Government of JERSEY

Health and Community Services

Committee Report

Exemption: Policy under development

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 October 2021		
Title of paper:	Serious Incident (SI) Assurance report		
Report author:	, Lead Manager Quality & Safety	**Presented by:**	, Lead Manager 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 (SIRP)

3. Key Issues

What are the key issues to be aware of?	• There were eleven notifications to panel in Q3 2021, six of these have been approved as Serious Incidents. Two cases have been referred to the Safeguarding Partnership Board for consideration of a Serious Case Review and the other cases are being reviewed within the care groups. • In Q3, 2021, one Serious Incident Investigation report was approved and closed by panel. • There are currently eleven SI's open, and seven case reviews. Four SI reports are waiting to be presented to panel. Excluding the reports ready for panel, only one remains in the red and this should be completed by November 2021. • The Serious Incident Review Panel has been cancelled on two occasions this quarter. This has resulted in a delay with the reports being heard by the panel. • Implementing monitoring, reviewing, and updating action plans is the

	care group's responsibility. However, ongoing tracking of recommendations and learning from SI's, which may span across multiple care groups and specialities, has been resumed by the Quality and Safety team.	
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 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. Risk Register ID 448: Learning from events & serious incidents 12
	Financial	
	Workforce	
	Performance	
	Reputational	
What action is being taken to mitigate risk?	An overarching review of learning from SI's is being undertaken and report will be presented to care groups and the Quality & Risk Committee. The SIRP meeting timetable, membership and terms of reference are under review.	

5. Recommendation

For noting.

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Health and Community Services

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Serious Incidents
Quarter 3, 2021

October 2021

Report prepared by
Lead Quality and Safety Manager

1. Notifications and Serious Incident July – October 2021

There were eleven Serious Incident (SI) notified to the Serious Incident Review Panel (SIRP) in quarter three, 2021. Five of these were within the Mental Health Service, four in Surgical Services, one within Medicine and one combined Surgical and Medical case. Two of these cases were referred to the Safeguarding Partnership Board for consideration of a Serious Case Review. In three cases the panel did not feel met the threshold for a serious incident was met, one of these was referred to the care group for further internal investigation and the second triggered a piece of work to be done between Associate Medical Directors that was to be fed back to the Medical Director.

Six serious incidents were agreed, one of which was a group of serious incidents being investigated by an external agency.

Incident date	Care Group	Incident	Huddle	Comments
	Surgical Services		Yes	Not to proceed to SI currently, but review case
	Surgical and Medical Services		No	External SI commissioned
	Mental Health and Social Care		Yes	Refer to Safeguarding Partnership Board, not for SI
	Mental Health & Medical Services		No	Work to be done on the patient pathway between physical and mental health by AMD's.
	Mental Health Service		Yes	Serious Incident Investigation commenced. This is the same patient as above, entire episode of care to be reviewed
	Mental Health Services		Yes	Refer to Safeguarding Partnership Board
	Surgical Services		No	Not to proceed to SI
	Surgical Services		No	Not for SI investigation, care group to investigate
	Medical Services		Yes	SI agreed
	Mental Health Services		Yes	SI agreed- external
	Surgical Services		Yes	SI agreed in liaison with external agency

2. Learning from Serious Incident Huddles

There were seven serious incident huddles in Q3. Each Mental Health potential serious incident triggered an immediate huddle. It has proved difficult in some cases within other care groups to get the correct stakeholders together to hold an SI huddle due to competing priorities. Information to inform decision making has been shared via phone, email and one to one meeting as opposed to being able to have a huddle to ensure that any immediate patient safety concerns have been addressed. In two cases the notifications did not have a huddle because they came to the department's attention the day before panel, so went straight to panel.

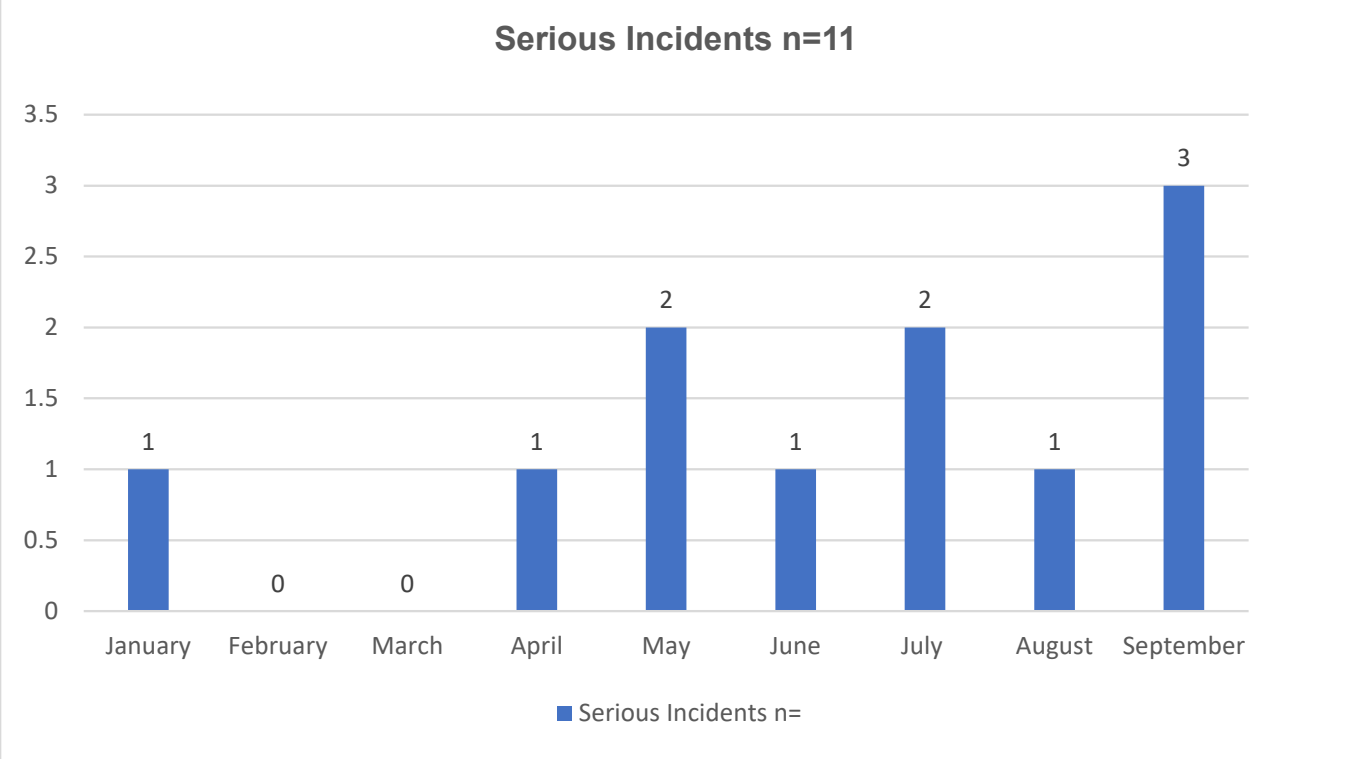
3. Closure of Serious Incidents in Quarter three

One SI was closed in quarter three of 2021, however there are currently 4 reports waiting to be presented to panel and one case review.

Incident date	Care Group	Level	Incident	Closed date
	Surgical Services	2	Monitoring and treatment of patient	September 2021

4. Year to Date Figures

At the end of Q3 there have been eleven serious incidents within HCS. In addition to this there are currently seven case reviews (level 1 SI's) with reports requested back to the SIRP



5. Open Serious Incidents

There are currently thirteen serious incidents open and seven case reviews. One SI remains outstanding from 2019, this report has been completed and is waiting to be presented to panel, however the panel it was scheduled for was cancelled.

There are currently four SI reports and one case review waiting to be presented to panel, which would bring the number of open cases down to nine. Excluding the reports completed and waiting to be presented to panel, there is only one other outstanding report in the red and it is anticipated that this will be completed by the end of October.

Incident date	Care Group	Level	Incident detail	Expected Date	Status
	Women & Children	2		16/12/19	Waiting for panel
	Women & Children	3		18/12/21	External - Guernsey
	Women & Children	2			Internal
	Surgical and Medical Services	3			External review
	Surgical Services	3		12/11/21	External review
	Surgical Services	3			External
	Medicine	2		30/04/20	Waiting for panel
	Medicine	2		21/07/21	
	Medicine	3		18/11/21	External- Guernsey
	Medicine	1		03/05/21	
	Medicine	2			TBC
	Mental Health & Medical Services	3			External
	Mental Health Services	3			External

2021	2020	2019	Ready for panel

6. Levels of all open Serious Incidents

A higher-than-average number of serious incidents are currently being investigated externally. This is due to 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	5
Level 3 (External)	8

7. Serious Incident Review Panel

Two meeting were cancelled in Q3 of 2021, both because of the panel not being quorate on the day. Additional meetings have had to be scheduled due to the volume of notifications in Q3. Cancellation of panels when key speakers are invited has resulted in a backlog of reports waiting to be presented for approval.

8. 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.

The Quality & Safety team are updating the current position statement on recommendations from SI's across HCS to disseminate across the Care Groups.