AGENDA ITEM
5.3

QUALITY & SAFETY COMMITTEE

DATIX CYMRU – INCIDENT REPORTING

Date of meeting	24/01/2023
FOI Status	Open/Public
If closed please indicate reason	Not Applicable - Public Report
Prepared by	Kellie Jenkins-Forrester, Head of Concerns & Business Intelligence
Presented by	Kellie Jenkins-Forrester, Head of Concerns & Business Intelligence
Approving Executive Sponsor	Executive Director of Nursing
Report purpose	FOR NOTING

Engagement (internal/external) undertaken to date (including receipt/consideration at Committee/group)		
Committee/Group/Individuals	**Date**	**Outcome**
		Choose an item.

ACRONYMS	
CTMUHB	Cwm Taf Morgannwg University Health Board
DCIQ	Datix Cloud IQ

1. SITUATION/BACKGROUND

The Once for Wales programme was established in 2017 by the Welsh Government as part of the response to address the recommendations set out in Keith Evans "The Gift of Complaints" Report.

Aimed at bringing consistency across NHS Wales with regards to the use of electronic tools, the programme commenced development and implementation of DatixCymru (DatixCloudIQ). The new system has many of the features that people will be familiar with from our existing RLDatix system, with the added benefit of being a bespoke cloud-based tool that meets the needs of Putting Things Right, through the development of specific functionality such as the Redress Module and Mortality Review process.

A key objective of the system is to support the Health Board in providing real time data and information that can facilitate ward to board assurance leading to improvements in quality, safety and experience for patients and staff. Through successful embedding of the system, we can take proactive steps to demonstrate that we are a listening and learning organisation.

The Health Board implemented the Incident Management Functionality of Datix Cymru on the 1st April 2022. As part of the implementation of this functionality a new All Wales Coding Structure was adopted. This moved the coding from a two tier structure in the Health Board's Legacy System to a three tier structure in Datix Cymru. In addition to this, a further segregation of incidents has been introduced in relation to who was affected. As result staff are adjusting to both a new system and a new coding structure.

It was reported at the Health, Safety & Fire Sub-Committee that since the implementation of the Incident Management Functionality, there had been a decrease of 50% in the number of incidents reported relating to staff. A report provided to Quality & Safety Committee in November 2022, summarised the position and the mitigation actions being implemented within the Health Board.

2. SPECIFIC MATTERS FOR CONSIDERATION BY THIS MEETING (ASSESSMENT)

2.1 Incident Reporting Data

A comparison of the incidents reported for the previous 4 years has been undertaken. The trend is provided in the chart below.

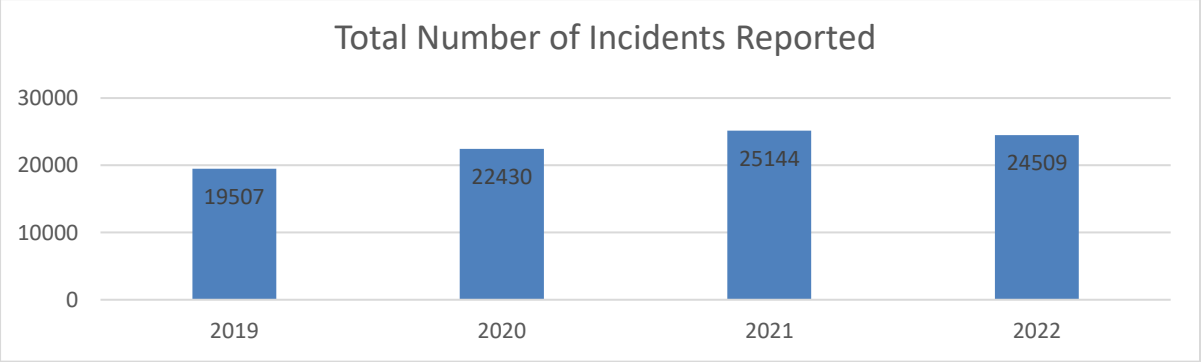


Chart 1: Total number of incidents reported

Whilst the overall number of incidents reported in 2022 has slightly decreased (by 635) compared to 2021, it remains higher than 2019 and 2020. The decrease in 2022 can be attributable to the increase in 2021 associated with the Covid Pandemic and the transition to a new system where a decrease in reported incidents would be expected.

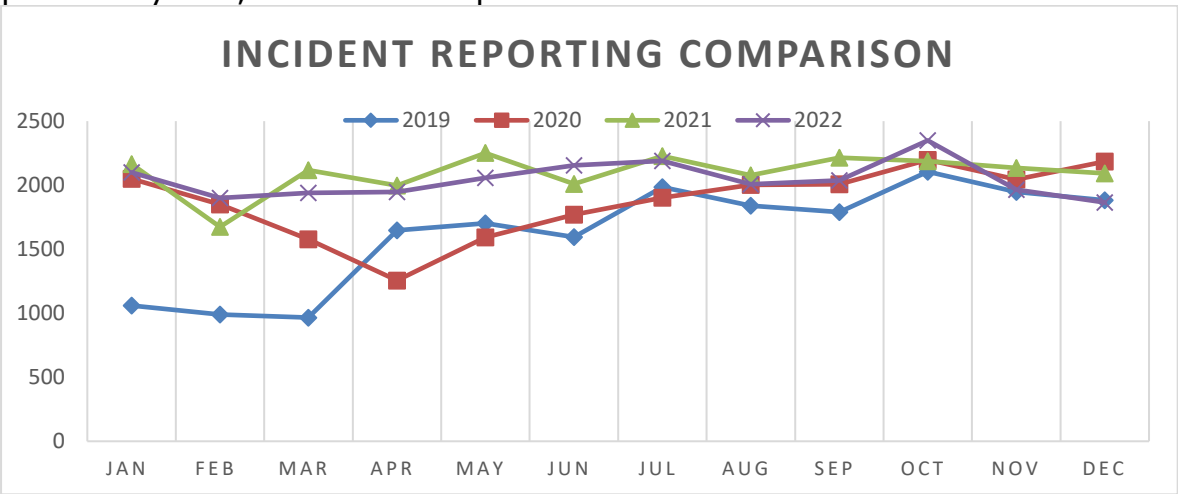
	Legacy System			Legacy /Datix Cymru*
Who was Affected	**2019**	**2020**	**2021**	**2022**
Patient	16,875	19,889	22,016	21,391
Non-Patient Safety	2,632	2,541	3,126	759
Organisational			2	940
Staff/Contractor				1,365
Public/Visitor				54
Totals	19,507	22,430	25,142	24,610

Table 1: Incidents by those affected

*Data for 01.04.22 to 31.03.22 is retrieved from the Legacy System. Data for the remaining year is retrieved from Datix Cymru.

The table above demonstrates that the Non-patient safety incidents have similar figures to the combined total of Organisational, Staff/Contractor and Public/Visitor incidents.

Further review of the data has identified that the number of incidents has continued to increase overall from April 2022. Whilst a reduction has been highlighted for November and December this is consistent with the trend in previous years, with the exception of 2020.



The previous report to Quality & Safety Committee advised that review of the Health & Safety specific codes had highlighted a decrease in the number of incidents being reported. A further review of those reported between 01.04.22 and 31.12.22 identifies that the number of incidents reported

under these specific codes remain lower than those pre 01.04.22 as demonstrated in the chart below.

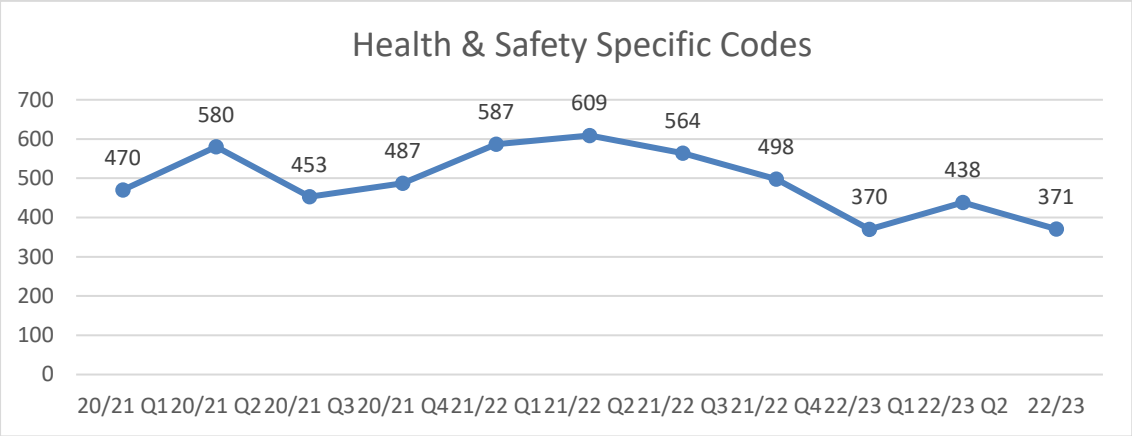


Chart 2: Health & Safety Specific Codes

3. KEY RISKS/MATTERS FOR ESCALATION TO BOARD/COMMITTEE

Further scrutiny of the high level incident data provides an assurance that incidents continue to be reported but under different coding types. This is reflective of the introduction of the new All Wales Coding structure that differs from the Health Board's legacy system. With information spanning two systems it adds an additional challenge in providing robust trend data. It is therefore recommended that direct comparison at a granular level with incident data prior to 01.04.22 is not undertaken.

Additional challenges impacting the provision of high quality data and reports during the early stages of implementation of the new system relate to:

- The Health Board undertook a number of developments within the legacy system to reflect internal processes and board information requirements that are not currently available within Datix Cymru as this forms part of the system enhancement programme. Alternative options to support the processes are being identified. These options are more resource intensive, due to the increased manual intervention required in presenting information.
- The effective and efficient extraction of data from Datix Cymru at a locality, service group and Speciality level continue to be challenging.

Whilst there are system requirements that have been escalated to the National team, there are a number of local measures being implemented to improve the validity of data held within the system. These include:

- Corporate validation following initial reporting of the incident to be undertaken by the Patient Safety, Health & Safety and Business Intelligence Teams. To facilitate this, a quality assurance checklist is being developed to facilitate consistency, highlight key fields for review and act as a prompt for immediate action or escalation. This will ensure incidents are coded appropriately and enable identification for themes and trends.

- Development of detailed guidance for top reporting / high risk incidents impacted by the change, i.e. restraints, clinically challenging behavior, community acquired pressure damage, absconding.
- Commencement of an audit programme by the Business Intelligence Team of closed incidents to confirm data accuracy and completeness of all required fields.

4. IMPACT ASSESSMENT

Quality/Safety/Patient Experience implications	Yes (Please see detail below)
	The RLDatix system provides data to enable opportunities for improvement in safety and experience to be identified.
Related Health and Care standard(s)	Governance, Leadership and Accountability
	If more than one Healthcare Standard applies please list below:
Equality Impact Assessment (EIA) completed - Please note EIAs are required for <u>all</u> new, changed or withdrawn policies and services.	No (Include further detail below) If yes, please provide a hyperlink to the location of the completed EIA or who it would be available from in the box below. If no, please provide reasons why an EIA was not considered to be required in the box below.
	Relates to the implementation of an All Wales System.
Legal implications / impact	There are no specific legal implications related to the activity outlined in this report.
Resource (Capital/Revenue £/Workforce) implications / Impact	There is no direct impact on resources as a result of the activity outlined in this report.
Link to Strategic Goals	Improving Care

5. RECOMMENDATION

5.1 The Quality and Safety Committee is asked to **NOTE** the contents of the report.