Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Serious Incident Report Quarter 1 2019/20

Governing Body meeting

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5 September 2019

Author(s)	Grace Mhora, Quality Manager Tracey Robinson, Quality Improvement Assistant
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 2019/20 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

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 1 report for 2019/20.

What assurance does this report provide to the Governing Body in relation to Governing Body Assurance Framework (GBAF) objectives?

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

Description of Assurances for Governing Body

Gain assurance that the Quality Assurance Committee is discharging its responsibilities effectively by noting the position for each provider and endorsing the Quarter 1 report for 2019/20.

Are there any Resource Implications (including Financial, Staffing etc.)?
Nil
Have you carried out an Equality Impact Assessment and is it attached?
Please attach if completed. Please explain if not, why not Not applicable
Have you involved patients, carers and the public in the preparation of the report?
Not applicable

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1.0 Introduction and Background

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. SIs 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.

1.1 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 SIs. 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 1 2019-2020, 21 SIs were reported by our providers. three of the 21 SIs reported were a 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. Work is ongoing to get responses to queries in time and to improve the quality of action plans.

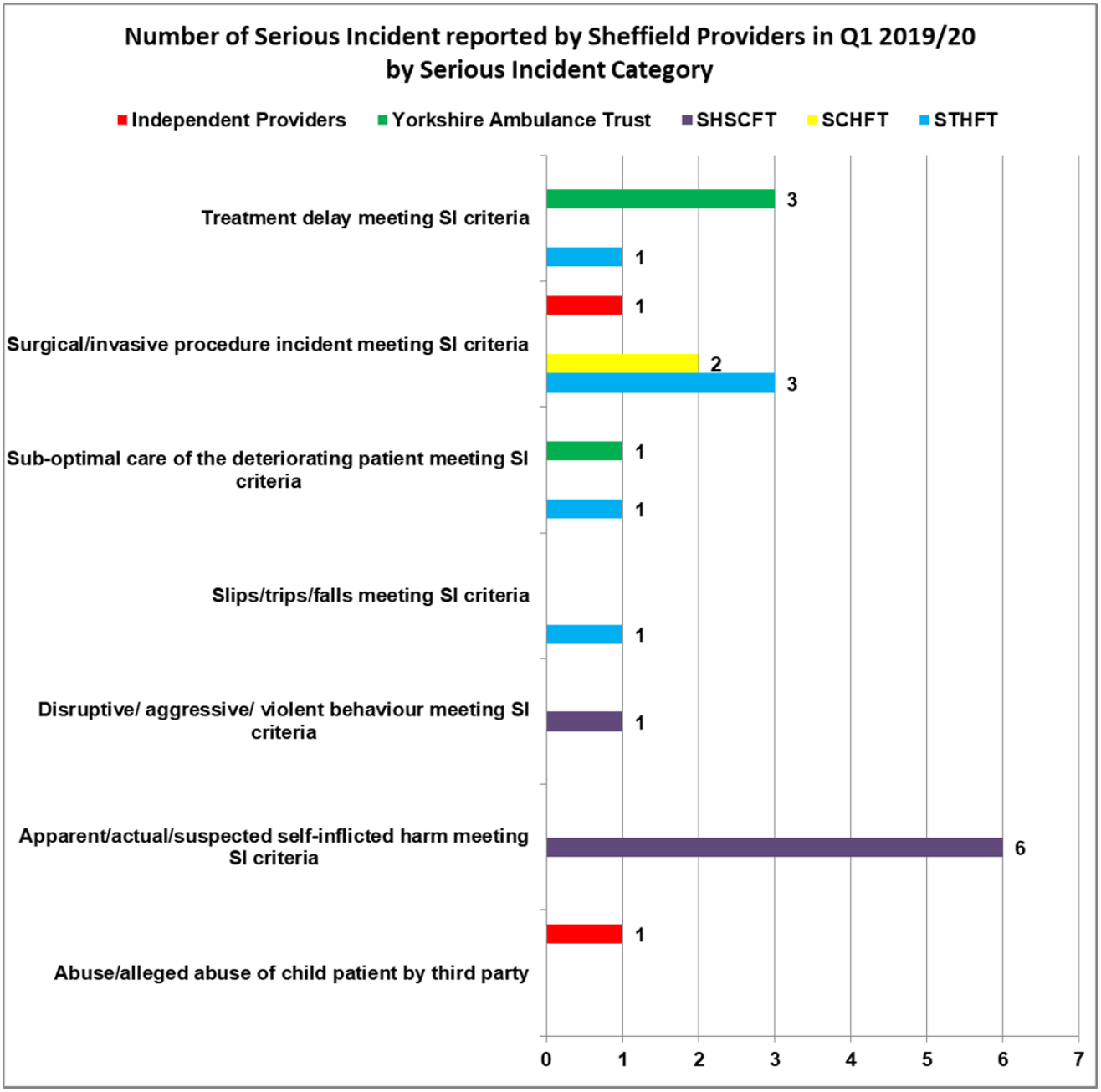
2.1 TABLE ONE

2019/20														
	SCHFT		SHSCFT		STHFT		IND Prov		YAS		General Practice		2019/20 Totals	
OPEN	Q1	2019/20 Total	Q1	2019/20 Total	Q1	2019/20 Total	Q1	2019/20 Total	Q1	2019/20 Total	Q1	2019/20 Total	Q1 Total	2019/20 Total
No. of SIs opened	2	2	7	7	6	6	2	2	4	4	0	0	21	21
Of which 'Never Events'	0	0	0	0	2	2	1	1	0	0	0	0	3	3
Of total number reported, within agreed timescale	2	2	6	6	6	6	1	1	0	0	N/A	N/A	15	15
CLOSED														
No. of SIs Closed	2	2	4	4	9	9	1	1	1	1	0	0	17	17
No. of SIs De-logged	0	0	3	3	1	1	0	0	0	0	0	0	4	4
TOTAL ONGOING AT END OF QUARTER	14	14	39	39	29	29	4	4	5	5	2	2	93	93
REPORTS AND ACTION PLANS RECEIVED IN QUARTER														
Initial Management Report received within 72 Hours	1 of 2 50%	1 of 2 50%	5 of 6 83%	5 of 6 83%	6 of 6 100%	6 of 6 100%	1 of 1 100%	1 of 1 100%	4 of 4 100%	4 of 4 100%	N/A	N/A	16 of 18 89%	17 of 19 89%
Reports/Action plans received within 12 weeks*	3 of 6 50%	3 of 6 50%	1 of 4 25%	1 of 4 25%	18 of 20 90%	18 of 20 90%	1 of 1 100%	1 of 1 100%	N/A	N/A	N/A	N/A	23 of 31 74%	23 of 31 74%
REPORTS REVIEWED IN QUARTER														
Reports reviewed in Quarter, graded as Good/Excellent	3 of 4 75%	3 of 4 75%	4 of 4 100%	4 of 4 100%	15 of 16 94%	15 of 16 94%	0 of 1 0%	0 of 1 0%	N/A	N/A	N/A	N/A	22 of 25 88%	22 of 25 88%
Action Plans reviewed in Quarter, graded as Good/Excellent	4 of 4 100%	4 of 4 100%	3 of 4 75%	3 of 4 75%	10 of 16 63%	10 of 16 63%	0 of 1 0%	0 of 1 0%	N/A	N/A	N/A	N/A	17 of 25 68%	17 of 25 68%
RESPONSES DUE IN QUARTER														
Responses received within given timescale (20 working days)	1 of 2 50%	1 of 2 50%	0 of 4 0%	0 of 4 0%	7 of 13 54%	7 of 13 54%	0 of 1 0%	0 of 1 0%	N/A	N/A	N/A	N/A	8 of 20 40%	8 of 20 40%

* Includes those within agreed extended timescale

3.0 **Trends in Reported Serious Incidents by Provider.**
Categories of SIs are defined in the SI Framework. Table two below details the categories allocated by Providers for all 21 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.

3.3 **SHSCFT**
Six of the seven 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 timelier.

3.4 **STHFT**

Three of the six SIs reported by STHFT were categorised as: Surgical/invasive procedure incident meeting SI criteria.

3.5 **YAS**

No trends identified.

3.6 **Independent Providers**

No trends identified.

3.7 **Primary Care**

No trends identified.

4.0 **Never Events**:

Three SIs reported in quarter one were also categorised as a 'Never Event'. All three Never Events reported were reported under the category of 'Surgical/invasive procedure incident meeting SI criteria'. One was a patient that had an incorrect tibial component inserted. The second due to misidentification, the patient received Botulinum Toxin injections into four sites on his face, instead of into his cervical muscles as intended. The third was a wrong site block due to the 'stop before you block' procedure not being carried out.

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 NHS Foundation Trust (STHFT)**

a) A retrospective review has identified *that from 2014 to November, 2018, there are 45* patients whose visual deterioration may have been related to delays in their glaucoma appointments.

Actions taken:

- Utilising non-medical staff in the glaucoma pathway
- Revisit the departmental decision regarding harm classification, giving consideration to standards used in other trusts

5.2 Sheffield Children's NHS Foundation Trust (SCHFT)

a) A patient was seen in clinic and investigations were organised and completed for a later date. A review appointment was arranged for approximately 6 weeks later which was cancelled by the family due to the patient being unwell. The appointment was rearranged for a later date. However, the scheduled clinic was cancelled as the clinician was on leave. When the patient was seen in clinic approximately 4 and a half months after the first appointment cancellation they were found to have reduced left kidney function.

Actions taken:

- A process is to be developed that escalates and triages patients back into the urgent booking system if clinics are cancelled.
- A review of the Annual leave and cover arrangements for clinicians is being undertaken.
- A process will be embedded that ensures review of urgent results rather than waiting for a review appointment.

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 ongoing on improvement of action plans following serious incidents.

Provider performance:

- STHFT has maintained the timely submission of final reports. The area for improvement is the timely submission of review responses.
- SCHFT very small numbers of reports. It is of note that a high proportion of the action plans are graded good or excellent. There can be an improvement in the timely submission of reports.
- SHSCFT have maintained their improvement in the submission of initial management reports (72 hour reports). Acknowledging the small numbers of final reports received there is an area of improvement in submitting these in time.

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 **Action / Recommendations for 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 2019/20

Paper prepared by: Grace Mhora Quality Manager / Tracey Robinson, Quality Improvement Assistant

On behalf of: Mandy Philbin, Chief Nurse

21 August 2019

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

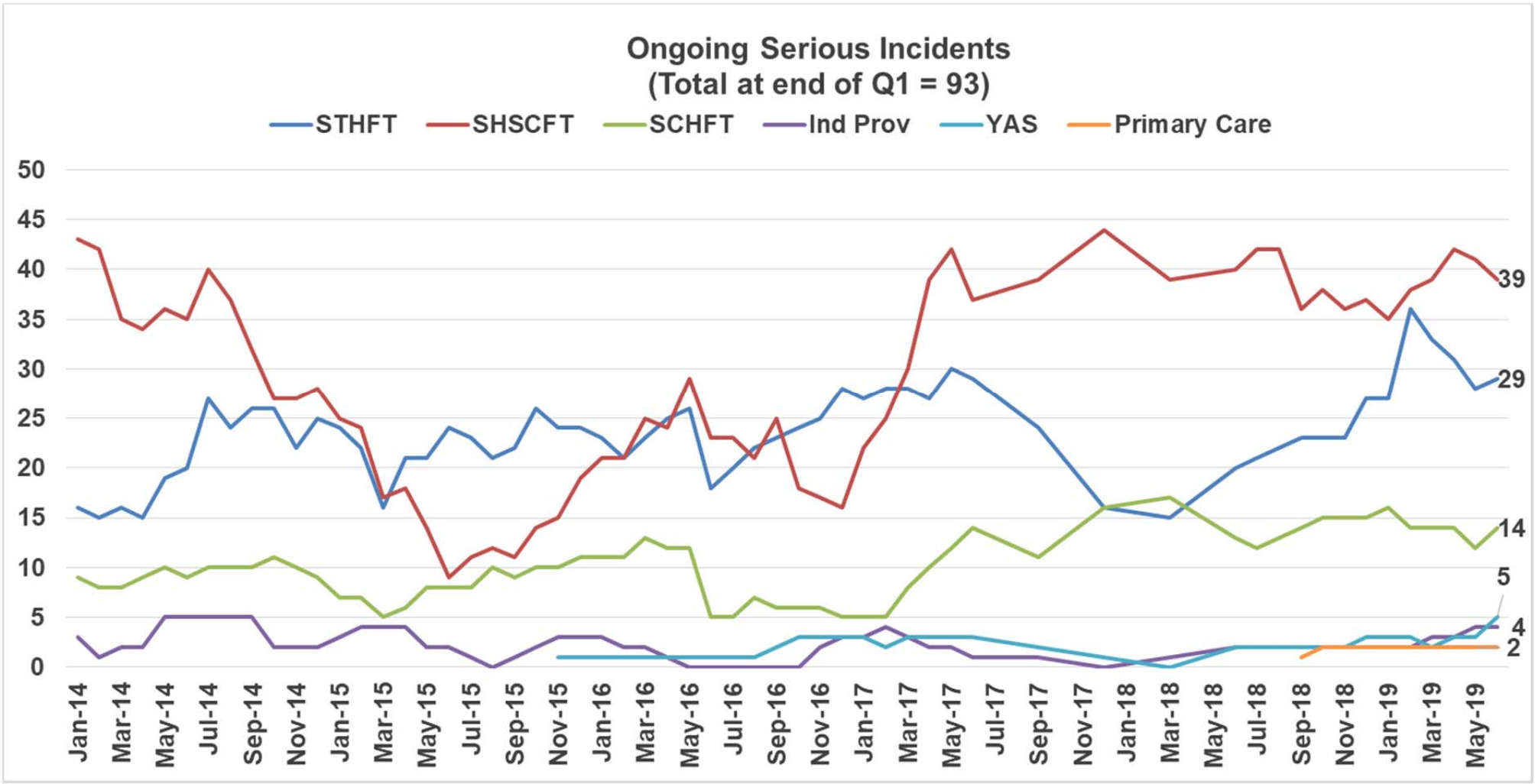
The following are the criteria of Never Events that are listed on the Never Events List 2018:

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


Ongoing Serious Incidents
(Total at end of Q1 = 93)
STHFT
SHSCFT
SCHFT
Ind Prov
YAS
Primary Care
50
45
40
35
30
25
20
15
10
5
0
39
29
14
5
4
2
Jan-14
Mar-14
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