Government of JERSEY

Health and Community Services

Serious Incidents
Position Statement and Plan

Health and Community Services

June 2019

Report prepared by [redacted]
Clinical Governance Management

HCS Assurance Committees – Risk and Oversight Quality and Safety Resources and Performance

1. Introduction

This paper is to provide assurance to the Quality and Safety Committee that a plan is in place to address the Serious Incident Investigations that are outstanding and have not met the timelines as outlined in the Policy and Procedure for the Management of Serious Incidents within Health and Social Services (2017). The position statement as of June 2019 shows that there are twenty Serious Incidents (SI) currently open within Health and Community Services (HCS) and twelve that have passed the expected timeline. All level one and two Serious Incidents should be completed within 60 working days, External level 3 SI's have up to six months to complete.

Levels of Serious Incidents June 2019

Level	No.	Comments
Level 1	1	
Level 2	14	
Level 3 (External)	5	All current level 3 SI's are in mental health patients who have died by suspected suicide.

In order to ensure a plan is in place for each SI a case manager has been assigned to each one. Of the twelve reports that have not met the expected timeline, two reports will be ready for the next Serious Incident Review Panel and are having final changes made to them.

Ten SI's are therefore outstanding, the relevant case manager has requested a progress report on these SI's and the Serious Incident Review Panel (SIRP) meets bi-monthly to go through each case. Details of these can be found below

	SI Reference	Incident Date	SI due date	Area	Level	Plan
1.	SI1702[redacted]	[redacted]	05/06/2017	OAMH	1	Manager liaising with the investigator to put a plan in place for completion
2.	SI1801[redacted]		02/04/2018	Hospital	2	Investigators reassigned to complete the report, report will be completed July 2019
3.	SI1808[redacted]		03/09/2018	Hospital	2	Report being completed by Guernsey
4.	SI181[redacted]		08/10/2018	Hospital	2	New investigator assigned, case has been handed over and investigation has been recommenced
5.	SI1820[redacted]		01/02/2019	Hospital	2	Discussions within Q&S regarding reassigning Investigators. Provisional brief report completed on the case
6.	SI1826[redacted]		26/02/2018	Hospital	2	Decision made to complete with a round table

7.	SI1827 [redacted]	26/02/2018	Hospital	2	Initial round table and safeguarding report completed. Decision made to complete a round table with relevant clinicians to complete the investigation
8.	SI1822 [redacted]	17/2/2019	AMH	2	Report in final draft, to be completed by July 2019
9.	SI1824 [redacted]	27/05/2019	AMH	3	Plans had been put in place for an investigation using a visiting independent consultant psychiatrist [redacted] Quotes have been obtained from UK companies to complete an independent external investigation.
10.	SI181 [redacted]	20/03/2019	AMH	2	SI Investigation commenced

There are two reports that are in final draft and will be ready for submission during July 2019, one of which has been long and complex cases to investigate with 12 staff interviews completed and one that has had the investigator reassigned

Eight SI's remain and four of these have clear plans in place to address them, there have been significant delays with a couple of these and new investigators are being appointed in two cases.

2. Mitigations of risk

Serious Incident Huddles are carried out on the majority of SI's within 48 hours of the incident to ensure that immediate actions can be taken to prevent the risk of the incident reoccurring and to identify any learning that can be taken forward immediately or urgent matters to address. Whilst this does not reduce the risk of not learning from the root cause of SI's that have not been investigated, it may reduce the risks.

3. Ongoing Risks

Six Serious incidents have been allocated to members of the Quality and Safety (Q&S) Team to be Lead Investigator or second investigator on. The team are struggling to complete these SI's within the limited resource of the team alongside the other Governance and Risk management workload and the oversight work and support the team provides to other SI's. Three of these SI's have significant delays associated with them.

4. Cause of current delays and plans in place to address these

a) **Dedicated time.** It has been escalated to the SIRP that having dedicated time is the main reason that SI's are not being completed in a timely manner, on average it takes between 10-15 days to complete a detailed level two or three investigation, and HCS traditionally has not given staff any protected time or additional pay for this. Cases of consultants working 11 hours

on Saturdays to complete investigations mean that it is increasingly difficult to get consultant staff to agree to complete a review. The Medical Director has agreed that time back can be negotiated with him in order to support this process. Further work on this needs to be done within the Q&S team to establish the cost to the organization of completing an SI investigation and a plan put in place to give staff either some protected pay or time off in lieu.

b) **Trained staff** HCS has trained approximately 80 staff in RCA methodology within the last 2 years, however many of the consultant and medical staff were unable to commit the time for training and only 3 consultants trained within HCS. While it is acknowledged that some staff may have trained elsewhere, the pool of consultants or senior medical staff able to perform SI investigations is very small and no middle grades or associate specialists have completed the training to date. A plan is in place to put on an additional training course at the latter end of 2019 targeting consultant and middle grade doctors. There will be some places for other members of the multi-disciplinary team, as it is acknowledged that that the multi-disciplinary team being involved in training has significant benefits.

c) **Appointing Investigators.** In the past there was often delays appointing investigators once an SI had been agreed. In order to address this when the SI huddle occurs or it is notified to panel the panel discuss potential investigators and a decision is generally made at the time and the relevant clinicians contacted post panel. This is aimed to reduce delays in the process.

d) **Number of Serious Incidents.** In 2018 the number of serious incidents significantly rose putting pressure on all parts of the process. The new SI framework is expected to be launched this summer recommending a reduced number of SI's and more time spent on the learning from these events and not only the investigation. This will be a big cultural shift, but will free up additional time to ensure that we learn from the incidents investigated and are not exhausting our limited resource carrying out investigations. The SI policy will need to be revised in line with this.

5. Future Plan

In addition to the plans made above, there is a need to change the process of SI's within the organisation. The current process cannot continue in its current format for a number of reasons, one being that the resource within the Quality and Safety team cannot meet the demands of the service and the organisation is currently not monitoring action plans or demonstrating in a comprehensive way that we are learning from the Serious Incident Investigations carried out. The process will need to change in line with the new Target Operating Model and the new Care Groups. Care Groups will need to be far more involved in the Serious Incident process, from notification to the formation of action plans. Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great that a heightened level of response is justified (NHS 2015). It is essential therefore that we can demonstrate that we are learning from our SI's.

e) **SIRP Membership** - The SIRP panel membership needs to be changed in order to reflect the new TOM. Associate Medical Directors from the main care group need to be involved in the SI

panel to ensure that the groups have far more ownership and responsibility within the SI framework from the SI huddle to the action plans.

f) **SI Huddle**- the relevant Clinical Directors do not consistently attend the SI huddle within their areas, going forward having the relevant Associate Medical Director at the huddle will be essential from the beginning. Decisions related to investigators for the SI can then be made as early as possible in the process by the multi-disciplinary team in order to prevent delays.

g) **Process-** the quality and safety team are currently responsible for supporting all SI's across HCS, from organizing and chasing investigators, monitoring the investigation, providing quality assurance and editing reports. Governance leads within the care groups will have key roles and responsibilities in supporting SI's in their care group with the support of the Q&S team. This should free up time within the Q&S team to provide oversight of the SI's process and monitor the action plans and learning from the care groups. The completed SI's should be presented back to the Care Groups Governance Groups and Action Plans drawn up within the groups before submitting the reports and action plans for approval by the SIRP. It is essential that care groups do not work in silo's, or deviate from the process put in place. There needs to be a clear line of sight to the Clinical Governance Manager and/or Head of Quality and Safety.

h) **Action Plans-** there needs to be clear and ongoing monitoring of recommendations and action plans. Themes will need to be collated from across HCS and an audit process put in place. Action plans need to developed and agreed within the care groups and centrally collated across HCS to ensure that learning is shared across areas

i) **Q&S Team** – the Q&S team will need to have a less direct role in the SI's within the organization and will need to delegate more responsibility to the care groups. This will ensure a greater degree of ownership within the care groups and release time within the Q&S team to support the care groups, ensure that they are not working in silo's and that they remain true to the process and ensure that oversight and assurance work is carried out to ensure that we are learning from our SI's . It will be essential to collate action plans and draw themes from these and the SI's and ensure learning occurs across the entire organization.

6. References

NHS (2015) Serious Incident Framework Supporting learning to prevent recurrence, available at https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

States of Jersey (2017) Policy and Procedure for the Management of Serious Incidents within Health and Social Services, available at https://soj/depts/HSS/Registered%20Documents/P%20Serious%20Incident%20Policy.pdf#search=serious%20incident

Government of JERSEY

Health and Community Services

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Serious Incidents 2019

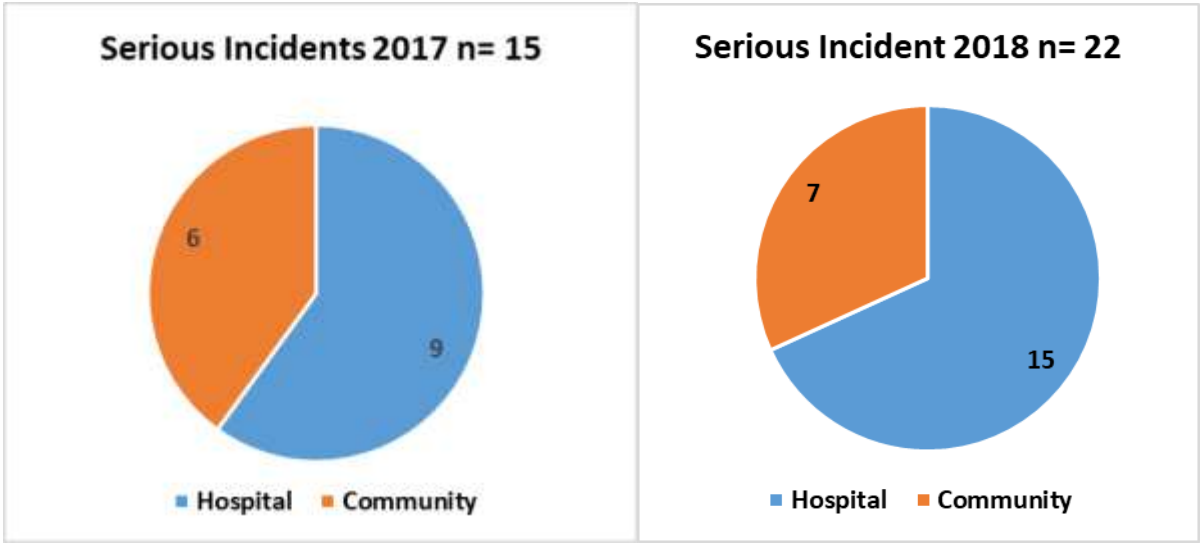
March 2020

Report prepared by [redacted]
Quality and Safety Manager

1. Serious Incidents 2019 (n=15)

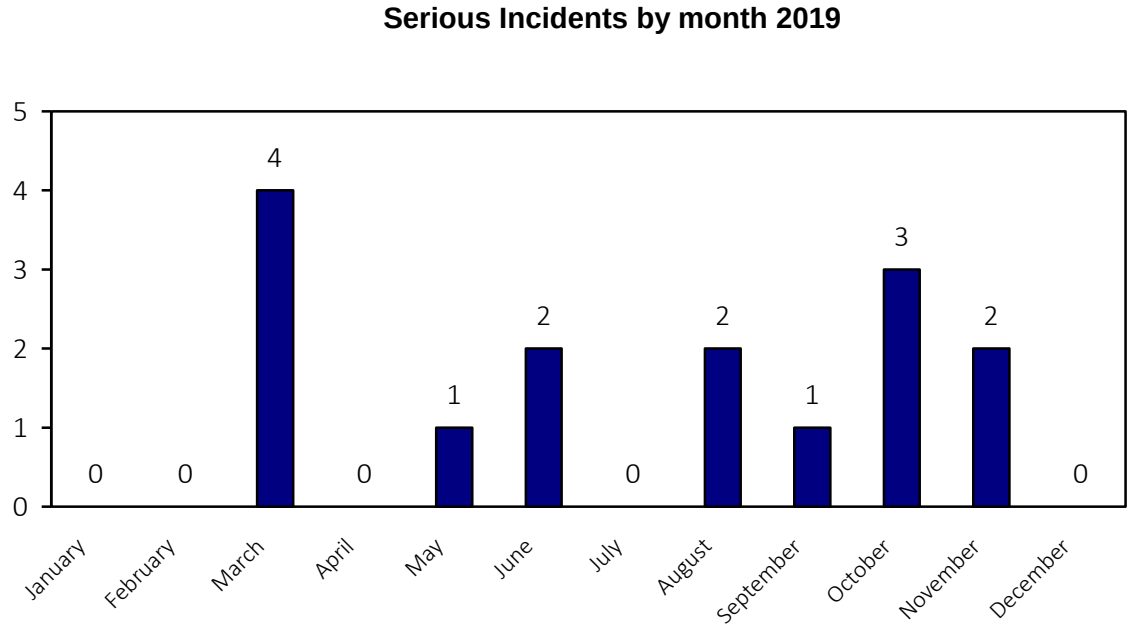
There were fifteen Serious Incidents (SI) within HCS in 2019 and two within the Ambulance Service when they were part of HCS. One of the serious incidents reported in November 2019 may date back to January 2019, the date that the actual incident occurred remains unclear. For the purpose of this report HCS only incidents, excluding the Ambulance Service will be included and the SI's will be allocated to the Care Groups that they would now fall into since the restructure in July 2019. This may differ from the 'Division' that they were previously in.

Figure 1,2 Serious Incidents 2017, 2018



Please note numbers may differ slightly from previously reported data as the Ambulance Service and Children's Service have been excluded in this report in order to aid comparison.

Figure 3- Serious Incidents by month 2019

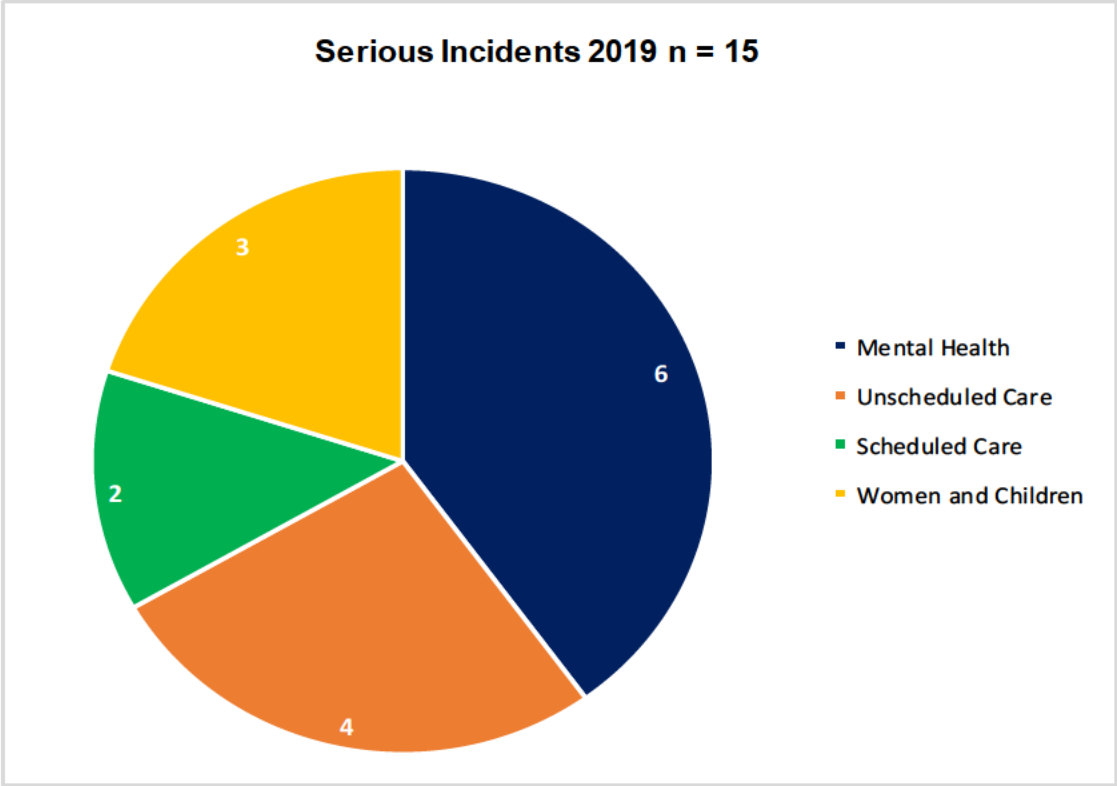


March had the highest number of Serious Incidents reported. [redacted]

2. Serious Incidents by Care Group 2019

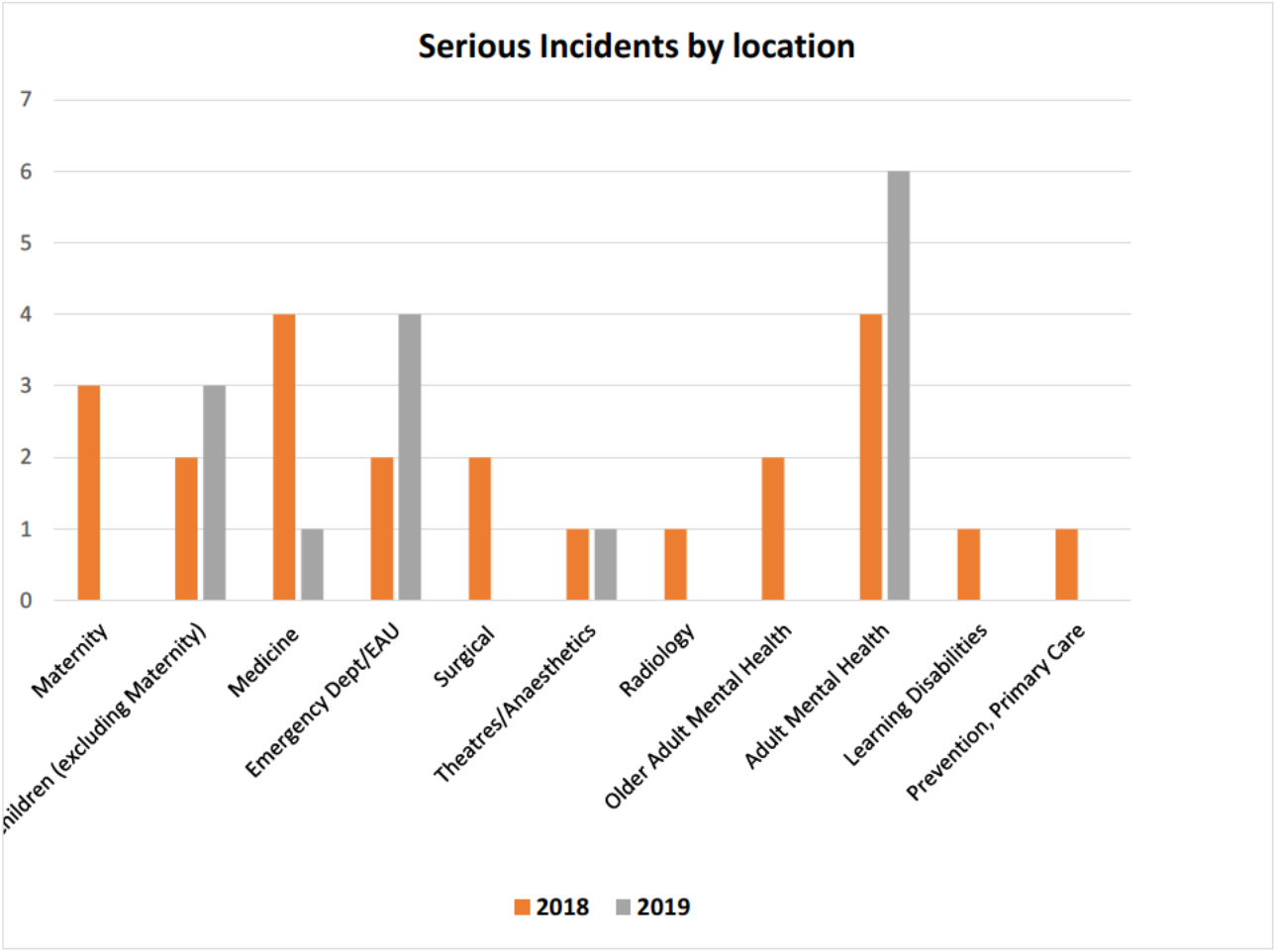
There were fifteen SI's in 2015 a drop from 22 in 2018. This number is consistent with 2017 (n = 15) and previous years. Although there were 22 SI's in 2018, two of these were later decommissioned. Mental Health Services had the largest number of Serious Incidents in 2019 (n=6). This was then followed by Unscheduled Care (n=4), Women, Children and Family Care (n=3) and Secondary Scheduled Care (n=2). A breakdown of the Serious Incidents within the Care Groups is as below.

Figure 4 - Serious Incidents 2019 by Care Group



This can be further broken down in figure 5 to a more specific location within the Care Group. Comparrison to 2018 has been included. Adult Mental Health have had six serious incidents, however this is split between Alcohol and Drug Services, adult and community teams and so not in one location. Three SI's were within the Emergency Department, however the outcome from one of these was that although there was some learning, the decisions made were not incorrect. Another effected both ED and EAU.

Figure 5 Serious Incident by location, 2018 and 2019



2.1 Mental Health Care Group

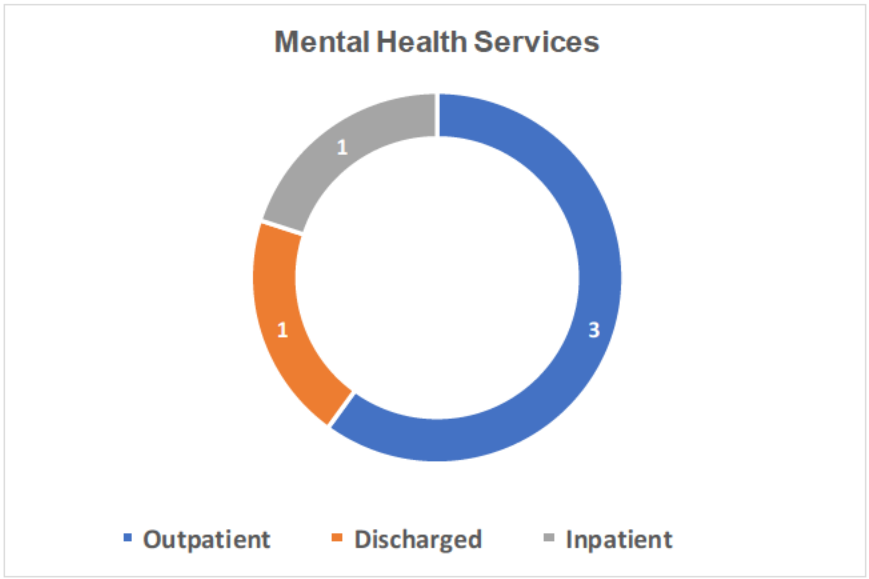
Forty percent of the HCS Serious Incidents (6) were within the MH Service. There were seven SI's within Mental Health in 2018.

Five of the six SI's (83%) relate to patients that deaths are believed to be by suicide whilst in contact, or within six months of contact with MH Services. In 2018 there were six deaths (out of seven SI's [86%]) that were believed to be as a result of suicide. In line with national guidance (NHS 2015) a Serious Incident Investigation is comissioned on any current patient or patient that has been seen within 6 months by Mental Health Services that dies by suspected suicide or comits a homicide.

Figure 6 Mental Health Serious Incidents 2019 n=6

Redacted - Article 25: Personal Information

Figure 7 Mental Health Serious Incidents



Three of the five patients that death is believed to be a suicide were patients that were under the Community Teams. [redacted]

[redacted]

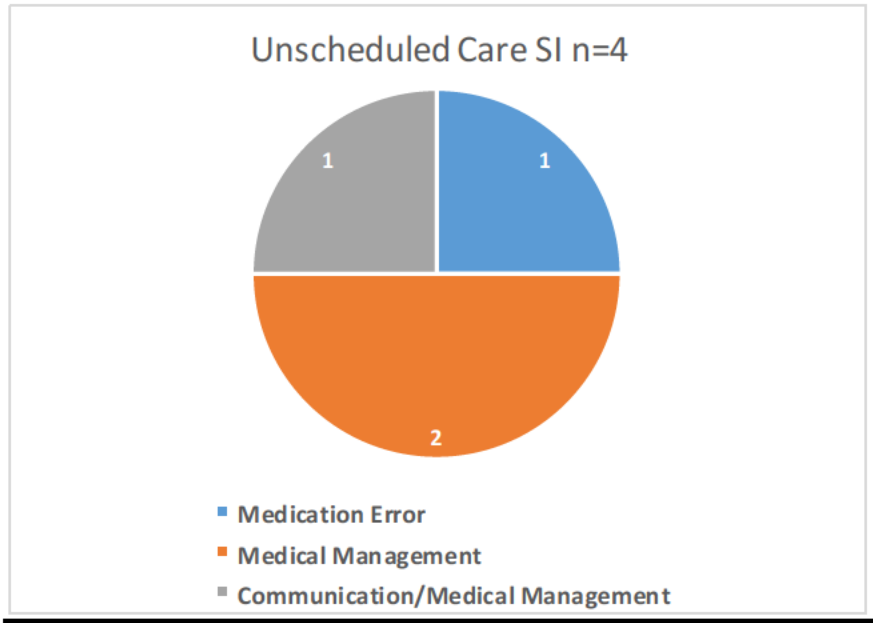
[redacted]

[redacted]

2.2 Secondary Unscheduled care

There were four Serious Incidents in 2019 within Unscheduled Care. [redacted]

Figure 8 Unscheduled Care Serious Incidents n=4



There were two issues within the ED that relate to the medical management of patients. [redacted]

2.3 Secondary Scheduled and Tertiary Care

There were two SI's within the Scheduled Care Group in 2019 as below. [redacted]

	Incident	Area
1.	[redacted]	Medical ward
2.		Day Surgery Theatre

2.4 Women Children and Family

There have been three SI's in 2019 within the Women, Children and Family Care Group, although one of these crosses three care groups [redacted]

[redacted] This investigation has not concluded and this SI may sit under the responsibility of a different care group when the report is finalised. [redacted]

	Incident	Area
3.	[redacted]	SCBU
4.		Robin Ward- this case also involves Clinical Support Services
5.		[redacted]

3. Themes from Hospital Serious Incidents

The Serious Incidents from across the hospital were pulled together in order to look for commonalities and themes.

Figure 8 Themes from Hospital Serious Incidents 2019

Redacted - Article 25: Personal Information

Four SI's relate to the medical management of the patient, however there is little in terms on themes to be drawn from this data. No other themes can be seen from the reported hospital SI's.

4. Harm to the patient

No serious incidents resulted directly in the death of any patients within 2019. However seven SI's were carried out following the death of a patient [redacted]

Level	Number
No Harm	3
Short term harm	2
Long term harm	1
Death of the patient	7

[redacted]

5. Levels of Serious Incidents 2019

Level	Number n=15
Level 1	2
Level 2	7
Level 3 (External)	6

Two Serious Incidents were investigated externally in 2018, one within Maternity (Women, Children and Family) and one within Mental Health Services. In comparison to this, six external level 3 Serious Incidents were commissioned in 2019. All of these are within the Mental Health Care Group at the request of the Mental Health Associate Medical Director. As there has been intense scrutiny on Mental Health Services in Jersey between 2018 and 2019, it was felt that this degree of independent external review of the incidents reported was required and would be more beneficial to the future development of the service.

6. Notifications and Serious Incident 2019

In addition to those that became SI's, eleven notifications of Serious Incidents were presented to the Serious Incident Review Panel (SIRP) that the panel did not consider meet the threshold for a Serious Incident Review. Many of these continued to further reviews within the Care Group and additional information was sought. One led to a safeguarding referral and two to projects being carried out to address known issues identified.

	Care Group	Incident	Outcome
1	Prevention, Primary and Intermediate Care	[redacted]	Previous SI completed on this, report to be written pulling together the relevant information and shared with the family
2	Secondary Unscheduled Care		External review requested of decisions made, not progressed to a full SI on the recommendations of this report
3	Secondary Unscheduled Care		On further review it was established that there were no delays and treatment provided was appropriate

4	Secondary Unscheduled Care	[redacted]	Identified that two different policies were in place, immediate policy changes made

5	Women, Children and Family Care	[redacted]	Round table review coordinated by care group to discuss communication issues between teams
6	Women, Children and Family Care		A review of this case was undertaken but it did not meet the threshold for an SI
7	Women, Children and Family Care		Handled within the care group, not SI

8	Secondary Scheduled and Tertiary Care	[redacted]	No harm came to the patient, apology to patient and Datix investigation completed
9	Secondary Scheduled and Tertiary Care		Not an SI, SJR agreed
10	Secondary Scheduled and Tertiary Care		The problem with discharge letters has been recognized as an organizational wide issue. This will be dealt with as a project
11	Scheduled Care		This was dealt with as a safeguarding matter

7. Learning from Serious Incident Huddles

Serious Incident Huddles were introduced in 2019 to ensure that any immediate actions required to ensure the safety of the patient(s)/ service user(s), other services users and staff are actioned immediately. Ten of the fifteen Serious Incidents resulted in an SI huddle being pulled together within 72 hours of reporting. Four of the Serious Incidents that did not have SI huddles came from information obtained from the coroner's office and were some days after the death of the patient. In one case the patient had been discharged from services many months before. Discussions were held with the Care Group Leads, but there was no need for immediate actions to be taken or patient safety concerns to be addressed. One SI was identified from a complaint nine months after the event and did not have an SI huddle. Discussions were held between the three AMD's that this involved as it spans three Care Groups.

While the majority of SI huddles resulted in additional information being requested and in some cases appropriate investigators assigned. Immediate changes to practice came out of many of the huddles. One involved an immediate change in the way medication is prescribed within a Care Group, two resulted in the reinforcement and reminder of policies to staff, and one in the writing of a procedure to accompany the policy.

8. Themes from Serious Incidents

Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified (NHS 2015). It is essential that we learn from our SI's in order to reduce the risk of the same event occurring again. At the point of writing this report six of the fifteen Serious Incidents from 2019 have not been completed, and two waiting ratification by the SIRP. This means that it is not possible to pull trends from the current data. When all of 2019 SI's are closed themes from all of the SI's across HCS will be analyzed. As many of 2018 SI's have only recently been closed, these will be examined at the same time in order to find themes and commonalities.

8.1 Mental Health Services Trends

Additional work needs to be done looking at trends across the eleven suicides within the Mental Health Services between 2018 and 2019. The Safeguarding Partnership Board (SPB) completed a Thematic Review on five of these cases. Whilst this has not been published to date, the lessons learned and recommendations from this report will need to be cross referenced with those from the Serious Incident Investigations. At the time of writing the Thematic Review, none of HCS's SI's were completed, so this did not input into their report. The SPB report has not been published to date, and so was not available to the SI investigators.

One of the five suicide serious incidents from 2019 has been ratified to date and one is pending ratification. It is therefore not possible to draw themes at this time. The remaining three SI's are all due for completion by the end of this month, and further thematic analysis can then be undertaken. Internally a thematic review of seven of the SI's was undertaken at the beginning of 2019.

9. Staff Support

Traditionally there has been little formal support available to staff following a Serious Incident. Support is provided from managers within the Care Group and the Quality and Safety Team. In 2019 Trauma Risk Management (TRIM) has begun to be offered to staff involved in the Serious Incidents. In four of the Serious Incidents TRIM was offered to staff and in three of these it was taken up. This is a system to provide support to trauma-exposed individuals, and where necessary assist them to access professional support. Additional staff within HCS have been trained up to ensure that the service can meet the demands placed upon it and to reduce the need to get this from external providers. In the future all staff involved in Serious Incidents will be offered TRIM.

10. Recommendations and Action Plans

Once the Serious Incident has been ratified by the SIRP it is the responsibility of the Care Group to produce the Action Plan and monitor the recommendations and this plan. The Quality and Safety Manager needs to ensure that the Quality and Safety Team maintain oversight of this and have an overall picture of all SI investigation recommendations and action plans. This will ensure that those with recommendations that span across the organisation are actioned appropriately. It will also provide the ability to audit and monitor the compliance with the recommendations. Work on this is currently underway.

11. Challenges in 2019

At the beginning of 2019 there was a large number of outstanding Serious Incidents and over 20 SI's remained open and were not progressing, many having not been allocated and if allocated they had not progressed. This was as a result of pressure in the Quality and Safety Team as a result of the high number of SI's in 2018, insufficient numbers of trained RCA investigators and the pressures from clinical commitments meat that staff did not have the time or capacity to take on SI's, and those that had been taken on were not progressing. A plan was put in place in June and further evaluated in September 2019 to address the backlog, specifically those dating back to 2018. Twenty candidates completed a two day Patient Safety Training course in December 2019, twelve of these were doctors. This has helped address the gap in medical staff trained to complete root cause analysis Patient Safety Investigations.

Care Group leads have been sent out monthly reports on their SI's since the groups formed in July 2020. In October 2019 the full position statement was presented to the AMD's and a discussion was held on how we could address the increasing backlog. It was agreed that all staff completing SI's would be offered protected time in which to complete them. This had a positive impact as staff have been released, and the number of outstanding SI's has been greatly reduced. The full position statement is currently being sent out to the Associate Medical Directors (AMD's) in order for them to see not only the incidents in their own groups, but where staff from their Care Group are working on other incidents and may need support/ time allocated.

The Serious Incident Policy has been updated to make the AMD's role clearer and outline their responsibilities and accountabilities. This had been shared and agreed with the AMD's, but the policy has not been sent for ratification at this time. NHS Improvement will be launching their new Patient Safety Investigation Framework imminently and it is anticipated that this will result in the need for a radical change to our current policy and the plan is for the policy to be changed and ratified to reflect all changes in April 2020.

12. Future Plans and Recommendations

I. Allow all staff across HCS 3 dedicated days to complete SI investigations, additional time may be negotiated on a case by case basis with the line manager.

The current drive to complete the backlog in SI's has meant that protected time has been offered to clinicians and staff completing these investigations. This has been on an ad hoc Care Group by Care Group basis. No internal SI's in 2019 met the 60 day timeline. In order achieve this, dedicated time needs to be allocated to every SI investigation and this should be standardised and written into policy across HCS.

II. Update the Serious Incident Policy and Procedure in line with the new Patient Safety Investigation Framework being released by the NHS in February 2020

The new SI Framework from NHS Improvements is due to be launched imminently. HCS will need to adapt their policy to be in line with this new framework. This should be completed by April 2020

III. There needs to be clear and ongoing monitoring of recommendations and action plans across HCS.

Collating the information on recommendation and action plans is essential to the learning from SI's within the organization. Themes will need to be collated from across HCS and an audit process put in place. Action plans need to developed, agreed and owned by the relevant Care Groups and centrally collated across HCS to ensure that learning is shared across areas. To date this has been a challenge

with the current resources allocated to SI's. It is anticipated that once the backlog of SI's has been cleared and we become up to date then this will become achievable.

IV. Complete a two year thematic review of 2018 and 2019 Serious Incidents

It is essential that HCS does not get into a cycle of using all of the allocated resource to carry out SI's without learning from them. The thematic review needs to be completed in order to assure the board that we can demonstrate that we are learning from the themes identified in the SI and in order to ensure we are aligning the SI framework with the Audit Framework and on-going Quality Improvement work within HCS.

V. Dedicated Administrative Support should be made available to support the SI process

A lot of time is spent assigning investigators, preparing packs, chasing reports and updates, sending out update reports, arranging meetings with staff and external investigator visits and timetables as well as SIRP meetings and minute taking. Additional administrative support dedicated to SI's would facilitate and streamline this process and free up managers time. A business case has been completed for this. The role would be shared with the Structured Judgement Reviews and Clinical Audit teams.

Government of JERSEY

Health and Community Services

Health and Community Services

Serious Incidents
January 2020

February 2020

Report prepared by [redacted]
Quality and Safety Manager

1. Notifications and Serious Incident January 2020

One Serious Incidents was notified to the Serious Incident (SI) Review Panel in January 2020. This related to a Serious Case Review report and a recommendation that health look into the management of the patient in more detail. This did not go forward as a Serious Incident, it was agreed that additional information and actions were required.

Incident date	Care Group	Incident	Comments
[redacted]	Prevention, primary & intermediate/scheduled care & tertiary	[redacted]	Further information is required and additional actions are required

2. Learning from Serious Incident Huddles

There were no SI huddles in January 2020 as the only case presented related to a completed Serious Case Review

3. Closure of Serious Incidents in January 2020

Five SI's were presented to the SI panel in January 2020, four of these were closed and one remains in draft pending further consultation with professionals and the family, and clarification over some facts contained within the report.

SI number	Incident date	Care Group	Level	Incident	Closed date
SI1911[redacted]	[redacted]	Secondary Scheduled and Tertiary Care	2	[redacted]	03/01/20
SI1904[redacted]		Secondary Unscheduled Care	2		10/01/20
SI1802[redacted]		Mental Health Services	2		08/01/20
SI181[redacted]		Women, Children and Family Care	2		31/01/20
SI1824[redacted]	[redacted]	Mental Health Services	3	[redacted]	**

**Further changes to be made to the report and draft to be shared with the family so this was presented but has not been closed.

4. Open Serious Incidents

There are currently 14 Serious Incidents open within Health and Community Services, however five of these have been completed and are waiting for sign off by the SIRP panel. One of the completed SI's has already been presented to panel and will be signed off when the changes have been agreed and further consultation completed. This leaves nine SI's from 2019 open. Two of the nine SI's had been due for completion in January, but there has been a delay of a month.

SI number	Incident date	Care Group	Level	Incident detail	Expected Date	Status	Estimated Completion
1910 [redacted]	[redacted]	Women, Children and Family	2	[redacted]	16/12/19		
190 [redacted]	[redacted]	Mental Health	3	[redacted]	17/09/19	External	March 2019
190 [redacted]	[redacted]	Mental Health	2	[redacted]	20/09/19	Currently being drafted	06/03/20
1908 [redacted]	[redacted]	Mental Health	3	[redacted]	08/03/20	Assigned to March on Stress Feb 2020	TBC
1909 [redacted]	[redacted]	Mental Health	3	[redacted]		Case notes review only to take place	4-6 weeks
1915 [redacted]	[redacted]	Mental Health	3	[redacted]	15/05/20	SI in draft	March 2020
1905 [redacted]	[redacted]	Unscheduled Care	2	[redacted]	13/08/19		29/02/20
1906 [redacted]	[redacted]	Scheduled Care	1	[redacted]	18/09/19		29/02/20
1914 [redacted]	[redacted]	Scheduled Care	1	[redacted]	06/02/20		

2019

Complete reports waiting for panel approval

1827 [redacted]	[redacted]	Women, Children and Family	2	[redacted]	22/02/19	Report ready for panel	
1912 [redacted]	[redacted]	Women, Children and Family	2	[redacted]	02/01/19	Panel 21/2/20	
1824 [redacted]	[redacted]	Mental Health	3	[redacted]	27/05/19	Been to panel, pending changes	
1810 [redacted]	[redacted]	Mental	1	[redacted]	20/02/19	Panel 21/2/20	

	[redacted]	Health		[redacted]			
1913[redacted]		Unscheduled Care	3			01/05/20	Report ready for panel (panel cancelled)

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Health and Community Services

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Serious Incidents
February 2020

March 2020

Report prepared by [redacted]
Quality and Safety Manager

1. Notifications and Serious Incident February 2020

One Serious Incidents was notified to the Serious Incident (SI) Review Panel in February 2020. [redacted] While this did not meet the threshold for a Serious Incident, the panel agreed that due to the severity of the incident that there was a clear need to look into this case further. An external Case Note Review has been commissioned.

Incident date	Care Group	Incident	Comments
[redacted]	Mental Health Services	[redacted]	For a case note review, not a Serious Incident

2. Learning from Serious Incident Huddles

There were no SI huddles in February 2020 as the only case presented related to an admission to the Mental Health Services and relates to his self-discharge 4 months ago

3. Closure of Serious Incidents in January 2020

Four SI's and a case review were presented to the SI panel in February 2020. All of the SI's presented were closed.

SI number	Incident date	Care Group	Level	Incident	Closed date
1827[redacted]	[redacted]	Women, Children and Family	2	[redacted]	28/02/20
1912[redacted]		Women, Children and Family	2		21/02/20
1913[redacted]		Unscheduled Care	3		21/02/20
1810[redacted]		Mental Health Services	2		28/02/20

4. Year to date figures

There have not been any SI's in 2020 to date. Two cases have been presented to panel, both require additional actions and work, but neither of these met the criteria for a Serious Incident

5. Open Serious Incidents

There are currently 10 Serious Incidents open within Health and Community Services. Three of these have been completed and are waiting for sign off by the SIRP panel. One of the completed SI's has already been presented to panel and will be signed off when the changes have been agreed and

further consultation completed. This leaves seven SI's from 2019 open. Four of the SI's are due for completion in March.

SI number	Incident date	Care Group	Level	Incident detail	Expected Date	Status	Estimated Completion
1910 [redacted]	[redacted]	Women, Children and Family	2	[redacted]	16/12/19		
1903 [redacted]		Mental Health	3		17/09/19	External	March 2019
1907 [redacted]		Mental Health	2		20/09/19	Currently being drafted	06/03/20
1908 [redacted]		Mental Health	3		08/03/20	Assigned to March on Stress Feb 2020	TBC
1909 [redacted]		Mental Health	3			Case notes review only to take place	4-6 weeks
1915 [redacted]		Mental Health	3		15/05/20	SI in draft	March 2020
1914 [redacted]		Scheduled Care	1		06/02/20		March 2020

2019

Complete reports waiting for panel approval

1824 [redacted]	[redacted]	Mental Health	3	[redacted]	27/05/19	Been to panel, pending changes. Represent to panel 13/03/19	
1905 [redacted]		Unscheduled Care	2		13/08/19	Present to panel 20/03/20	
1906 [redacted]		Scheduled Care	1		18/09/19	Present to panel 13/03/19	

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Serious Incidents
Quarter 2, 2020

July 2020

Report prepared by [redacted]
Quality and Safety Manager

1. Notifications and Serious Incident February 2020

Two Serious Incidents were notified to the Serious Incident (SI) Review Panel in quarter two of 2020, bringing the total number up to three. The two cases both have led to External Serious Incident Investigations.

Incident date	Care Group	Incident	Comments
[redacted]	Women and Children	[redacted]	External SI commissioned
	Mental Health		External SI commissioned

2. Learning from Serious Incident Huddles

There was one SI huddles in quarter two, following the Mental Health case. There were a number of meetings for case one as the situation unfolded and more information came to light.

3. Closure of Serious Incidents in Quarter two

As a result of covid-19 there has been a significant delay in closing SI's that were completed. Three virtual meetings were held to close cases as the restrictions eased.

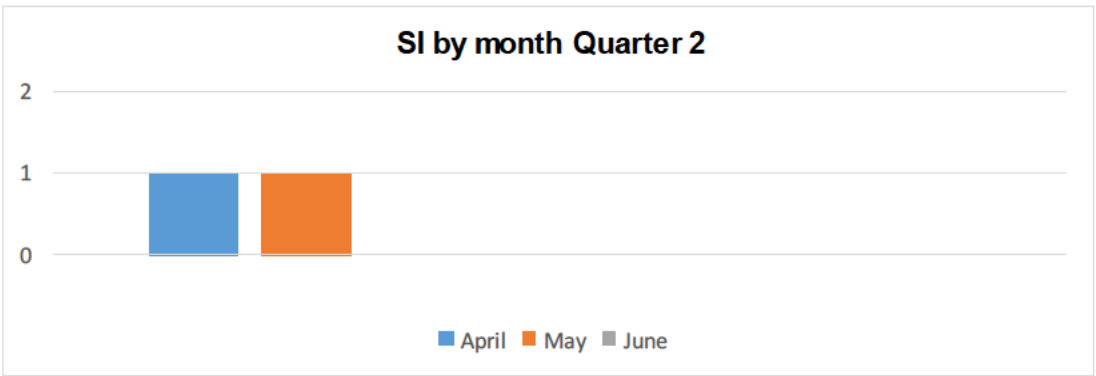
SI number	Incident date	Care Group	Level	Incident	Closed date
SI1824 [redacted]	[redacted]	Mental Health	3	[redacted]	15/6/20
SI1915 [redacted]		Mental Health	3		15/6/20
SI1909 [redacted]		Mental Health	3		24/6/20

In addition to the three SI's presented to panel, one case note review commissioned by the panel was presented and approved.

	[redacted]	Mental Health	3	[redacted]	24/6/20

4. Year to date figures

There have been two SI's in 2020 to date. Five cases were presented to panel in 2020, one went forward as a case note review.



5. Levels of Serious Incidents Quarter 2

All of the SI's in 2020 have required external investigators

Level	Number n=15
Level 1	0
Level 2	0
Level 3 (External)	2

6. Open Serious Incidents

There are currently eight Serious Incidents open within Health and Community Services. Four of these have been completed and are waiting to be signed off by the SIRP panel. This will leave four SI's open, one of which is expected to be completed in the next month.

SI number	Incident date	Care Group	Level	Incident detail	Expected Date	Status	Estimated Completion
191 [redacted]	[redacted]	Women & Children	2	[redacted]	16/12/19		
SI201 [redacted]		Women & Children	3		30/10/20	External inv. Assigned	
1907 [redacted]		Mental Health	2		20/09/19	Currently being drafted	06/03/20
SI202 [redacted]		Mental Health	3		06/11/20	External inv. Assigned	

2020	2019

Complete reports waiting for panel approval

1906 [redacted]	[redacted]	Scheduled Care	1	[redacted]	18/09/19	
1914 [redacted]		Scheduled Care	1		06/02/20	March 2020
1903 [redacted]		Mental Health	3		17/09/19	External report
190 [redacted]		Mental Health	3		08/03/20	External report

7. Challenges 2020

Covid-19 has led to significant challenges in getting reports that are completed signed off. It remains a challenge coordinating virtual meetings around the commitments of the panel and clinical teams.

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Serious Incidents
Quarter 3, 2020

September 2020
Report prepared by [redacted]
Quality and Safety Manager

1. Notifications and Serious Incident July- September 2020

Seven Serious Incidents (SI) were notified to the Serious Incident Review Panel (SIRP) in quarter three of 2020, five of these were agreed as SI's bringing the total number of cases for 2020 to seven. Two cases did not fit the criteria for an SI, recommendations were made for the management of these cases outside of the SI framework.

Incident date	Care Group	Incident	Comments
[redacted]	Mental Health	[redacted]	Panel agreed learning and actions had been taken, no significant harm came to the patient. Not for SI investigation
	Medicine		UK Care Provider written to, this was not an SI that occurred in our care
	Mental Health		SI commissioned
	Radiology		External peer review report commissioned
	Orthopedics		Round table review and SI commissioned
	Women, Children and Family		Round table review and SI commissioned
	Medicine		SI commissioned

2. Learning from Serious Incident Huddles

There were two SI huddles in quarter three, four of the Serious Incidents were notified to panel some time after the event, three of these dated back to 2019 and came to light in August and September 2020, it was therefore not appropriate to pull together a huddle within 48 hours. A number of meetings were held to discuss each of the cases prior to them being presented to panel.

Of the two huddles that occurred, immediate action was taken to safeguard patients and ensure that staff were supported.

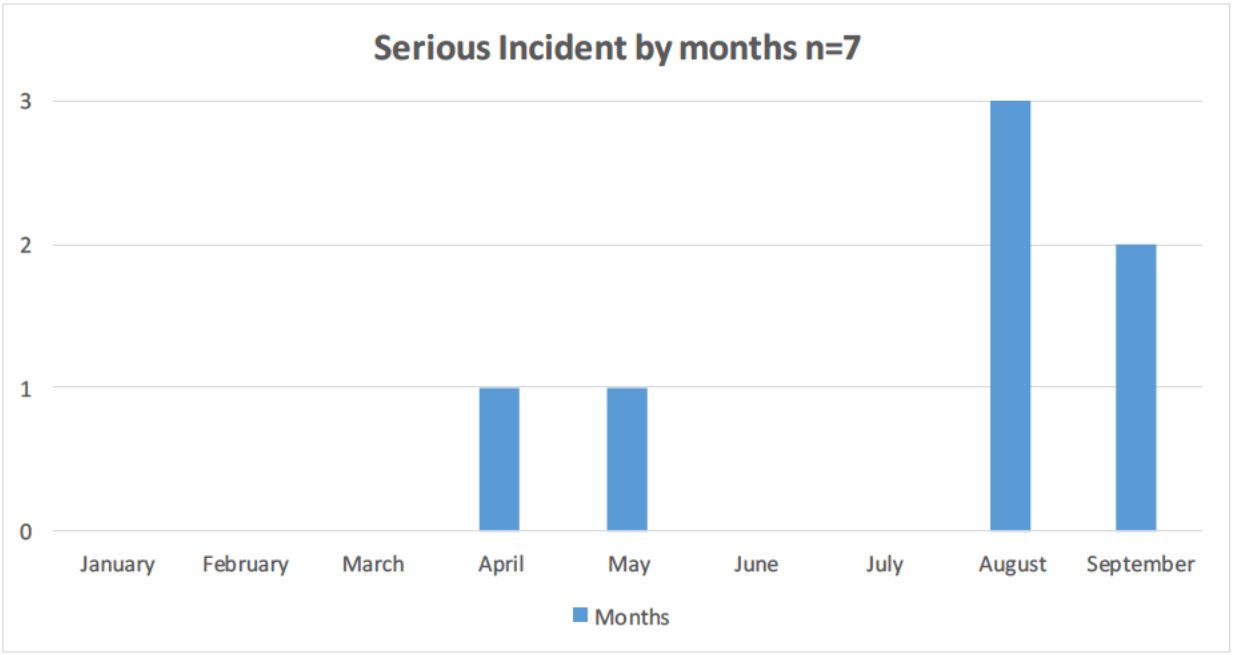
3. Closure of Serious Incidents in Quarter three

Seven serious incidents were closed in quarter three of 2020.

Incident date	Care Group	Level	Incident	Closed date
[redacted]	Women, Children and Family	3	[redacted]	25/08/20
	Emergency Care and Medicine	3		25/08/20
	Gynaecology	1		11/09/20
	Mental Health	3		11/09/20
	Mental Health	3		11/09/20
	Radiology	3		25/09/20
	Medicine	2		25/09/20

4. Year to date figures

There have been seven SI's in 2020 to date. Two of the three SI's reported in August were incidents that pre-date August.



5. Levels of Serious Incidents Quarter 3

Of the five SI's in Q3, only one is being completed as an external review. We are trying to reduce the reliance on external reviews but in this case as the department is small and it was a specialist area there was a need for peer review externally.

Level	Number	Year to date
Level 1	0	0
Level 2	4	4
Level 3 (External)	1	3

6. Open Serious Incidents

There are currently eight Serious Incidents open within Health and Community Services. One of these is waiting for panel in the next week, leaving seven open. Two serious incident are in the red, dating back to 2019, one of these is ready for panel and the final one is currently being drafted.

Incident date	Care Group	Level	Incident detail	Expected Date	Status
[redacted]	Women & Children	2	[redacted]	16/12/19	In draft
	Women & Children	3		30/10/20	External inv. Assigned
	Women & Children	2		30/11/20	Round table review

[redacted]	Mental Health	2	[redacted]	20/09/20	Ready for panel
	Mental Health	3		06/11/20	External inv. Assigned
	Mental Health	2		30/11/20	Investigators assigned
[redacted]	Orthopaedics	2		26/08/20	Investigators assigned
	Medicine	2		06/12/20	

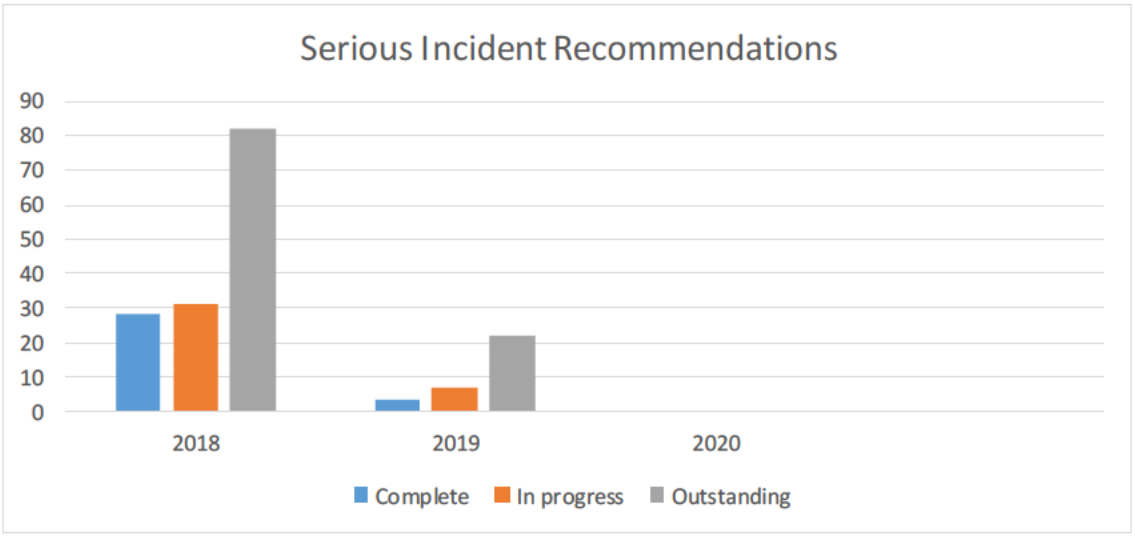
2020	2019	Ready for panel

7. Learning from Serious Incidents

The Thematic Review- Learning from Serious Incidents 2018 has been completed following the recent closure of all 2018 SI's and will be presented at the next Quality, Performance and Risk Meeting. There remains two outstanding SI's from 2019, the Thematic Review will be completed when these are closed.

Recommendations from 2018-2020 serious incidents have been collated, there remains some work to do on this establishing what has already been completed and some of the expert case reviews have comments made by the author on practices that are currently being extracted from the text and made into recommendations.

Within the next four weeks all Associate Medical Directors will be sent a spreadsheet of their outstanding actions, and meetings will be arranged with them to discuss a plan, consider if the recommendation is still relevant and assign owners to any that do not have one. The below data is therefore draft data, and likely to significantly change. This will be further cleansed and broken down by care group for future reporting.



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Serious Incidents
Quarter 4, 2020

December 2020
Report prepared by [redacted]
Head Quality and Safety

1. Notifications and Serious Incident September – December 2020

There was one Serious Incident (SI) notified to the Serious Incident Review Panel (SIRP) in quarter four, 2020. The one notification did not fit the criteria for an SI however, the panel requested further update following a learning event. Two further notifications were deferred until the next meeting scheduled Q1 2021.

Incident date	Care Group	Incident	Comments
[redacted]	Social Care & Medical Services (Diagnostics)	[redacted]	Not for Si but for round table learning event and outcome report back to panel.
	Medicine Services General & Specialist Medicine Oncology		Deferred until next meeting
	Surgical Services Surgical Specialties, Orthopaedics		Deferred until next meeting

2. Learning from Serious Incident Huddles

There was one SI huddles in quarter four related to the 13 November incident.

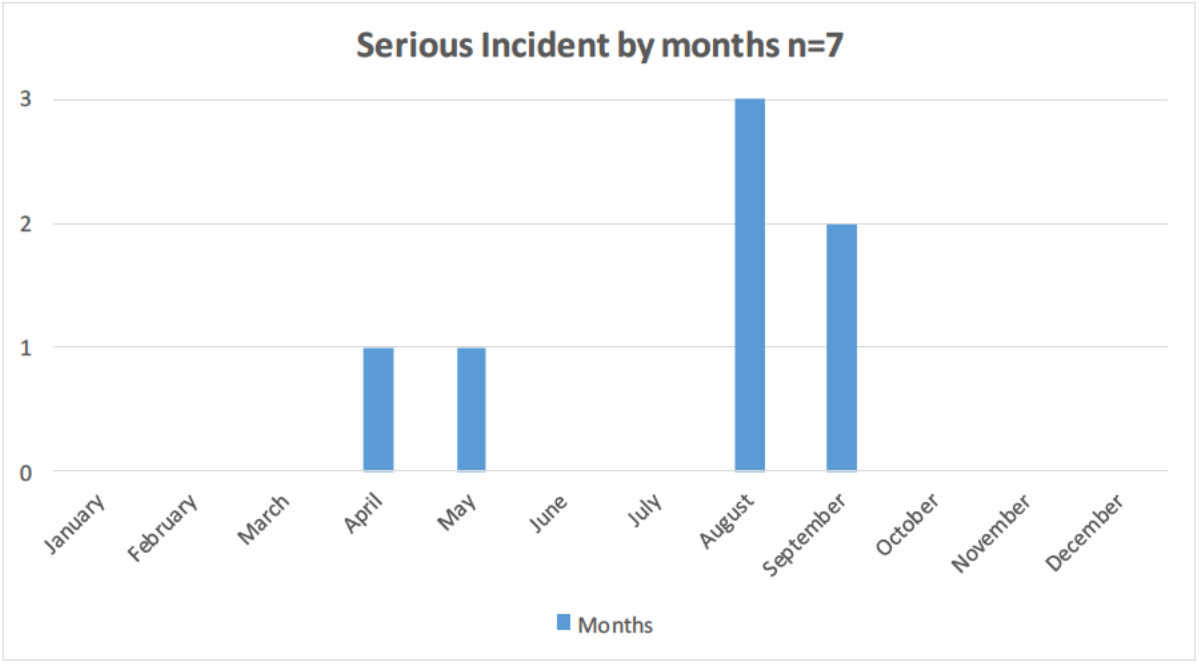
3. Closure of Serious Incidents in Quarter four

Two serious incidents were closed in quarter four, 2020.

Incident date	Care Group	Level	Incident	Closed date
[redacted]	Mental Health	2	[redacted]	20/11/2020
	Maternity	3		16/12/2020

4. Year to date figures

There have been seven SI's in 2020. A year-end report will follow.



5. Open Serious Incidents

There are currently six serious incident investigations open within Health and Community Services. Two of these are completed awaiting a date for panel, and another will shortly be ready for panel, leaving three open. One of the serious incident investigations open dates back to 2019, this is being followed up by the care group, the other which was due in November 2020 was given and extension; currently awaiting an update on the position of this report.

Incident date	Care Group	Level	Incident detail	Expected Date	Status
[redacted]	Women & Children	2	[redacted]	16/12/19	In draft being followed up by Associate Chief Nurse Head of Midwifery
	Women & Children	2		30/11/20	Final draft awaiting panel date
	Mental Health	3		06/11/20	Final draft scheduled for panel January 2021
	Mental Health	2		30/11/20	Investigators have requested extension
	Orthopaedics	2		26/08/20	In final draft pending one outstanding question
	Medicine	2		28/02/20	Significant work already undertaken complex case may require extension.

2020	2019	Ready for panel

Health and Community Services

Health and Community Services

Serious Incidents
Quarter 1, 2021

April 2021
Report prepared by [redacted], Head Quality and Safety

1. Notifications and Serious Incident January – March 2021

There were three Serious Incident (SI) notified to the Serious Incident Review Panel (SIRP) in quarter one, 2021. Two notifications did not fit the criteria for an SI, however, the panel has requested further updates when reviews are complete. There are outstanding Maternity Service notifications which had to be rescheduled to Q2 due to the work required by the Scrutiny Panel taking precedence.

Incident date	Care Group	Incident	Comments
[redacted]	Medicine Services General & Specialist Medicine Oncology	[redacted]	Deferred from meeting 2/11/2020. Notified within care group governance meeting and case reviewed by service. Notified to SIRP 27/01/2021 Chief pharmacist to be requested to review timeline for notification of MHRA new safety guidance on monitoring.
	Surgical Services/ Critical Care		Incident notified by Tertiary Centre 20/01/21 Notified to panel 12/02/2021 SI agreed
	Mental Health Services		Notified to Panel 12/02/2021 with 72 hour report. Not for SI to undertake MDT case review. To come back to panel for presentation of review.

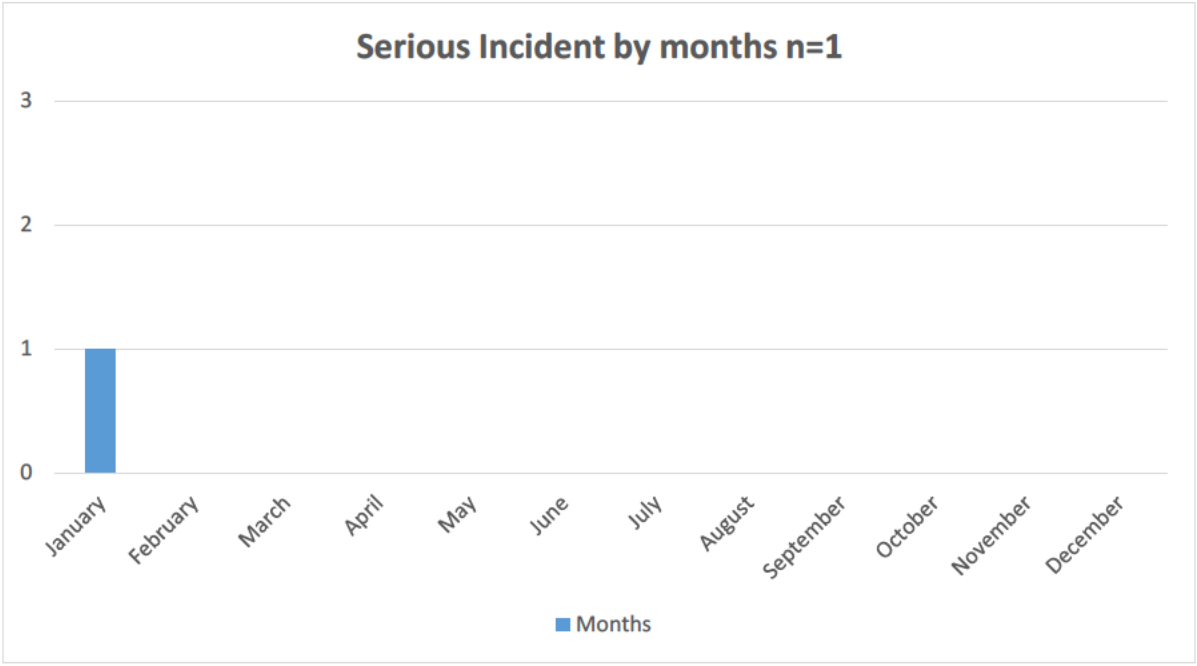
2. Learning from Serious Incident Huddles

There was one SI huddle in quarter one, this related to the incident 22/01/21, which was notified to panel. The 72 hour report resulted in a case load review by the community mental health team care coordinators. Emotional support was offered to staff across all agencies involved.

3. Closure of Serious Incidents in Quarter One

Incident date	Care Group	Level	Incident	Closed date
[redacted]	Mental Health	3	[redacted]	02/02/2021

4. Year to Date Figures



5. Open Serious Incidents

There are currently five SI's open, two of the reports are complete, awaiting presentation to panel. One report outstanding from 2019 is being followed up by the care group.

Incident date	Care Group	Level	Incident detail	Expected Date	Status
[redacted]	Women & Children	2	[redacted]	16/12/19	In draft being followed up by Associate Chief Nurse Head of Midwifery
	Women & Children	2		30/11/20	Final draft awaiting panel date
	Mental Health	2		30/11/20	Investigators have requested extension
	Orthopaedics	2		26/08/20	Final draft awaiting panel date
	Medicine	2		30/04/20	Significant work already undertaken complex case may require extension.

2020	2019	Ready for panel

6. Serious Incident Review Panel

The following meetings were cancelled in Q1, 2021:

Friday 19 February 2021; Friday 24 February 2021 and Friday 12 March 2021

The reason for the cancelled meetings related to the panel members and invitees availability. The cancellation of the meeting, which was to focus on cases from the Maternity Service, arose due to work required by the team to prepare for the review of Jersey's maternity services by the scrutiny panel.

A review of meeting schedules is underway to maximize attendance. The terms of reference and membership of the SIRP are also under review. A paper is being prepared for the panel and once agreed, will be taken to the Quality and Risk committee for approval.

7. Learning from Serious incidents

Once the serious Incident report is approved, it remains the responsibility of the care group to implement the recommendations; monitoring, reviewing and updating action plans and reporting progress in the performance reports.

Organisational wide tracking of recommendations and learning from SI's, which may span across multiple care groups and specialities, by the Quality & Safety Team, was deferred in 2020 due to lack of resources within the team. This position has now resolved with additional staff on secondment in place

The Quality & Safety team are supporting an organisational wide review of SI action plans and themes to identify priorities for patient safety improvement work and to consider ways to more effectively disseminate lessons learned.

8. Professional and formal duty of candour

A process for monitoring the application of professional and formal Duty of Candour is to be developed, breaches of the policy in respect of formal duty of candour will be monitored and reported.

9. Patient Safety Incident Response Framework

The current NHS Serious Incident Framework, to which we align the HCS local guidance, will be replaced in the near future with an updated approach, 'The Patient Safety Incident Response Framework'.

The new framework aims to provide for a more proactive approach towards learning from incidents, promoting a proportionate range of safety management processes. The investigation approach is one which prioritises the best opportunities for learning, quality over quantity. There will be a strengthened focus on engaging and supporting patients, families and staff involved in safety incidents in order to support the development and maturity of safety cultures across organisations.

There are currently a number of pilot sites across the NHS testing the new framework; feedback from the pilot sites has been positive. The requirement for all NHS trusts to adopt the new framework is unlikely to come before spring 2022. The Quality & Safety Team are beginning to review the introductory documents and consider how we prepare to adopt the new framework.