Health and Social Care Board

Public Health Agency

# Learning Report

# Serious Adverse Incidents

## October 2016 - March 2017

## June 2017

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# SECTION 1

## 1.0 BACKGROUND AND INTRODUCTION

From 1 May 2010 the responsibility for the management and follow up of Serious Adverse Incidents (SAIs) transferred from Department of Health, Social Services and Public Safety (DHSSPS) to the Health and Social Care Board (HSCB) working jointly with Public Health Agency (PHA) and collaboratively with Regulation Quality Improvement Authority (RQIA). In response, the HSCB issued the Procedure for the Reporting and Follow up of SAIs (the Procedure) to all HSC organisations and Special Agencies.

Two revisions to the procedure have since been undertaken, the first of which was issued in October 2013 and the most recent in November 2016.

## 2.0 MANAGING SERIOUS ADVERSE INCIDENTS REPORTED

The current arrangements for managing SAIs reported to the HSCB/PHA are:

- Regional reporting system for all SAIs;
- SAIs are reviewed by senior professional officers; in addition, the HSCB senior management team receives and considers all SAIs on a weekly basis;
- SAIs are allocated to a nominated professional officer, who is the Designated Review Officer (DRO) responsible for reviewing learning summary reports for level 1 SAI reviews and quality assuring reports for both level 2 and 3 SAI reviews; in conjunction with the relevant DRO professional group within the programme of care;
- DRO Professional Group meet to consider learning summary and SAI review reports and identify themes and trends from within the programme of care where the SAI has occurred;
- SAI Review Sub Group (SAIRSG) meetings to consider reports, identify themes and learning;
- Overarching HSCB-PHA Quality Safety and Experience (QSE) Group to consider the issues identified by the SAIRSG and agree actions and assurance arrangements;
- The Safety and Quality Alerts (SQA) Team provide an assurance mechanism for any actions to be taken forward as a result of regional learning;
- Escalation if required in respect of:
    - timescales for receipt of SAI and review reports

- assurances on action being taken forward by reporting organisations following the incident review.

## 3.0 WORK TAKEN FORWARD DURING THE REPORTING PERIOD

### *THE REVISED PROCEDURE FOR THE REPORTING AND FOLLOW UP OF SAIS (NOVEMBER 2016)*

The HSCB and PHA have now completed the review of the Procedure for the Reporting and Follow up of SAIs, in consultation with DoH, HSCB/PHA DROs, Trust professionals and Governance leads. A revised procedure was issued to all ALBs in November 2016.

The main changes to the procedure are as follows:

- ***Quality Assurance of Level 1 SEA Review Reports***

    - The revised process requires reporting organisations to quality assure the robustness of level 1 SEA Reviews prior to submission to the HSCB. The changes to the process have been discussed with Designated Review Officers (DROs), Trust professional Directors and Trust Governance Leads.

    - Level 2 and 3 SAI Reviews will continue to be managed as per the current SAI process.

    - Additional guidance on the use of an 'incident debrief' for each level of SAI review has been developed in order to provide organisations with a mechanism to support staff and to identify any immediate service actions.

    - The role of HSCB/PHA DROs has been updated to reflect the above amendments.

- ***Never Events***

In line with DoH circular HSC (SQSD) 56/16 (Never Events), the current SAI notification form has been revised to enable reporting organisations to identify relevant SAIs as a Never Event and confirm that Service Users/Family/Carers have been informed.

A new field has also been set up on the HSCB DATIX reporting system which will allow all Never Events to be recorded in line with the current categories listed in the NHS England Never Event list.

Regional learning identified from Never Events will be promoted and communicated across the HSC.

- ***Engagement/Communication with Service Users/Family/Carers following a Serious Adverse Incident***

    - *Service User/Family/Carer Engagement Checklist*

The above checklist which forms part of all levels of review reports, has been updated to reflect where relevant, the service user/family/carer has been advised:

- the SAI is a never event;
- if the case has been referred to the Coroner, where the reporting organisation had a statutory duty to notify the Coroner.

    - *A guide for Health and Social Care Staff (Addendum 1 of procedure refers)*

The above guidance, which is now an addendum to the procedure, has been revised to reflect:

- the term 'SAI Review' (this has also been reflected throughout the revised procedure);

- a service user/family's right to contact the Northern Ireland Public Services Ombudsman (NIPSO) where they are dissatisfied with the HSC organisation's attempts to resolve their concerns following a SAI review.

- the engagement leaflet has been updated to reflect the organisation's responsibility to advise the service user/family/carer of a Never Event.

*Appendix C provides an analysis on service user/family/carer engagement checklists received during for the period 1 October 2016 - 31 March 2017 and appendix D provides an update on analysis from the previous reporting period.*

- ***Reporting of Falls***

The Report on Falls Resulting in Moderate to Service Harm was issued in March 2016. As a result, a new process has been developed with phased implementation, which enables HSC Trusts to undertake a timely post falls review, and report the learning from these incidents to the Regional Falls Group, rather than being routinely reported as SAIs.

In addition to the above, all other changes to the process, previously communicated to ALBs since October 2013, have been incorporated within the revised procedure.

- ***Implementation***

All aspects of the procedure were to be implemented with immediate effect, with the exception of the new learning summary template which was to be fully implemented by 1 January 2017.

The procedure can be accessed via the following link:
http://insight.hscb.hscni.net/download/safety_quality_and_learning/serious_adverse_incidents/Procedure-for-the-reporting-and-follow-up-of-SAIs-2016.pdf

## *DESIGNATED REVIEW OFFICER (DRO)*

- ***DRO Protocol***

A series of DRO workshops were held during January and February 2017, across each of the four HSCB/PHA localities, in order to review the DRO and Early Alert Protocols and align them to the revised SAI Procedure. A new DRO Protocol and Early Alert Protocol were subsequently issued to DROs on 3 April 2017 following approval by the HSCB Senior Management Team. Both protocols can be accessed via the following link:

http://insight.hscb.hscni.net/information-for-designated-review-officers-dros/

- ***DRO Professional Groups***

DRO professional groups for the following programmes have continued to meet on a monthly basis:

- Paediatrics and Child Health
- Maternity
- Mental Health
- Acute

During the reporting period a further three groups from the following programmes have now been established and will also meet on a regular basis:

- Integrated Care
- Adult Services
- Children's Services

These groups have contributed significantly to overall quality and safety structures within the HSCB/PHA in terms of:

- Multi-professional input / wider circle of experience,
- Group sign off , decisions not focused on one individual
- More complete understanding of the range of SAI issues within these service areas leading to the identification of regional trends
- Expedites regional learning

Over the next few months a further group will be established to oversee those SAIs which fall within the remit of Corporate Services.

***TRAINING***

- ***Regional Governance Leads Workshop***

A regional governance leads workshop was held on Friday 11 November 2016, in Clothworthy House, Antrim Castle Gardens and was attended by Governance Leads within the HSCB, PHA, the six HSC Trusts and DoH.

The workshop provided an opportunity to discuss:

- the implementation of the new SAI Process
- taking forward recommendations from the Regional Learning System project
- Quality 2020 – Strengthening our response to adverse incident.
-

The SHSCT Governance Lead also provided a comprehensive presentation on complaints categorisation within the SHSCT.

A further workshop is planned in the same venue for 8 June 2017.

## 4.0 SAIs REPORTED DURING PERIOD OCT 2016 TO MAR 2017

During the period 1 October 2016 to 31 March 2017, the HSCB received 180 SAI notifications. This represents an overall decrease on the previous six months (March - Sept 2016) when 200 SAI notifications were reported to the HSCB. This reduction continues to be largely attributed to revised reporting arrangements put in place, during 2016, for the reporting of child deaths and is explained further in Appendix B - A breakdown of these SAIs by reporting organisation and programme of care.

## 5.0 DE-ESCALATION OF SAIs

HSC organisations/Special Agencies or Commissioned Service Providers are encouraged to report SAIs, however, it is recognised that SAI reports can be based on limited information at the time of reporting and further review may identify that the incident no longer meets the criteria of a SAI.

In such instances a request can be submitted, by the reporting organization, to de-escalate or withdraw the SAI, however, the decision to approve the de-escalation/withdrawal will be made by the HSCB/PHA Designated Review Officer.

During the reporting period one (1) SAI notification received was de-escalated/ withdrawn.

## 6.0 DUPLICATE SAI REPORTING

On occasions a notification may be received from one or more organisations relating to the same incident. In such instances, a lead organisation will be identified to take forward the incident review and follow up and the duplicate notification will be closed.

During the reporting period no duplicate SAI notifications were received.

# SECTION 2

## 1.0 LEARNING FROM SERIOUS ADVERSE INCIDENTS

### *HSCB/PHA STRUCTURE FOR LEARNING FROM SAIs*

It is important that when a serious event or incident occurs, that there is a systematic process for investigating and learning from incidents. The key aim from this process is to improve patient safety and reduce the risk of recurrence, not only within the reporting organisation, but across the HSC as a whole.

The HSCB, working closely with the PHA, is responsible for identifying and disseminating regional learning from its monitoring role in relation to SAIs, complaints and patient client and experience.

- **Quality Safety and Experience (QSE) Group**

The HSCB and PHA established a, jointly chaired, QSE Group to provide an overarching, streamlined approach in relation to how the HSCB and PHA meet their statutory duty of Quality. This multi-disciplinary group meet on a monthly basis to consider learning, patterns/trends, themes or areas of concern, and agree appropriate actions to be taken, from all sources of safety and quality information received by the HSCB and PHA.

A Regional SAI Review Subgroup reports to, and supports the work of the QSE Group.

- **Safety Quality and Alerts Team (SQAT)**

The SQAT group, which is closely aligned to the work of QSE, is responsible for performance managing the implementation and assurance of Regional Safety and Quality Alerts / Learning Letters / Guidance issued by HSCB/PHA in respect of SAIs.

The process is overseen by a joint PHA/HSCB SQAT which is a multidisciplinary group chaired by the PHA Medical Director/ Director of Public Health. The Group meet fortnightly to co-ordinate the implementation of regional safety and quality alerts, letters and guidance issued by the DHSSPS, HSCB, PHA and other organisations. This provides a mechanism for gaining regional assurance that alerts guidance have been implemented or that there is an existing robust system in place to ensure implementation.

The HSCB/PHA SQAT issue a Bi-annual Report on Safety and Quality Alerts. This report provides an overview of the alerts reviewed by the SQAT in the reporting period and details key safety / quality improvements following the issue of alerts. The latest edition and previous issues of the PHA/HSCB Report on Safety and Quality Alerts are available to access using the following link:

http://intranet.hscb.hscni.net/documents/Safety_and_Quality_Learning_Letters.html#TopOfPage

***SAI LEARNING MECHANISMS***

Possible **Learning actions** following the review of SEA / RCA review reports:

- **Local organisational actions**

- **Regional actions**

  - ***Disseminate***
    - Issue a urgent Learning Letter
    - Issue a Learning Letter / Alert
    - Include an article in the Learning Matters Newsletter or Medicines Safety Matters Newsletter or GMS Newsletter

  - ***Implement***
    - Through an existing work stream or established group
    - Through a Thematic Review
    - Establish a task and finish group

  - ***Inform others***
    - Refer to other regulatory body
    - Commission or organise training event/workshop

## 2.0 DISSEMINATION OF LEARNING INITIATIVES

Learning from SAIs is a significant element to improving practice. However the HSCB and PHA are cognisant that each and every SAI has an impact on individuals and families. Therefore, whilst for the purposes of this report patient identifiable information has been removed, this is not intended to diminish the personal impact that these incidents have had on the individuals involved.

The following initiatives were identified as part of the SAI review process and relate to learning from trends, reviews and individuals cases. Some of these initiatives may relate to learning identified and reported in previous reports as part of on-going work.

***THE FOLLOWING ITEMS ARE NEW LEARNING ISSUED SINCE LAST REPORT:***

- **SQR/SAI/2016/021** (AS & MCH) Use of ventilator filters in the resuscitation of neonates;
- **SQR/SAI/2017/022** (AS & MH) Prescribing of Methadone;
- **SQR/SAI/2017/023** (MCH & PHC) Sepsis due to untreated urinary tract infections in pregnancy;
- **SQR/SAI/2017/024** (ELD) Management of Diabetes in Nursing and Residential Homes;

- **SQR/SAI/2017/025** (MCH) Risk of genital tract sepsis during pregnancy and in the postnatal period.

**SAFETY AND QUALITY BEST PRACTICE REMINDER LETTERS RELATING TO THE ABOVE ARE AVAILABLE TO ACCESS USING THE FOLLOWING LINK:**

http://intranet.hscb.hscni.net/documents/Learning_Letters/Safety%20and%20Quality%20Best%20Practice%20Reminder%20Letters/index.html

## *LEARNING FROM SAIs WITHIN FAMILY PRACTITIONER SERVICES (FPS)*

There are a range of other initiatives across the HSC where learning from SAIs is shared with FPS practitioners to reduce the risk of recurrence. There have been a number of SAI related learning communications issued to FPS including the following:

- GP learning was issued arising from an SAI review regarding klebsiella sepsis in pregnancy following untreated UTIs - GMS newsletter - Winter 2017
http://primarycare.hscni.net/download/DocLibrary/GMS/GMS%20newsletter/GMS-Update-Winter-2017.pdf

- Following an incident which resulted in the loss of a specialist medication from the reception area of a GP surgery, an article was included in the GMS newsletter reminding practices to have a protocol in place that covers the receipt, safe storage, handling and issuing of medicines and that they have good communication in place between the Trust pharmacy, the GP surgery and the patient.
http://primarycare.hscni.net/download/DocLibrary/GMS/GMS%20newsletter/GMS-Update-Winter-2017.pdf

- In relation to the theft of dental prescriptions during a surgery break in, a professional letter was issued to all general dental practitioners in Northern Ireland to remind them of good practice regarding prescription security and the appropriate actions to take when prescriptions are stolen. An item was published in the HSCB's General Dental Services News Sheet with a link to the prescription security guidance on the BSO website:
http://www.hscbusiness.hscni.net/pdf/December_2016_Newsheet.pdf

- A professional letter was issued to Community Pharmacists with a specific patient reminder form for Special Order medicines. This was developed following an incident where a child receiving a specialist medication for treating epilepsy was admitted to hospital following a seizure, due to a gap in treatment. Ensuring patients and carers know the importance of ordering their specialist medications well in advance of running out was a key learning point from the review.
Letter available on Medicines Governance website:
www.medicinesgovernance.hscni.net

- A reminder letter issued to Community Pharmacies on preventing selection errors, in particular with beta-blockers. This was following on from a historic SAI for which learning communications had already been issued, however the recent letter was issued in response to further professional and public awareness of the case following court proceedings.

## NEWSLETTER – "LEARNING MATTERS"

An essential element of improving services is the dissemination of information and a variety of methods are used to ensure learning is shared such as learning letters, alerts and reports. In addition the PHA/HSCB has developed a newsletter to compliment the other methods and to provide a forum where local learning from SAIs, reviews and complaints can be shared regionally.

Learning Matters Newsletter provides a method of sharing learning relating to SAIs, complaints, reviews and patient experience across Northern Ireland. The sixth edition was issued in December 2016 and covered the following topics:

- Intravenous Tramodol in Emergency Departments
- Missed diagnosis of head and neck injuries
- Blood components Special Requirements & out of Hours Tranfusion
- Importance of risk assessment for venous thromboembolism in pregnant women
- Accurate communication of actions and results
- Home oxygen and the risk of fires
- Integrated Elective Access Protocol (IEAP) referrals
- National Patient Safety Alerts
- Reminder of Best Practice Guidance (SQR) Letters.

Previous editions of the newsletter can be viewed at:

http://www.publichealthagency.org/publications/learning-matters-newsletters

A further special edition for commissioned services will be issued in June 2017.

## THEMATIC REVIEWS

Thematic Reviews are commissioned by the HSCB/PHA QSE Group, to review trends and patterns. These in-depth reviews ensure that local patterns are considered within the regional and national context and ensuing recommendations and key learning points are disseminated across the HSC.

There were no thematic reviews issued during this reporting period.

## HSC SAFETY FORUM

In addition to facilitating the Annual Regional SAI Learning Event, the HSC Safety Forum welcomes information on key themes arising from SAIs to inform their improvement work. The Forum also provides assistance on specific SAIs on request.

Within the Safety Forum QI programmes, HSC Trust improvement teams are encouraged to present the learning from SAIs to inform change. Current areas of Safety Forum work influenced by specific SAIs, or themes from groups of SAIs, include communication and handover, sepsis, medication safety in paediatrics and recognition of the deteriorating patient (including early warning scores and escalation).

## OTHER LEARNING ACTIONS

There are a range of other learning actions, which existing work streams or groups are taking forward or have been asked to consider by the HSCB/PHA, as a result of learning identified from SAIs. Examples include:

- Regional Falls Group
- Maternity Quality Improvement Collaborative
- Paediatric Quality Improvement Collaborative
- NICaN
- Think Family Regional Sub Group
- CAMHS Manager's Forum
- National Poisons Information Service – Clinical Standards Group

## ANTICOAGULANTS AND/OR ANTIPLATELETS

A regional task and finish group, with provider organisations, will be convened to focus on safety issues relating to anticoagulants and/or anti platelet therapy.

# SECTION 3

## NEXT STEPS

## 1.0 THEMATIC REVIEWS

Following an in-depth review of SAI reports, the following thematic reviews were undertaken:

- ***REGIONAL REVIEW OF SAIs RELATING TO CHOKING ON FOOD***

A request was approved by the Quality Safety and Experience group to review and identify the numbers and types of SAIs and adverse incidents relating to choking on food reported in the period 1 May 2010 to 31 March 2017.

This review will help to identify themes, consider any regional learning and determine if any further actions are required to reduce/prevent reoccurrence of these incidents.

## 2.0 SAI LEARNING EVENT S

- ***HSC SAFETY FORUM ANNUAL LEARNING EVENT***

The third Annual Regional SAI Learning Event will be held on Tuesday 23 May 2017 at Mossley Mill. The event will continue to facilitate our ability to share and learn from SAIs in health and social care and progress a regional approach to reviews and learning.

It is intended to repeat the parallel workshop approach themed on the following programmes of care: Acute Services, Maternity and Paediatrics, Mental Health, Primary and Social Care and on issues with a high regional profile such as severe sepsis, unrecognised deterioration, anticoagulant and antiplatelet and poor communication/teamwork.

- ***MH LEARNING / TRAINING EVENT AUTUMN 2017***

Following a number of SAIs relating to transfers arrangements, a Protocol for the transfer of adult mental health patients between HSC Trusts was developed and shared with HSC Trusts in July 2015.

This protocol represents best practice in the transfer arrangements of adult mental health patients/service users between HSC Trusts. The HSCB plan to hold a workshop to review this protocol and share the learning in Autumn 2017.

# SECTION 4

## CONCLUSION

Within the HSCB/PHA there is a continued commitment to learn from SAIs, to improve services and to reduce the risks of recurrence, both within the reporting organisations and across the HSC as a whole. The dissemination of learning following SAIs and ensuring that quality improvements are embedded into practice remains a key priority for the HSCB/PHA.

This report demonstrates actions planned and achieved in the period from October 2016 to March 2017. It also highlights the broad range of work that is routinely undertaken and reaffirms our commitment to safety, effectiveness and patient and client focus.

Since the last report, five learning letters/reminders of best practice have been disseminated to the relevant HSC organisations and a “Learning Matters” newsletter was issued in December 2016. The next “Learning Matters” newsletter will be a special edition for commissioned services and will be issued in June 2017, to compliment the other methods of learning and to provide a forum where learning from SAIs, reviews and complaints is shared regionally and in a format that reaches all levels of staff across the wider HSC.

Quality, Safety and Patient Experience are a significant focus for the HSCB and PHA and both organisations will work in partnership with the HSC to improve the quality of care by learning from incidents and improving standards regionally.

## APPENDIX A

**REVISED CRITERIA FROM 1 FEBRUARY 2016**

**DEFINITION OF AN ADVERSE INCIDENT AND SAI CRITERIA**

**'Any event or circumstances that could have or did lead to harm, loss or damage to people, property, environment or reputation'.**[1] arising during the course of the business of a HSC organisation / Special Agency or commissioned service

The following criteria will determine whether or not an adverse incident constitutes a SAI.

**SAI CRITERIA**

- serious injury to, or the unexpected/unexplained death of:
  - a service user (*including a Looked After Child or a child whose name is on the Child Protection Register and those events which should be reviewed through a significant event audit*)
  - a staff member in the course of their work
  - a member of the public whilst visiting a HSC facility;

- unexpected serious risk to a service user and/or staff member and/or member of the public;

- unexpected or significant threat to provide service and/or maintain business continuity;

- serious self-harm or serious assault (*including attempted suicide, homicide and sexual assaults*) by a service user, a member of staff or a member of the public within any healthcare facility providing a commissioned service;

- serious self-harm or serious assault *(including homicide and sexual assaults*)
  - on other service users,
  - on staff or
  - on members of the public

  by a service user in the community who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;

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[1] Source: DHSSPS How to classify adverse incidents and risk guidance 2006
www.dhsspsni.gov.uk/ph_how_to_classify_adverse_incidents_and_risk_-_guidance.pdf

- suspected suicide of a service user who has a mental illness or disorder (*as defined within the Mental Health (NI) Order 1986*) and/or known to/referred to mental health and related services *(including CAMHS, psychiatry of old age or leaving and aftercare services*) and/or learning disability services, in the 12 months prior to the incident;

- serious incidents of public interest or concern relating to:
  - any of the criteria above
  - theft, fraud, information breaches or data losses
  - a member of HSC staff or independent practitioner.

**ANY ADVERSE INCIDENT WHICH MEETS ONE OR MORE OF THE ABOVE CRITERIA SHOULD BE REPORTED AS A SAI.**

**APPENDIX B**

## ANALYSIS OF SAI ACTIVITY OCTOBER 2016 – MARCH 2017

The HSCB has **received 180 SAI Notifications** from across Health and Social Care (HSC) for the above period. The information[2] below has been aggregated into summary tables with commentary to prevent the identification of individuals.

Table 1 and Charts 1 & 2 below provide an overview of all SAIs reported by organisation and includes **comparison** of activity:

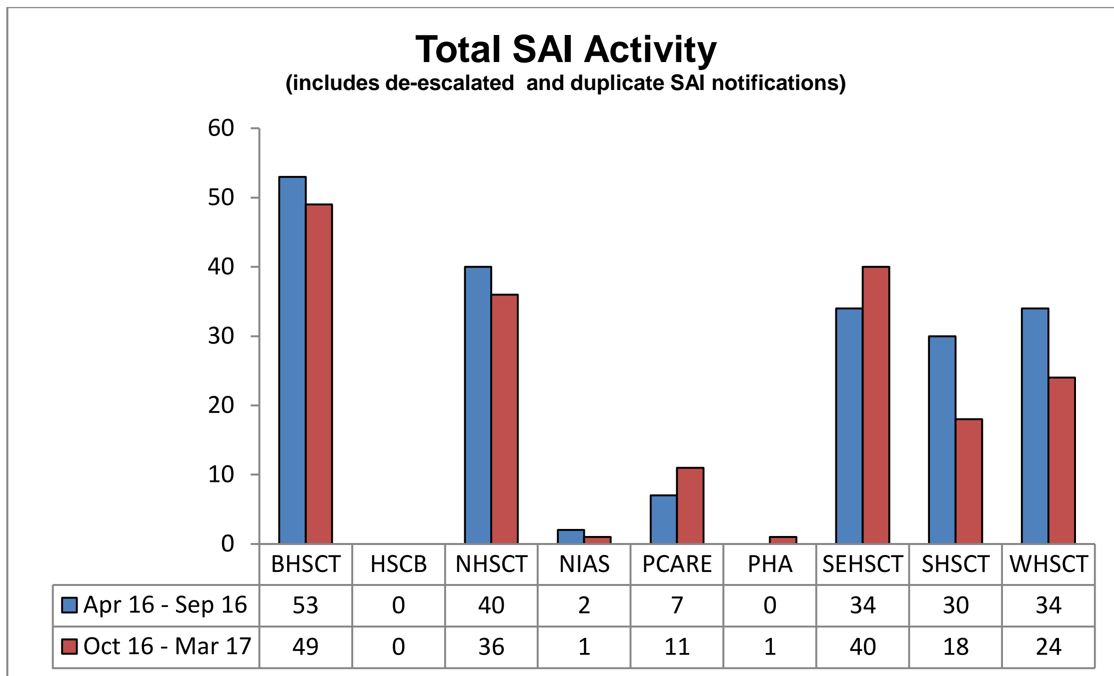
- for the previous six months reporting period April to September and
- for the same reporting period (year on year) October to March.

The reduction in notifications continues to be largely attributed to the revised reporting arrangements put in place, during 2016, for the reporting of child deaths.

| TOTAL ACTIVITY | Oct 15 – Mar 16 | Apr 16 - Sep 16 | Oct 16 - Mar 17 |
|---|---|---|---|
| **BHSCT** | 75 | 53 | 49 |
| **HSCB** | 1 | 0 | 0 |
| **BSO** | | 0 | |
| **NHSCT** | 38 | 40 | 36 |
| **NIAS** | 0 | 2 | 1 |
| **PCARE** | 11 | 7 | 11 |
| **PHA** | 0 | 0 | 1 |
| **SEHSCT** | 51 | 34 | 40 |
| **SHSCT** | 56 | 30 | 18 |
| **WHSCT** | 40 | 34 | 24 |
| **Totals:** | **272** | **200** | **180** |

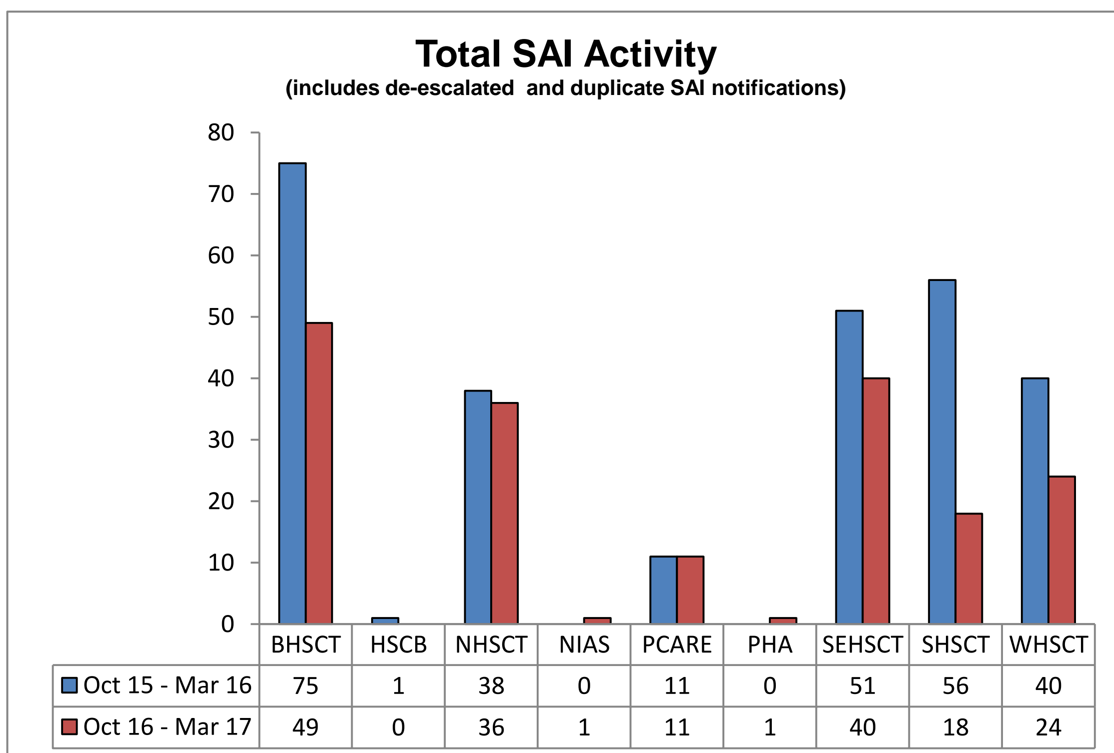
**Table 1**

[2] Source- HSCB DATIX Information System




| | BHSCT | HSCB | NHSCT | NIAS | PCARE | PHA | SEHSCT | SHSCT | WHSCT |
|---|---|---|---|---|---|---|---|---|---|
| Apr 16 - Sep 16 | 53 | 0 | 40 | 2 | 7 | 0 | 34 | 30 | 34 |
| Oct 16 - Mar 17 | 49 | 0 | 36 | 1 | 11 | 1 | 40 | 18 | 24 |

**Chart 1**




| | BHSCT | HSCB | NHSCT | NIAS | PCARE | PHA | SEHSCT | SHSCT | WHSCT |
|---|---|---|---|---|---|---|---|---|---|
| Oct 15 - Mar 16 | 75 | 1 | 38 | 0 | 11 | 0 | 51 | 56 | 40 |
| Oct 16 - Mar 17 | 49 | 0 | 36 | 1 | 11 | 1 | 40 | 18 | 24 |

**Chart 2**

## SAI DE-ESCALATION

SAI reports submitted can be based on limited information at the time of reporting. If on further review the incident does not meet the criteria of an SAI, a request can be submitted by the reporting organisation to de-escalate or withdraw the SAI.

In line with the HSCB Procedure for the reporting and follow up of SAIs the reporting organisation can provide information on why the incident does not

warrant further review under the SAI process. This information is considered by the HSCB/PHA DRO prior to approving any de-escalation.

During the reporting period **one (1) SAI notification** received was subsequently **de-escalated/withdrawn**.

| TOTAL DE-ESCALATED/WITHDRAWN | Oct 15 – Mar 16 | Apr 16 - Sep 16 | Oct 16 - Mar 17 |
|---|---|---|---|
| **BHSCT** | 2 | 0 | 0 |
| **NHSCT** | 0 | 0 | 1 |
| **SHSCT** | 1 | 0 | 0 |
| **WHSCT** | 1 | 1 | 0 |
| **Totals:** | **4** | **1** | **1** |

## DUPLICATE SAI NOTIFICATIONS

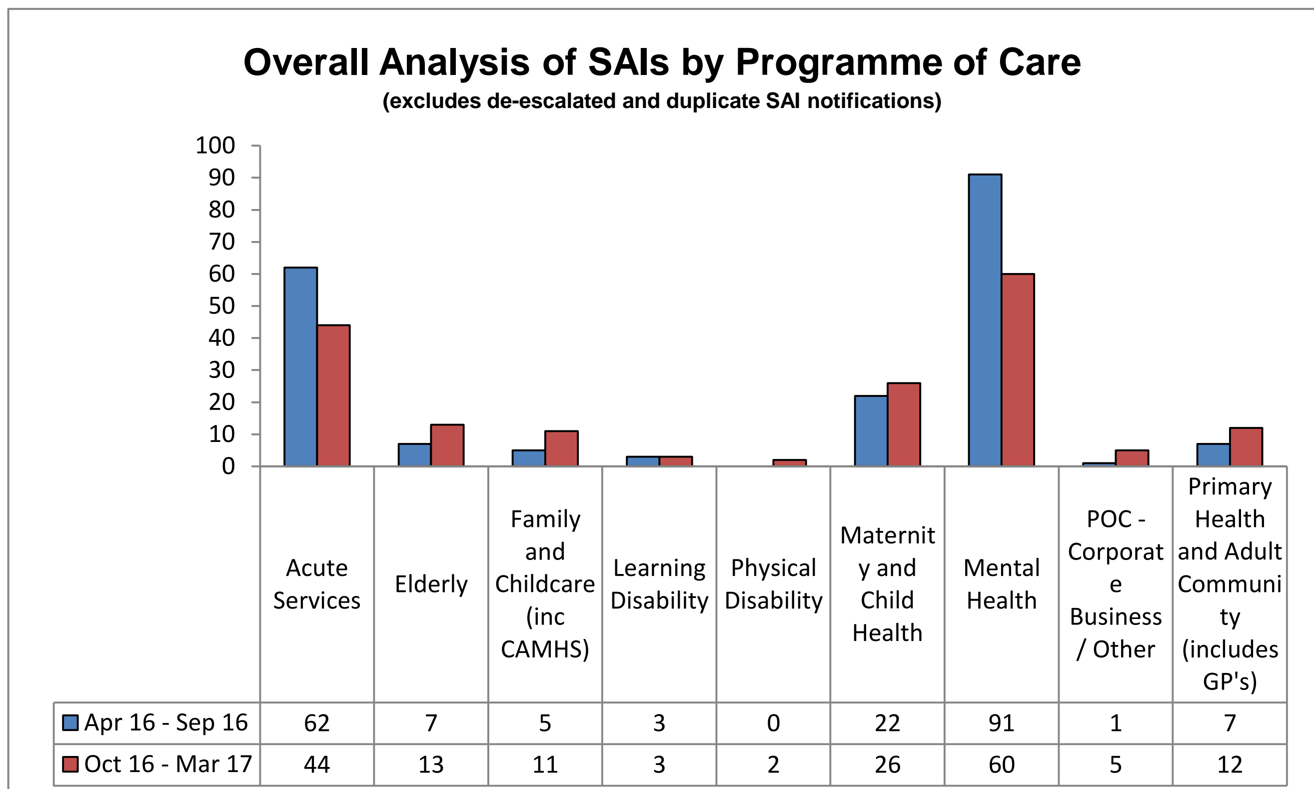
A notification may be received from one or more organisation but relating to the same incident. During the reporting period no duplicate SAI notifications were received.

## SAI ANALYSIS BY PROGRAMME OF CARE

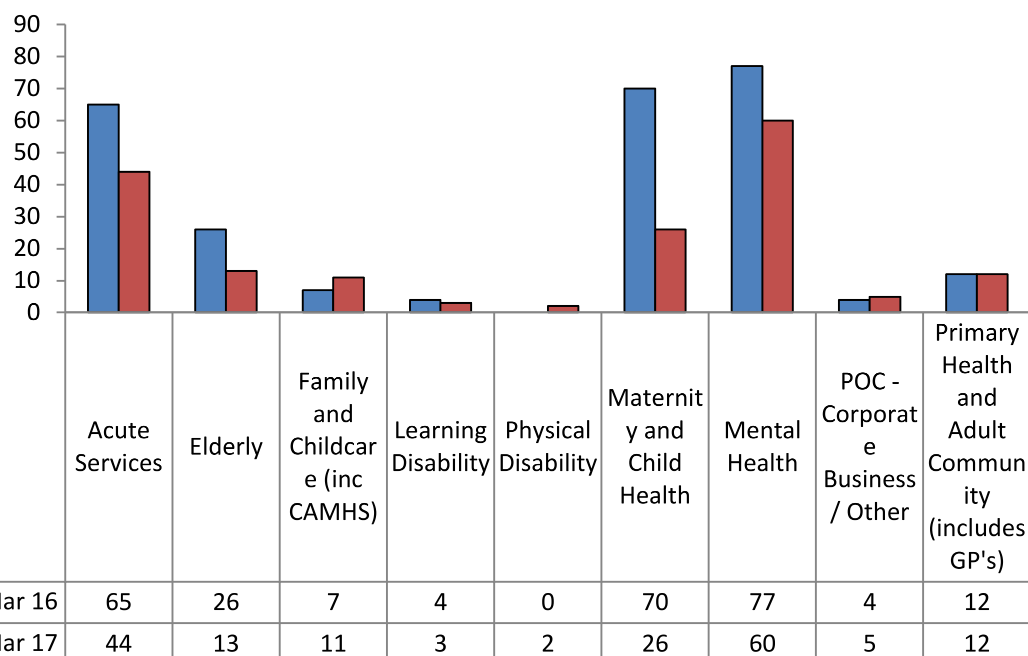
SAIs are categorised by Programmes of Care as follows:

- Mental Health
- Acute Services
- Family and Child Care
- Learning Disability
- Corporate Business / other
- Maternity and Child Health
- Primary Health and Adult Community (Including General Practice)
- Elderly
- Physical Disability and Sensory Impairment
- Health Promotion and Disease Prevention

De-escalated and duplicate SAI notifications have been **excluded** from the analysis in the remainder of this report.




| | Acute Services | Elderly | Family and Childcare (inc CAMHS) | Learning Disability | Physical Disability | Maternity and Child Health | Mental Health | POC - Corporate Business / Other | Primary Health and Adult Community (includes GP's) |
|---|---|---|---|---|---|---|---|---|---|
| Apr 16 - Sep 16 | 62 | 7 | 5 | 3 | 0 | 22 | 91 | 1 | 7 |
| Oct 16 - Mar 17 | 44 | 13 | 11 | 3 | 2 | 26 | 60 | 5 | 12 |




| | Acute Services | Elderly | Family and Childcare (inc CAMHS) | Learning Disability | Physical Disability | Maternity and Child Health | Mental Health | POC - Corporate Business / Other | Primary Health and Adult Community (includes GP's) |
|---|---|---|---|---|---|---|---|---|---|
| Oct 15 - Mar 16 | 65 | 26 | 7 | 4 | 0 | 70 | 77 | 4 | 12 |
| Oct 16 - Mar 17 | 44 | 13 | 11 | 3 | 2 | 26 | 60 | 5 | 12 |

## *ACUTE SERVICES*

| ORGANISATION | Oct 15 – Mar 16 | Apr 16 - Sep 16 | Oct 16 - Mar 17 |
|---|---|---|---|
| **BHSCT** | 21 | 20 | 15 |
| **NHSCT** | 7 | 11 | 6 |
| **NIAS** | 0 | 2 | 1 |
| **SEHSCT** | 6 | 4 | 8 |
| **SHSCT** | 14 | 7 | 4 |
| **WHSCT** | 17 | 18 | 10 |
| **Totals:** | **65** | **62** | **44** |

**Current period:** Forty-four (44) SAIs were reported. The top four groups related to the following classifications/categories. Ten (10) incidents being the most reported in any one category.

**Classification/category**

- Diagnosis failed or delayed
- Medication
- Implementation of care or ongoing monitoring/review
- Accident that may result in personal injury

## *MATERNITY & CHILD HEALTH*

| ORGANISATION | Oct 15 – Mar 16 | Apr 16 - Sep 16 | Oct 16 - Mar 17 |
|---|---|---|---|
| BHSCT | 30 | 15 | 14 |
| NHSCT | 5 | 0 | 6 |
| SEHSCT | 8 | 2 | 4 |
| SHSCT | 17 | 2 | 1 |
| WHSCT | 10 | 3 | 1 |
| **Totals:** | **70** | **22** | **26** |

**Current period:** Twenty-six (26) SAIs relating to maternity and child health were reported.

The overall reduction, in the number of cases for this programme, can be directly related to the revised child death review process which became effective from 1 February 2016.

## *FAMILY & CHILD CARE*

| ORGANISATION | Oct 15 – Mar 16 | Apr 16 - Sep 16 | Oct 16 - Mar 17 |
|---|---|---|---|
| BHSCT | 1 | 2 | 4 |
| NHSCT | 2 | 1 | 1 |
| SEHSCT | 3 | 1 | 2 |
| SHSCT | 0 | 1 | 2 |
| WHSCT | 1 | 0 | 2 |
| **Totals:** | **7** | **5** | **11** |

**Current period:** Eleven (11) SAIs relating to family and childcare were reported. The largest classification/category group (n=10) related to 'Abusive, violent, disruptive or self-harming behaviour'.

## *OLDER PEOPLE SERVICES*

| ORGANISATION | Oct 15 – Mar 16 | Apr 16 - Sep 16 | Oct 16 - Mar 17 |
|---|---|---|---|
| BHSCT | 2 | 0 | 1 |
| NHSCT | 1 | 2 | 3 |
| SEHSCT | 7 | 2 | 8 |
| SHSCT | 14 | 1 | 1 |
| WHSCT | 2 | 2 | 0 |
| **Totals:** | **26** | **7** | **13** |

**Current period:** Thirteen (13) SAIs reported related to older people services. The largest classification/category group (n=5) related to slips, trips, falls and collisions.

## *MENTAL HEALTH*

| ORGANISATION | Oct 15 – Mar 16 | Apr 16 - Sep 16 | Oct 16 - Mar 17 |
|---|---|---|---|
| BHSCT | 15 | 16 | 11 |
| HSCB | 1 | | 0 |
| NHSCT | 20 | 25 | 16 |
| SEHSCT | 24 | 24 | 14 |
| SHSCT | 10 | 17 | 9 |
| WHSCT | 7 | 9 | 10 |
| **Totals:** | **77** | **91** | **60** |

**Current period:** Sixty (60) SAIs relating to adult mental health services were reported. 72% (n=43) related to suspected / attempted suicides* or unexpected deaths.

**Suspected suicide – suicide (completed) whether suspected or proven. It should be noted that in the absence of knowledge of the inquest verdict, all of these cases have been classified as "suspected suicides" regardless of the circumstances in which the individual was reported to have been found.*

## *LEARNING DISABILITY SERVICES*

| ORGANISATION | Oct 15 – Mar 16 | Apr 16 - Sep 16 | Oct 16 - Mar 17 |
|---|---|---|---|
| BHSCT | 1 | 0 | 1 |
| NHSCT | 2 | 0 | 1 |
| SEHSCT | 0 | 1 | 1 |
| SHSCT | 0 | 2 | 0 |
| WHSCT | 1 | 0 | 0 |
| **Totals:** | **4** | **3** | **3** |

**Current period:** Three (3) SAIs relating to learning disability services were reported.

## *PHYSICAL DISABILITY AND SENSORY IMPAIRMENT*

| ORGANISATION | Oct 15 – Mar 16 | Apr 16 - Sep 16 | Oct 16 - Mar 17 |
|---|---|---|---|
| NHSCT | 0 | 0 | 1 |
| SEHSCT | 0 | 0 | 1 |
| **Totals:** | **0** | **0** | **2** |

**Current period:** Two (2) SAIs were reported relating to physical disability and sensory impairment.

## *PRIMARY HEALTH AND ADULT COMMUNITY (INC. GENERAL PRACTICE)*

| ORGANISATION | Oct 15 – Mar 16 | Apr 16 - Sep 16 | Oct 16 - Mar 17 |
|---|---|---|---|
| PCARE | 11 | 7 | 11 |
| SEHSCT | 1 | | 1 |
| **Totals:** | **12** | **7** | **12** |

**Current period:** Twelve (12) SAIs relating to Primary Health and Adult Community were reported. The largest classification/category group (n=6) was 'Medication'.

## *CORPORATE BUSINESS*

| ORGANISATION | Oct 15 – Mar 16 | Apr 16 - Sep 16 | Oct 16 - Mar 17 |
|---|---|---|---|
| BHSCT | 0 | 0 | 3 |
| NHSCT | 1 | 0 | 1 |
| SEHSCT | 2 | 0 | 0 |
| PHA | 0 | | 1 |
| WHSCT | 1 | 1 | 0 |
| **Totals:** | **4** | **1** | **5** |

**Current period:** Five (5) SAIs were reported relating to corporate business.

## *HEALTH PROMOTION AND DISEASE PREVENTION*

No reported incidents

**APPENDIX C**

## Analysis of Checklists RECEIVED 1 October 2016 to 31 March 2017

| **Table 1a - Analysis of Engagement with service user/ family/carer** | **BHSCT** | | **NHSCT** | | **NIAS** | | **SEHSCT** | | **SHSCT** | | **WHSCT** | | **TOTAL** | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Checklists received** | **48** | **100%** | **35** | **100%** | **0** | **0%** | **38** | **100%** | **24** | **100%** | **16** | **100%** | **161** | **100%** |
| Patient/Service User/Family **informed** incident was being reviewed as an SAI | 39 | 81% | 31 | 89% | 0 | 0% | 27 | 71% | 22 | 92% | 14 | 88% | 133 | 83% |
| Service User/Family **not informed** incident was being reviewed as an SAI | 9 | 19% | 4 | 11% | 0 | 0% | 11 | 29% | 2 | 8% | 2 | 13% | 28 | 17% |

| **Table 1b - Analysis of Rationale for service user/ family/carer not informed that incident was being reviewed as an SAI** | **BHSCT** | | **NHSCT** | | **NIAS** | | **SEHSCT** | | **SHSCT** | | **WHSCT** | | **TOTAL** | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Not informed** | **9** | **100.0%** | **4** | **100.0%** | **0** | **0%** | **11** | **100.0%** | **2** | **100.0%** | **2** | **100.0%** | **28** | **100.0%** |
| Impact on health/safety /security and/or wellbeing | 4 | 44.4% | 2 | 50.0% | 0 | 0% | 4 | 36.4% | 1 | 50.0% | 0 | 0.0% | 11 | 39.3% |
| Involves suspected /actual abuse by family | 0 | 0.0% | 0 | 0.0% | 0 | 0% | 0 | 0.0% | 1 | 50.0% | 0 | 0.0% | 1 | 3.6% |
| No NOK or contact details | 2 | 22.2% | 1 | 25.0% | 0 | 0% | 3 | 27.3% | 0 | 0.0% | 2 | 100.0% | 8 | 28.6% |
| Not applicable | 0 | 0.0% | 0 | 0.0% | 0 | 0% | 1 | 9.1% | 0 | 0.0% | 0 | 0.0% | 1 | 3.6% |
| Other rationale provided | 3 | 33.3% | 1 | 25.0% | 0 | 0% | 3 | 27.3% | 0 | 0.0% | 0 | 0.0% | 7 | 25.0% |

| Table 2a - Analysis of SEA/ RCA Reports shared/not shared | BHSCT | | NHSCT | | NIAS | | SEHSCT | | SHSCT | | WHSCT | | TOTAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Checklists received** | **48** | **100.0%** | **35** | **100.0%** | **0** | **0%** | **38** | **100.0%** | **24** | **100.0%** | **16** | **100.0%** | **161** | **100.0%** |
| SEA/RCA Report shared | 11 | 22.9% | 16 | 45.7% | 0 | 0% | 16 | 42.1% | 8 | 33.3% | 8 | 50.0% | **59** | **36.6%** |
| SEA/RCA Report **not** shared | 37 | 77.1% | 19 | 54.3% | 0 | 0% | 22 | 57.9% | 16 | 66.7% | 8 | 50.0% | **102** | **63.4%** |

| Table 2b - Analysis of SEA/RCA Reports not shared | BHSCT | | NHSCT | | NIAS | | SEHSCT | | SHSCT | | WHSCT | | TOTAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Report not shared** | **37** | **100.0%** | **19** | **100.0%** | **0** | **0%** | **22** | **100.0%** | **16** | **100.0%** | **8** | **100.0%** | **102** | **100.0%** |
| Family participated - Declined RR | 0 | 0.0% | | 0.0% | 0 | 0% | | 0.0% | 1 | 6.3% | 2 | 25.0% | **3** | **2.9%** |
| Family withdrew | 0 | 0.0% | 2 | 10.5% | 0 | 0% | 3 | 13.6% | 0 | 0.0% | 1 | 12.5% | **6** | **5.9%** |
| Final Review Report to be shared with SU/FAM | 28 | 75.7% | 5 | 26.3% | 0 | 0% | 5 | 22.7% | 11 | 68.8% | 1 | 12.5% | **50** | **49.0%** |
| Impact on health/safety/ security and/or wellbeing | 3 | 8.1% | 2 | 10.5% | 0 | 0% | 4 | 18.2% | 2 | 12.5% | 0 | 0.0% | **11** | **10.8%** |
| Involves suspected /actual abuse by family | 0 | 0.0% | 1 | 5.3% | 0 | 0% | | 0.0% | 1 | 6.3% | 0 | 0.0% | **2** | **2.0%** |
| No NOK or contact details | 3 | 8.1% | 1 | 5.3% | 0 | 0% | 3 | 13.6% | 0 | 0.0% | 2 | 25.0% | **9** | **8.8%** |
| No response to correspondence | 1 | 2.7% | 4 | 21.1% | 0 | 0% | 1 | 4.5% | 1 | 6.3% | 2 | 25.0% | **9** | **8.8%** |
| Other rationale provided | 0 | 0.0% | 1 | 5.3% | 0 | 0% | 3 | 13.6% | 0 | 0.0% | 0 | 0.0% | **4** | **3.9%** |
| Review Report discussed with SU/FAM | 2 | 5.4% | 3 | 15.8% | 0 | 0% | 3 | 13.6% | 0 | 0.0% | 0 | 0.0% | **8** | **7.8%** |

| Table 2b - Analysis of SEA/RCA Reports not shared | BHSCT | NHSCT | NIAS | SEHSCT | SHSCT | WHSCT | TOTAL |
|---|---|---|---|---|---|---|---|
| **NOTE: The data recorded in the above tables are reported from a 'live' database and will be subject to change following planned/further engagement** | | | | | | | |

## APPENDIX D

## UPDATE USER ENGAGMENT INFORMATION PREVIOUSLY REPORTED

**PERIOD 1 APRIL 2016 to 30 SEPTEMBER 2016 – POSITION AS REPORTED IN HSCB-PHA SAI Learning Report – Edition 11**

| Analysis of SEA/ RCA Reports shared/not shared | BHSCT | | NHSCT | | NIAS | | SEHSCT | | SHSCT | | WHSCT | | TOTAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Checklists received** | **50** | **100.0%** | **41** | **100.0%** | **1** | **100.0%** | **40** | **100.0%** | **49** | **100.0%** | **37** | **100.0%** | **218** | **100.0%** |
| SEA/RCA Report shared | 14 | 28.0% | 12 | 29.3% | 0 | 0.0% | 10 | 25.0% | 12 | 24.5% | 19 | 51.4% | **67** | **30.7%** |
| SEA/RCA Report **not** shared | 36 | 72.0% | 29 | 70.7% | 1 | 100.0% | 30 | 75.0% | 37 | 75.5% | 18 | 48.6% | **151** | **69.3%** |

**PERIOD 1 APRIL 2016 to 30 SEPTEMBER 2016 – UPDATED POSITION**

| Analysis of SEA/ RCA Reports shared/not shared | BHSCT | | NHSCT | | NIAS | | SEHSCT | | SHSCT | | WHSCT | | TOTAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Checklists received** | **50** | **100.0%** | **41** | **100.0%** | **1** | **100.0%** | **40** | **100.0%** | **49** | **100.0%** | **37** | **100.0%** | **218** | **100%** |
| SEA/RCA Report shared | 27 | 54% | 24 | 59% | | 0% | 17 | 43% | 35 | 71% | 22 | 59% | **125** | **57%** |
| SEA/RCA Report **not** shared | 23 | 46% | 17 | 41% | 1 | 100% | 23 | 58% | 14 | 29% | 15 | 41% | **93** | **43%** |

**NOTE: The data recorded in the above tables are reported from a 'live' database and will be subject to change following planned/further engagement**