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:	Quality and Risk Assurance Committee		
Date of meeting:	27 April 2022		
Title of paper:	Serious Incident (SI) Assurance report		
Report author:	, Quality & Safety Manager	**Presented by:**	, (Acting) Head of Quality & Safety

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 ten notifications to panel in Q1 2022. • Four of these have been approved as Serious Incidents. • In Q1, 2022, two Serious Incident Investigation reports were approved and closed by panel. • There are currently thirteen SI's open. • Two SI reports are waiting to be presented to panel. • Excluding the reports ready for panel, four SI's are now in the red. • Six SI's are being externally investigated (Level 3) • There has been a change in how SI notifications are presented to panel, they are now presented to the Executive team. • Regular meetings have been set up between the Care Group Clinical Governance co-ordinators and Quality and Safety to ensure cohesive and coordinated working. Implementing monitoring, reviewing and updating action plans is the care group's responsibility.	
How does this matter	Improved Islanders' experience of Health & Community Services	✓

relate to HCS objectives? *(tick as appropriate)*	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 that HCS does not review serious safety events in a timely manner to support harm free care. Risk that HCS does not demonstrate learning from safety events and does not effectively share learning across the organisation. ID 448: 12
	Financial	
	Workforce	
	Performance	
	Reputational	
What action is being taken to mitigate risk?		

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Serious Incidents
Quarter 1, 2022

January 2022

Report prepared by
Quality and Safety Manager

1. Notifications and Serious Incident January – March 2022

There were ten Serious Incident (SI) notified to the Serious Incident Review Panel (SIRP) in quarter one (Q1), 2022. Two from the Mental Health (MH) Care Group, three from the Surgical Care Group, two from the Medical Care group, one which is a joint one between Adult Social Care (ASC) and MH, a joint one between the Surgical Care Group and Medical Care Group and a joint one between ASC, MH and Medical Care Group.

Four of the ten notifications were taken forward as Serious Incidents. All four investigations are being completed by H&CS staff. Of the six cases that did not meet the criteria for a Serious Incident, one surgical case was very similar to an incident that is currently being investigated as SI and panel felt that the learning would be similar. One case from the MH service was referred to the Safeguarding Partnership Board (SPB) and the other would undergo an internal review and feedback to the Care Group Performance Meeting.

The case within Mental Health is being investigated internally and will feedback learning and an action plan to the Care Group Performance Meeting. The case that involved ASC, MH and the Medical Care Group would have a round table review and the remaining two notifications were considered not to require further action and did not meet the criteria for an SI to be commissioned.

Incident date	Care Group	Incident	Huddle	Comments
	Medical and Surgical Services		No	Level 2 SI commissioned
	Surgical Services		Yes	Not for SI due to similar incident currently being investigated as an SI
	Medical Services		No	Not for SI
	Mental Health		Yes	Not for SI – referred to SPB
	Medical Services		No	Not for SI
	ASC/OAMH/Medical		Yes	Not for SI but round table review commissioned
	Surgical Services		No	Level 2 SI commissioned
	Surgical Services		Yes	Level 2 SI commissioned
	Adult Social Care		Yes	Level 2 SI commissioned
	Mental Health		Yes	Not for SI – internal review

2. Learning from Serious Incident Huddles

There were six SI huddles in Q1 2022. The SI huddles however are not being run in line with the SI policy, many are being held within care groups only or are conversations between two/three people or not happening until weeks after the safety event. Important information risks being lost with this approach and there is no documented discussion or learning from the event. In 2022 we need to ensure that we have a clear consistent approach in place to SI huddles in line with the policy and that we can demonstrate that huddles occurred, that someone from Q&S attended and any immediate actions/ lessons have been actioned. The Quality and Safety team will be hosting learning events throughout the year and some training about Safety Huddles will be included.

3. Closure of Serious Incidents in Quarter three

Three SI's were closed in Q1 of 2022, there are two SI completed waiting to be presented to panel.

Incident date	Care Group	Level	Incident	Closed date
	Medical Services	2		31/03/2022
	Women, Children and Family Care	2		10/02/2022

4. Open Serious Incidents

There are currently thirteen serious incidents open. There are currently two reports ready to be presented at panel. There are four SI's in the red. This is multifactorial, there have been delays within the Q&S team allocating investigators, delays sourcing clinical investigators in the current climate of covid and delays in the reports being written and presented to panel.

Incident date	Care Group	Level	Incident detail	Expected Date	Status
	Women & Children	2		**06/05/2022**	Internal

	Surgical and Medical Services	3		06/05/2022	External review
	Surgical Services	3		27/05/2022	External review
	Surgical Services	3			External Waiting for panel
	Medicine	2			Waiting for panel
	Medicine	2		30/05/22	Investigators appointed in Jan 22 Internal
	Medical and Surgical Services	2		03/05/22	External Review including a HCS Doctor.
	Medical and Surgical Services	2		30/04/22	Internal
	Mental Health & Medical Services	3		28/05/22	External
	Mental Health Services	3		30/06/22	External
	Surgical Services	2		30/06/22	Internal
	Surgical and Medical Services	2		09/06/22	Internal
	ASC	2		30/06/22	Internal

2021	2022	Ready for panel

5. Levels of all open Serious Incidents

Five serious incidents are currently being investigated externally. This is due to both pressures within the service and the sensitivities around some of the current SI's

Levels of Serious Incidents	Number
Level 1 (Case Review)	These are not included in the SI numbers

Level 2	7
Level 3 (External)	6

6. Serious Incident Review Panel

There has been a change in how SI notifications are presented to panel. The executive team have requested that once the Quality and Safety Team receive a notification that it is presented to panel. Panel consists of the Medical Director, Chief Nurse and Director of Mental Health and ACS. All three do not have to be present for notifications to be notified.

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

7. Learning from Serious incidents

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.

The current live position statement on recommendations is currently being updated by the relevant Care Group Governance coordinators. This is now part of the monthly Performance Reports. Once the data in the recommendations have been cleansed and is accurate, the Quality and Safety Team will be in a stronger position to demonstrate themes and learning from SI's in 2022.

The 2021, end of year report for Serious Incidents has also been completed & presented to this Committee March 2022.