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:	26 January 2022		
Title of paper:	Serious Incident (SI) Assurance report		
Report author:	, Acting Head of Quality & Safety	**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 (SIRP)

3. Key Issues

What are the key issues to be aware of?	• There were eight notifications to panel in Q4 2021, four of these have been approved as Serious Incidents. • In Q4, 2021, three Serious Incident Investigation reports were approved and closed by panel. • There are currently twelve SI's open, and four case reviews. One SI report is waiting to be presented to panel. Excluding the reports ready for panel, six SI's are now in the red. • Five SI's are being externally investigated (Level 3) • The Serious Incident review panel has been cancelled on six occasions this quarter. This has resulted in a delay with a report being heard by the panel. • 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. Q&S will be reporting on lessons learnt and

	recommendations from 2022 to ensure that we can demonstrate learning from SI.	
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. ID 448: 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.	

Government of JERSEY

Health and Community Services

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Serious Incidents
Quarter 4, 2021

January 2022

Report prepared by
Interim Head of Quality and Safety

1. Notifications and Serious Incident October-December 2021

There were eight Serious Incident (SI) notified to the Serious Incident Review Panel (SIRP) in quarter four (Q4), 2021. One additional notification that had previously been presented to panel was returned for reconsideration as further information had become available. Four of these were taken forward as Serious Incidents. Of the four cases that did not meet the criteria for a Serious Incident, one had already had a case review completed within Women and Children and this will be presented to panel. Two of the cases were not considered to need any further action and did not meet the criteria for an SI. The final case was within Mental Health and it was noted that there had been identified learning points within that had already being actioned within the care group, the panel was reassured that lessons had been learnt.

One of the agreed serious incidents relates to a group of serious incidents being investigated by an external agency.

Incident date	Care Group	Incident	Huddle	Comments
	Surgical Services		Yes	External SI being completed
	Women, Children and Family		Yes	Level 2 SI commissioned
	Women, Children and Family		Yes	Case Review – report back to panel
	Mental Health Service		Yes	Not for an SI, patient had only had one telephone call with services
	Mental Health Service		Yes	Actions already identified and being actioned by MH Services
	Medical and Surgical Services		No	Level 2 SI commissioned
	Medical Services		Yes	Not for SI
	Surgical Services			Level 2 SI

2. Learning from Serious Incident Huddles

There were six SI huddles in Q4 2021. 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. 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.

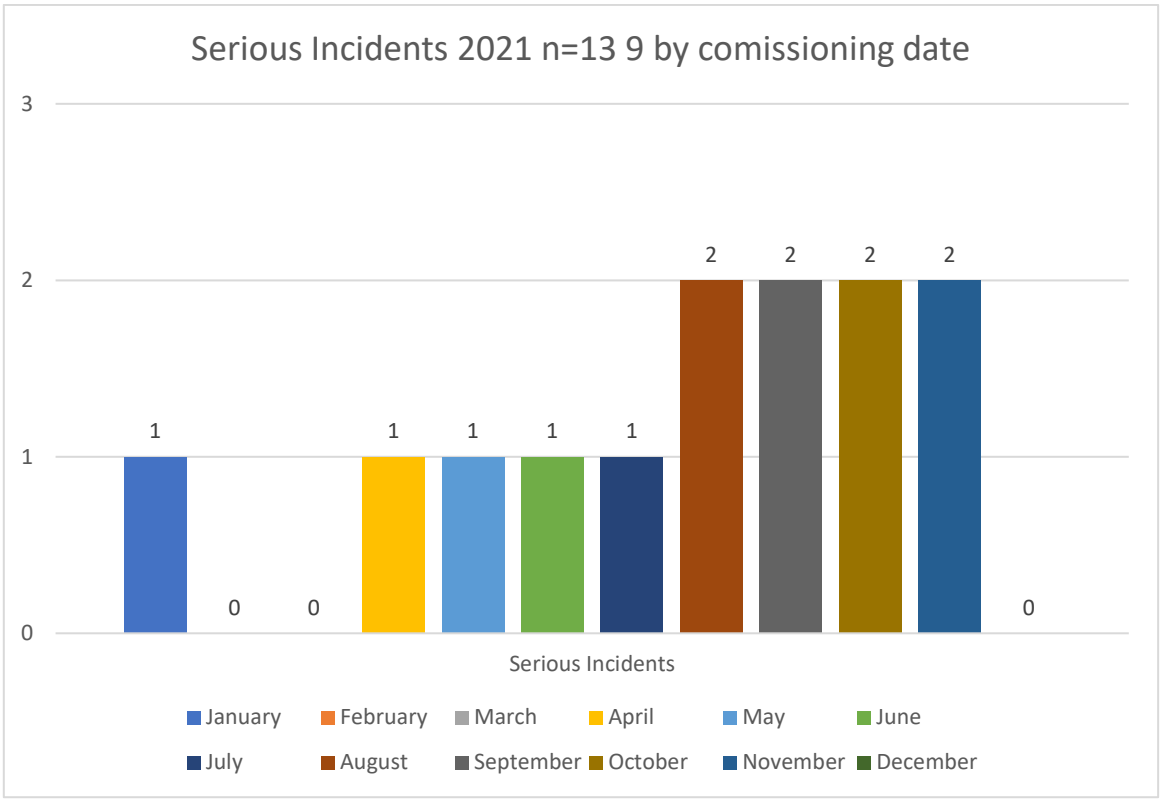
3. Closure of Serious Incidents in Quarter three

Three SI's were closed in Q4 of 2021, there is one SI completed waiting to be presented to panel.

Incident date	Care Group	Level	Incident	Closed date
	Women and Children	2		28/10/21
	Medical Services	2		28/10/21
	Medical Services	2		28/10/21

4. Year to Date Figures

There were four SI's commissioned in Q4. There were 13 SI's reported in total in 2021 within HCS. In addition to this there was one other case presented in Q4 that requires further investigation outside of the SI framework.



5. Open Serious Incidents

There are currently twelve serious incidents open and four case reviews. One SI remains outstanding from 2020, this report has been completed and is waiting to be presented to panel, however the panel has been cancelled three times causing a significant delay in presenting this case.

There are currently seven 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. Work is being done to improve this position in 2022.

Incident date	Care Group	Level	Incident detail	Expected Date	Status
	Women & Children	3		18/12/21	External - Guernsey
	Women & Children	2			Internal
	Surgical and Medical Services	3		01/22	External review
	Surgical Services	3		12/11/21	External review
	Surgical Services	3			External
	Surgical Services	2			Investigators TBC as this was re-presented to panel
	Medicine	2		21/07/21	
	Medicine	2		10/12/21	Investigators appointed in Jan 22
	Medicine	2			Waiting for panel
	Medical and Surgical Services	2		03/02/22	
	Mental Health & Medical Services	3		Feb 2022	External
	Mental Health Services	3		March 2022	External

2021	2020	2019	Ready for panel

6. 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	8
Level 3 (External)	5

7. Serious Incident Review Panel

Six out of the nine SI meetings were cancelled in Q4 of 2021. All the meetings were cancelled as a result of key Executives being unable to attend, meaning that the meeting would not be quorate. Cancellation of panels when key speakers were invited has resulted in one report waiting for three months to be presented for approval. There are currently no panel dates set for 2022

8. 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. Two thousand and twenty-two reports will include an update on specifics learnt as well as updates on compliance with the recommendations. An end of year report for Serious Incidents will also be completed.