Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Serious Incident Report Quarter 1 2018/19

Item 18f

Governing Body meeting

6 September 2018

Author(s)	Grace Mhora, Quality Manager
Sponsor Director	Mandy Philbin, Chief Nurse

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 1 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

Consideration and Approval.

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 Q1 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

NHS
Sheffield
Clinical Commissioning Group

Serious Incident Report Quarter 1 2018/19

Governing Body meeting

6 September 2018

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 One 2018-2019, 26 SIs were reported by our Providers. Two of the SIs were Never Events. Table one below details the stipulated timeframes and the Providers performance in meeting these as set out in the Serious Incident Framework 2015. Meeting these timeframes remains an area for improvement which Quality Managers continually work with Providers to improve. Significant improvements been achieved in the submission of initial investigation reports in 72 hours in the last quarter.

2.2 TABLE 1

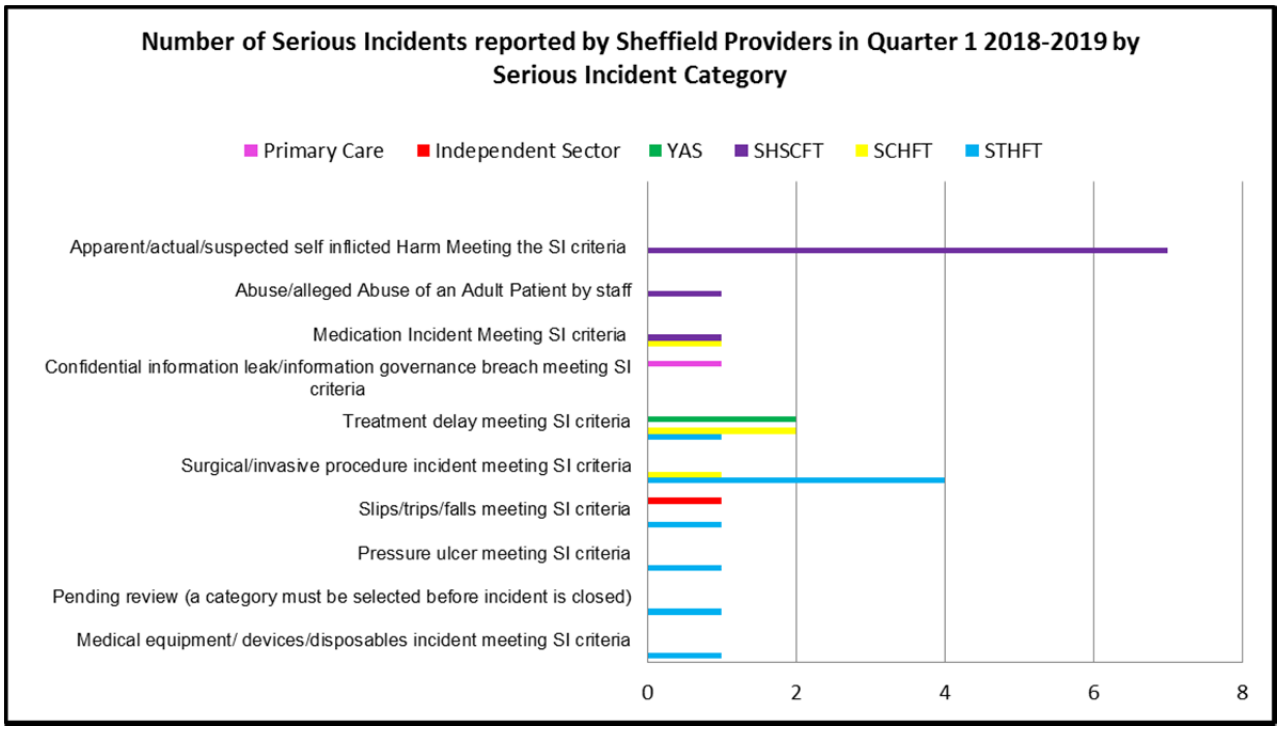
2018/19														
OPEN	SCHFT		SHSCFT		STHFT		IND Prov		YAS		General Practice		2018/19 Totals	
	Q1	Year to date	Q1	Year to date	Q1	Year to date	Q1	Year to date	Q1	Year to date	Q1	Year to date	Q1 Total	Year to date
No. of SI's opened	4	4	9	9	9	9	1	1	2	2	1	1	26	26
Of which 'Never Events'	1	1	0	0	1	1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

* 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 2 below details the categories allocated by Providers for all 26 SI's logged this Quarter**.**

3.2 **TABLE 2**



3.3 **SCHFT**

Two of the Four SIs reported by SCHFT related to Treatment delay meeting SI criteria. It is acknowledged these numbers are too small to identify any trends or themes.

3.4 **SHSCFT**

Seven of the Nine 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.

3.5 **STHFT**

Four out of the Nine SIs reported by STHFT were classified as Surgical/invasive procedure incident meeting SI criteria. There are no themes in these incidents as they are all in different departments and heterogenic in nature. One of the SI's reported by STHFT is yet to be allocated a category. This SI related to correspondence letters.

3.6 **YAS**

Both SIs reported by YAS were related to Treatment Delay meeting the SI criteria.

3.7 **Independent Providers**

No trends identified.

3.8 **Primary Care**

No trends identified.

4.0 **Never Events**:

Two SIs reported in the Quarter were also categorised as Never events. Both of the Never Events reported in Quarter one were reported as Serious Incidents under the category Surgical/invasive Procedure Incident meeting the SI criteria. The details of the Never events are below:

STHFT Reported a Never Event which was a retained swab. The swab was identified whilst the patient was still in the theatre. The swab count was incomplete. An x-ray was conducted which identified the retained swab.

SCHFT Reported a Never Event which was a patient who was listed for the insertion of grommets and an adenoidectomy had a right tonsillectomy initiated in error.

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 Children's Hospital Foundation Trust (SCHFT)**

a) A patient underwent Upper Gastrointestinal examination and colonoscopy. It was discovered that the gastroscope used for the procedure had also been used on the previous patient in theatre. An infection screen was undertaken, the result of which was negative. The family has been informed and have met with senior clinicians. Additional controls have been implemented to reduce future risk

Actions taken:

- The development of a Standard Operating Procedure for the change in process required when scopes are sent to an external Trust for cleaning.
- To use a system of clear task allocation within theatres identifying the roles of the staff within the theatre at the beginning of each shift.
- To document within the pre-operation checklist if disinfected equipment has been checked.

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

a) A patient had Level C6/7 of their spine operated on rather than the intended and consented level of C5/6. This incident occurred despite applying the usual intraoperative imaging checks that are done to ensure that the correct level is being operated upon. The standard practice used as a marker was a spinal needle manipulated into a shape by the Neurosurgeon

Actions taken:

- The Trust is to source an appropriate ‘marking needle’ produced commercially.

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

a) The Trust was informed by the Coroner's office on that a patient who had recently been seen and discharged from the CMHT had taken his own life by ingesting chemicals.

Actions taken:

- The implementation and evaluation of a Volitional Help Sheet (VHS) which is a brief intervention tool encourages people to think about critical situations when they are tempted to self-harm and to consider alternative solutions.
- Training is to be developed and in the assessment of suicidal intent in adults who on the autistic spectrum and delivered to the relevant staff groups.

6.0 Conclusion

Due to the numbers of SIs being small it is difficult to contribute any trends or themes. Key areas that have identified for improvement with all the providers are action plans following SIs and their evaluation to ensure the actions are effective. This has been included in all the Providers Local Quality Schedule for this financial year and Quality Managers will work with their providers to get assurance on these processes.

The Provider performance remains varied:

- STHFT have improved the quality of the Serious Incident reports and it has been recognised that they can share their practice with other Providers.
- SCHFT have improved on their compliance with meeting the 72 hour reports timeframe going from 50% (2 out of 4) in Q4 to 80% when 4/5 reports were submitted within the 72 hour timeframe.
- SHSCFT have maintained the timeliness in submitting the Final reports with ¾ 75% submitted within the timeframe in Quarter One.

7.0 Key Points:

- The Quality Managers continue to work with Providers to understand the underlying issues related to meeting the timeframes for submission of investigation reports and respond to Queries and improve these measures.
- Improvements/Changes to practice have been made following SI Investigations.
- Further 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 Q1 report for 2018/19

Paper prepared by: Grace Mhora Quality Manager and Tracey Robinson, Clinical Audit Assistant

On behalf of: Mandy Philbin, Chief Nurse

August 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

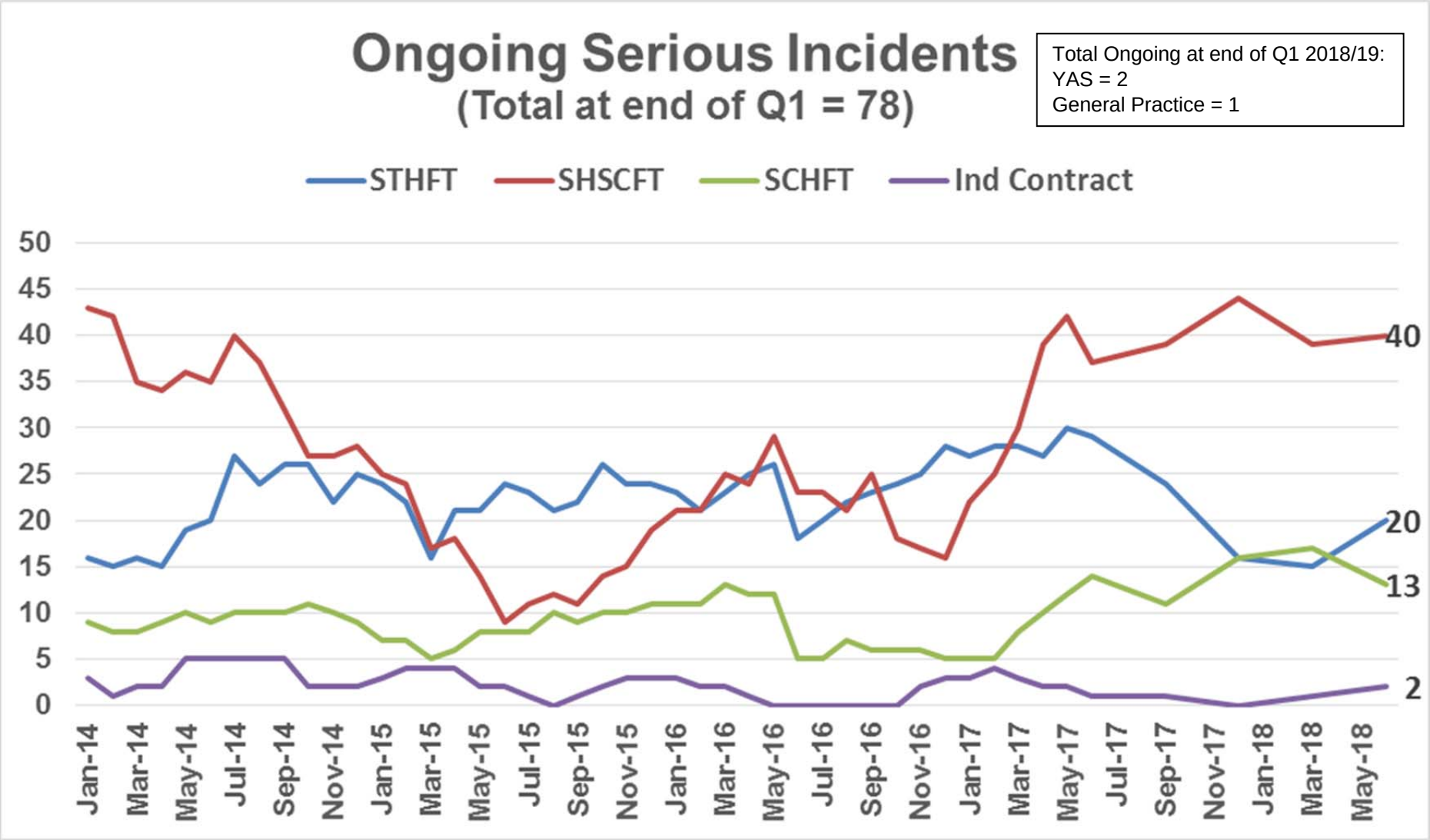
Wrong site surgery
Wrong implant/prosthesis
Retained foreign object post procedure

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)