Health and Social Care Board

Public Health Agency

# Learning Report

# Serious Adverse Incidents

## April - September 2017

## December 2017

**CONTENTS**

# 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 SAIs REPORTED DURING PERIOD APR - SEPT 2017

During the period 1 April to 30 September 2017, the HSCB received 186 SAI notifications. This represents an overall increase on the previous six months (Oct 2016 to Mar 17) when 180 SAI notifications were reported to the HSCB. Appendix B provides breakdown of SAIs by reporting organisation and programme of care.

## 4.0 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 seven (7) SAI notifications received were de-escalated/ withdrawn.

## 5.0 SAI NEVER EVENTS

DoH circular HSC (SQSD) 56/16 (Never Events), introduced a never events process based on the NHS England list of never events. Information relating to these events are captured as part of the SAI process. During the reporting period seven (7) SAI notifications received which were classified as never events.

## 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. The process to identify learning from SAIs is also supported by a range of professional groups which have been developed for the following programmes.

- Paediatrics and Child Health
- Maternity
- Mental Health
- Acute
- Integrated Care
- Adult Services
- Children's Services
- Corporate Services

- **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

- **Regional Links**

Governance Officers from the HSCB, the PHA and the six HSC Trusts, meet on a bi-annual basis to share experiences, best practice and to consult on a range of issues in relation to the reporting and follow up of SAIs across the HSC.

***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:*

### REMINDER OF BEST PRACTICE GUIDANCE (SQR):

- **SQR/SAI/2016/026** (Acute) Reducing the risk of throat packs being retained after surgery
- **SQR/SAI/2016/027** (MCH and PHC) How to Examine Newborns for Red Reflexes
- **SQR/SAI/2016/028** (Acute) Blood Transfusion and the risk of Transfusion-Associated Circulatory Overload (TACO)
- **SQR-SAI-2017-029 (**Acute and Primary Healthcare) - Acute Management of diarrhoea related to cancer treatment

### PROFESSIONAL LETTERS:

- **PL/2017/015 -** Serious Adverse Incident Investigation: Professional Issues Highlighted

**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:

- Following a SAI related to cervical screening, learning has been shared and a number of actions have been taken to embed lessons learned in practice and safety and quality of care:
    - A professional letter was issued in December 2015 (ICPL / 2015 / 010) to practices
    - NI Training and Audit Requirements for Cervical Smear Takers issued May 2016

- Northern Ireland Standards for Nurse and Midwife Education Providers: Cervical Screening Sample Taking issued Dec 2016
- Reporting Recommendations for cervical cytology issued by the various laboratories in August 2016
- HSCB is updating the Audit of Abnormal Smear Follow Up in General Practice

- In July 2015, The Medicines Regulatory Group (DoH) was undertaking routine community pharmacy inspections and noted an unusually high number of private prescriptions being dispensed for 'Z' drugs (controlled drugs prescribed for insomnia). This is not considered to be normal practice and is contrary to HSCB advice. The following learning has been identified and shared:

  - Early learning letter issued to community pharmacies and GPs across the primary care system - April 2016
  - Professional letter issued to all GP practices, GPs and sessional doctors – Private Prescriptions for HSC patients – Regulatory Investigation – 05 April 2016
  - Professional letter issued to community pharmacists: Supply of Controlled Drugs – Responsibilities for Dispensing – 5th April 2016
  - Professional letter issued to all locums employed at practices involved since 2011, outlining their contractual and ethical responsibilities for the treatment of patients under health service arrangements.
  - GMS Newsletter article regarding learning relating to GP locum signatures

  http://primarycare.hscni.net/download/DocLibrary/GMS/GMS%20newsletter/GMS-Update-summer-2017.pdf

- A number of SAIs have been reported whereby prisoners on medication continue to have their prescriptions dispensed in the community. The issue has been referred to the SEHSCT Prison Health Workstream and work is ongoing.

  - GMS Newsletter article – Spring 2017: Prescription Fraud while a patient is detained in prison. Practices were advised to mindful of the importance of under-ordering as well as over-ordering as a sign of possible fraudulent activity and to undertake regular medication reviews for patients on medication prone to abuse. Checking the photo ID of persons collecting scripts who are not the patient was also suggested.
    http://primarycare.hscni.net/download/DocLibrary/GMS/GMS%20newsletter/GMS-Update-spring-2017.pdf

- An incident occurred where a patient was prescribed Oramorph concentrated solution (20mg/ml). The pharmacy label stated 20mg as required for the pain. The label was inadvertently read as 20ml which was given in the evening. The following morning the district nurse was concerned about the patient and called the GP who administered naloxone (opioid reversal agent) with good effect. The following learning was shared:

- Article in NI Medicines Management Newsletter – February 2016
- Referral to HSC Safety Forum for consideration at 2017 SAI Learning Event

- Learning was shared with all GPs in the GMS newsletter (Spring 2017) following an SAI review regarding warfarin management and patients with labile INRs. This included:

  - Ensuring that all INR results and warfarin doses are logged onto Computer Decision Support Software, including GP Out of Hours and other sources.
  - Avoiding INR sampling on Fridays unless absolutely necessary to facilitate practice results interpretation and follow-up.
  - Checking INR 3-7 days following commencement of a drug where there is a possibility of drug interaction.
  - Avoidance of Miconazole gel for patients on warfarin; http://primarycare.hscni.net/download/DocLibrary/GMS/GMS%20newsletter/GMS-Update-spring-2017.pdf

- GP learning regarding information governance and information security was shared with GP practices as a follow-up to an SAI review involving an information breach.
  http://primarycare.hscni.net/download/DocLibrary/GMS/GMS%20newsletter/GMS-Update-spring-2017.pdf

- An HSCB Learning Letter was issued to all GPs and community pharmacies following an SAI Review and a Coroner's Case involving the unexpected death of a patient prescribed morphine – August 2017.
  http://primarycare.hscni.net/download/DocLibrary/uncategorised/HSCB-letter-Re-Learning-arising-from-the-unexpected-sudden-death-of-a-patient-prescribed-morphine-310817.pdf

- GP learning and guidance relating to the prescribing drugs of addiction was issued - NI Medicines Management newsletter - September 2017 Volume 8, Issue 9
  http://niformulary.hscni.net/PrescribingNewsletters/PDF/NIMM_2017/NIMM_NewsletterVol8Issue9Sep17.pdf

**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 next publication (Edition 7) will be a Special Edition for Regulated Services, it will be issued in the coming months and will cover the following topics:

- Management of Insulin
- Dependent Diabetes in Nursing Homes
- Denture Care Caution with meal packaging
- Equipment related issues
- Falls in Nursing and Residential Homes
- Security at Care Homes

Previous editions of the newsletter can be viewed at:
http://www.publichealthagency.org/publications/learning-matters-newsletters

Edition 8 is currently being produced.

## 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 ensuring 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
- Regional NIMATS (*maternity information system*) Steering Group
- NICaN Haematology Clinical Reference Group
- Regional Group on Specialist Medicines (*a sub group of HSCB Medicines Management Forum*)
- Counter Fraud and Probity Unit
- Diabetic Foot Team
- Prison Healthcare Group

- Modernising Radiology Clinical Network (MRCN)
- Networks - Vascular / Trauma / Pathology / Radiology
- Scheduled Care Programme Board
- Regional Medicines Safety Group
- Regional Information Governance Advisory Group
- Emergency Department Clinical Group

## ANTICOAGULANTS AND/OR ANTIPLATELETS

A regional task and finish group, with provider organisations, has been 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. This report will be circulated in the coming months.

## 2.0 SAI LEARNING EVENTS

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

The third Annual Regional SAI Learning Event was held on Tuesday 23 May 2017 at Mossley Mill. The event provided an opportunity to share and learn from SAIs in health and social care and progress a regional approach to reviews and learning.

There was a parallel workshop approach, at the event, relating to the following work streams: Acute Services, Maternity Services, Mental Health and Social Care, Primary and Community Care and on issues with a high regional profile such as severe sepsis, unrecognised deterioration, anticoagulant and antiplatelet and poor communication/teamwork.

- ***MENTAL HEALTH 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 held a workshop on 23 October 2017 to review the Transfer of Patients' protocol and share the learning; the revised protocol will be amended and issued to the service in November 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 April 2017 to September 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, four learning letters/reminders of best practice and one professional letter have been disseminated to the relevant HSC organisations. The next “Learning Matters” newsletter will be a special edition for regulated services and will be issued in the coming months and a further generic edition is currently being produced, 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;

[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 APRIL – SEPTEMBER 2017

The HSCB has **received 186 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 October to March and
- for the same reporting period (year on year) April to September

| TOTAL ACTIVITY | Apr 16 - Sep 16 | Oct 16 - Mar 17 | Apr 17 - Sep 17 |
|---|---|---|---|
| **BHSCT** | 53 | 49 | 39 |
| **HSCB** | 0 | 0 | 2 |
| **BSO** | 0 | 0 | 0 |
| **NHSCT** | 40 | 36 | 28 |
| **NIAS** | 2 | 1 | 3 |
| **PCARE** | 7 | 11 | 9 |
| **PHA** | 0 | 1 | 1 |
| **SEHSCT** | 34 | 40 | 46 |
| **SHSCT** | 30 | 18 | 31 |
| **WHSCT** | 34 | 24 | 27 |
| **Totals:** | **200** | **180** | **186** |

**Table 1**

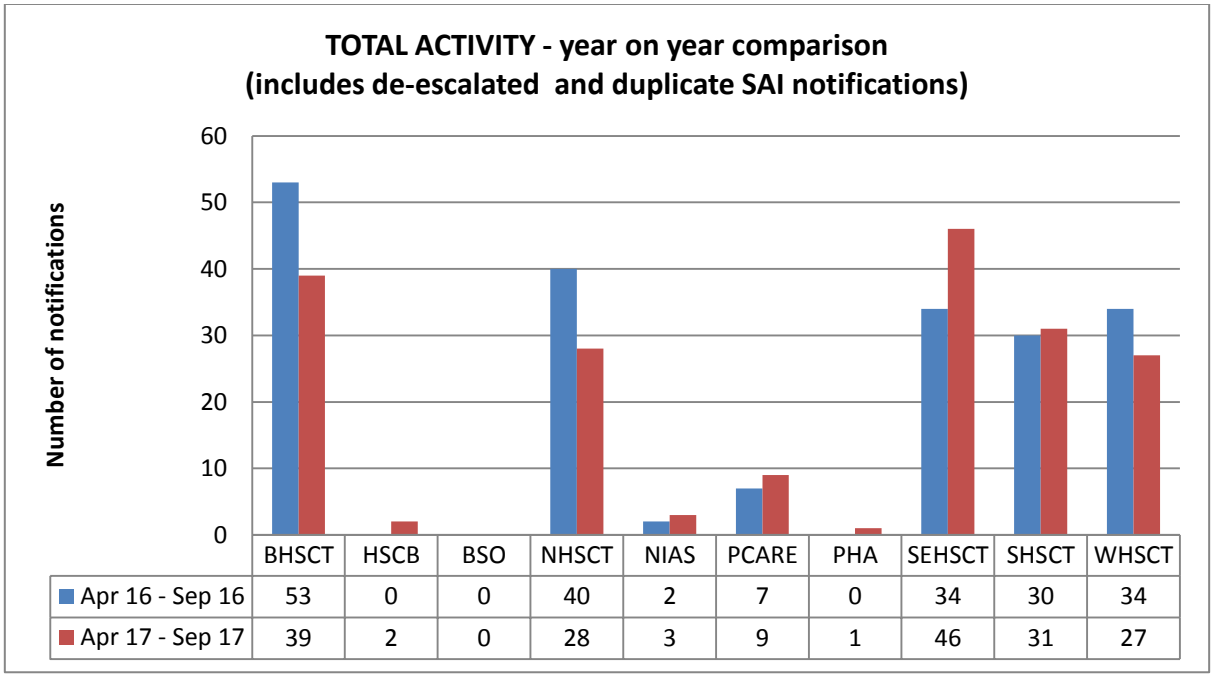
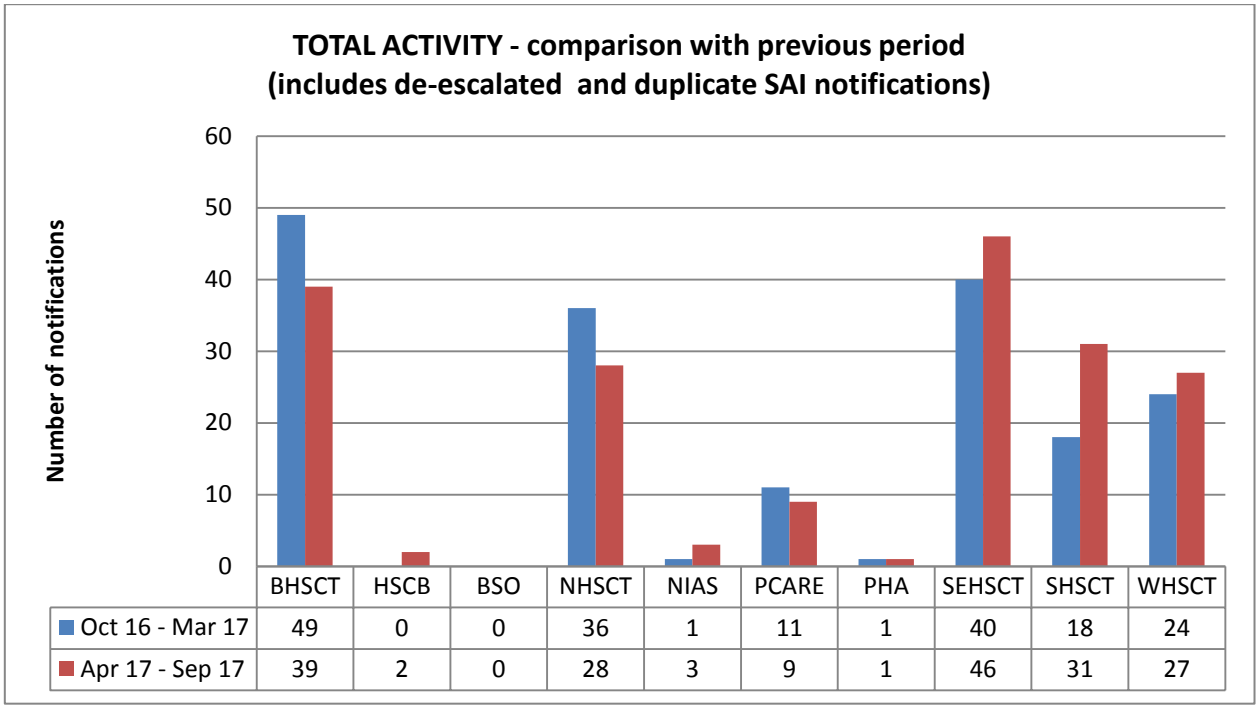



**Chart 1**

[2] Source- HSCB DATIX Information System




| | BHSCT | HSCB | BSO | NHSCT | NIAS | PCARE | PHA | SEHSCT | SHSCT | WHSCT |
|---|---|---|---|---|---|---|---|---|---|---|
| Oct 16 - Mar 17 | 49 | 0 | 0 | 36 | 1 | 11 | 1 | 40 | 18 | 24 |
| Apr 17 - Sep 17 | 39 | 2 | 0 | 28 | 3 | 9 | 1 | 46 | 31 | 27 |

**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 **seven (7) SAI notifications** received were subsequently **de-escalated/withdrawn**.

| TOTAL DE-ESCALATED/WITHDRAWN | Apr 16 - Sep 16 | Oct 16 - Mar 17 | Apr 17 - Sep 17 |
|---|---|---|---|
| **BHSCT** | 0 | 0 | 1 |
| **NHSCT** | 0 | 1 | 1 |
| **NIAS** | 0 | 0 | 1 |
| **PCARE** | 0 | 0 | 1 |
| **SEHSCT** | 0 | 0 | 3 |
| **WHSCT** | 1 | 0 | 0 |
| **Totals:** | **1** | **1** | **7** |

## 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.

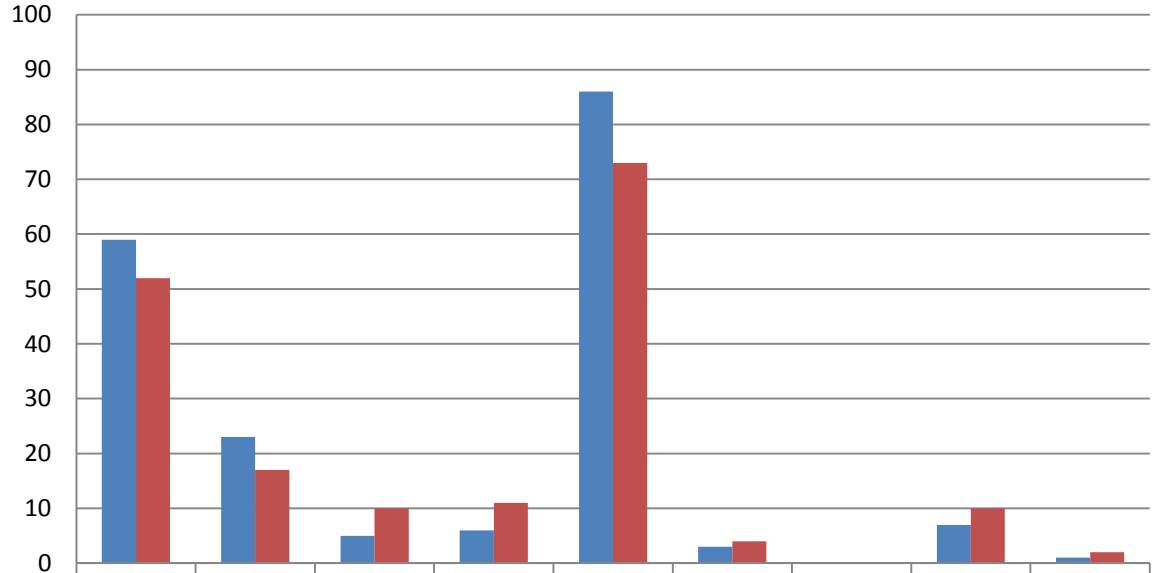
## SAI ANALYSIS BY PROGRAMME OF CARE

SAIs are categorised by Programmes of Care as follows:

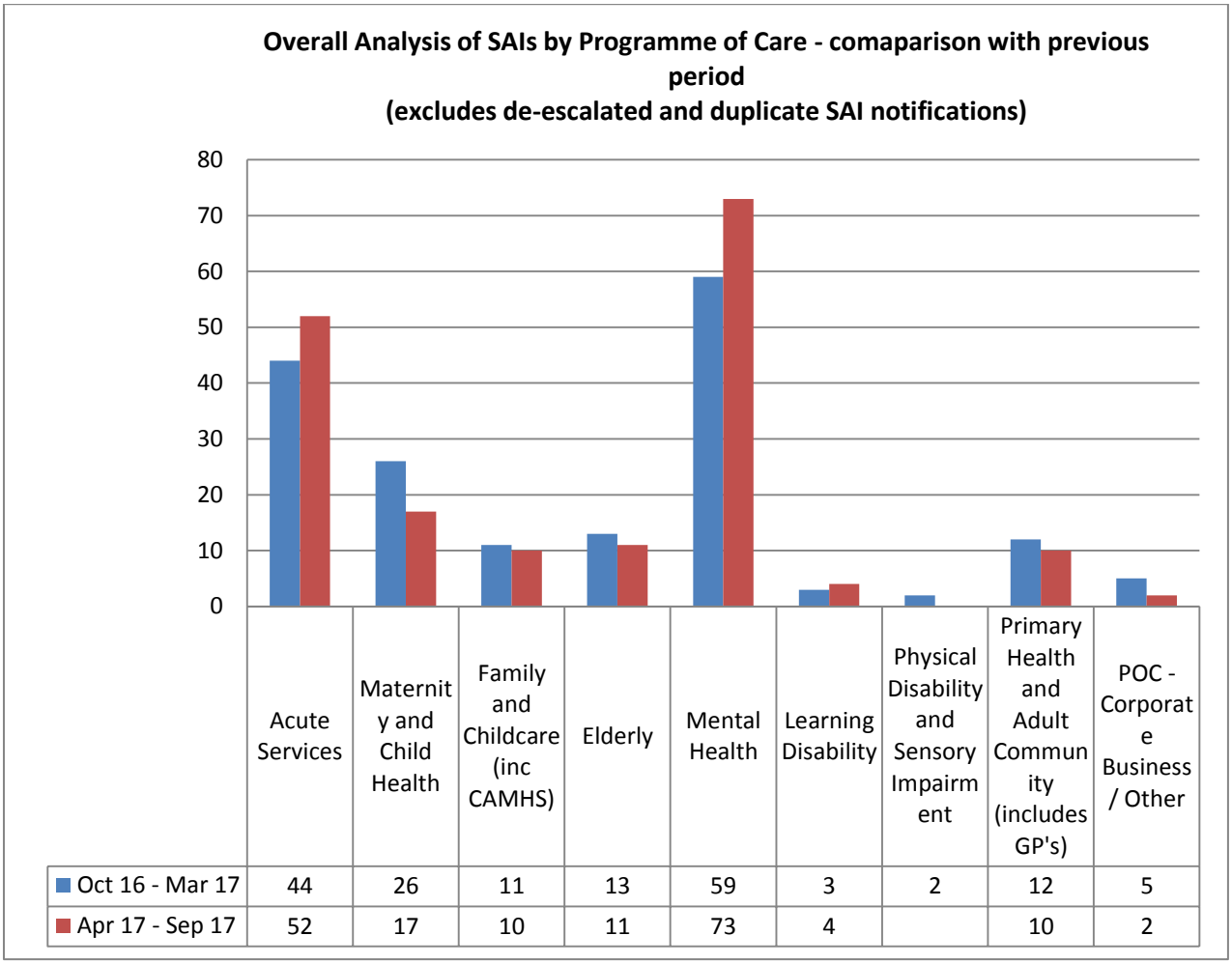
- Mental Health
- Acute Services
- Family and Child Care
- Learning Disability
- Corporate Business / other
- Maternity and Child Health
- Primary Health and Adult Community (Including General Practice)
- Elderly
- Physical Disability and Sensory Impairment
- Health Promotion and Disease Prevention

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

**Overall Analysis of SAIs by Programme of Care - year on year comaparison (excludes de-escalated and duplicate SAI notifications)**




| | Acute Services | Maternity and Child Health | Family and Childcare (inc CAMHS) | Elderly | Mental Health | Learning Disability | Physical Disability and Sensory Impairment | Primary Health and Adult Community (includes GP's) | POC - Corporate Business / Other |
|---|---|---|---|---|---|---|---|---|---|
| Apr 16 - Sep 16 | 59 | 23 | 5 | 6 | 86 | 3 | | 7 | 1 |
| Apr 17 - Sep 17 | 52 | 17 | 10 | 11 | 73 | 4 | | 10 | 2 |




## *ACUTE SERVICES*

| ORGANISATION | Apr 16 - Sep 16 | Oct 16 - Mar 17 | Apr 17- Sep 17 |
|---|---|---|---|
| **BHSCT** | 20 | 15 | 16 |
| **HSCB** | 0 | 0 | 1 |
| **NHSCT** | 11 | 6 | 3 |
| **NIAS** | 2 | 1 | 2 |
| **SEHSCT** | 4 | 8 | 5 |
| **SHSCT** | 7 | 4 | 7 |
| **WHSCT** | 18 | 10 | 15 |
| **Totals:** | **62** | **44** | **49** |

**Current period:** Forty-nine (49) SAIs were reported. The top four groups related to the following classifications/categories. Eleven (11) incidents being the most reported in any one category.

**Classification/category**

- Diagnosis failed or delayed
- Access, Appointment, Admission, Transfer, Discharge
- Medication
- Treatment, procedure

## *MATERNITY & CHILD HEALTH*

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

**Current period:** Fifteen (15) SAIs relating to maternity and child health were reported. The largest classification/category group (n=5) related to Labour/Delivery

## *FAMILY & CHILD CARE*

| ORGANISATION | Apr 16 - Sep 16 | Oct 16 - Mar 17 | Apr 17 - Sep 17 |
|---|---|---|---|
| **BHSCT** | 2 | 4 | 1 |
| **NHSCT** | 1 | 1 | 2 |
| **SEHSCT** | 1 | 2 | 2 |
| **SHSCT** | 1 | 2 | 3 |
| **WHSCT** | 0 | 2 | 1 |
| **Totals:** | **5** | **11** | **9** |

**Current period:** Nine (9) SAIs relating to family and childcare were reported. The largest classification/category group (n=7) related to 'Abusive, violent, disruptive or self-harming behaviour'.

## *OLDER PEOPLE SERVICES*

| ORGANISATION | Apr 16 - Sep 16 | Oct 16 - Mar 17 | Apr 17 - Sep 17 |
|---|---|---|---|
| **BHSCT** | 0 | 1 | 1 |
| **NHSCT** | 2 | 3 | 4 |
| **SEHSCT** | 2 | 8 | 2 |
| **SHSCT** | 1 | 1 | 3 |
| **WHSCT** | 2 | 0 | 1 |
| **Totals:** | **7** | **13** | **11** |

**Current period:** Eleven (11) SAIs reported related to older people services. The largest classification/category group (n=3) related to slips, trips, falls and collisions.

## *MENTAL HEALTH*

| ORGANISATION | Apr 16 - Sep 16 | Oct 16 - Mar 17 | Apr 17- Sep 17 |
|---|---|---|---|
| **BHSCT** | 16 | 11 | 12 |
| **HSCB** | 0 | 0 | 0 |
| **NHSCT** | 25 | 16 | 14 |
| **PHA** | 0 | 0 | 1 |
| **SEHSCT** | 24 | 14 | 29 |
| **SHSCT** | 17 | 9 | 11 |
| **WHSCT** | 9 | 10 | 6 |
| **Totals:** | **91** | **60** | **73** |

**Current period:** Seventy three (73) SAIs relating to adult mental health services were reported. 68% (n=50) related to suicide (completed), whether proven or suspected

**Suspected suicide or 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 | Apr 16 - Sep 16 | Oct 16 - Mar 17 | Apr 17 - Sep 17 |
|---|---|---|---|
| **BHSCT** | 0 | 1 | 0 |
| **NHSCT** | 0 | 1 | 1 |
| **SEHSCT** | 1 | 1 | 1 |
| **SHSCT** | 2 | 0 | 2 |
| **WHSCT** | 0 | 0 | 0 |
| **Totals:** | **3** | **3** | **4** |

**Current period:** Four (4) SAIs relating to learning disability services were reported.

## *PHYSICAL DISABILITY AND SENSORY IMPAIRMENT*

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

**Current period:** There were no cases reported relating to physical disability and sensory impairment.

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

| ORGANISATION | Apr 16 - Sep 16 | Oct 16 - Mar 17 | Apr 17 - Sep 17 |
|---|---|---|---|
| **PCARE** | 7 | 11 | 2 |
| **SEHSCT** | | 1 | 7 |
| **Totals:** | **7** | **12** | **9** |

**Current period:** Nine (9) SAIs relating to Primary Health and Adult Community were reported. The largest classification/category group (n=7) was 'Medication'.

## *CORPORATE BUSINESS*

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

**Current period:** Two (2) SAIs were reported relating to corporate business.

## *HEALTH PROMOTION AND DISEASE PREVENTION*

No reported incidents

**APPENDIX C**

## Analysis of Checklists RECEIVED 1 APRIL – 30 SEPTEMER 2017

| Table 1a - Analysis of Engagement with service user/ family/carer | BHSCT | | NHSCT | | NIAS | | SEHSCT | | SHSCT | | WHSCT | | TOTAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Checklists received** | **38** | **100.0%** | **37** | **100.0%** | **1** | **100.0%** | **34** | **100.0%** | **24** | **100.0%** | **27** | **100.0%** | **161** | **100.0%** |
| Patient/Service User/Family **informed** incident was being reviewed as an SAI | 32 | 84.2% | 32 | 84.2% | 1 | 100.0% | 28 | 82.4% | 22 | 91.7% | 24 | 88.9% | 139 | 86.3% |
| Service User/Family **not informed** incident was being reviewed as an SAI | 6 | 15.8% | 5 | 15.8% | | 0.0% | 6 | 17.6% | 2 | 8.3% | 3 | 11.1% | 22 | 13.7% |

| 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** | **6** | **100.0%** | **5** | **100.0%** | | | **6** | **100.0%** | **2** | **100.0%** | **3** | **100.0%** | **22** | **100.0%** |
| Environmental/infrastructure related with no harm | 3 | 50.0% | | 0.0% | | | 1 | 16.7% | | 0.0% | | 0.0% | 4 | 18.2% |
| Impact on health/safety /security and/or wellbeing | | 0.0% | 2 | 40.0% | | | 3 | 50.0% | | 0.0% | 1 | 33.3% | 6 | 27.3% |
| No NOK or contact details | 1 | 16.7% | 3 | 60.0% | | | 1 | 16.7% | 1 | 50.0% | 1 | 33.3% | 7 | 31.8% |
| Other rationale provided | 2 | 33.3% | | 0.0% | | | 1 | 16.7% | 1 | 50.0% | 1 | 33.3% | 5 | 22.7% |

| Table 2a - Analysis of SEA/ RCA Reports shared/not shared | BHSCT | | NHSCT | | NIAS | | SEHSCT | | SHSCT | | WHSCT | | TOTAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Checklists received** | **38** | **100.0%** | **37** | **100.0%** | **1** | **100.0%** | **34** | **100.0%** | **24** | **100.0%** | **27** | **100.0%** | **161** | **100.0%** |
| SEA/RCA Report shared | **2** | **5.3%** | **12** | **32.4%** | | **0.0%** | **6** | **17.6%** | **13** | **54.2%** | **10** | **37.0%** | **43** | **26.7%** |
| SEA/RCA Report **not** shared | **36** | **94.7%** | **25** | **67.6%** | **1** | **100.0%** | **28** | **82.4%** | **11** | **45.8%** | **17** | **63.0%** | **118** | **73.3%** |

| Table 2b - Analysis of SEA/RCA Reports not shared | BHSCT | | NHSCT | | NIAS | | SEHSCT | | SHSCT | | WHSCT | | TOTAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| **Report not shared** | 36 | **100.0%** | **25** | **100.0%** | **1** | **100.0%** | **28** | **100.0%** | **11** | **100.0%** | **17** | **100.0%** | **118** | **100.0%** |
| Not applicable | 1 | 2.8% | | 0.0% | | 0.0% | | 0.0% | | 0.0% | | 0.0% | 1 | 0.8% |
| Draft Review Report shared with SU/FAM | | 0.0% | | 0.0% | | 0.0% | 2 | 7.1% | 1 | 9.1% | | 0.0% | 3 | 2.5% |
| Family participated - Declined RR | 1 | 2.8% | | 0.0% | | 0.0% | | 0.0% | | 0.0% | | 0.0% | 1 | 0.8% |
| Family withdrew | | 0.0% | | 0.0% | | 0.0% | 2 | 7.1% | | 0.0% | | 0.0% | 2 | 1.7% |
| Final Review Report to be shared with SU/FAM | 29 | 80.6% | 14 | 56.0% | 1 | 100.0% | 13 | 46.4% | 6 | 54.5% | 10 | 58.8% | 73 | 61.9% |
| Impact on health/safety/ security and/or wellbeing | 1 | 2.8% | 1 | 4.0% | | 0.0% | 5 | 17.9% | 1 | 9.1% | 1 | 5.9% | 9 | 7.6% |
| No NOK or contact details | 1 | 2.8% | 3 | 12.0% | | 0.0% | 1 | 3.6% | | 0.0% | 1 | 5.9% | 6 | 5.1% |
| No response to correspondence | | 0.0% | 4 | 16.0% | | 0.0% | 1 | 3.6% | 2 | 18.2% | 3 | 17.6% | 10 | 8.5% |
| Other rationale provided | 3 | 8.3% | | 0.0% | | 0.0% | 3 | 10.7% | 1 | 9.1% | 1 | 5.9% | 8 | 6.8% |

| Table 2b - Analysis of SEA/RCA Reports not shared | BHSCT | | NHSCT | | NIAS | | SEHSCT | | SHSCT | | WHSCT | | TOTAL | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| Review Report discussed with SU/FAM | | 0.0% | 3 | 12.0% | | 0.0% | 1 | 3.6% | | 0.0% | 1 | 5.9% | 5 | 4.2% |

**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 ON USER ENGAGMENT INFORMATION PREVIOUSLY REPORTED

**PERIOD 1 OCTOBER 2016 to 31 MARCH 2017 POSITION AS REPORTED IN HSCB-PHA SAI Learning Report – Edition 12**

| **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%** |

**PERIOD 1 OCTOBER 2016 to 31 MARCH 2017 – UPDATED POSITION**

| **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 | 33 | 68.8% | 19 | 54.3% | 0 | 0% | 20 | 52.6% | 16 | 66.7% | 9 | 56.3% | **97** | **60.2%** |
| SEA/RCA Report **not** shared | 15 | 31.3% | 16 | 45.7% | 0 | 0% | 18 | 47.4% | 8 | 33.3% | 7 | 43.8% | **64** | **39.8%** |

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