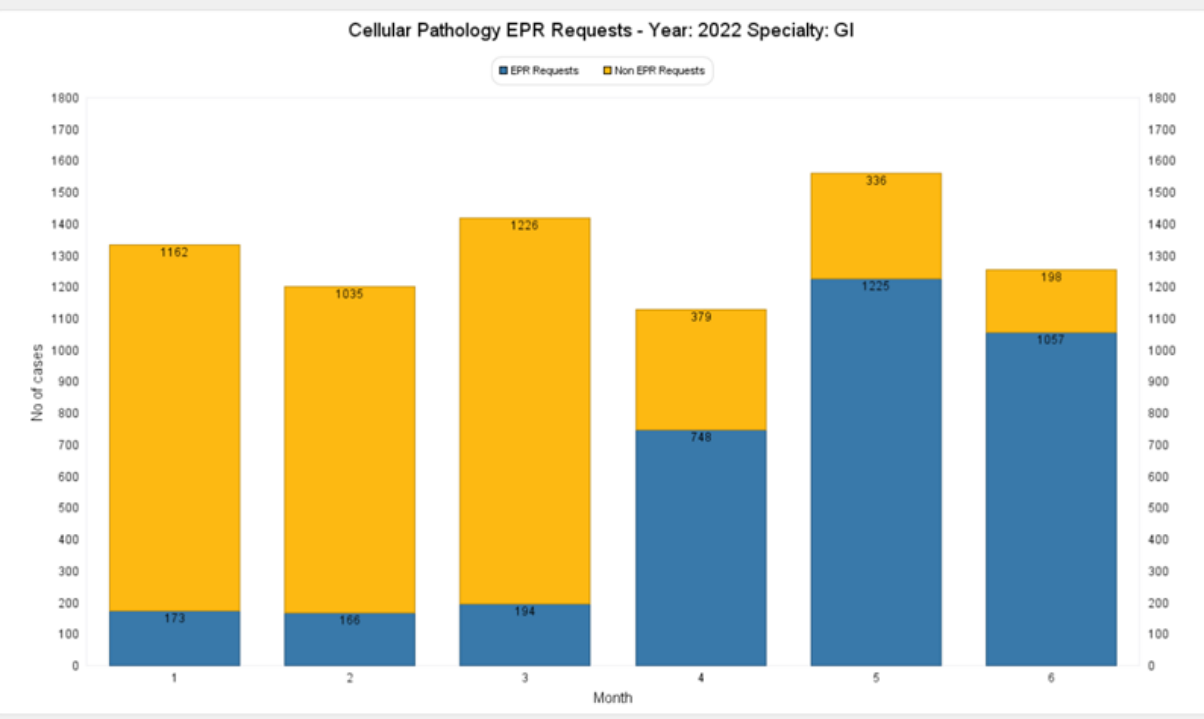
b. In laboratory medicine, specimens may be rejected unless accompanied by an electronic request. There are some areas where this approach works (e.g. blood samples for blood group and antibody screening) and results is near-100% compliance. However, that solution is not available to non-repeatable specimens, such as biopsies sent for histopathology.

c. The approach to the task and finish group is data-driven, meaning that the group focuses its attention on the clinical areas where the largest number of paper requests come from. Reasons for using paper requests are multifactorial and not straightforward, so the problem requires a facilitative approach and change management methodology. For example, the Gastroenterology team have been working with the EPR team (prior to the setting up of the task and finish group) to solve the complex issues that are unique to this service, as they use different software for recording their clinical information and require precise recording of anatomical locations of multiple specimens in any single procedure. Latest data from June 2022 demonstrates the success of the collaboration between endoscopy and digital teams. The chart below

demonstrates the improvement for GI specimens, which includes endoscopy and non-endoscopy specimens. When adjusted to exclude non-endoscopy specimens, the source data for June 2022 shows that there were only 82 paper requests (9%) from Endoscopy; this can be compared to a 96% paper request rate in January 2022.

d. Work continues with non-endoscopy GI, breast, gynaecology and NOC teams, because the data shows the majority of paper requests are coming from these areas. The learning from success in Endoscopy is expected to be extremely useful in tackling the unique problems of these identified services, some of which have similar root causes.

Graph 7: Cellular pathology request routes



3.2. 2122-021, a patient underwent surgical excision of a lesion and the histopathology specimen was not received by the laboratory

a. This is one of a cluster of cases (four in total between January and May 2021) in which histopathology specimens went missing and were unaccounted for after being taken in Churchill theatres.

b. It was recognised that the processes involved in the packaging and transportation of Histopathology specimens between OUH hospital sites did not provide sufficient security or traceability to avoid the loss of a non-repeatable specimen. The investigators described this as “an organisational ‘blind spot’ that has arisen

due to the fragmentation of responsibilities and a lack of ‘whole process’ oversight”.

c. A task-and-finish group was set up in order to address the issues, which involved all four divisions, corporate teams (clinical and non-clinical procurement, facilities management) and outsourced companies (transport and portering). The logistical complexity was apparent when the existing processes were mapped and the group set about redefining the process, with the aim of piloting the change in Churchill theatres and then rolling out to the rest of the Trust. It is of note that biopsies are taken in over 100 clinical areas in the Trust and therefore a robust pilot and proof of concept was the first prerequisite to embedding change.

d. The new process in the Churchill was phased:

   i. Bagging, tagging, logging and boxing of specimens

   ii. Transport

   iii. Electronic tracking

   iv. Share the learning Trust-wide

e. The pilot, incorporating phases 1-3 has been successful and the new process is fully embedded in Churchill theatres. The outer boxes, which contain the bagged specimens and are sealed with a uniquely numbered tamper-evident tag, are fitted with a radio frequency identification tag (RfID) which ensures the box is identifiable on the Trust’s existing software (that is used for tracking other items, such as beds) and can locate a box anywhere within the Trust’s four main sites. For the inter-site journey, bar code tracking is used by one of the two companies which provide this service. There are plans, as part of a Trust-wide review of inter-site transport arrangements to ensure that there is a single provider for specimen transport, which will ensure consistency of process and this will include barcode tracking.

f. An EPR-linked tracking process for specimen transport is in development.

g. Work is underway to consider moving this pilot to the rest of the Trust, with the focus next on the Horton.

3.3. 2122-058 & -094, patients died by suicide in a ward and the discharge lounge.

a. There has been a large increase in staff trained through a mental health first aid workshop and mental health champions have been

appointed on the ward. The focus of the champions is to support patients and staff.

3.4. 2122-002, an intrauterine contraceptive device was inserted without consent whilst performing gynaecological surgery. The root causes of this incident were the lack of recognition that the device insertion would require consent, as its use was in line with recommendations and guidance, and that the need for insertion was not anticipated by the registrar, and so the possibility was not included on the consent form.

a. A quality improvement project was undertaken in response to this incident, and consent information supplied in clinic letters has improved.

b. Bespoke consent forms have been adopted by Gynaecology.

c. The Division has organised a cross-surgical working group on consent, which is examining documentation of informed consent and the timing of consent.

3.5. 2021-048, delayed administration of antibiotics to a patient with sepsis.

a. Pharmacy has made it easier for time-critical medicines to be dispensed swiftly, with a clear separation of queues for patients and staff, and posters encouraging staff awaiting time-critical medicines to go to the front of the queue.

3.6. 2021-050, a patient received an overdose of insulin using the incorrect type of syringe.

a. Insulin syringes are now stored along with the insulin stock, to reduce any ambiguity about which devices are used with which medication. This development was bolstered by a safety message to all staff, which also included details on how to reorder insulin syringe stock.

4. SIRIs in which the patient died

4.1. Table 5 shows the SIRIs involving patient deaths FYs 2019/20, 2020/21 and 2021/22.

4.2. 29 SIRIs involved patients who died. In 3 cases it was felt the incident did not impact on the outcome for the patient. There were 26 SIRIs where the impact to the patient was death. Of these 26 SIRIs there were 6 cases related to unexpected patient deterioration, 6 maternity events, 2 relating to self-harm, 2 related to falls, 1 related to delays receiving surgery and 1 related to infection control (see below).

4.3. There is one Trust level investigation into all probable and definite OUH nosocomial probable and/or definite COVID-19 transmissions resulting in death or serious harm.

4.4. SIRIs involving deaths are presented to the Mortality Review Group (MRG) by the investigator to facilitate Trust wide learning. MRG has consultant representation from all divisions.

Table 5: SIRIs involving patient deaths FYs 2019/20, 2020/21 and 2021/22:

Year	**2019/20**	**2020/21**	**2021/22**
Total number of SIRIs involving a death	14	19	29
Impact of the incident was the death of the patient.	12	14	26
Incident categories			
Diagnosis and treatment	0	0	8
Unexpected patient deterioration/suboptimal care of the deteriorating patient	9	6	6
Devices, equipment or resources	1	1	0
Accident (not falls)	1	0	0
Operative incident	1	1	1
Infection control	1	1	1
Maternity event	1	1	4
Hospital acquired thrombosis	0	1	0
Intrauterine and neonatal death	0	2	2
Fall	0	0	2
Chemotherapy management	0	0	0
Equipment and environment	0	0	0
Self-harm	**0**	**1**	**2**
Learning and action themes			
Review of practice and procedures	✓	✓	✓
Training and Education	✓	✓	✓
Documentation and the electronic patient record	✓	✓	✓
Multidisciplinary team working	✓	✓	✓
Clinical audits and service evaluation	✓	✓	✓

In comparison with FY 2020/21 death related SIRIs we can observe:

4.5. The number of SIRIs involving deaths has increased in FY 2021/22 from the previous financial year. These cases have been reviewed by the Clinical Outcomes Manager, and this increase is not felt to be indicative of any trend.

4.6. Unexpected patient deterioration/suboptimal care of the deteriorating patient remains a common incident category theme.

4.7. Out of the 6 identified during FY 2021/22, these cases had a SIRI report discussed at MRG, 5 cases were felt to not have been avoidable (more than 50% probability). There was evidence of avoidability in one case and significant learning was identified as part of the SIRI investigation.

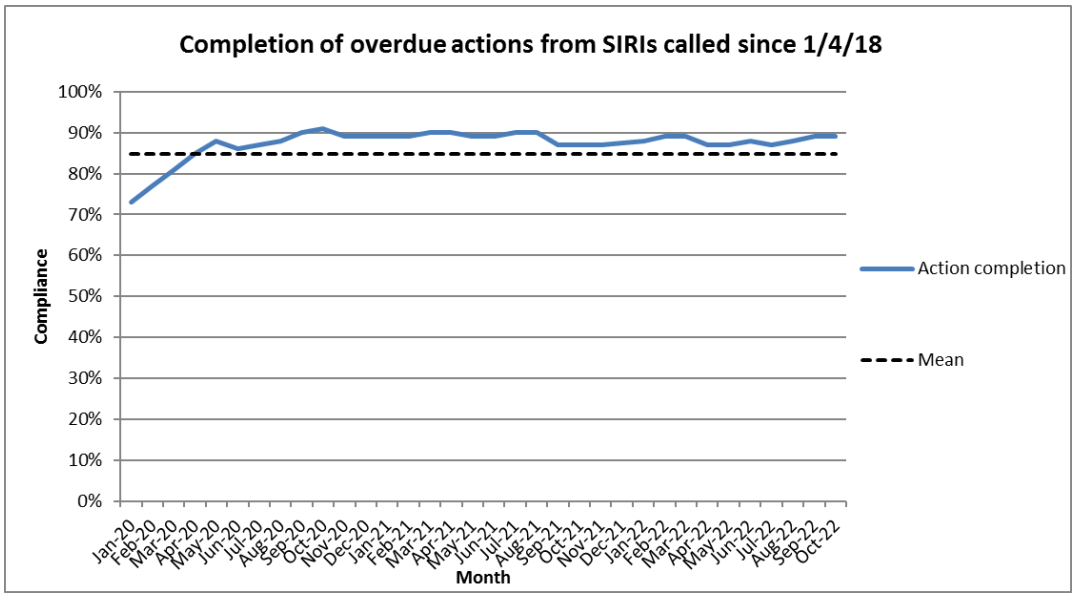
4.8. The category of 'diagnosis and treatment' has seen a notable rise in 2021/22. Incidents within this category include delays to treatment and misdiagnosis. Further review of the incidents in this category has occurred and no specific themes of concern have been identified. This incident category will be monitored closely over the next financial year.

4.9. Whilst the common learning and action themes have remained review of practice and procedures, training and education, documentation and the EPR system the individual actions under these themes are different to those from last year. Learning has been disseminated across the trust via weekly safety messages and clinical safety huddles. Identified learning from mortality is included in the quarterly and annual Learning from Deaths report.

5. SIRI Actions

5.1. Graph 8 demonstrates that the January 2020 instigation of the Serious Incident Group (SIG) in which SIRI actions are tracked, improved completion rates and brought them to a plateau above the 85% mean rate. The most recently available data shows that 89% of actions created against SIRIs called from 1 April 2018 onwards with an expired target date had been fully completed.

Graph 8: Monthly completion rates for overdue actions from SIRIs called since 1 April 2018



5.2. The Trust recognises that actions identified at the point of an investigation may not prove feasible in the longer term or may require more time than originally predicted. SIG gives Divisions the opportunity to table actions that have proven challenging. The group can either agree an official extension to the target date or mandate a specific individual or department to assist with delivery.

5.3. Actions from SIRIs called since 1 April 2020 are managed on Ulysses, allowing swift and accurate reporting by Divisions or Corporate Clinical Governance.

6. Future Plans

6.1. A weekly patient safety message will continue to be sent to all staff. These are emailed to all Trust accounts and contain brief summaries to explain new practice or to bolster best practice. They are often created in response to incidents as specified in action plans but may also be inspired by discussions at governance meetings or from national communications such as CAS alerts or new NICE guidance.

6.2. Human Tissue Act-reportable incidents will all be managed much as Ionising Radiation (Medical Exposure) Regulations (IRMER) incidents currently are, with coverage at the SIRI Forum and an update at SIG (see section 10.6, below).

6.3. The National Patient Safety Strategy was launched July 2019, and the Patient Safety Incident Response Framework (to replace the current Serious Incident Framework (2015)) was published in August 2022. The Trust's Patient Safety Specialist team will address implementation of this, alongside a wider steering group, under the oversight of the Interim Deputy Chief Medical Officer and the Head of Clinical Governance. The current process is detailed in Appendix 1. The new framework will entail a significant change in the philosophy and practice of incident management. The main changes include:

a. Adoption of the Learning from Patient Safety Events system, which will replace both NRLS and STEIS. Work is ongoing with Ulysses and the national leads to confirm how this will be achieved.

b. Transition from nationally defined SIRIs to Trust-managed Patient Safety Incident Investigations (PSII); this will also entail a move from root cause analyses to more bespoke investigation structures, reports and investigation timeframes.

c. The number and expected themes of PSIIs will be laid out in a Patient Safety Incident Response Plan to describe the local strategic and operational arrangements for a proportionate and co-ordinated response to patient safety incidents.

d. Greater involvement of patients in governance processes. This will include increasing the input of patients/guardians/next-of-kin in PSIIs, and the creation of patient safety partners to sit on primary governance meetings (the recruitment process for these has begun).

e. The adoption of training for all staff against a national Patient Safety Syllabus.

7. Quality Priorities

7.1. Five of the Trust's 8 quality priorities for FY 2022/23 are particularly relevant to issues raised above:

- Introduction of triangulation of complaints, claims, incidents and inquests has continued from FY 2021/22 with a particular focus on learning from claims. This quality priority aims to facilitate communication between the relevant OUH departments about the nature of these issues, allows for optimal efficiency in addressing the issues, and a combined approach to patient and relative responses, investigations, and systemic improvements.
- Reducing Pressure Ulcer priority is focussed on reducing the incidence of Category 2 and above Hospital Acquired Pressure Ulceration (HAPU) by 30%. Pressure Ulcer Prevention Summit event took place on the 18 August 2022 with representation from across the organisation and beyond to co-create deliverable improvement projects.
- Medication Safety priority has particular focus on Insulin Safety and reducing opioid use, overseen by the Medicines Safety Group.
- Results Endorsement priority is focussed on ensuring that the results of requested tests / investigations are seen and acted upon and is important to avoid serious findings being missed and patients coming to harm.
- Reduce incidents of violence, aggression and / or abuse initiated by members of the public directed towards patients or Trust staff. These incidents may cause significant distress for both patients and staff, either directly, or indirectly as witnesses of such incidents

7.2. The process for setting quality priorities begins in the preceding financial year, so although the Trust's incident profile will have informed the final selection, along with many other drivers such as patient satisfaction surveys, the full information contained in all SIRI root cause analysis reports will not have been available.

8. Recommendations

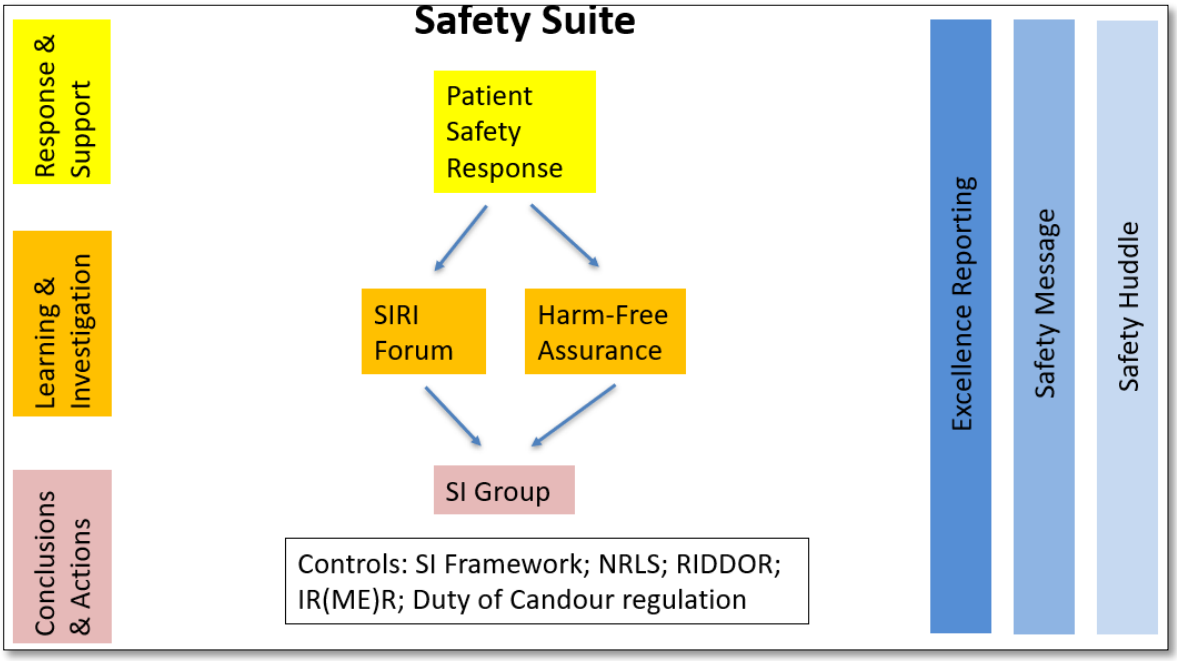
8.1 The Trust Board is asked to note the content of this report for information.

9. Appendix 1: The SIRI process including Duty of Candour

The Safety Suite

9.1. These are multiple processes to help streamline incident management and learning from incidents. Diagram one below demonstrates how these processes interact.

Diagram 1



9.2. The Trust's Patient Safety Response (PSR) meeting, in which representatives from Clinical Governance and each Division meet Monday to Friday to discuss all incidents called with Moderate or above impact, was trialled from 12 March 2019. Following an evaluation process for this pilot at the end of July 2019, the PSR meeting was formally launched Trust wide on 17 September 2019.

9.3. In FY 2021/22's meetings 1164 incidents were discussed, of which 97 had their impact downgraded. In 38 cases, departments were visited by a delegation from the PSR meeting, to ensure that patients and staff were suitably supported.

9.4. The SIRI forum is a weekly meeting where incidents are presented and the level of investigation and level of impact is agreed by a multi-disciplinary team with departments and divisional managers encouraged to attend and to take ownership of decisions made about levels of investigation. It is a forum founded on Just Culture and mutual respect.

This meeting is also attended by subject matter experts such as the Chief Clinical Information Officer, Information Governance (IG), human factors leads and the thrombosis lead as required.

9.5. The agenda for these meetings is created by the central Patient Safety Team (PST) working closely with Divisional governance staff. PST meets weekly with the Director of Safety & Effectiveness and Head of Clinical Governance with a provisional list of incidents that may meet the criteria for a SIRI or Divisional or have important cross-Divisional shared learning.

9.6. Following on from a CQC inspection related to incidents reportable under the IRMER it was agreed that the SIRI forum would be an effective place to monitor these incidents. Consequently, Medical Physics review all incidents categorised as Radiation Incidents and inform central PST which incidents are CQC reported IRMER reportable incidents. These are then presented at the SIRI forum to raise awareness of issues and actions needed, and the investigation outcomes are shared at SIG.

9.7. The Harm-Free Assurance Group oversees specific incidents.

a. The Tissue Viability team reviews all hospital-acquired category 2, 3 and 4 pressure damage incidents with the local manager, to identify investigation levels. Where a SIRI or Divisional is proposed, this is also agreed with Divisional management. These decisions are noted at the SIRI Forum, with discussion only required where a consensus decision has not been feasible.

b. All patient falls are overseen by the Head of Therapies, whilst there is a Falls Lead vacancy, and Divisionally agreed decisions are similarly noted in the forum.

c. Nutrition incidents of moderate or greater impact.

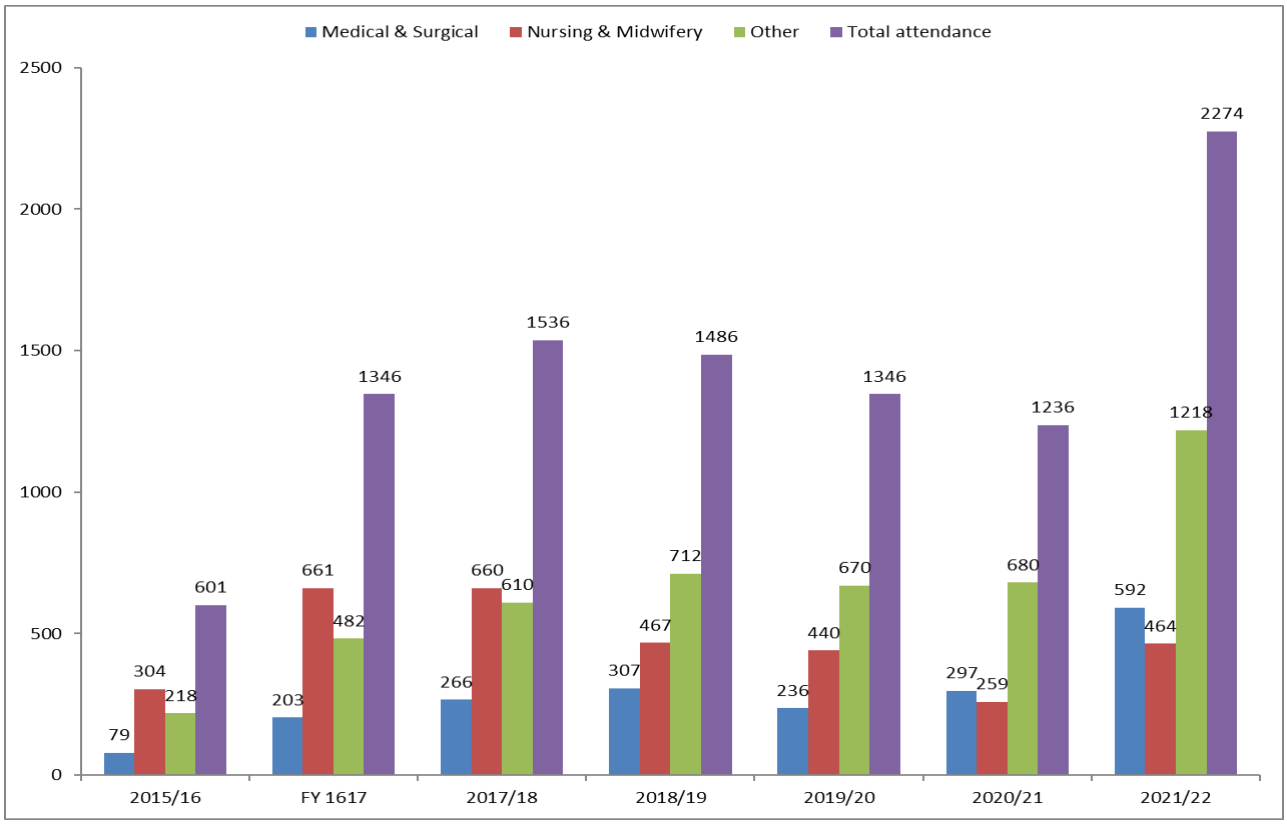
9.8. Any incident reporting a hospital-acquired thrombosis (HAT) is reviewed by the Thromboprophylaxis team (TT) and a HAT screen is completed to ascertain whether it was potentially preventable. TT informs the central PST when there is a potentially preventable HAT that requires inclusion on the SIRI forum agenda.

9.9. The Health & Safety team (H&S) reports any patient harm incidents resulting from a fall to the Health and Safety Executive, when these incidents fit the criteria under the Reporting of Injures and Dangerous Occurrences Regulations (RIDDOR) report. To aid the process of identifying any such incidents, the SIRI forum was identified as a place where minutes can reflect H&S's advice on whether incidents meet these RIDDOR criteria.

9.10. Monthly meetings occur between central PST and the Trust's Legal team to review all open inquests. Any inquest that may meet the criteria for a SIRI is cross-checked with the incident management system and a review by the Division is requested. This is an extra safety net for identifying potential SIRIs. There is also an opportunity of issues relating to inquests, claims or complaints to be discussed at the weekly Serious Incident Group (SIG) meetings, and a monthly review of any red-graded legal cases.

9.11. At SIG, SIRIs and selected Divisional and local investigations are presented roughly halfway through their investigation period. This enables any early learning and action to be shared across the Senior Divisional representatives, identify any blockers to progress, further suggestions made by the group as well as to discuss any issues faced by the investigator.

Graph 7: SIRI Forum attendance by staff group showing the number of nursing staff, medical staff and other staff who have attended. The 'others' category includes clinical risk expertise, Information Governance, Pharmacy and laboratory staff, H&S, and observers such as trainee nurses or medics. (NB the forum began in June 2015, so FY 1516 only covers 10 months).



9.12. The total attendance at SIRI Forums in FY 2021/22, at 2274, was significantly above the mean of 1537 from all 6 full years in which the

forum has taken place. This is because of the move to virtual meetings during the early days of the pandemic, which has allowed many medical, surgical, nursing, and midwifery staff to attend for specific discussions without impacting on clinical activity. There has also been significant increase in other staff attending, most of whom are governance, assurance, or safeguarding staff. Staff from all groups who are not based on the JR site will also find it easier to attend more frequently.

9.13. Although the virtual meetings began the previous financial year, during the height of the pandemic staffing challenges meant that many staff were unable to attend meetings.

9.14. Overall SIRI forum attendance rose by 84% from FY 2020/21 figures, and 48% from the mean.

Duty of Candour (DoC)

9.15. The legal, professional and regulatory DoC has been embedded into the Trust's day-to-day governance processes within the Divisions with weekly monitoring via the SIRI Forum (table 3).

9.16. The PST updates incidents as a failsafe system following each SIRI forum's discussion to ensure that it accurately reflects actions relating to the DoC.

9.17. The Divisional governance staff upload the written evidence of DoC onto each incident record. The SIRI forum's agenda and minutes remind staff that updates, and evidence should also be added to the patients' notes.

Table 3: DoC compliance from FY 2021/22 by quarter

Quarter 2021/22	DoC verbal compliance	DoC written compliance
1	100% (125/125)	100% (125/125)
2	100% (166/166)	100% (166/166)
3	100% (269/269)	100% (269/269)
4	100% (282/282)	100% (282/282)

9.18. There can be complications relating to Duty of Candour, such as a patient's contact details being out of date, which can delay the completion of one or both elements. All cases requiring Duty of Candour are managed in the Trust's weekly SIRI Forum and Divisional representatives supply updates on progress to confirm that these cases are being actively managed, and report when the obligations have finally been addressed.

9.19. In situations where DoC cannot be completed or there are complications, the case is discussed in either SIG or the SIRI forum where it is confirmed whether there are other ways in which the DoC can be achieved. If agreed, it is not appropriate or all avenues have been exhausted the rationale is documented on the Ulysses incident form. In these cases it is considered that DoC has been addressed.

Weekly Safety Messages

9.20. Since February 2019 the Patient Safety Team has sent a weekly Safety Message email to all staff. Topics from the 52 messages sent in FY 2021/22 include the use or readback when confirming medications, point-of-care blood tests, social media use by Trust employees, anticoagulation before procedures, the role of the Technologies Advisory Group, and best practice for shared inbox use.

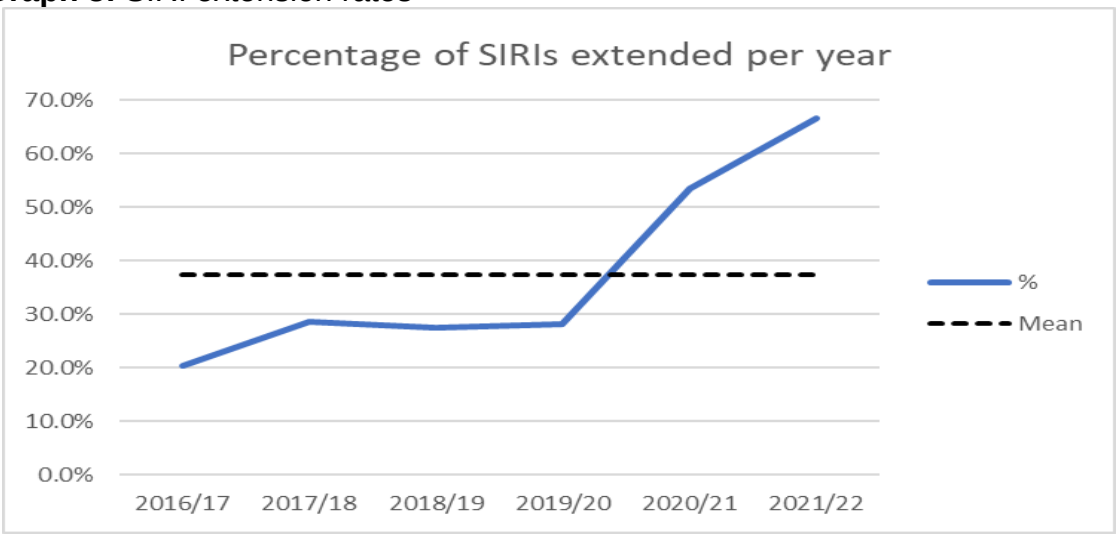
10. Appendix 2: SIRI overview

SIRI overview

10.1. As in the previous three financial years, there were no delays in completing SIRI reports beyond the national guidance time scale of 60 working days or an agreed extension from the ICB.

10.2. However, 67% of FY 2021/22 SIRI investigations that weren't reclassified required an agreed extension request (see Graph 8 below). This follows a rate of 53% in FY 2020/21, which was a notable increase on the previous 4 years' rates. The primary reason for extensions in the past 2 years is the impact of COVID-19 and the pressures on staff. NHSEI andICB agreed that extensions should and would be granted without question during the most significant period of the pandemic's impact, but since the publication of the first draft of the new Patient Safety Incident Response Framework, which states that in future, organisations will be able to agree their investigation timeframes at the outset beyond the 60-day target currently in place, The ICB has agreed that any extension that is within 6 months of the case's addition to STEIS or which is required because of an issue outside of the control of OUH will be automatically agreed. OUH is also increasingly supplying draft reports to patients and relatives, again in preparation for practice required under the forthcoming framework. An ICB representative attends the weekly SIG meetings, and so has assurance that investigations are being well managed even if extensions are required.

Graph 8: SIRI extension rates



11. Appendix 3: Additional training and communication activities

11.1. Training by the Patient Safety Academy continued to be funded across the Thames Valley region by Health Education England. Courses were offered to OUH staff on human factors, incident analysis and quality improvement

11.2. A root cause analysis training course has been delivered by PST once per month since September 2018 (with a brief pause during the height of the COVID-19 pandemic). 103 staff members were trained in FY 2021/22. All staff are welcome to attend, with special emphasis on consultants who may lead SIRI investigations.