Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Serious Incident Report Quarter 4 2018/19

Item 22m

Governing Body meeting

2 May 2019

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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 4 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 4 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
Have you carried out an Equality Impact Assessment and is it attached?
Please attach if completed. Please explain if not, why not N/A
Have you involved patients, carers and the public in the preparation of the report?
N/A

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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. 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 SIs 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 SIs reported and provide assurance of improvements in the quality of care in our Providers following SIs 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 four 2018-2019, 37 SIs were reported by our Providers. 3 of the 37 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. All the providers have maintained improvements in the submission of initial investigation reports in 72 hours. Work is ongoing to get responses to queries in time and to improve the quality of action plans.

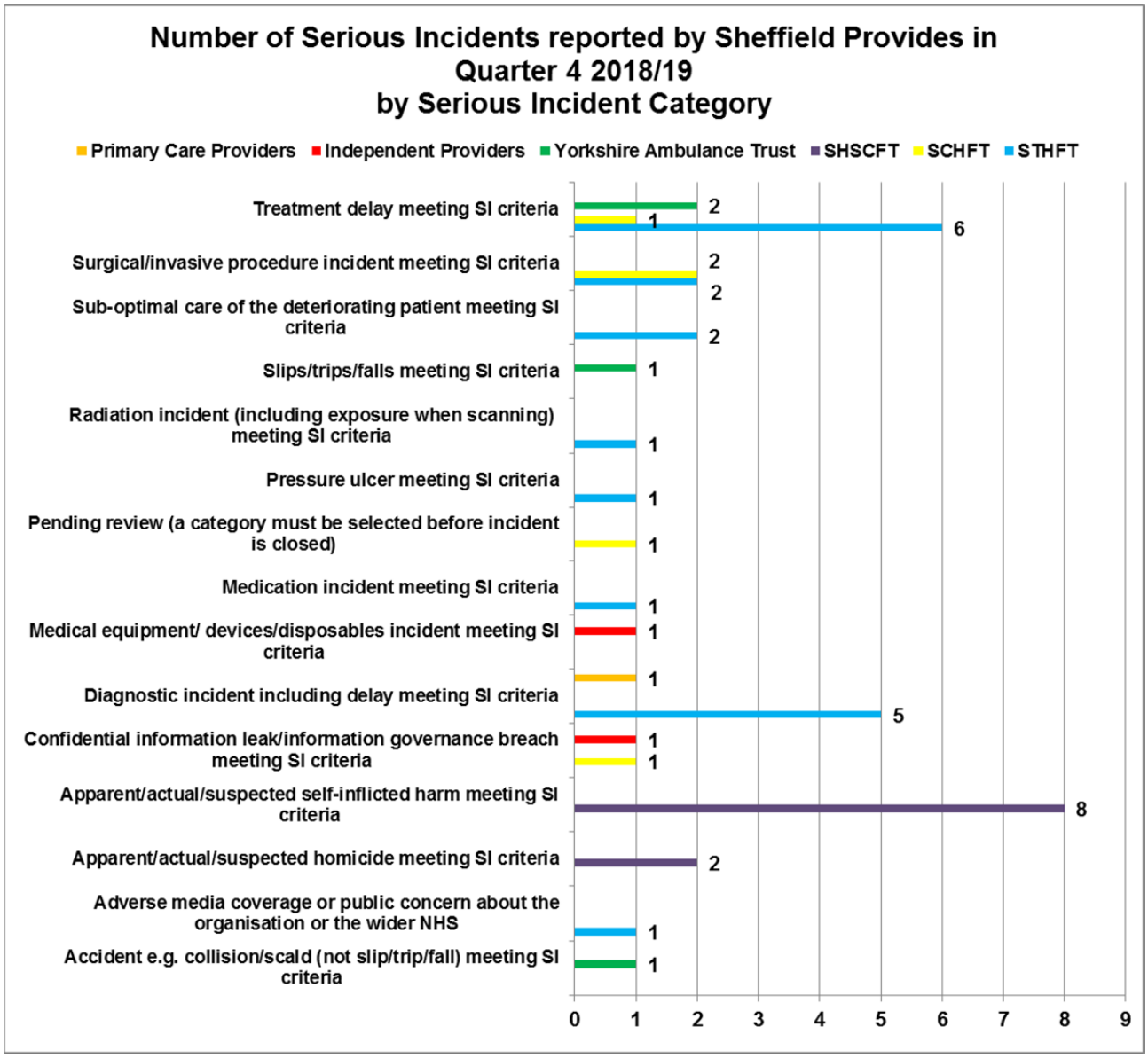
2.1 **TABLE ONE**

2018/19																																		
	SCHFT					SHSCFT					STHFT					IND Prov					YAS					General Practice					2018/19 Totals				
OPEN	**Q1**	**Q2**	**Q3**	**Q4**	**2018/19 Total**	**Q1**	**Q2**	**Q3**	**Q4**	**2018/19 Total**	**Q1**	**Q2**	**Q3**	**Q4**	**2018/19 Total**	**Q1**	**Q2**	**Q3**	**Q4**	**2018/19 Total**	**Q1**	**Q2**	**Q3**	**Q4**	**2018/19 Total**	**Q1**	**Q2**	**Q3**	**Q4**	**2018/19 Total**	**Q1 Total**	**Q2 Total**	**Q3 Total**	**Q4 Total**	**2018/19 Total**
No. of SIs opened	4	5	2	5	16	9	8	10	10	37	9	9	10	19	47	1	1	1	2	5	2	1	2	1	6	1	0	1	1	3	26	24	26	38	114
Of which 'Never Events'	1	1	0	1	3	0	0	0	0	0	1	0	1	2	4	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	2	1	1	3	7
Of total number reported, within agreed timescale	2	5	2	5	14	7	8	10	7	32	9	9	9	19	46	1	1	1	1	4	2	1	2	1	6	1	N/A	0	1	2	22	24	24	34	104
CLOSED																																			
No. of SIs Closed	9	4	1	6	20	5	4	6	2	17	5	5	6	9	25	0	1	1	1	3	0	0	2	1	3	1	0	0	0	1	20	14	16	19	69
No. of SIs De-logged	0	0	0	0	0	3	8	3	6	20	0	0	0	4	4	0	0	0	0	0	0	0	0	1	1	1	0	0	1	2	4	8	3	12	27
TOTAL ONGOING AT END OF QUARTER	13	14	15	14	14	40	36	37	39	39	19	23	27	33	33	2	2	2	3	3	2	3	3	2	2	1	1	2	2	2	77	76	86	93	93
REPORTS AND ACTION PLANS RECEIVED IN QUARTER																																			
Initial Management Report received within 72 Hours	4 of 5 80%	5 of 5 100%	2 of 2 100%	5 of 5 100%	16 of 17 94%	3 of 6 50%	6 of 8 75%	5 of 9 55%	6 of 11 54%	20 of 34 59%	8 of 9 89%	8 of 10 80%	8 of 9 89%	19 of 19 100%	43 of 47 91%	1 of 1 100%	1 of 1 100%	1 of 1 100%	2 of 2 100%	5 of 5 100%	2 of 2 100%	N/A	2 of 2 100%	1 of 1 100%	5 of 5 100%	1 of 1 100%	N/A	0 of 1 0%	N/A	1 of 2 50%	18 of 23 78%	19 of 23 83%	18 of 24 75%	33 of 38 87%	88 of 108 81%
Reports/Action plans received within 12 weeks*	2 of 5 40%	4 of 4 100%	3 of 4 75%	0 of 3 0%	9 of 16 56%	3 of 4 75%	N/A	1 of 1 100%	1 of 1 100%	5 of 6 83%	2 of 5 40%	5 of 7 71%	3 of 9 33%	4 of 10 40%	14 of 31 45%	1 of 1 100%	1 of 2 50%	N/A	1 of 1 100%	3 of 4 75%	N/A	1 of 2 50%	N/A	2 of 2 100%	3 of 4 75%	1 of 1 100%	N/A	N/A	N/A	1 of 1 100%	9 of 16 56%	11 of 15 73%	7 of 14 50%	8 of 17 47%	35 of 62 56%
REPORTS REVIEWED IN QUARTER																																			
Reports reviewed in Quarter, graded as Good/Excellent	3 of 5 60%	2 of 4 50%	3 of 4 75%	2 of 2 100%	10 of 15 67%	3 of 5 60%	N/A	N/A	0 of 1 0%	3 of 6 50%	2 of 2 100%	4 of 8 50%	8 of 8 100%	9 of 11 82%	23 of 29 79%	1 of 1 100%	1 of 1 100%	N/A	1 of 1 100%	3 of 3 100%	N/A	1 of 1 100%	N/A	1 of 1 100%	2 of 2 100%	N/A	N/A	N/A	N/A	N/A	9 of 13 69%	8 of 14 57%	11 of 12 92%	13 of 16 81%	41 of 55 74%
Action Plans reviewed in Quarter, graded as Good/Excellent	3 of 5 60%	3 of 4 75%	4 of 4 100%	2 of 2 100%	12 of 15 80%	1 of 5 20%	N/A	N/A	1 of 1 100%	2 of 6 33%	0 of 2 0%	0 of 8 0%	3 of 8 37.5%	5 of 11 45%	8 of 29 27%	1 of 1 100%	0 of 1 0%	N/A	1 of 1 100%	2 of 3 33%	N/A	N/A	N/A	1 of 1 100%	1 of 1 100%	N/A	N/A	N/A	N/A	N/A	5 of 13 38%	3 of 13 23%	7 of 12 58%	10 of 16 62%	25 of 54 46%
RESPONSES DUE IN QUARTER																																			
Responses received within given timescale (20 working days)	3 of 6 50%	1 of 4 25%	4 of 6 67%	1 of 2 50%	9 of 18 50%	0 of 7 0%	1 of 2 50%	N/A	N/A	1 of 9 11%	0 of 1 0%	3 of 7 43%	3 of 6 50%	2 of 11 18%	8 of 25 32%	N/A	2 of 2 100%	N/A	N/A	2 of 2 100%	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	3 of 14 21%	7 of 15 47%	7 of 12 58%	3 of 13 23%	20 of 54 37%

* 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 37 SIs 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**
Eight of the Ten 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**

Six of the Nineteen SIs reported by STHFT were categorised as: Treatment delay meeting SI criteria and Five were categorised as: Diagnostic incident including delay meeting SI criteria. Concerns remain regarding the management of deteriorating patients and a trust wide action plan has been received.

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 four were also categorised as a 'Never Event'. Two Never Events reported were reported under the category of 'Surgical/invasive procedure incident meeting SI criteria'. One was a patient that left theatre and entered PACU with a throat pack in situ and the second was Botulinum Toxin injections given to wrong leg. The third was reported under the category 'Medication incident meeting SI criteria'. It was a Fascia-Iliaca Block (FIB) administered for pain control to the incorrect side.

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 baby required a cannula in its left hand as a previous one had come out to enable blood glucose management. Due to the difficulties in cannulation, this was bandaged in place. Approximately 8 hours later fluid was seen on the bandage and when examined there was a significant extravasation injury.

Actions taken:

- Redesign of NICU observation chart to incorporate phlebitis 5 point scoring system and training of nursing and medical staff to be competent in phlebitis score assessment and documentation.
- Review of the Extravasation Injuries in Neonates Guidelines.

b) A missing patient was found deceased with apparent self-inflicted harm.

Actions taken:

- Acute Medical Nursing Staff now receiving training on direct questioning of patients with mental health conditions.

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

a) A patient under treatment from the Early Intervention Services was found hung at home.

Actions taken:

- Reviewed Care Co-ordinated caseloads.
- Protocol developed to ensure carers are having annual assessments.

5.3 **Sheffield Children's Foundation Trust (SCHFT)**

A patient who had a cast applied following surgery was found to have developed a Grade 4 pressure ulcer on their right knee when the cast was removed. Following discovery of the pressure ulcer, the patient was admitted to the Burns unit on the same day and the wound was washed, debrided and sutured 2 days later.

Actions taken:

- Casting practitioners require back-ground information in relation to other health needs associated with each patient
- There should always be at least two casting practitioners in theatre when casting anaesthetised patients
- There needs to be discussions with parents/carers and patients around the risk of skin breakdown/integrity when placing patients in hip spicas.

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 submitted the majority of the reports that were outstanding. This is not reflected in this quarter's reports due to those that were not received in the stipulated timeframe. The Trust continues to maintain the quality of their reports.
- SCHF have maintained their improvement in the submission of initial management reports (72 hour reports). There has been a dip in the submission of final reports this quarter although there are very small numbers.
- SHSCFT have maintained their improvement in the submission of initial management reports (72 hour reports) although there is room for improvement.

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 Q4 report for 2018/19

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

On behalf of: Mandy Philbin, Chief Nurse

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