Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Serious Incident Report Quarter 2 2018/19

Item 20i

Governing Body meeting

1 November 2018

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Purpose of Paper

Sheffield CCG has a role to ensure that Serious Incidents (SIs) in our commissioned services, and within our commissioning function, are reported, investigated and appropriately acted on.

This paper is to provide an update on new SIs in Quarter 2 2018/19 for which the Governing Body has either a direct or a performance management responsibility.

Key Issues

- The Quality Managers continue to work with providers to understand the underlying issues related to meeting the timeframes for submissions of investigation reports and respond to queries and improve these measures.
- Improvements / changes to practice have been made following serious incident investigations.
- Further work is ongoing to assess the processes for evaluating the effectiveness of actions following serious incidents in preventing similar incidents in the future.

Is your report for Approval / Consideration / Noting

Noting.

Recommendations / Action Required by Governing Body

The Governing Body is asked to consider the contents of this report and gain assurance that the Quality Assurance Committee is discharging its responsibilities effectively by noting the position for each provider and endorsing the Quarter 2 report for 2018/19.

Governing Body Assurance Framework

Which of the CCG's objectives does this paper support?

- To improve the quality and equality of healthcare in Sheffield
- To improve patient experience and access to care

Are there any Resource Implications (including Financial, Staffing etc.)?
Nil

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1.0 Introduction and background

1.1 Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great that a heightened level of response is justified (NHS England 2015). NHS Sheffield Clinical Commissioning Group (SCCG) has responsibility for the performance management of all Serious Incidents (SIs) reported by our Providers. SI's are managed in accordance with The Serious Incident Framework 2015 (NHS England). The Framework outlines the management of SIs in relation to NHS funded care and defines the roles of Commissioners and Providers in these circumstances. Some SI's are also categorised as Never Events. Never Events are Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers (NHS Improvement 2018). Further information and details of the criteria that are used to define SIs and Never Events is available on Appendix 1.

1.2 The purpose of this paper is to give SCCG Governing Body an overview of how we and our Providers are meeting the obligations set out in the SI Framework. Give the Governing body an overview of the current trends in SI's reported and provide assurance of improvements in the quality of care in our Providers following SI's by examples of changes to practice following SI's. This paper also serves to add to the intelligence the Governing body has when they make commissioning decisions as to the possible issues within our care system.

2.0 Provider Performance

In Quarter Two 2018-2019, 24 SIs were reported by our Providers. Of the 24 SI's reported one was a Never Event. Table one below details the stipulated timeframes and the Providers performance in meeting these as set out in the Serious Incident Framework 2015. There have been improvements in the submission of initial investigation reports in 72 hours and timely reporting of serious incidents. Further work is ongoing to get responses to queries in time and to improve the quality of action plans.

2.1 TABLE ONE

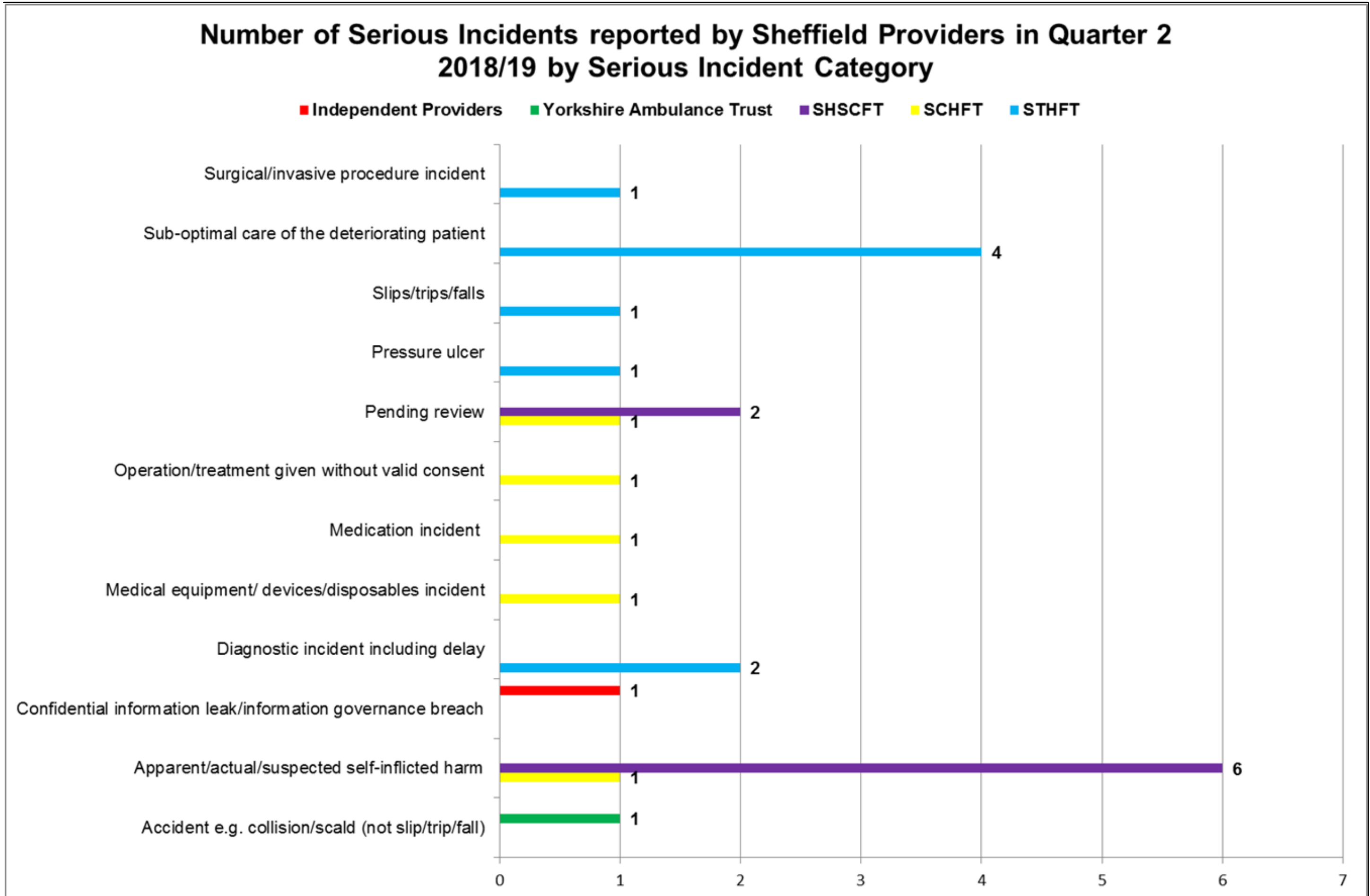
2018/19																					
	SCHFT			SHSCFT			STHFT			IND Prov			YAS			General Practice			2018/19 Totals		
OPEN	Q1	Q2	Year to date	Q1	Q2	Year to date	Q1	Q2	Year to date	Q1	Q2	Year to date	Q1	Q2	Year to date	Q1	Q2	Year to date	Q1 Total	Q2 Total	Year to date
No. of SI's opened	4	5	9	9	8	17	9	9	18	1	1	2	2	1	3	1	0	1	26	24	50
Of which 'Never Events'	1	1	2	0	0	0	1	0	1	0	0	0	0	0	0	0	0	0	2	1	3
Of total number reported, within agreed timescale	2	5	7	7	8	15	8	9	17	1	1	2	2	1	3	1	N/A	1	21	24	45
CLOSED																					
No. of SI's Closed	9	4	13	5	4	9	5	5	10	0	1	1	0	0	0	1	0	1	20	14	34
No. of SI's De-logged	0	0	0	3	8	11	0	0	0	0	0	0	0	0	0	1	0	1	4	8	12
TOTAL ONGOING AT END OF QUARTER	13	14	14	40	36	36	19	23	23	2	2	2	2	3	3	1	1	1	77	76	79
REPORTS AND ACTION PLANS RECEIVED IN QUARTER																					
Initial Management Report received within 72 Hours	4 of 5 80%	5 of 5 100%	9 of 10 90%	2 of 5 40%	6 of 8 75%	8 of 13 61%	8 of 9 89%	7 of 9 78%	15 of 18 83%	1 of 1 100%	1 of 1 100%	2 of 2 100%	2 of 2 100%	N/A	2 of 2 100%	1 of 1 100%	N/A	1 of 1 100%	18 of 23 78%	19 of 23 83%	37 of 46 80%
Reports/Action plans received within 12 weeks*	2 of 5 40%	3 of 4 75%	5 of 9 55%	3 of 4 75%	N/A	3 of 4 75%	2 of 5 40%	4 of 6 67%	6 of 11 54%	1 of 1 100%	0 of 1 0%	1 of 2 50%	N/A	1 of 2 50%	1 of 2 50%	1 of 1 100%	N/A	1 of 1 100%	9 of 16 56%	8 of 13 61%	17 of 29 59%
REPORTS REVIEWED IN QUARTER																					
Reports reviewed, graded as Good/Excellent	2 of 4 50%	1 of 2 50%	3 of 6 50%	3 of 5 60%	N/A	3 of 5 50%	2 of 2 100%	4 of 8 50%	6 of 10 60%	1 of 1 100%	1 of 1 100%	2 of 2 100%	N/A	1 of 1 100%	1 of 1 100%	N/A	N/A	N/A	8 of 12 67%	7 of 12 58%	15 of 24 62%
RESPONSES DUE IN QUARTER																					
Responses received within given timescale (20 working days)	3 of 6 50%	1 of 3 33%	4 of 9 44%	0 of 7 0%	1 of 2 50%	1 of 9 11%	0 of 1 0%	3 of 7 43%	3 of 8 37%	N/A	2 of 2 100%	2 of 2 100%	N/A	N/A	N/A	N/A	N/A	N/A	3 of 14 21%	7 of 14 50%	10 of 28 36%

* Includes those within agreed extended timescale

3.0 **Trends in Reported Serious Incidents by Provider.**

Categories of SI's are defined in the SI Framework. Table two below details the categories allocated by Providers for all 24 SI's logged this Quarter.

3.1 **TABLE TWO**



3.2 **SCHFT**

It is acknowledged these numbers are too small to identify any trends or themes. However it with worth noting there was another Never event last quarter categorised as an Operation/treatment without valid consent. Assurance has been received from the Trust as to mitigating actions they are implementing to prevent a recurrence whilst the investigations are underway.

3.3 **SHSCFT**

Six of the Eight SIs reported by SHSCFT were categorised as: Apparent/actual/suspected self-inflicted harm meeting SI criteria. It is worth noting a significant number of Incidents reported under this category are de-logged after an investigation does not find any significant lapses or acts that may have contributed to the incident. Work is continuing with Trust to ensure this process is more timely.

3.4 **STHFT**

Four out of the Nine SIs reported by STHFT were classified as Sub-optimal care of a deteriorating patient meeting SI criteria. Being cautious about attributing themes to small numbers it has been acknowledged similar contributory factors have been found in other SI investigations in the last year with regards to the management of deteriorating patients. Assurance has been sought from the Trust. As well as the implementation of the Second National Early Warning Score Tool (NEWS2), the Trust is undertaking a review of their management of deteriorating patients. We will receive an action plan from them next month.

3.5 **YAS**

The SI reported by YAS was related to an Accident e.g. collision/scald (not slip/trip/fall) meeting the SI criteria.

3.6 **Independent Providers**

No trends identified.

3.7 **Primary Care**

No trends identified.

4.0 **<u>Never Events</u>**:

One SI reported in the Quarter was also categorised as a Never event. The Never Event reported in Quarter one was reported as a Serious Incident under the category Operation/treatment given without valid consent.

SCHFT Reported a Never Event which was a patient who underwent tonsillectomy and cautery to nose. They also had an adenoidectomy which was not consented for.

5.0 **Changes to practice following Serious Incident Investigation**

The examples below, taken from reviewed incident reports, serve to illustrate that in virtually all cases, the investigation process identified some improvements to be made. These relate to incidents where action has been taken and the investigation is closed, so will generally not relate to those reported in this quarter.

5.1 **Sheffield Teaching Hospitals Foundation Trust (STHFT)**

a) A patient attended the Emergency department following an episode of shortness of breath which led to a collapse and loss of consciousness. There was a delay in him being seen by a Clinician and when he was assessed it was believed he had a Pulmonary Embolism. There was a delay in responding to his vital signs and he subsequently deteriorated and died.

Actions taken:

- A Vital signs working group has been developed by the Trust to improve observations and escalation.
- All prescribed medications to be administered are being checked via safety rounds/'ticket to ride'

5.2 **Sheffield Health and Social Care Foundation Trust (SHSCFT)**

a) The Out of Hours Team (OOH) were contacted by South Yorkshire Police (SYP) who informed them that Service User R had been reported missing by his wife. A body was found in a lake in Bingham Park, which was confirmed by SYP as being Service User R.

Actions taken:

- The Trust has introduced standardised tools and associated documentation for assessing suicide risk to enhance clinical practice.
- The introduction of a Trust wide suicide prevention training program for all staff.
- Develop a rating score to identify patients at highest risk of suicide.

6.0 Conclusion

Due to the numbers of SIs being small it is difficult to contribute any trends or themes. However where repeating contributory factors emerge we continue to work with providers to gain assurance that they are putting in place actions to mitigate the risk of recurrence. Work is continuing on improvement of action plans following serious incidents.

Provider performance:
- STHFT have maintained timely submission of final reports.
- SCHFT have maintained their improvement in the submission of initial management reports (72 hour reports).
- SHSCFT improved in the submission of initial management reports (72 hour reports).

7.0 Key Points:
- Where there are emerging concerns these are being addressed with the Provider and assurance sought when required.
- Improvements/Changes to practice continue to be made following SI Investigations.
- Work is ongoing to assess the processes for evaluating the effectiveness of actions following SIs in preventing similar incidents in the future.

8.0 Recommendations

The Governing body is asked to consider the contents of this report and gain assurance that the Quality Assurance Committee is discharging its responsibilities effectively by noting the position for each provider and endorsing the Q2 report for 2018/19

Paper prepared by Grace Mhora Quality Manager and Tracey Robinson, Clinical Audit Assistant
On behalf of Mandy Philbin, Chief Nurse
9 October 2018

Appendix 1

1. Criteria for Serious Incidents and Never Events

Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great that a heightened level of response is justified (NHS England 2015). Serious incidents are managed in accordance with The Serious Incident Framework published by NHS England in 2015. The Guideline outlines the management of serious incidents in relation to NHS Funded care and defines the roles of Commissioners and Providers in these circumstances. The following extracts are from the NHS England Serious Incident Framework 2015: Available from:
https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

"Serious Incidents include:
Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:

- Unexpected or avoidable death of one or more people. This includes
  - Suicide/self - inflicted death; and
  - Homicide by a person in receipt of mental health care within the recent past.

- Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent:
  - The death of the service user; or
  - Serious harm;

- Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where:
  - Healthcare did not take appropriate action/intervention to safeguard against such abuse
  - Where abuse occurred during the provision of NHS-funded care.

An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:

Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues.

- Property damage;
- Security breach/concern;

- Incidents in population-wide healthcare activities like screening and immunisation programmes where the potential for harm may extend to a large population;
- Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS);
- Systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/ unit closure or suspension of services); or
- Activation of Major Incident Plan (by provider, commissioner or relevant agency)
- Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation.

Never Events:
Never Events are defined as Serious Incidents that are wholly preventable because guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers NHS Improvement published The Never Events Policy & Framework 2018 that stipulates the criteria for a serious incident to be reported as a Never Event. The Framework is available from**:**
https://improvement.nhs.uk/documents/2265/Revised_Never_Events_policy_and_framework_FINAL.pdf

In the Never Events Policy & Framework 2018 all the criteria numbered a-d below should be met in order for a serious incident to be classified as a Never event:

a. Patient Safety Incidents that are wholly preventable where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and have been implemented by healthcare providers.
b. The incident should have the potential to cause serious patient harm or death. However, serious harm or death does not need to have happened as a result of a specific incident for that incident to be categorised as a Never Event.
c. There is evidence that the Never Event has occurred in the past – for example, through reports to the National Reporting and Learning System (NRLS) – and that the risk of recurrence remains.
d. It must be clearly defined and its occurrence easily recognised – this requirement helps minimise disputes around classification, and ensures focus on learning and improving patient safety
e. Further to the Never Events Policy & Framework is a List of Never events: This is available from: https://improvement.nhs.uk/documents/2899/Never_Events_list_2018_FINAL_v6.pdf

The following are the criteria of Never Events that are listed on the Never Events List 2018:

Surgical
Wrong site surgery

Wrong implant/prosthesis
Retained foreign object post procedure

Medication
Mis-selection of a strong potassium solution
Administration of medication by the wrong route
Overdose of insulin due to abbreviations or incorrect device
Overdose of methotrexate for non-cancer treatment
Mis-selection of high strength midazolam during conscious sedation
Mental health
Failure to install functional collapsible shower or curtain rails **General**

- Falls from poorly restricted windows
- Chest or neck entrapment in bed rails
- Transfusion or transplantation of ABO-incompatible blood components or organs
- Misplaced naso- or oro-gastric tubes
- Scalding of patients
- Unintentional connection of a patient requiring oxygen to an air flowmeter.

Appendix 2 (Please note that this chart does not include YAS or General Practice due to lack of long term data)