South East London Integrated Care System

NHS South East London

ICS Harms Monitoring Synnovis Pathology incident Primary Care & Community

SEL System Potential Harms Monitoring - Introduction

In response to the Synnovis Pathology Cyber-attack SEL ICB Incident Management Gold Command require a process for monitoring, identifying and responding to potential patient harm as a result of the ongoing service delivery impact.

This process will not replace individual organisations approach to managing harm within their services but aims to give a system overview.

Primary Care Clinicians will be expected to follow their current clinical processes for immediate escalation of individual patient clinical concerns.

SEL System Harm Review – Primary Care

A SEL System Harm Review will form part of the overall System Level 3 Critical Incident – Incident Review arrangements, which will comprise of two complimentary reviews related to the system level 3 critical incident will be undertaken across the SEL integrated care system led the ICB

A SEL System Harm Review Panel will be established to oversee the harm reviews.

It is anticipated that separate clinically led harm reviews will need to be undertaken at GSTT, KCH, LGT and in primary care. Harm reviews will need to consider both immediate and potential for longer term harm.

The following slides set out a suggested approach for undertaking a risk/harm review in primary care.

Objectives of a Risk/Harm Review in Primary Care

South East London Integrated Care System

- To establish whether risk of harm or actual harm, either immediate or longer term, has come to any patient in primary care, as a result of the Level 3 Critical Incident including:
  - risk or actual patient harm caused as a result of any delays to GP Direct Access flows (Consultant Connect – advice/guidance and electronic referrals)
  - risk or actual harm caused by failure of actions requested by GPs or other providers which may have adversely affected a patient's treatment pathway
  - risk or actual harm caused by Synnovis, GSTT, KCH services moving to a paper-based system
  - Risk or actual harm due to impact from reduced primary care capacity to manage switch to paper based systems and delayed processes

- The primary care risk of harm/actual harm review will
  - take a consistent approach to identifying the potential risk of harm using an agreed risk assessment tool
  - undertake an assessment of actual harm where risk assessment tool indicates this, using a sampling approach
  - use of the shared definitions of harm agreed by SEL Harm Review Panel
  - ensure actual harms are captured and feed into the overall SEL System Harm Review
  - identify learning for the system that will feed into the overall learning for the overall System Level 3 Critical Incident

Scope and Approach

The scope:

- The scope is limited to the level 3 critical incident that was declared due to the Cyber attack at Synnovis on Monday 3 June 2024.

The Approach:

- A Primary Care Risk/Harm Review Panel, will be established to:
  - review the risk of harm, scale and specific impact on primary care using the revised risk assessment tool
  - review the scale and specific impact of a move to paper based results/patient outcomes
  - review the scale and impact of delayed requests for tests/pathology
  - agree a methodology for sampling from each of the above, to identify risk of harm using the agreed Harm review definitions
  - where risk of harm is moderate or above, agree a harm review to establish actual patient harm
  - identify system learning, recommendations and actions to the SEL Gold Command

Patient Cohorts

The SEL Primary Care Risk/Harm reviews will include, but not be limited to, the following patient cohorts:

- risk of harm to patients in primary care due to the disruption of data flows in GP direct access
- risk of harm to patients as a result of the move to paper-based results and/or patient outcomes
- risk of harm to patients due to a delay in care caused by capacity in Synnovis during the Level 3 Incident

Outputs and Reporting

The Primary Care Risk Review Panel will :

- Provide assurance to the Gold Command that a comprehensive review of risk of harm/review of actual harm has been undertaken in primary care,
  - confirm that where required that appropriate actions have been taken to mitigate/address any risk of/or actual harms and that consideration has been given to the potential of any longer-term harm.
- Capture any wider learning and a plan for dissemination
- Contribute to the development of system wide recommendations for improvement and process for implementation

SEL System Potential Harms Monitoring: Proposal

In conjunction with providers the current systems in place will be utilised for monitoring and reporting namely:

- For Primary and Community Care a modified version of the Quality Alert process;
  - https://forms.office.com/e/Upu05MamVC#
- ICB will set up a weekly system wide review panel with the Primary Care Providers
  - The numbers, types and categories of incidents reported (Synnovis related only)
  - The potential harm that may have been caused as a direct result of the cyber attack
  - Identify key/new themes, trends, risks, gaps and concerns from incidents, deaths, complaints
  - Escalation to Gold Command
- Quality Information Team to collate information submitted to review panel
  - Daily review of incidents reported
  - Triangulation of complaint information direct to the ICB

SEL System Potential Harms Monitoring – Definition of Harm & Levels of Concern

South East London Integrated Care System

NHSE Definition of Harm

- **Minor Harm** (Patient was harmed with mild and short-term impact on physical, mental or social functioning)
- **Moderate Harm** (Patient was harmed causing a medium–term impact on physical, mental or social functioning)
- **Major Harm** (Patient was harmed causing a major long-term/permanent impact on physical, mental or social function or shortening of life-expectancy)
- **Critical Harm/Death** (Patient died as a **DIRECT** result of the incident. The death must relate to the incident rather than the natural course of a person's underlying condition)

LFPSE Definitions

- **Very concerned**
- **Fairly concerned**
- **Not very concerned**
- **Not at all concerned**

Risk Assessment Tool – Primary Care

South East London Integrated Care System

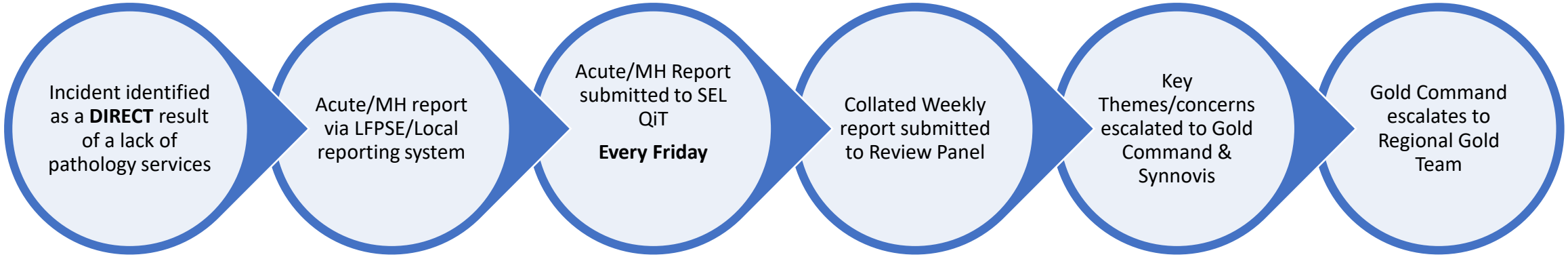
Level 3 Critical Incident - Assessing risk of harm in primary care				
Assessment of Impact / Scale of potential areas of risk to harm to consider:				
	YES	NO	Comments	Assessment of scale
A) lack of access to advice and guidance				
B) Delayed referral or request for investigation				
C) Delayed receipt of clinical results summary requiring urgent action				
Risk assessment areas for consideration				
	YES	NO	Comments	Assessment of scale
Were clinical decisions made to either delay or request investigations				
Was there a delay is accessing advice and guidance				
Were there delays in clinical transmission from pathology				
Has clinical decision making been recorded in the patients notes				
Please complete the section below for specific patient numbers				
If yes, is there a backlog of patients requiring pathology testing? Yes/no				
Is the practice aware of any specific incidents of actual patient harm? Yes/no				
Does the practice have a backlog of patient activity as a result of the Critical Incident				
Is there a backlog of patients needing to be referred for investigations? Yes / No				
Have paper-based results/summaries been received Yes/No				
Has there has been **any risk of** physical or psychological harm as a result either A) B) or C) above?				
Adverse Physical Harm Risk Assessment (please select yes/no in the appropriate box) NB this is not an indication of actual harm				
Is there any evidence of worsening physical condition due to the delays caused by the Critical Incident (including pain / discomfort)?			Please choose yes/no from the boxes below	Assessment of scale
a. no significant change in treatment options and outcome likely unchanged			**A. No Harm risk**	
b. limited treatment options due to delays caused by the Critical Incident and outcome likely unchanged			**B. Low Harm risk**	
c limited treatment options due to delays caused by the Critical Incident and outcome likely changed			**C. Moderate Harm risk**	
d. significant change in treatment options and likely change in outcome			**D. Serious Harm risk**	

	YES or NO	Number
If moderate or serious psychological and/or physical adverse impact has been identified, for any individual patient, has there been a Duty of Candour discussion with the family?		
Have any patients complained formally or informally?		

To support monitoring of workload implications please state how much clinician time has been taken to complete this risk assessment: Hours:Minutes

Name of GP Practice	
Name of Lead Clinician	
Date:	

SEL System Potential Harms Monitoring – Process



- Weekly incident report
- Level of harm *(moderate or above)*
- Complaints/PALs
- Deaths
- (*Not an exhaustive list*)

- Minor
- Moderate
- Major
- Critical

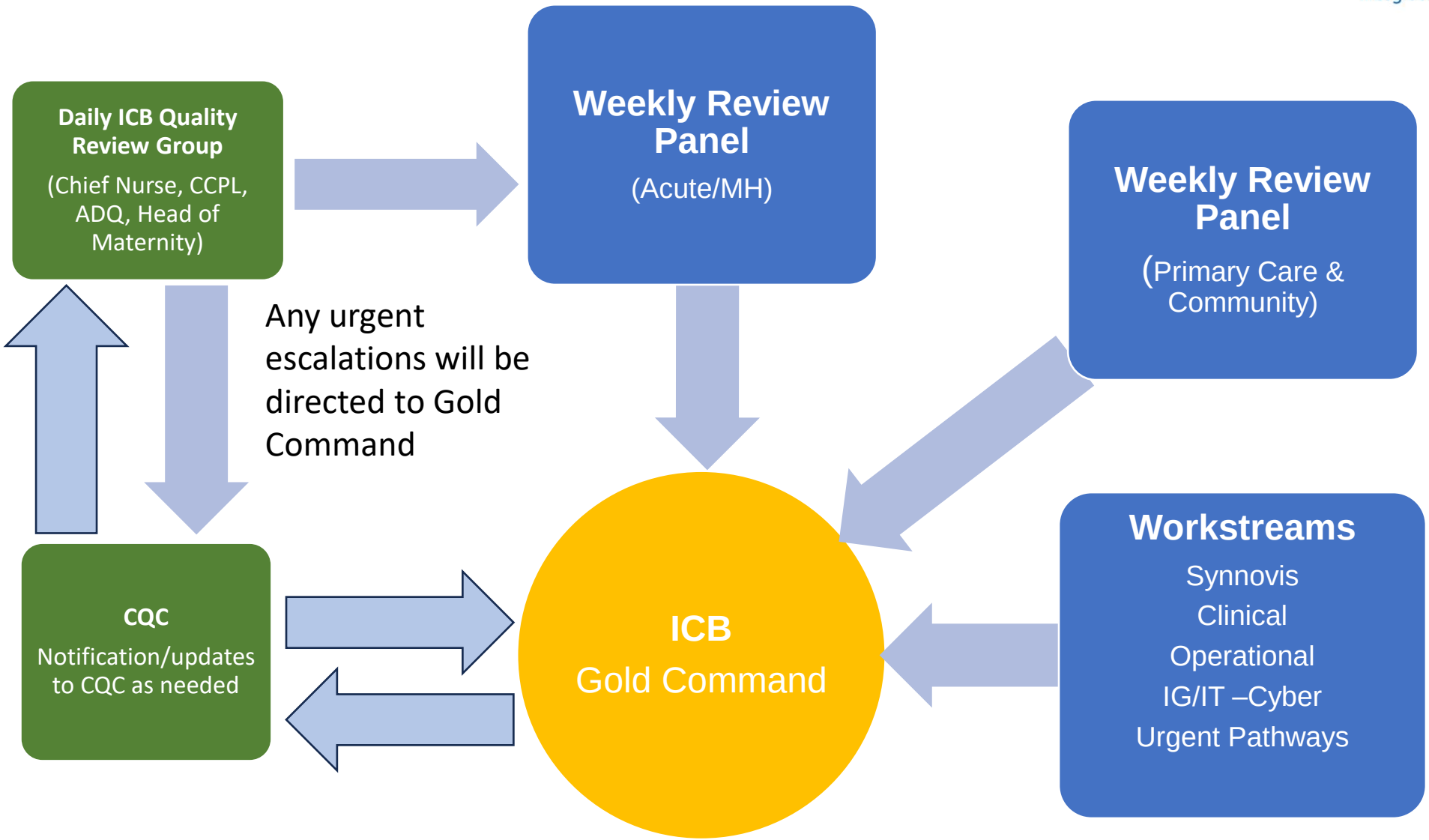
- QiT add to Datix
- Escalate Major/Critical harm to local Gold command

- QiT to triangulate all data received including QA's
- Design and submit a weekly report to the Review Group
- Identify and highlight any key harms/trends/concerns

- Review items for escalation
- Review Risk Assessment Tool
- Monitor the impact
- Ensure mutual support is available to ensure continuity of care
- Reports collated for Gold command
- Provide updates to CQC

- Provide guidance to Review panel
- Escalate concerns to Regional
- Feedback information from Region to ICB Gold
-

SEL System Potential Harms Monitoring – Governance Process



SEL System Potential Harms Monitoring – Modified reporting from for Primary Care

South East London Integrated Care System

- https://forms.office.com/e/Upu05MamVC#

SEL System Potential Harms Monitoring – Objectives of Clinical Review Panel

South East London Integrated Care System

- To establish the impact the incident has had on patients/services within SEL
- To establish whether any harm has come to the patient as a DIRECT result of availability of pathology results/ability to submit samples
- To establish whether any urgent actions were requested which may have affected the patient treatment pathway and whether these were processed
- To determine whether the deterioration in the patient's condition was as a result of the availability of pathology results/ability to submit samples
- To review all major/critical outcomes that occurred in patients whose results were not received by the clinical team/GP to investigate whether the death is linked to pathology
- To escalate risks/themes/concerns to Gold Command
- To update ICB Gold Command
- To provide a combined final report on the findings of the group(s)