Government of JERSEY

Health and Community Services

Committee Report

Guidance on completing this report	• Complete all parts of the report template • Ensure issues are described succinctly • Limit the report to no more than 3 pages • Attach any additional relevant information as appendices • All reports to be provided 10 working days before the meeting

Report to: *(delete as appropriate)*	Quality and Risk Assurance Committee		
Date of meeting:	August 24 2022		
Title of paper:	Serious Incident (SI) Assurance report		
Report author:	, Quality & Safety Manager	**Presented by:**	, Quality & Safety Manager

1. Purpose

What is the purpose of this report? *(brief statement & tick as appropriate)*	To provide a quarterly summary for information and assurance of the efficacy of the serious incident management framework.	Information	✓
		Approval	
		Assurance	✓

2. Background

Which committee or group has this been presented to before (if any)?	Serious Incident Review Panel

3. Key Issues

What are the key issues to be aware of?	• There were 25 Serious Incidents (SI) notified to the Serious Incident Review Panel (SIRP) in Quarter 2, 2022. • Of the twenty-five notifications presented to SIRP, twenty-one of these cases had safety huddles in line with policy. • Eighteen of the twenty-five notifications were taken forward as Serious Incidents. • Of the seven cases that did not meet the criteria for a Serious Incident, three will be reviewed as round table discussions and two will undergo a care group review, leaving two for no further action required. • Five SI's were closed in Quarter 2, 2022. • There are currently twenty-five serious incidents open. • There are five reports ready to be presented at panel, four of which have dates scheduled in. There are eleven SI's where the reports are not completed in the red.

	• Work has occurred to ensure that SI huddles are occurring in line with the policy. The acting Lead Quality and Safety manager attended twenty-six SI huddles in Q2 2022. There has been a significant increase in the amount of SI huddles being held as only six SI huddles occurred in Q1, 2022. • Regular meetings have been set up between the Care Group Governance coordinators and the Quality and Safety Team to ensure that we are working collaboratively and that the Care Groups are working towards the same objectives with SI's and action plans. There is evidence of learning from safety events.	
How does this matter relate to HCS objectives? *(tick as appropriate)*	Improved Islanders' experience of Health & Community Services	✓
	Improved health outcomes of Islanders	✓
	Improved partnership working to deliver person-centred, sustainable & safe health & community services as detailed in the Jersey care Model (JCM).	
	Improved working environment for staff increasing recruitment & retention.	
	Improved resilience of HCS, particularly in relation to any Covid-19 related surge in health cases.	
	High quality safe services with good clinical & corporate functions.	✓
	Deliver services within the financial envelope assigned to HCS.	

4. Risk implications

Are there any associated risks? *(Please include Risk ID if included within the risk register)*	Quality & Safety	Risk ID: 951 Inability to source specialist experts to undertake a serious safety event investigation within a timely manner 12 Risk ID: 448 Learning from events & serious incidents 15
	Financial	
	Workforce	
	Performance	
	Reputational	
What action is being taken to mitigate risk?	Recruitment plans to expand the Quality and Safety team are in place.	

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Serious Incidents
Quarter 2, 2022

July 2022

Report prepared by
Acting Lead Quality and Safety Manager

1. Notifications and Serious Incident January – March 2022

There were twenty-five Serious Incidents (SI) notified to the Serious Incident Review Panel (SIRP) in quarter two (Q2), 2022. Ten from the Medical Care Group, six from the Surgical Care Group, one from Mental Health Care Group, one from the Prevention, Primary and Intermediate Care Group, one from the Ambulance Service, two from Woman and Children's, and one from Children, Young People, Education and Skills. There are three joint ones between Medical and Surgical Care Groups.

Of the twenty-five notifications presented to SIRP, twenty-one of these cases had safety huddles in line with policy. Eighteen of the twenty-five notifications were taken forward as Serious Incidents. Three cases will be added to an ongoing investigation as they fit the terms of reference. Two will form part of a thematic review examining trauma pathways. Two of the serious incidents will be externally investigated as level three investigations. . Ten cases will be completed by Health and Community staff as level two investigations.

Of the seven cases that did not meet the criteria for a Serious Incident, three will be reviewed as round table discussions and two will undergo a care group review, leaving two for no further action required.

	Incident date	Care Group	Incident	Origin of Notification	Huddle	Comments
1		Medical Services		Internal	No	Round Table Review commissioned.
2		Medical Services		Internal	Yes	Agreed to proceed to Serious Incident investigation
3		Medical Services		Internal	Yes	Round Table Review Commissioned
4		Medical Services		Complaint from family	Yes	Agreed to proceed to Serious Incident investigation
5		Medical Services		Internal	Yes	Agreed to proceed to an external Serious Incident Investigation
6		Medical Services		Internal	Yes	Not for SI but round table review commissioned
7		Medical and Surgical Services		Internal	No	Agreed to process to Serious Incident Investigation (add to existing investigation)

8		Mental Health		Datix	Yes	Level 2 SI commissioned
9		Medical Services		Datix	Yes	Not for SI. Care Group requested to complete an internal review
10		Medical Services		Internal	Yes	Not for SI when notified. Following other similar cases this will form part of a thematic review to be investigated externally as part of the serious investigation framework.
11		Surgical Services		Datix	Yes	Agreed to proceed to Serious Incident investigation
12		Surgical Services		Datix	Yes	Agreed to proceed to Serious Incident investigation
13		Ambulance Services		Internal	Yes	Agreed to proceed to Serious Investigation if required following police investigation
14		Surgical Services		Datix	Yes	Agreed to proceed to Serious Incident investigation
15		Medical Services		Internal	Yes	Agreed to proceed to Serious Incident investigation
16		Primary and Preventative Care		Internal	Yes	Not for SI. Care Group requested to complete an internal review
17		Surgical Services		Internal	No	Following other similar cases this will form part of a thematic review to be investigated externally as part of the serious investigation framework.
18		CYPES		Internal	No	Agreed to proceed to an external Serious Incident Investigation
19		Medical		Internal	Yes	Agreed to proceed

		Services				to Serious Incident investigation
20		Woman's and Children's		Datix	Yes	Agreed to proceed to Serious Incident investigation
21		Surgical Services		Internal	Yes	Agreed to proceed to Serious Incident investigation
22		Medical and Surgical Services		Internal	Yes	Level 2 SI commissioned (add to existing investigation)
23		Medical and Surgical Services		Internal	Yes	Level 2 SI commissioned (add to existing investigation)
24		Surgical Services		Internal	Yes	No further action
25		Women's and Children's		Internal	Yes	No further action

2. Learning from Serious Incident Huddles

Work has occurred to ensure that SI huddles are occurring in line with the policy. The acting Lead Quality and Safety manager attended twenty-six SI huddles in Q2 2022. There has been a significant increase in the amount of SI huddles being held as only six SI huddles occurred in Q1, 2022. Over the next quarter, the aim will be to support the Care Group Governance leads to chair these meetings and ensure they occur within the appropriate timeframe. Following twenty-six SI huddles, the decision was made to notify twenty-two of these incidents to the serious incident panel, one remains to be notified to panel as awaiting the notification from the Surgical Care Group.

Once the serious Incident report has been approved, it becomes the responsibility of the care group to implement the recommendations; and to monitor and review action plans. This then feeds into the performance reports. Regular meetings have been set up between the Care Group Governance coordinators and the Quality and Safety Team to ensure that we are working collaboratively and that the Care Groups are working towards the same objectives with SI's and action plans.

Feedback on learning from Woman and Children Care Group ( )

In May there was a 6.35 Massive Obstetric Hemorrhage (MOH) rate. All 5 of the births were high risk for different reasons and were managed well. One was recognised to be of particular difficulty and the Consultant was present in the operating theatre and was the surgeon for the elective Caesarean section. MOH happens on a fairly regular basis and staff follow the MOH guideline and there is a proforma in the back of the guideline stating what to do and how to manage the MOH with drugs etc.

All women are risk assessed for their likelihood of experiencing an MOH and if deemed high risk they will have blood cross matched instead of just group and saved etc. Sometimes if deemed necessary a consultant will conduct the delivery.

An incident has led to the agreement of pushing forward the Anti D business case. In 2008 NICE recommended prophylactic Anti D for all Rhesus negative women and this was commenced 20th June with antenatal clinic, blood transfusion and community midwifery collaborating. Targeted Anti D administration has not commenced as the funding has not been agreed. There are a large number of incident forms that have not been investigated and this challenge has been escalated several times.

Feedback on learning from the Medical Care Group ( )

Following patient safety events and feedback from staff, medical cover has been increased and over bank holidays senior consultant reviews are occurring using a team A and team B approach to ensure timely and regular review for inpatients over the bank holidays.

In addition to this to ensure seamless quick reference handover to the weekend teams the medical ward teams are completing a Friday Ward round proforma.

Learning from SI's now being shared initially with ward teams and power point prepared and ready to share at next ward meeting, care group governance meeting and supervisory meeting.

Medical Safety Huddles have been reinstated each morning to ensure new patients are handover and any issues on wards shared from day to night teams.

The Care Group is fully engaged in the pressure area task group, FIT project and has been providing support and guidance on Datix investigation and completing RCAs to ward managers and deputies.

Feedback on learning from Adult Social Care (ASC) ( )

Learning arising from the joint project between Primary Care and Adult Social Care.

People with learning disability and their carers often find it difficult to access appropriate healthcare. Health screening is commonly undertaken to identify individuals who are deemed at higher risk for disease for further diagnostic testing so that they may possibly benefit from interventions to modify the natural course of disease.

This project focuses on the health screening for cervical, breast and bowel cancers and diabetes for adults with learning disabilities, who are a hard-to-reach vulnerable group.

The medically unfit policy is about guiding clinicians' decisions as to whether a client is medically unfit to undertake a screening assessment / intervention/ procedure.

The project group identified that the medically unfit policy requires a review in respect of our chosen clientele i.e., people with learning disabilities. This work is now underway and being led by the radiographer within the project team. Due note must be taken of the Capacity and Right to Self Determination (Jersey) Law.

Learning from Complaint

ASC have one complaint Part of the complaint dealt with social media contact with clients. Staff and carers often work closely to ensure the best possible outcomes for our clients and staff need to be clear of the important distinction between 'being friendly' and 'being friends'. however, we have outlined to them how this is important for maintaining a professional relationship and to ensure staff are not accused of favoritism. It would have been better had the situation not arisen in the first place and it is clear that staff in the community are not always aware of Government of Jersey policies, such as the social media policy. We have learned that we need clear routes of disseminating corporate and local policy and guidelines to outlying areas in the community.

We now have a governance framework in place which will allow us to compile a governance practice workbook, a recommendation of the JCC. In addition to this, we are working with individual teams to improve their governance structures and our communication pathways to ensure that key information reaches every area of the care-group no matter how remote. This is work in progress at the time of writing.

Organisational Wide Learning

Following SI investigations, SI notifications and concerns raised within the organisation, there has been executive sponsorship to implement a project that focuses on the improvement of the recognition, escalation and rescuing of the sick patient. This work is in progress and has various workstreams included in the project.

3. **Closure of Serious Incidents in Quarter three**

Five SI's were closed in Q2 of 2022.

Incident date	Care Group	Level	Incident	Closed date
	Medical Services and Mental Health Services	3		28/04/22
	Medical Services	2		20/05/22
	Medical Services	2		20/05/22
	Medical Services	2		09/06/22
	Surgical Services	3		17/06/22

4. **Open Serious Incidents**

There are currently twenty-five serious incidents open. There are five reports ready to be presented at panel, four of which have dates scheduled in. There are eleven SI's where the reports are not completed in the red. This is multifactorial, there have been delays within the Q&S team allocating investigators, delays sourcing clinical investigators and delays in the reports being written and presented to panel. This risk has been placed on the risk register.

	Incident date	Care Group	Level	Incident detail	Expected Date	Status
1		Women & Children	3		**30/09/2022**	Following internal investigator not completing the investigation, External investigators have been appointed.
2		Surgical Services	3		**30/10/2022**	External review
3		Surgical Services	3			External
4		Medical and Surgical Services	2			External Review including a HCS Doctor.
5		Surgical Services	2		**30/09/22**	Internal
6		Surgical and Medical Services	2			Internal
7		ASC	2		**30/09/22**	Internal
8		Medical Services	2		**20/09/22**	Internal
9		Medical Services	2		**20/09/22**	Internal
10		Medical Services	3		**11/11/22**	External
11		Medical Services	2			Internal
12		Mental Health	2		**20/09/22**	Internal
13		Surgical Services	2			Internal
14		Surgical Services	2		**20/09/22**	Internal
15		Surgical Services	2		**20/10/22**	Internal
16		Surgical Services	2		**15/10/22**	Internal
17		Medical	2		**20/09/22**	Internal

		Services				
18		Medical Services	2		**20/10/22**	Internal
19		Surgical Services	3		**22/10/22**	External Thematic Review
20		Women, children and family	2		**5/09/22**	Internal
21		Ambulance	?			
22		CYPES	3		**13/10/22**	External
23		Medical Services	2		**12/11/22**	Internal
24		Mental Health Services	3		**05/11/22**	External
25		Mental Health Services Adult Social Care	3		**12/11/22**	External

2021	**2022**	**Ready for panel**

5. Levels of all open Serious Incidents

Levels of Serious Incidents	**Number**
Level 1 (Case Review)	These are not included in the SI numbers
Level 2	16
Level 3 (External)	8
Pending police investigation	1

6.Serious Incident Review Panel

Panel dates are set for this year. There have been six panel meetings, two notification panel meetings and once cancelled panel meeting in Q1 2022.