NHS
Sheffield Clinical Commissioning Group

Serious Incident Report Quarter 1 2013/14

Governing Body meeting N

5 September 2013

Author(s)/Presenter and title	Tony Moore, Senior Quality Manager
Sponsor	Kevin Clifford, Chief Nurse

Key messages

- Sheffield Clinical Commissioning Group (SCCG) 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 1 2013/14 for which the Governing Body has either a direct or a performance management responsibility.

Assurance Framework (AF) (2012/13)

Risk Reference Number: N/A

How does this paper provide assurance to the Governing Body that the risk is being addressed?
The paper provides information required as part of the National Standard contracting process and is existing assurance against current controls.

Is this an existing or additional control:
Existing - AF 2.1

Equality/Diversity Impact

Has an equality impact assessment been undertaken? No

Which of the 9 Protected Characteristics does it have an impact on?
SIs could potentially impact on all characteristics

Public and Patient Engagement

None

Recommendations

The Governing Body is asked to:

- Note the position for each Provider and to endorse the Quarter 1 report for 2013/14.
- Support the development of revised data reporting.

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1.0 Introduction and background

1.1 NHS Sheffield Clinical Commissioning Group (SCCG) has responsibility for the performance management of all Provider Serious Incidents (SIs). Procedures for this are currently still based on the requirements of NHS Yorkshire & the Humber (NHS Y&H), until an agreement is reached with the NHS England Area Team. This is being actively worked on.

1.2 All NHS organisations utilise the Department of Health (DH) incident reporting module of the STEIS / UNIFY system to log and manage serious incidents. This is supplemented by a locally created and managed database, to keep track of progress on all SI's and to generate management and reporting information.

1.3 Every reported SI is individually managed to ensure that relevant reporting deadlines are being met and that the final investigation has used recognised Root Cause Analysis (RCA) techniques in line with national guidance. In addition the report and remedial action plan must be of a sufficient quality, when reviewed by SCCG Quality Managers.

1.4 Each Provider has a set of quality indicators built into their contract, which also includes a specific schedule setting out their and our responsibilities for SI management. These are encapsulated within the data in this report.

1.5 Individual incidents and performance data are discussed at informal meetings with the Providers and at Contract Quality Review meetings, and there is ongoing dialogue with Providers at frequent intervals.

1.6 This report provides details on the performance of Providers together with incident trends and lessons learned. Individual Provider's performance is seen in Appendix 1.

1.7 Having taken note of feedback given, we have amended the data set reported and have set out a new presentation, which focuses more closely on our requirements, as opposed to the more complex data set required by the former SHA. NHS England has confirmed that it does not require that data.

1.8 We plan to further develop our data reporting and presentation in the light of any additional feedback.

2.0 Definition of a Serious Incident

2.1 A SI may be defined as an incident where a patient, member of staff, or member of the public has suffered serious injury, major permanent harm, or unexpected death. Incidents involving confidential information loss or where there is cluster / pattern of

incidents or actions, including those of NHS staff, which have caused or are likely to cause significant public concern may also constitute a SI.

2.2 Some SIs has been identified by the DH as 'Never Events'. These are events known to have very serious consequences. The DH publishes a list of 'Never Events' annually and there are currently still 25 never events, two with slightly different parameters to last year. These are included in the NHSS procedure and agreed with individual Providers as there are financial penalties through the DH standard contract, should such an event occur.

3.0 Provider performance

3.1 Providers are contractually required to meet criteria in respect of timeliness of initially logging an incident within two working days and in the provision of an investigation report and action plan - within 12 weeks (60 working days), unless an extension is agreed.

4.0 Sheffield Children's FT (SCHFT)

4.1 Four new incidents were reported in Q1. Two (50%) of these were reported within the two working days timeframe.

4.2 One incident was closed and one de-logged, leaving eight incidents on-going at the end of Q1.

4.3 No reports were reviewed in Q1.

4.4 We are still awaiting three investigation reports which are now overdue. One of these has been subject to ongoing police investigations, preventing an internal investigation from being completed. The reasons for the other delays are under discussion with SCH.

5.0 Sheffield Health & Social Care FT (SHSCFT)

5.1 Nine new incidents were reported in Q1. Of these, eight (89%) were reported within the two working days timeframe.

5.2 Five investigation reports were reviewed in Q1, all of which were received within the 12 week deadline. Of these, one was graded as "Excellent", three as "Good" and one as "Fair"

5.3 Two incidents were closed in Q1 and one de-logged, leaving 52 on-going incidents at the end of Q1.

5.4 The continuing increase in numbers ongoing is due to a lag in receiving responses to queries placed by SCCG following review of incident reports. This has been discussed with the trust and a further plan has now been agreed. The Trusts Senior management is aware of the issue and is keen to see progress. An agreement has been reached that is now resulting in a minimum of confirmation that action plans have been implemented for all incidents in 2011 & prior. It is anticipated that there will be significant improvement by the end of Q2.

5.5 We are awaiting investigation reports for 13 SIs which are now overdue. This has been raised formally with the Trust.

6.0 Sheffield Teaching Hospitals FT (STHFT)

6.1 Four new incidents were logged in Q1. One (25%) Of these incidents were reported within the 48 hour timeframe.

6.2 Two investigation reports were reviewed in Q1, of which, one was received within the 12 week deadline. One was graded as “Good” and one as “Fair”.

6.3 Six SIs were closed during Q1 which left 17 incidents remaining on-going at the end of Quarter 1 2013/14.

6.4 We are awaiting one investigation report which is now overdue.

7.0 Independent Contractors and Providers.

7.1 One new incident was logged in Q1 (Thornbury Hospital). This was outside the two working days timeframe.

7.2 One report was reviewed in Q1, which was graded ‘fair’.

7.3 One incident was closed leaving two incidents on-going at the end of Q1. This second incident also involves STHFT and a final response from them is awaited. The Independent Provider contribution is satisfactory.

7.4 SIs are quite rare in individual Independent providers. It is equally unusual for there to be a joint involvement with a Foundation Trust. In general some support for Independent Providers is required to enable them to understand their responsibilities. In this quarter we were informed of an incident long after it had happened and been investigated.

8.0 Incident trends

8.1 The most prevalent incident types by organisation for Q1 were:

SCHFT - Failure to obtain consent
SHSCFT - Suicide / attempted suicide by Outpatient (in receipt)
STH - Slips, trips and falls
Independent Providers – Drug incident

9.0 Changes to practice following SIs

The examples below, taken from reviewed incident reports, serve to illustrate that in virtually all cases, the investigation process identified at least some improvement that could be made. Sometimes these do not directly bear on individual incidents, but may, for example, serve to remind staff about timely communication or about the need for complete and comprehensive clinical records.

9.1 **Sheffield Children's Hospital Foundation Trust (SCHFT)**

a. Death following surgery: This was last ditch surgery on a baby with fatal abnormalities, thus the death was not unexpected, but some lessons were nonetheless identified. The child had sadly died whilst the mother was still in an adjacent Hospital

Learning included: The efforts of the staff involved in order to reunite mother and child for ethical reasons is to be commended, however the considerations of the Coroner and his jurisdiction of the body should have been considered and complied with.

b. Death following admission (second presentation)

Learning included: The Paediatric Early Warning tool was not correctly or effectively utilised to demonstrate the deterioration and management requirements of the patient.

A more formalised method of communication for referral is required. Use of the 'SBAR' tool would have led to effective, concise and focused information sharing leading to a clear recommendation.

A large number of medical staff were aware of the patient's observations and his condition, getting tired and long pauses between breaths but few physically reviewed the patient during his care at the Trust.

9.2 **Sheffield Health and Social Care Trust (SHSCT)**

a. Service User (community) found trying to hang herself in her garden.

Learning included
The Section 17 Leave Policy was not clearly understood by staff, many believing that there is now a requirement to treat all patients as if they are detained (in respect of Section 17 Mental Health Act). All nursing and medical staff should be aware of the implications of the Section 17 Leave Policy and the role of the consultant with regard to informal patients at risk of suicide, especially out of hours.

b. Death of Service User (community), after allegedly jumping out of the window of his flat.

Learning included
A recorded risk assessment should have been commenced on initial assessment and added to as more information was gathered. Workers should recognise the importance of accurate and timely documentation.

The importance of using supervision to discuss clinical and work related concerns should not be underestimated and should be available to all staff.

c. Service User (community) had been found dead in the bath

Learning included

There were missed opportunities in the 24 hours before his death to effectively engage family and friends in the Service Users care, which would have ensured the decisions taken were more informed and comprehensively documented. On three occasions concerns were raised about Service User. His mother spoke to medical staff on two

occasions suggesting caution and querying his wellness and level of insight, none of this vital information was passed on to nursing staff.

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

a. **Retained object post surgery**: Patient returned to theatre for a planned cystoscopy, 14 days after sustaining a surgical bladder injury at a previous operation. While undertaking the cystoscopy procedure the surgeon removed a swab retained from the previous procedure.

Learning included
Change in the use of the whiteboard in theatres
Change in processes to ensure the final check takes place when the operation is complete
Introduction of SBAR communication tool
A full audit of practice has been undertaken and completed

b. **Wrong blood type had been selected for a baby on the Neonatal Intensive Care Unit**. The baby is group A negative, whilst the blood that the unit selected and transfused was O positive.

Learning included
Implementation of a system of using different fridges for neonatal blood
Software company to make changes to the Apex system to ensure that warning messages are less likely to be overlooked. The blood issuing process has been reviewed to highlight 'hot spots' of potential human error and minimise the opportunity for error.

An Alert sticker has been introduced to alert both laboratory staff and NNU staff when O negative blood has not been dispensed. Additional information to support staff knowledge and practice has been incorporated into both the Neonatal Blood Prescription chart and the NICU guideline Blood Transfusion.

c. **A mother had a significant bleed following a Caesarean section**. A Rusch balloon and vaginal pack were inserted to stop the bleed. Later the balloon was removed but the vaginal pack was left in situ until it was found approximately 6 weeks later.

Learning included
Changes have been made to communications protocols and documentation.
Clearer information is handed over between departments when items have been deliberately left in situation.
Standardised handover using SBAR principles has been instituted.

10.0 Conclusion

10.1 **SCH** is a low, but consistent reporter, though timeliness of initial reporting still needs to improve.

10.2 **SHSCT** remains the highest reporting Provider in Sheffield, though this is as expected for a Mental Health Trust. We have highlighted the number of overdue reports and though these are substantially to do with the Trust tightening its quality assurance

process, we remain in active discussion about receipt of these backlog reports. Of those reports received all were within the 12 weeks timeframe.

Whilst at the end of Q1 there has been little progress on the number of ongoing incidents waiting for a response after review, there is now significant activity, which will reduce the number by the end of Q2.

10.3 **STH** has an ongoing issue of timeliness of initial reporting within two working days. This has been raised previously through contract quality review meetings and through informal engagement. The Trust has very recently agreed to review its incident screening process to try to make an improvement. The recently implemented investigation reporting template is beginning to improve the quality of reports.

10.4 **Independent contractors / Providers** have a generally low incidence of SIs we work with them to ensure that there is a robust investigation and that our requirements are clearly understood

11.0 Recommendations

11.1 The Governing Body is asked to:

- Note the position for each Provider and to endorse the Quarter 1 report for 2013/14.
- Support the development of revised data reporting.

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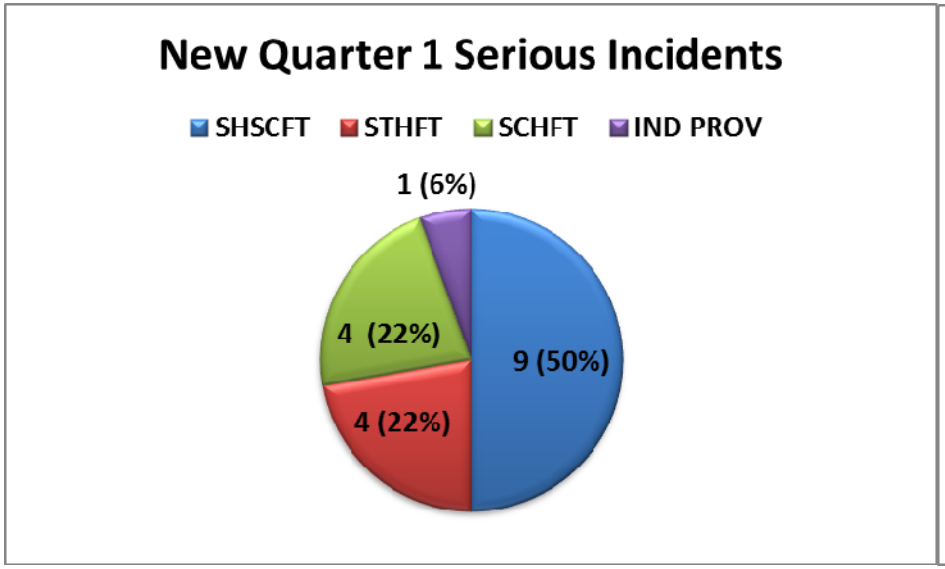
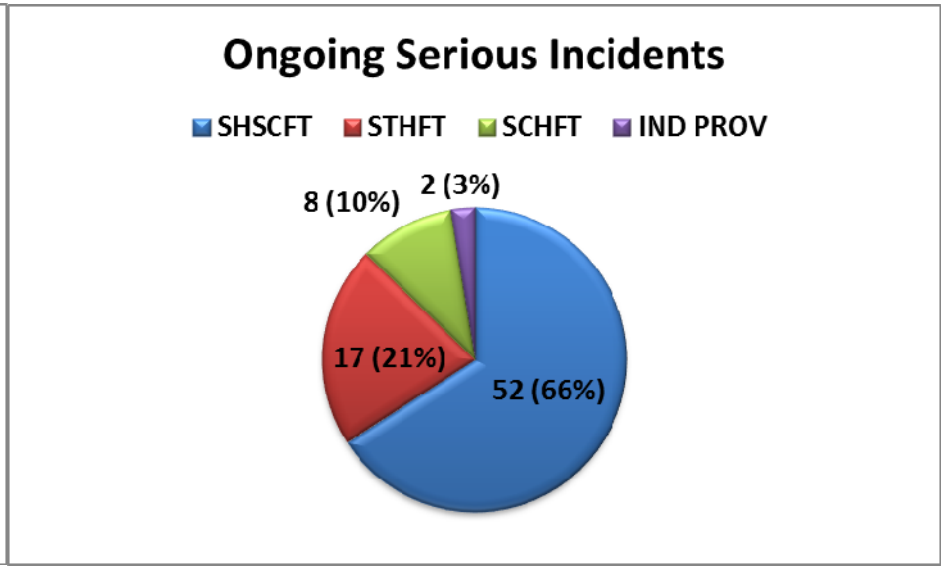
On behalf of: Kevin Clifford, Chief Nurse

August 2013

Appendix 1

	Quarter 1 2013/14				
OPEN	**SCHFT**	**SHSCFT**	**STHFT**	**IND PROV**	**Q1 Total**
No. of SUI's opened in quarter	4	9	4	1	18
Of these no. reported within timescale (within 2 working days)	1	8	1	0	10
CLOSED					
No. of SUI's Closed in quarter	1	2	6	1	10
No. of SUI's De-logged in quarter	1		1	0	3
TOTAL ONGOING AT END OF QUARTER	8	52	17	2	79
REPORTS AND ACTION PLANS RECEIVED					
% reports/action plans received within 12 weeks*	100%	100%	50%	100%	88%
% reports graded as Good/Excellent	N/A[1]	80%	50%	0%	43%
% of reports reviewed in quarter, returned to Provider requiring further information	N/A	100%	100%	100%	100%
* Includes those within agreed extended timescale					





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Is this an existing or additional control:
Existing control AF 2.1.

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Has an equality impact assessment been undertaken? No

Which of the 9 Protected Characteristics does it have an impact on?
SIs could potentially impact on all characteristics

Public and Patient Engagement

None

Recommendations

- The Governing Body is asked to note the new SIs for June and July 2013 for each organisation

Serious Incident Position for June/July 2013						
Organisation	**Number of SIs Opened**		**Number of SIs Closed/De-logged**		**Total Ongoing**	
	June	**July**	**June**	**July**	**June**	**July**
SCHFT	3	0	1	0	8	8
SHSCFT	1	2	1	1	52	53
STHFT	2	5	2	2	17	20
Independent Contractors	0	0	0	0	2	2
SCCG (not including Safeguarding)	0	0	0	0	0	0
SCCG Safeguarding Children	0	0	0	0	1	1
SCCG Safeguarding Adults	0	0	0	0	0	0
Total SI's	**5**	**7**	**4**	**3**	**80**	**84**

New SIs opened in June/July 2013			
STEIS number	**Organisation**	**Date reported**	**Type of Incident**
2013/16821	SCHFT	7/06/13	Failure to Obtain Consent
2013/17447	SCHFT	14/06/13	Surgical Error
2013/17715	SCHFT	18/06/13	Failure to Obtain Consent
2013/17969	SHSCFT	19/06/13	Attempted Suicide by Inpatient (In receipt)
2013/20297	SHSCFT	11/07/13	Unexpected Death of Community Patient (In receipt)
2013/21498	SHSCFT	23/07/13	Unexpected Death of Community Patient (In receipt)
2013/17813	STHFT	18/06/13	Failure to act on test results
2013/17833	STHFT	18/06/13	Slips/Trips and Falls
2013/19511	STHFT	4/07/13	Surgical Error
2013/21308	STHFT	22/07/13	Failure to act on test results **(Never Event Near Miss)**
2013/21341	STHFT	22/07/13	Communicable Disease and Infection Issue
2013/21500	STHFT	23/07/13	Retained Swab **(Never Event)**
2013/22293	STHFT	30/07/13	Hospital Equipment Failure