investor in excellence

disability confident EMPLOYER

NHS Rotherham Clinical Commissioning Group

Public Session

PATIENT SAFETY/QUALITY

ASSURANCE REPORT

NHS ROTHERHAM CCG

2 SEPTEMBER 2020

This report is intended to keep Governing Body members informed on Quality & Safety across commissioned services & not intended for decision making.

CONTENTS

NHS ROTHERHAM

1. INFECTION PREVENTION AND CONTROL (IPC)

a) Healthcare Associated Infection (HCAI)

RDaSH: There have been no cases of Health Care Associated Infection so far this year (2020/21).

Hospice: There have been no cases of Health Care Associated Infection so far this year (2020/21).

HCAI:	TRFT	NHSR
MRSA	0	0
MSSA	2	24
Clostridium Difficile	7	26
E Coli	3	57

MRSA
No MRSA cases.

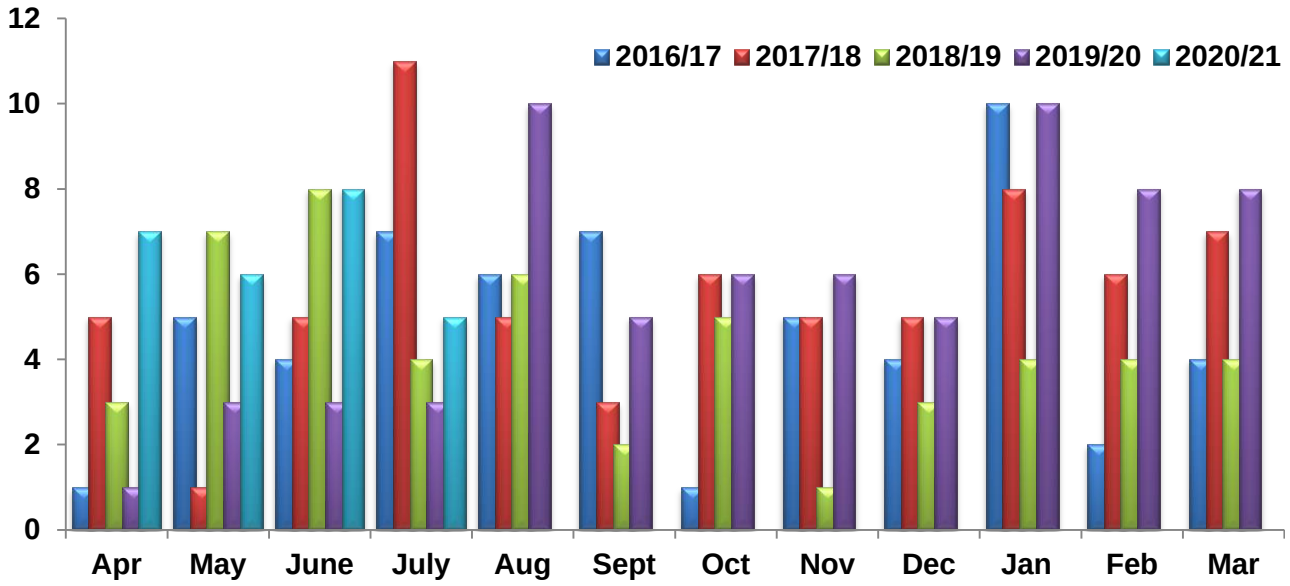
Clostridium Difficile Infections (CDI)
Post infection reviews are being undertaken on all cases of Clostridium Difficile within Rotherham. This will be a continual and reviewed process. The process will highlight any lapses in quality of care and any learning outcomes within both Community and Acute Trusts.

TRFT 2020/21 Target = No target set for CDI												
Month ➡	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Monthly Actual	**2**	**1**	**2**	**2**								
Monthly Plan	To date there has been no targets published for 2020/21.											
Year to Date	**2**	**3**	**5**	**7**								
Year to Date Plan	To date there has been no targets published for 2020/21.											

NHS Rotherham CCG 2020/21 = No target set for CDI												
Month ➡	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Monthly Actual	**7**	**6**	**8**	**5**								
Monthly Plan	To date there has been no targets published for 2020/21.											
Year to Date	**7**	**13**	**21**	**26**								
Year to Date Plan	To date there has been no targets published for 2020/21.											

Figure comparison for NHS Rotherham CCG of CDI

The chart below shows a side by side comparison of the number of all CDI cases by years.

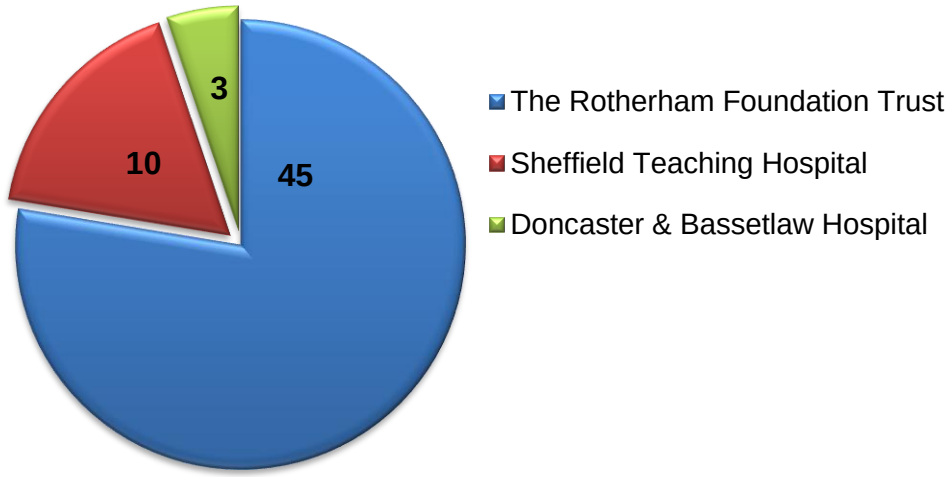


E Coli

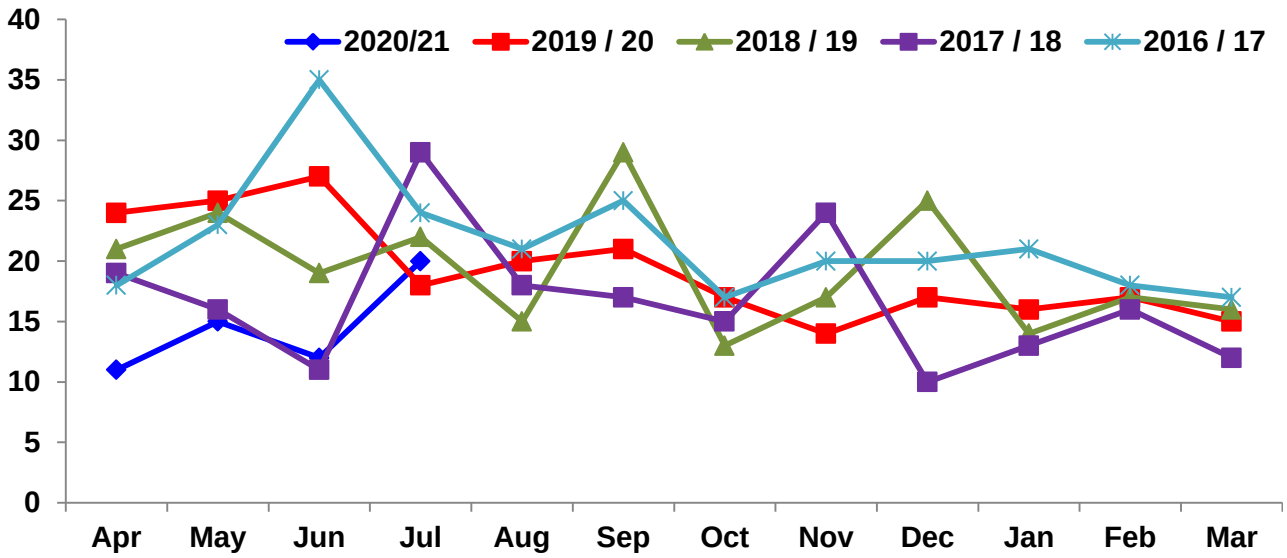
E Coli bacteraemia rates are high and have nationally increased in the last 5 years. There is a national reduction priority and local initiatives are on-going.

TRFT 2020/21 Target = No target set for E Coli												
Month ➡	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Monthly Actual	**0**	**1**	**0**	**2**								
Monthly Plan	To date there has been no targets published for 2020/21.											
Year to Date	**0**	**1**	**1**	**3**								
Year to Date Plan	To date there has been no targets published for 2020/21.											
RCCG 2020/21 Target = No target set for E Coli												
Month ➡	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar
Monthly Actual	**11**	**15**	**12**	**20**								
Monthly Plan	To date there has been no targets published for 2020/21.											
Year to Date	**11**	**26**	**38**	**58**								
Year to Date Plan	To date there has been no targets published for 2020/21.											

E Coli -The chart below details where these samples were taken.



E Coli - The chart below shows a monthly comparison of the number of E Coli cases in years.



b) COVID-19

- There is intermittent contact from GP practices asking for advice regarding IPC and the guidance, there has been no national guidance published so all advice given is based on the guidance that there is and advised to refer to this. The lack of guidance has been raised with the regional NHSE&I team as an area of concern.
- A Primary Care outbreak flowchart has been developed by the Consultant for Public Health in Rotherham, this includes support from Infection Prevention and Control and the CCG, this has not yet needed to be enacted.
- The Hot Hub: IPC support was given with Standard Operating Procedures (SOPS), walk rounds and IPC support and advice.
- Care home support and teaching was completed in line with the national request. This remains in place if requested or required by individual care homes. There is a process in place regarding the management of local outbreaks in care homes with an Incident Management Team (IMT) with collaborative working between the care homes, Local Authority, TRFT, PHE, and the CCG.

- During August there has been/are 7 open outbreaks registered with Public Health England (PHE), within care homes, these have IMT meetings and actions in place in place. The theme currently appears to be related to staff with minimal resident infectivity. The positive cases are low members of asymptomatic staff identified from the care home staff and resident testing.
- Support with 'returning to Oak house' from an IPC perspective is taking place based on current guidance.
- Support with Flu planning in primary care from an IPC perspective is occurring based on current guidance.

Norovirus

Since the last reporting period, to date there has been one Care Home with confirmed norovirus. PHE support has been given throughout.

2. MORTALITY RATES

The Hospital Standardised Mortality Ratio (HSMR) currently sits at 117 (March 2020 data) and the Summary Hospital-level Mortality Indicator (SHMI) at 119. These continue to be statistically significantly higher than expected, but are expected to notably fall in coming months due to all non-elective activity (NEL) now being counted as part of the national return/data analysis. Issues related to quality of care and coding continue to be looked at in detail and reported by the Medical Examiner in conjunction with the detailed mortality report provided by Dr Foster to provide further insight into the themes and trends affecting the Trust's data. The Medical Examiner service is currently challenged due to COVID-19 and staff sickness, but the Medical Director is actively trying to expand the number of Medical Examiners and Medical Examiner Officers in post to improve resilience.

3. SERIOUS INCIDENTS (SI) AND NEVER EVENTS (NE)

SI Position 21.07.2020 – 19.08.2020	TRFT	RDASH	RCCG	**Out of Area	YAS	GP / Hospice
Open at start of period	47	15	2	1	0	0
Closed during period	0	2	0	1	0	0
De-logged during period	2	0	0	0	0	0
New during period	8	1	0	0	0	0
New Never Event during period	0	0	0	0	0	0
Total Open at end of period	53	14	2	0	0	0
Of the above the number that are NE	1	0	0	1	0	0
Final Report Status						
Final Reports awaiting additional information	5	0	0	0	0	0
*Investigations on "Hold"	2	0	2	0	0	0
CCG approved Investigations above 60 days	0	6	0	0	0	0
Investigations above 60 days without approval	25	0	0	0	0	0
Final Reports due at next SI Meeting	40	13	0	N/A	0	0

* On "Hold" pending investigation being undertaken by Police or Healthcare Safety Investigation Branch (HSIB)
**Out of Area: *Performance Managed by responsible CCG. Final Reports are discussed by committee for comment/closure agreement upon receipt as response is time sensitive.*

Attached as Appendix A is a copy of the Serious Incidents Annual Report

4. SAFEGUARDING VULNERABLE CLIENTS

SAVE THE DATES! **Keep up to date with Safeguarding training events and publications** http://intranet.rotherhamccg.nhs.uk/training-materials-for-practitioners.htm	02/11/2020 to 05/11/2020	@NHSSafeguarding is back with a #UniqueWeek of MS Live Events 2nd to 5th November, 12.00 to 13.00. Further details including speakers and timings will be shared in due course. This is our time to be brave & bold so that we all safeguard everyone who might require support in their trauma informed journey. Missed our #FabulousFortnight? Click here to find all the recorded events, Q+As and presentations on our FutureNHS Platform.
	16/11/2020 to 20/11/2020	Reminder - safeguarding awareness week dates have been agreed across South Yorkshire : 16th – 20th November, this is in line with the Ann Craft Trust Safeguarding Week. Task and finish groups have been initiated with further details of events to follow. If you would like to contribute to the planning process, please e-mail Catherine.warrener@rotherham.gov.uk
	19/10/2020	Child Exploitation Day (virtual) - Rotherham Safeguarding Children Partnership are offering this workshop to help with the identification, support and protection of children who are being exploited. This workshop is suitable for all agencies and settings who work with children, young people and their families. It is of particular interest to those who have safeguarding responsibilities.
	20/10/2020	An Introduction To Child Exploitation - Rotherham Safeguarding Children Partnership are offering this workshop to help with the identification, support and protection of children who are being exploited. This workshop is suitable for all agencies and settings who work with children, young people and their families.
	13/05/2021	Reminder that the new date for the Safeguarding PLTC is Thursday 13th May 2021. Training will take place virtually with further details on the programme for the day to follow “Life Long 13/05/2021 Legacy” event.

VRU
South Yorkshire
Violence Reduction Unit

The South Yorkshire Violence Reduction Unit is based at Shepcote Lane in Sheffield and is working across South Yorkshire to prevent and reduce violent crime.

In South Yorkshire, we are taking a public health approach to preventing and reducing violence, looking at the causes of violence, working in partnership to prevent violence before it starts, halt the progression of violence once it has already begun and provide ways out for people already entrenched in violent behaviour.

The full South Yorkshire Reduction Unit information for Practitioners is available on the internet.

The following animation explains the public health approach to violence:
https://www.youtube.com/watch?v=VZOEnCd6uiI&t=22s

You can find out more about the South Yorkshire Violence Reduction Unit on their website www.southyorkshireviolencereductionunit.com or by following on Twitter @SY_VRU

SAVE THE DATES! @NHSSafeguarding is back with a #UniqueWeek of MS Live Events 2nd to 5th November, 12.00 to 13.00

Further details including speakers and timings will be shared in due course. **This is our time to be brave & bold so that we all safeguard everyone who might require support in their trauma informed journey.**

Missed our #FabulousFortnight? Click here to find all the recorded events, Q+As and presentations on our FutureNHS Platform.

Safeguarding PLTC Virtual Event

May 2021

M	T	W	T	F	S	S
					1	2
3	4	5	6	7	8	9
10	11	12	13	14	15	16
17	18	19	20	21	22	23
24	25	26	27	28	29	30
31						

"Life Long Legacy"

Reminder that the new date for the Safeguarding PLTC is **Thursday 13th May 2021. Training will take place virtually with further details on the programme for the day to follow** "Life Long Legacy" event.

Safeguarding Awareness Week 2020	Reminder - safeguarding awareness week dates have been agreed across South Yorkshire : **16th – 20th November**, this is in line with the Ann Craft Trust Safeguarding Week. Task and finish groups have been initiated with further details of events to follow. If you would like to contribute to the planning process, please e-mail **Catherine.warrener@rotherham.gov.uk**.
CHILD EXPLOITATION DAY **Virtual Workshop** **October 19th 2020 10.00am-12.00pm (break) 1.00pm-3.00pm**	Rotherham Safeguarding Children Partnership are offering this workshop to help with the identification, support and protection of children who are being exploited. To book a place you need to be registered onto the Virtual College system. If you are not already registered you can do this via the link: https://rotherhamlscb.safeguardingchildrenea.co.uk/
AN INTRODUCTION TO CHILD EXPLOITATION **Virtual Workshop** **October 20th 2020 9.30am–11.15am (break) 11.45am-12.30pm**	Rotherham Safeguarding Children Partnership are offering this workshop to help with the identification, support and protection of children who are being exploited. To book a place you need to be registered onto the Virtual College system. If you are not already registered you can do this via the link: https://rotherhamlscb.safeguardingchildrenea.co.uk/
THE CHILD SAFEGUARDING PRACTICE REVIEW PANEL **Safeguarding Children at Risk of Criminal Exploitation**	A national review into adolescent deaths or serious harm where criminal exploitation was a factor has now been published. This review sets out recommendations and findings for government and local safeguarding partners to protect children at risk of criminal exploitation. It is a qualitative study of 21 cases from 17 local areas regarding children who died or experienced serious harm where criminal exploitation was a factor. Full report on the CSPR website: https://www.gov.uk/government/publications/safeguarding-children-at-risk-from-criminal-exploitation
Safeguarding children at risk from sudden unexpected infant death (SUDC)	Review published regarding sudden unexpected death in infancy (SUDI) in families where the children are considered at risk of significant harm**.** This review sets out recommendations and findings for government and local safeguarding partners to better protect infants from sudden unexpected death in infancy (SUDI). The aim is to identify what might have been done differently and how to improve approaches to embed safer sleeping advice in families with children considered to be at risk of significant harm through child abuse or neglect. Full report: https://www.gov.uk/government/publications/safeguarding-children-at-risk-from-sudden-unexpected-infant-death

AUGUST UPDATE

Safeguarding Adults:

- Regular virtual meetings with partners and providers continue to meet statutory safeguarding responsibilities.
- Work continues on planning safeguarding awareness week which will take place the week commencing 16th November 2020.
- The CCG have inputted on the Rotherham Safeguarding Adults Board (RSAB) annual report, with its contribution received by the board.
- The RSAB has seen the publication of SAR Elizabeth. http://www.rsab.org.uk/downloads/file/25/safeguarding-adult-review-elizabeth
- NHSE/I have published a Covid19 MCA/DoLS and Best Interest rapid read to assist during Covid19 available in the intranet: http://intranet.rotherhamccg.nhs.uk/Downloads/Safeguarding/2020/Covid%20MCA%20DoLS%20RAPID%20READ%20Online.pdf

The Safeguarding Annual Update 2019 20

Is now going through governance, providing an overview of key issues and activities taking place across the Rotherham health economy in relation to safeguarding children and adults for the year 2019/20. Some of the key points:

- ***Rotherham Safeguarding Children Partnership Multi-Agency Arrangements for Safeguarding Children*** published June 2019
- ***Safeguarding Children, Young People and Adults at Risk in the NHS: Safeguarding Accountability and Assurance Framework*** (SAAF) updated in August 2019. The SAAF now becomes a joint NHS England and NHS Improvement Framework and builds on its predecessor by strengthening the NHS commitment to promoting the safety, protection and welfare of children, young people and adults.
- ***South Yorkshire Partnership to tackle Modern Slavery launched*** in May 2019 – a regional response to tackling modern slavery.
- ***Health & Justice Board Sexual Assault & Abuse Strategy High Volume Fund*** – funds secured for the innovative Rotherham Trauma & Resilience Service (TRS) in order to continue the work of supporting and delivering a wraparound health and wellbeing offer to victims/survivors of historic sexual exploitation.
- ***Know the line campaign*** launched September 2019 asking individuals to: **SEE IT, CALL IT, STOP IT**. A short video highlighting woman's experiences of sexual harassment can be found at: **https://youtu.be/JId0LBuYlUQ**
- ***Covid-19*** – On 23rd March the country went into lockdown but our safeguarding work continued virtually with partners across Rotherham and the wider SY&B ICS footprint.

Multi Agency Safeguarding Hub (MASH)

- The MASH is operating well with the support of virtual and on-site staff.
- Mechanisms are in place to review, assess and plan for domestic abuse cases, including how MARAC will operate.
- Daily MADA meetings being held for victims of high risk domestic abuse
- Health Professionals in the MASH are assisting with information sharing for other areas as required – i.e Early Help, strategy meetings.
- Fostering and Adoption, and Special Guardianship medicals - Joint working with LAC designated doctor and social care.

ICON – Work is taking place with partners around this NHS E&I block contracted intervention for use across the North region.

Fundamentally a public health message – research across England demonstrates that the intervention is even more successful when the work is not labelled as a safeguarding message. However the ultimate purpose of the work is to reduce abusive head trauma not colloquially as Shaken Baby Syndrome. The impact of Shaken Baby Syndrome is catastrophic for the individual, the family and ultimately society. As babies who endure this often die or are left with significant lifelong disabilities.

ICON represents:
* I – Infant crying is normal – peaks around 2 – 6 weeks.
* C –Comforting methods can help - in line with Baby Friendly compliance.
* O – It's OK to walk away – not controlled crying it's to support the parents in calming down
* N – Never, ever shake a baby – clear unambiguous message, needs to be given by everyone

It is an evidence based programme consisting of a series of brief 'touchpoint' interventions that reinforce the simple message making up the ICON acronym. https://iconcope.org/. This is a well-researched programme in America and Canada with the findings being clear that parental understanding of crying strengthens their coping strategies, concluding that there is a need for parenting education and support which 'normalises' crying and offers practitioners an opportunity to reduce abusive head trauma. The series of touchpoints include brief interventions required all with consistent message, babies cry, its normal, you must never shake the baby – you can cope.

CARE HOME CONCERNS (no change since last report)

CQC Rating	No:
Outstanding	0
Good	27
Requires Improvement	7
Inadequate	0
Not Rated	1

Of the 35 Adult Res/Nursing care homes 27 (77.1%) are Good, 7 (20%) are rated "Requires Improvement", there are no providers rated as "Inadequate". There is 1 (2.9%) new service that is not yet rated. During 2020/21 (1/4/20-7/7/20) there have been 145 contract concerns raised against all providers, which is 1 less than what was reported during the same period in 2019/20. Of the 145, 43(29.6%) relate to Adult Residential/Nursing care, with 20 providers being identified. **There are no providers currently in contract default**

CARE HOME AND CQC REPORTS

No reports published in Rotherham for the previous month.

MISSING EPISODES REPORTED TO HEALTH MASH

The information below has been collated by the Health MASH team and relates to notifications received from 1st July 2020 to 31st July 2020

Number of reported Missing Notifications **48**

→ Involving **63** Children/ unborn babies

→ Of which **23** are female ●

→ And **27** were male ■

→ There were also **13** expectant mothers named in the notifications ▲

Youngest Child was born in 2020 ⟷ Oldest Child was born in 2002

Outcome of missing episodes

Found / Closed notifications: **22**

National missing notifications that are not located in Rotherham: **26**

Open (Still reported as missing): **0**

From the Missing Episode Notifications received:
23
Were reported as LAC Children

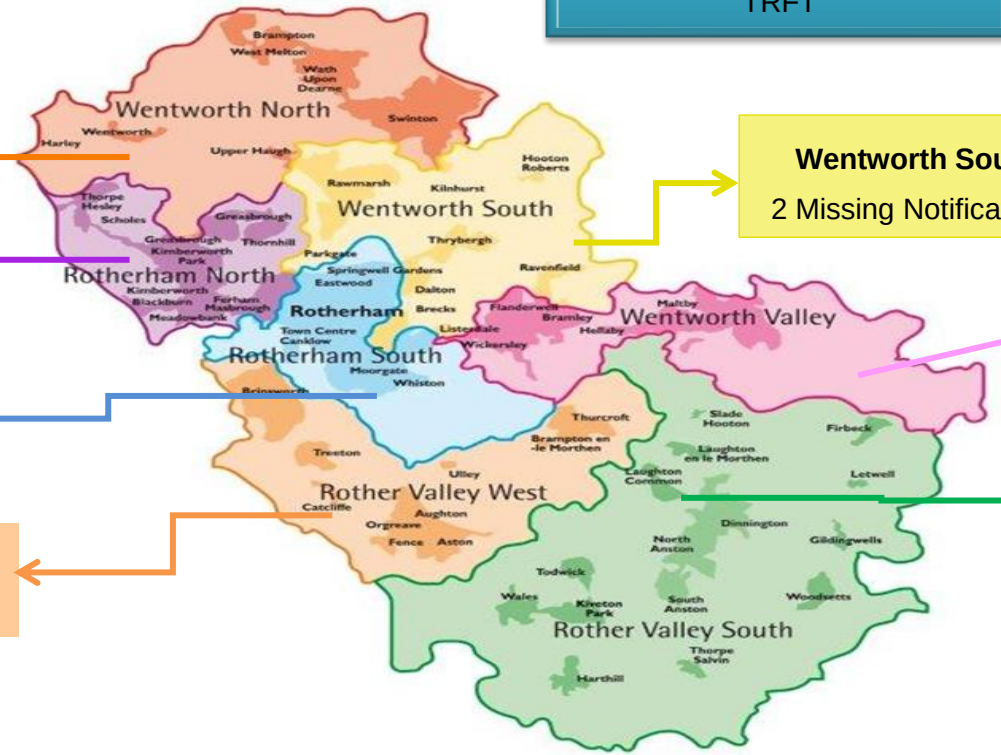
Source Of Notification	Number received
Police	22
RMBC	26
TRFT	0

Wentworth North
0 Missing Notifications

Rotherham North
3 Missing Notifications

Rotherham South
2 Missing Notifications

Rother Valley West
2 Missing Notifications



Wentworth South
2 Missing Notifications

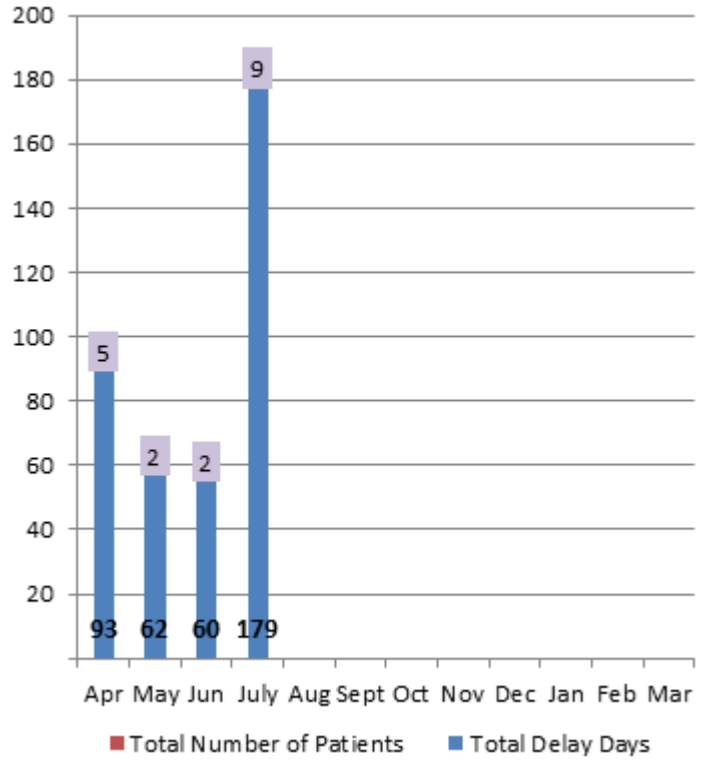
Wentworth Valley
1 Missing Notifications

Rother Valley South
1 Missing Notifications

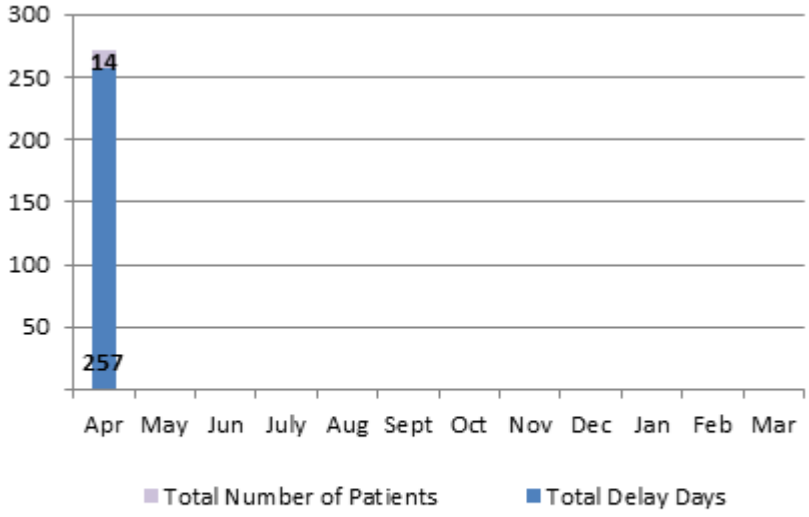
Out of Area Notifications
37

5. DELAYS IN TRANSFER OF CARE (DTOC)

Adult Mental Health



Older People's Mental Health



6. ADULT CONTINUING HEALTHCARE (CHC)

NHS Continuing Healthcare and COVID-19 Planning

The Hospital Discharge Service Requirements were published on 19th March 2020 and set out the Hospital Discharge Service Requirements for all NHS trusts, community interest companies and private care providers of acute, community beds and community health services and social care staff in England, which has been adhered to from Thursday 19th March 2020. It also sets out requirements around discharge for health and social care commissioners (including Clinical Commissioning Groups and local authorities).

National NHS Continuing Healthcare COVID-19 emergency preparedness

Acute and community hospitals were advised that they must discharge all patients as soon as they are clinically safe to do so. Transfer from the ward should happen within one hour of that decision being made to a designated discharge area. Discharge from hospital should happen as soon after that as possible, normally within 2 hours. Implementing these Service Requirements was expected to free up to at least 15,000 beds by Friday 27th March 2020, with discharge flows maintained after that.

Temporary arrangements for NHS Continuing Healthcare (NHS CHC) have been implemented for the duration of the COVID-19 emergency period. These arrangements cover:

- The assessment of eligibility for NHS CHC funding - NHS CHC assessments for individuals on the acute hospital discharge pathway and in community settings will not be required until the end of the COVID-19 emergency period

- Individual requests for a review of an eligibility decision (i.e. Local Resolution and Independent Review) Individuals can still make requests for a review of an eligibility decision however the time frame for a response will be relaxed

- Three- and twelve-month reviews of NHS CHC packages of care There is an expectation that CCGs will take a proportionate view to undertaking three- and twelve-month reviews to ensure that the individual's care package is meeting their needs and to ensure that any concerns raised are addressed as appropriate

Our objective throughout the COVID-19 emergency period has been to implement the following temporary arrangements:

<u>Expedite safe discharge of patients from acute hospital beds under Emergency Preparedness Resilience and Response (EPRR) arrangements.</u>

We have redeployed nurses to support the Discharge team at Rotherham Hospital and the community bed bases, which means that our team works into a 7 days a week 8am-8pm rota.

<u>Reduce the NHS CHC assessment burden in and out of hospital settings.</u>

We have provided advice and support to our colleagues and individuals.

We have provided a 7 day a week duty service rather than a 5 day week service.

We have supported individuals with weekly welfare telephone calls to give individuals a chance to discuss and address any challenges.

<u>Release clinical and support staff to support the system to manage the COVID-19 outbreak.</u>

Care home Support – We have worked with the care home support team to provide an identified nurse who has been in regular telephone contact with individual care homes providing advice and support to deal with issues and challenges.

We have supported COVID-19 testing in care homes.

We have sourced and delivered PPE to individuals and care homes.

Update

The latest government guidance published on 31st July 2020 states the following:

"… The Government has further decided that CCGs must resume NHS Continuing Healthcare assessments from 1 September 2020… Any patients discharged from hospital between 19 March 2020 and 31 August 2020, whose discharge support package has been paid for by the NHS, will need to be assessed and moved to core NHS, social care or self-funding arrangements."

In line with the above guidance, the CHC team are working with partner agencies to undertake relevant assessments from 1 September 2020.

7. PRIMARY CARE

As work is underway to restore all Primary Care clinical services, so are plans to ensure contract quality and performance. The Team has continued to remotely monitor all practices and provide support and guidance where necessary, but we have now also reinstated the Contract and Quality visits remotely using video-conferencing. Our visit review with Blyth Road in late July was a success, and provided us with a model for roll-out. We're now in the process of proceeding with planned 'visits' as well as implementing a catch-up programme for those that were missed at the peak of the pandemic.

We've also recently reviewed the National Patient Survey information for each practice; this performance will be linked with the Primary Care Dashboard to identify any outliers and, if necessary, a programme of peer support reviews will be out in place. In the past these informal meetings have helped practices to look at their own performance and use best practice examples from others to make real changes and improve patient care.

8. FRACTURED NECK OF FEMUR INDICATOR

The Royal College of Physicians Hip Fracture Database shows that there have been 29 people presenting at TRFT with hip fractures in April - May 2020.

9. CQUIN UPDATE

TRFT

NHS England and NHS Improvement suspended the 2020/21 Commissioning for Quality and Innovation (CQUIN) from April to July 2020 and there is therefore no requirement to take action to implement the CQUIN requirements, nor carry out CQUIN audits or submit CQUIN performance data. Further guidance is expected imminently and this is expected to confirm that the operation of the 2020/21 CQUIN scheme will remain suspended for all providers for the remainder of the year; an allowance for CQUIN will continue to be included in the block payments made to Trusts.

RDaSH

NHS England and NHS Improvement suspended the 2020/21 Commissioning for Quality and Innovation (CQUIN) from April to July 2020 and there is therefore no requirement to take action to implement the CQUIN requirements, nor carry out CQUIN audits or submit CQUIN performance data.

10. COMPLAINTS

Via TRFT

The Trust received 125 concerns (83 in May) and 11 formal complaints (6 in May) in the month of June. 5 complaints were closed. No local resolutions meetings were held due to social distancing restrictions. Complaints responded to within the agreed timescale 60% (20% in May). This relates to two responses that were submitted late. There were 2 complaints re-opened in June, making the total currently being re-investigated 19. All out of date complaint responses have now been cleared and the Trust is on trajectory to achieve 100% compliance with timescales during July.

Via RCCG

No formal complaints have been received during the period.

The pause on complaint investigations has now been lifted; one complaint remains outstanding which required comment from Adult Mental Health Services, RDaSH. The CCG is awaiting this comment and is actively being pursued. ONGOING

Two contacts have been made by MPs regarding the delay in patients awaiting hip/knee replacement surgery. The current position on surgery has been provided. CLOSED

11. ELIMINATING MIXED SEX ACCOMMODATION

RDaSH/Hospice – there have been no recent breaches.

TRFT - there have been no breaches to date for 2020-21.

12. CQC INSPECTIONS

During July 2020 the Care Quality Commission have undertaken a review of the Children's Pathway and Safeguarding. This included data requests, interviews and a site visit. Following this, the Trust submitted an action plan to address specific concerns. As part of delivering on the action plan (Safeguarding Quality Improvement Plan), a weekly meeting has been arranged to review and update the plan, with fortnightly updates to the CQC (along with required evidence) and weekly review at Executive Team Meeting. The interim and final reports including action plans will be monitored through the joint Contract Quality Meetings for assurance purposes.

In addition to this, the Trust continue to respond to all other CQC requirements including updating outstanding actions from previous inspections and responding to ad hoc enquiries. During COVID-19, the CQC requested that any good practice that was identified by the Trust should be submitted to the CQC who would retain this and it would be used in future inspection reports.

13. ASSURANCE REPORTS

TRFT

A&E

Whilst the Trust are not currently reporting the 4-hour standard due to being a Field Test pilot site, the published HES statistics evidence that the Trust's Time to Triage performance met the 15 minute standard for every single day of the month, which has never been achieved before. The 3 core field test pilot metrics were all comfortably met in month. This was possible due to strong flow through the organisation, despite the need to cohort Covid-19 patients in appropriate beds. There were no 12-hour trolley waits, with a total of 1 ambulance handover over 60 minutes (compared to 46 in the same month last year).

Due to the release of capacity throughout the hospital, this has led to good flow out of ED on a daily basis. Attendances are now, over the last few weeks, at last year's averages with a number of particularly busy days each week.

Cancer Standards

Cancer care remains a significant concern given the volume of patients now waiting for diagnostics or treatment, but capacity was significantly increased in June with the revision to the NHS and British Society of Gastroenterologists (BSG) guidance on endoscopy. However, many cancer patients will still not be diagnosed and treated as quickly as previously although all patients are being clinically triaged and regularly clinically reviewed to ensure appropriate prioritisation of patients. Use of the Independent Sector for cancer procedures (diagnostics and treatment) is being maximised wherever possible.

On the main indicator of 62-day treatment in May the Trust saw an expected deterioration and this was down to reduced completion of pathways 58.5% against the 82% target with a slight improvement in June (not yet validated).

62-day performance has been a challenge to deliver and sustain for a long period of time at TRFT. The Trust have historically struggled to deliver the standard within the Lower GI and Urology specialties in particular, although there are also challenges in the smaller tumour sites such as Head and Neck and Lung. In pre-Covid times, approximately half of these used to be due to late referrals of patients to tertiary centres. Since March, the more significant issue has been Covid, particularly the

constraint around the types of procedures that could be carried out (including endoscopy) and the need to cancel all non-urgent surgery. This has led to a growing waiting list, of whom now a significant proportion have been waiting over 62 days. Now surgical and diagnostic activity has increased, these long-waiting patients are gradually being treated, and appearing as breaches within the performance data.

All 104+ day patients waiting are now being discussed with the regional team on weekly calls every Thursday.

Other targets (2 week waits and 31 days) are showing a positive position, but this is due to reduced numbers and limited referrals.

2 new indicators have been included but the trust do not yet have an agreed target, nor do they have a national target for last years "FDS" faster diagnostic standard which showed a reduction from 75% last year to 56% Q1 so far.

The Trust is now running all diagnostics for cancer patients, in order to confirm the original clinical triage decision of low or medium risk, and also to ensure timely diagnosis for the emotional wellbeing of patients.

18wws

Referral to Treatment performance dropped down to 53% in June given the number of long-waiters who have not been treated during the pandemic, although the overall size of the waiting list remains low compared to historically. This is expected to increase this quarter given the increasing numbers of referrals and continued constraints on elective theatre capacity. All but one service is breaching 18 weeks.

52wws

There have been 9 x 52-week breaches.

6 Week Diagnostics

The validated position for DMO1 for June is 62.8% this is across all specialties.

Other TRFT Operational/Performance Areas to Note

Venous Thromboembolism (VTE)

The VTE risk assessment completion levels increased significantly in June, which is likely due to the mandatory nature of a new field required within the electronic patient record (EPR). Issues with paper forms not being uploaded to Meditech are being picked up directly with services.

Workforce

There has been a reduction in Registered Nurse/Midwife fill rates on days and an increase on nights when compared to those for May with an increase in Healthcare Support Worker shift fill rates on days and a reduction on nights. The overall vacancy rate has reduced with recruitment plans included during June 2020, this is in part be as a result of the temporary recruitment of student nurses on paid placement.

The principle of ensuring the safest staffing has been considered and aligned to operational planning processes so that care can be provided during the pandemic. Nurse staffing has been temporarily increased in some wards and departments to safely manage the increase in acuity and patient numbers in those areas. Colleagues have been redeployed from temporarily closed wards to support those with increased acuity and/or capacity.

Recently recruited seven nurses from overseas these have completed the quarantine period and will be commencing their inductions. The trust has also seen seventeen members return to nursing who are also undergoing the induction process.

NHS Safety Thermometer – TRFT

There has been no further update received regarding the replacement national system for monitoring patient safety.

Looked After Children

The percentage of Initial Health Assessments (IHA) completed within the statutory 20 working day timeframe was 75% for June 2020. During the month, 8 IHAs required completion, of which 6 were within timescale. Both patients who received assessment outside the 20-day timeframe were due to patient choice, as both patients had been given appointments within 20 days but these failed on the day. Assessments are currently being undertaken virtually rather than face to face.

Clinically Led Visits

Clinically led visits are currently on hold due to the COVID-19 pandemic.

14. ASSOCIATE CONTRACTS

Trust	A&E Four Hour Access Standard	RTT 18ww Incomplete Pathways May 2020 %	Cancer 62 day wait from urgent GP referral to first definitive treatment May 2020 %	6 Week Diagnostic May 2020 %
Sheffield Teaching Hospitals NHS Foundation Trust	Not available	76.0	64.4	62.98
Doncaster & Bassetlaw Hospitals NHS Foundation Trust	Not available	72.3	81.6	71.63
Barnsley Hospital NHS Foundation Trust	Not available	73.9	76	73.01
Sheffield Children's Hospital NHS Foundation Trust	Not available	68.4	N/A	47.02

15. CARE AND TREATMENT REVIEWS

DToCs – There are currently seven working age DToCS two of which are longstanding, both of whom are awaiting suitable placements. There are also five more recent DToCs, two patients are awaiting housing, one is awaiting Mental Capacity Act/Best Interest (MCA/BI) assessment, one requires funding documentation to be completed and the other is awaiting a low secure bed. There are also four older people's DToCs, two of which are awaiting a care package and two awaiting a suitable placement. The CCG continues to contribute to the weekly RDaSH DToC virtual meetings.

16. WINTERBOURNE SUBMISSION

During this reporting period there haven't been any learning disability patients admitted to hospital nor have there been any discharges in respect of the three long standing inpatients.

17. DYNAMIC SUPPORT REGISTER

During this reporting period there have been no community or inpatient CETR or CTRs. The CCG continues to contribute virtually to the weekly Dynamic Support Register meetings Chaired by RDaSH.

18. LEARNING DISABILITY MORTALITY REVIEWS (LeDeR)

During July there weren't any notifications to LeDeR. The CCG continues to work towards the trajectory for completion of all existing reviews as per NHSE/I guidance.

Sue Cassin – Chief Nurse
September 2020

APPENDIX A

NHS Rotherham Clinical Commissioning Group	
Serious Incident Committee Meeting – 15/07/20 **Operational Executive – 24/07/20** **Strategic Clinical Executive – 29/07/20** **Audit & Quality Assurance Committee (AQuA) – 01/09/20** **Clinical Commissioning Group Governing Body - 02/09/20**	
Serious Incident (SI) & Never Event (NE) Annual Report 01/04/2019 to 31/03/20	
Lead Executive:	**Sue Cassin, Chief Nurse**
Lead Officer:	**Kirsty Leahy, Head of Quality**

Purpose:

To provide Operational Executive (OE) with assurance of continued learning and provider management of Serious Incidents and Never Events.

Background:

NHS Rotherham Clinical Commissioning Group (CCG) has the responsibility for performance management of all Serious Incidents (SI) and Never Events (NE) reported by commissioned providers, the process follows the NHS England Serious Incident Framework (updated March 2015). The NHS England Serious Incident Framework (March, 2015) defines Serious Incidents as 'acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse, Never Events (NE) incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services'.

Ensuring patients are safe from harm is a priority for the CCG, the strong emphasis on performance and quality contract management sustains and disseminates improvements throughout commissioned services. This report provides an overview of trends and themes identified in relation to incidents during 2019/20.

Analysis of key issues and of risks

All reported SI & NE, are individually performance managed, with a provider organisation comprehensive action plan. Individual incidents and performance data are discussed regularly. Information and incident reports are utilised in holding providers to account at Quality Review meetings held between each provider and the CCG.

Across the CCG commissioned services between April 2019 and March 2020 there were 107 reported SI. This compares to 87 reported SI in the previous year.

The report will provide analysis of the CCG main providers and highest reporting organisations, The Rotherham Foundation Trust (TRFT) and Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH).

TRFT
70 reported incidents
15 incidents de-logged
55 incidents to go through the full SI process

Maternity / Obstetrics, Diagnostic / Treatment Delay and Suboptimal Care were the highest reportable recurring themed serious incidents accounting for 56% of the 55 incidents.

Pressure Ulcers, Slips/Trips/Falls and Abuse / Alleged Abuse have increased in comparison to the last reporting period.

The report will look at the actions & recommendations being undertaken with the aim to reduce these incidents.

RDaSH
30 reported incidents
30 incidents to go through the full SI process

Apparent / actual / suspected self-inflicted harm is the highest reportable recurring themed serious incidents with an outcome of 'unexpected/potentially avoidable death' for 21 of the 28 incidents.

The report will look at the actions & recommendations being undertaken along with the work supporting measures in reducing these incidents relating to suspected suicides.

Final Reports outside of the process timeframe remain an issue for both TRFT and RDaSH, this is being monitored and addressed via Contract Quality.

Patient, Public and Stakeholder Involvement:
N/A
Equality Impact:
N/A
Financial Implications:
N/A
Human Resource Implications:
N/A
Procurement Advice:
N/A
Data Protection Impact Assessment
N/A
Approval history:
SI & NE Committee Members
Recommendations:
Paper is for noting & feedback

ANNUAL REPORT

NHS
Rotherham
Clinical Commissioning Group

SERIOUS INCIDENT & NEVER EVENT ANNUAL REPORT

April 2019 to March 2020

CONTROL RECORD	
Title	Serious Incident & Never Event Annual Report 2019/20
Reference	NHS Rotherham Clinical Commissioning Group (CCG)
Purpose	To provide an overview of Serious Incidents & Never Events.
Audience	NHS Rotherham Clinical Commissioning Group Governing Body
Status	Draft
Issue date	July 2020
Owner	NHS Rotherham Clinical Commissioning Group
Author	Kirsty Leahy, Head of Quality
Assisted by	Lesley McNeill, Quality Assurance Officer
Target audience	NHS Rotherham Clinical Commissioning Group Governing Body
Distribution list	NHS Rotherham Clinical Commissioning Group
Method	Intranet
Access	Open Access

CONTENTS

1. INTRODUCTION

NHS Rotherham Clinical Commissioning Group (CCG) has the responsibility for performance management of all Serious Incidents (SI) reported by commissioned providers, the process follows the NHS England Serious Incident Framework (updated March 2015). Healthcare is complex and high risk, and on occasion SI occur, however it is essential that when they do occur the incident or event is robustly investigated and actions are undertaken to reduce the risk of reoccurrence.

The NHS England Serious Incident Framework (March, 2015) defines Serious Incidents as 'acts or omissions in care that result in: unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm, including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services'.

Never Events (NI) are Serious Incidents (SI) that are entirely preventable because guidance and/or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

Serious, largely preventable, patient safety incidents should not occur if the available preventative measures have been implemented by healthcare providers. In broad terms, serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare.

Ensuring patients are safe from harm is a priority for the CCG, the strong emphasis on performance and quality contract management sustains and disseminates improvements throughout commissioned services. This report provides an overview of trends and themes identified in relation to incidents during 2019/20.

2. PROCESS AND ASSURANCE

NHS organisations use the Department of Health (DH) incident reporting module, Strategic Executive Information System (StEIS) to log and manage serious incidents. All reported SI are individually performance managed to ensure that relevant reporting deadlines are being met and that the Provider has investigated and written the final investigation report in line with national guidance. In addition to the report there must be a comprehensive Provider action plan. Individual incidents and performance data are discussed regularly with Providers within informal meetings, and formally within Contract Quality meetings.

There are 3 levels of investigation for a serious incident:

1. Concise (suited to less complex incidents which can be managed by individuals or a small group/team)
2. Comprehensive (complex issues which should be managed by a multidisciplinary team involving experts and/or specialist investigators)
3. Independent (for incidents where the integrity of the internal investigation is likely to be challenged or where it will be difficult for an organisation to conduct an objective investigation internally due to the size of the organisation, or the capacity/capability of the individuals or number of organisation/s).

Organisations providing NHS care in England are required to demonstrate accountability for effective governance and learning following a SI or NE. The CCG monitor and performance manage reportable incidents in accordance with the:

NHSE Serious Incident Framework (NHS England 2015)
https://improvement.nhs.uk/resources/serious-incident-framework/

Never Events Policy and Framework (Revised January 2018)
https://improvement.nhs.uk/resources/never-events-policy-and-framework/

Commissioned NHS providers have an obligation to ensure that when a SI or NE occurs, the methodology applied is commonly known as Root Cause Analysis (RCA) and is utilised for driving improvement ensuring systematic measures in place for:

- Safeguarding people, property, the service's resources and its reputation
- Understanding why the event occurred
- Ensuring that steps are taken to reduce the chance of a similar incident happening again
- Reporting to other bodies where necessary and sharing the learning

The CCG Serious Incident Committee review all submitted final reports and has the responsibility to close or hold the report pending further investigation. The process is to ensure closure is only approved once it is clear that there has been a robust investigation and the action plan appropriately addresses the root causes of the incident and suitable action taken to reduce the risk of recurrence.

Duties include:

- SI and NE are managed and investigated appropriately and in a transparent manner
- The investigation should be of a good quality, underpinned by clear terms of reference
- It should demonstrate the application of robust investigative methodologies with resultant recommendations, which link back to the findings
- Incidents closed when satisfied with the investigation: recommendations and action plans submitted and local monitoring arrangements in place
- The action plans agreed with providers have a clear trajectory with named responsible leads
- Action plans should incorporate review dates to measure effectiveness and ensure actions are undertaken
- Learning is embedded and demonstrated through regular thematic reviews
- Where there is a need or requirement, independent investigators are appointed
- Investigations are quality assured to ensure that they are robust and demonstrate the use of recognised principles of investigation
- Independent contractors have access to support
- There is effective co-ordination of complex multi-agency RCA investigations

Decisions to close an investigation are based on objective and measurable evidence. Where commissioners have concerns about closing an incident additional information will be requested prior to agreeing closure.

The investigation should be completed and a final report and action plan submitted within 60 working days of the incident being reported. If there is a likelihood that the report will not be completed within this time frame, then an extension request can be submitted but this must have compelling reasons why this will not be met, e.g. police investigation. A new submission date will be considered and the Provider will be informed if agreed, along with the details of the new submission date.

It is often clear that a Serious Incident has occurred but where this is not the case providers should engage in open and honest discussions with their commissioners (and others as required) to agree the appropriate and proportionate response. Where it is not known whether an incident is a Serious Incident, it is better to err on the side of caution and treat the incident as a Serious Incident until evidence is available to demonstrate otherwise.

Serious Incident reports can be downgraded and relevant records amended at any stage in the investigation. Any downgrading must be agreed with the relevant commissioner on a case by case basis. Incidents that are found to not meet the threshold of a serious incident can be de-logged and must be managed in line with the organisation's risk management and patient safety policies if appropriate (Serious Incident Framework 2015).

3. LEARNING FROM PATIENT SAFETY INCIDENTS MOVING FORWARD

The NHS Patient Safety Strategy Safer Culture, Safer Systems, Safer Patients July 2019 highlights that the 2015 Serious Incident Framework set the expectations for when and how the NHS should investigate Serious Incidents. However, compelling evidence from national reviews, patients, families, carers and staff and an engagement programme in 2018 revealed that organisations struggle to deliver these. While recognising the importance of learning from what goes well, identifying incidents, recognising the needs of those affected, undertaking meaningful analysis and responding to reduce the risk of recurrence remain essential to improving safety. Doing this well requires the right skills, systems, processes and behaviours throughout the healthcare system. The Patient safety Incident Response Framework (PSIRF) will support the NHS to operate systems, underpinned by behaviours, decisions and actions, which assist learning and improvement, and allow organisations to examine incidents openly without fear of inappropriate sanction, support those affected and improve services.

This was expected to be impended by autumn 2021 however is now on hold due to COVID-19

https://improvement.nhs.uk/documents/5472/190708_Patient_Safety_Strategy_for_website_v4.pdf

NHS England & NHS Improvement (NHSE&I) issued the following guidance at the end of March 2020 in light of the Pandemic:

Reporting and uploading patient safety incidents to The National Reporting and Learning System (NRLS) should continue as is practical and appropriate. Particular categories of incidents such as Never Events and Serious Incidents should be reported as usual wherever possible. Where Serious Incidents have occurred, immediate action must be taken to ensure patient safety, the mandatory requirement to undertake investigations is likely to be removed. However, if an investigation (or appropriate response for deriving learning) can be achieved this should be undertaken. Additionally, Providers should keep in place a core response so that any immediate action to protect patient safety that is feasible in the current circumstances is taken. The requirement to meet a hard 60-day deadline for the investigation of identified serious incidents will be suspended.

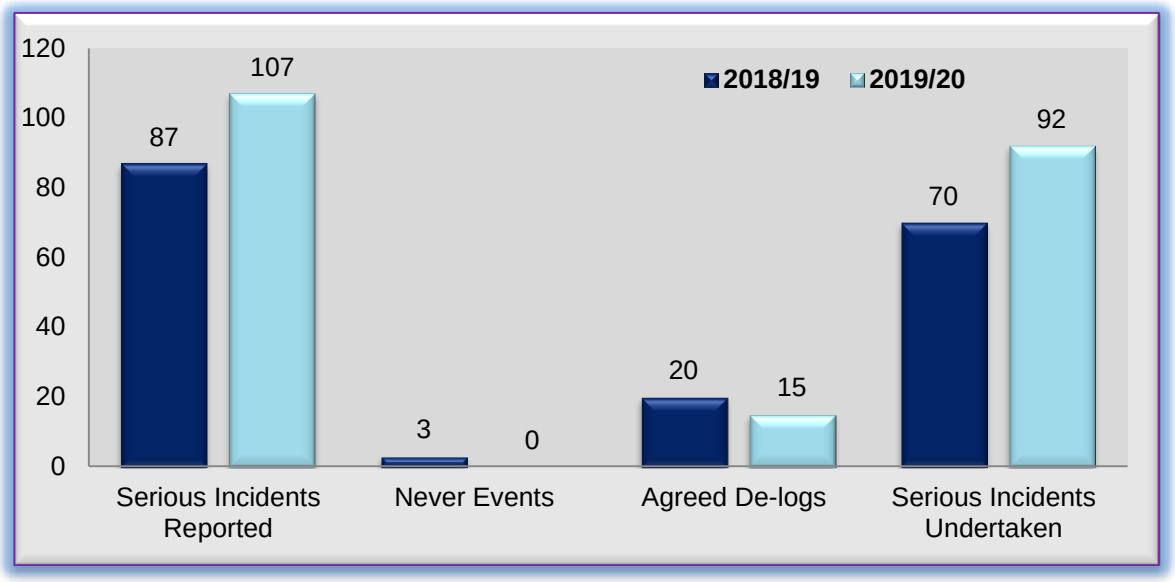
Following return to business as usual, a process of triage and prioritisation of identified serious incidents for investigation should take place, with a proportionate and realistic assessment of the relevance and value of the learning likely to be generated given the extraordinary circumstances. Investigation reports with action plans that have been completed and submitted to Commissioners can be closed with no requests for further information unless there is a fundamental failing to address the learning points. Adherence to Duty of Candour principles must continue to be upheld, with oversight and follow-up of compliance being pragmatic in approach.

Although the guidance does not affect the data for this reporting period it will be reflected in the 2020/21 Annual Report. A request was made, of our 2 main providers, and assurance established that going forward they would manage the SI process in line with the new guidance.

4. ALL SERIOUS INCIDENTS & NEVER EVENTS REPORTED BY ALL PROVIDERS

4.1 Incidents by Year Comparison

Graph 1: The number of incidents report on StEIS across the CCG commissioned services between 01 April 2019 & 31 March 2020 compared to 01 April 2019 & 31 March 2019.



Across the CCG commissioned services between 01 April 2019 & 31 March 2020 the number of incidents reported by provider that went through the SI process were:

- 55 TRFT (70 reported incidents of which 15 agreed de-logs)
- 30 RDaSH
- 3 YAS
- 2 RCCG
- 2 Out of Area

Independent Contractor & GP Serious Incidents are logged on StEIS by the CCG on their behalf and follow the SI & NE Management Process with support from the CCG. The number of incidents is usually low, there are no incidents in this and 2018/19 reporting period compared to 2 GP and 1 Hospice incident for 2017/18.

Serious Incidents involving patients registered with a Rotherham GP that occur under Yorkshire Ambulance Service NHS Trust (YAS) are jointly performance managed by NHS Wakefield CCG being the lead commissioner and NHS Sheffield CCG for Quality Assurance. NHS Rotherham CCG are updated in the process and asked to comment on the final report prior to their closure process. There have been 3 incidents in this reporting period incident compared to none in the last reporting period and 2 in 2017/18.

Serious Incidents involving patients registered with a Rotherham GP that take place out of the Rotherham CCG area are performance managed by the CCG where the incident occurred. NHS Rotherham CCG are kept informed and asked to comment on the final report prior to closure. This process is reversed for out of area patients that are involved in a serious incident at a service commissioned by the CCG, 2 incidents occurred both in this and 2018/19 reporting period compared to 6 in 2017/18.

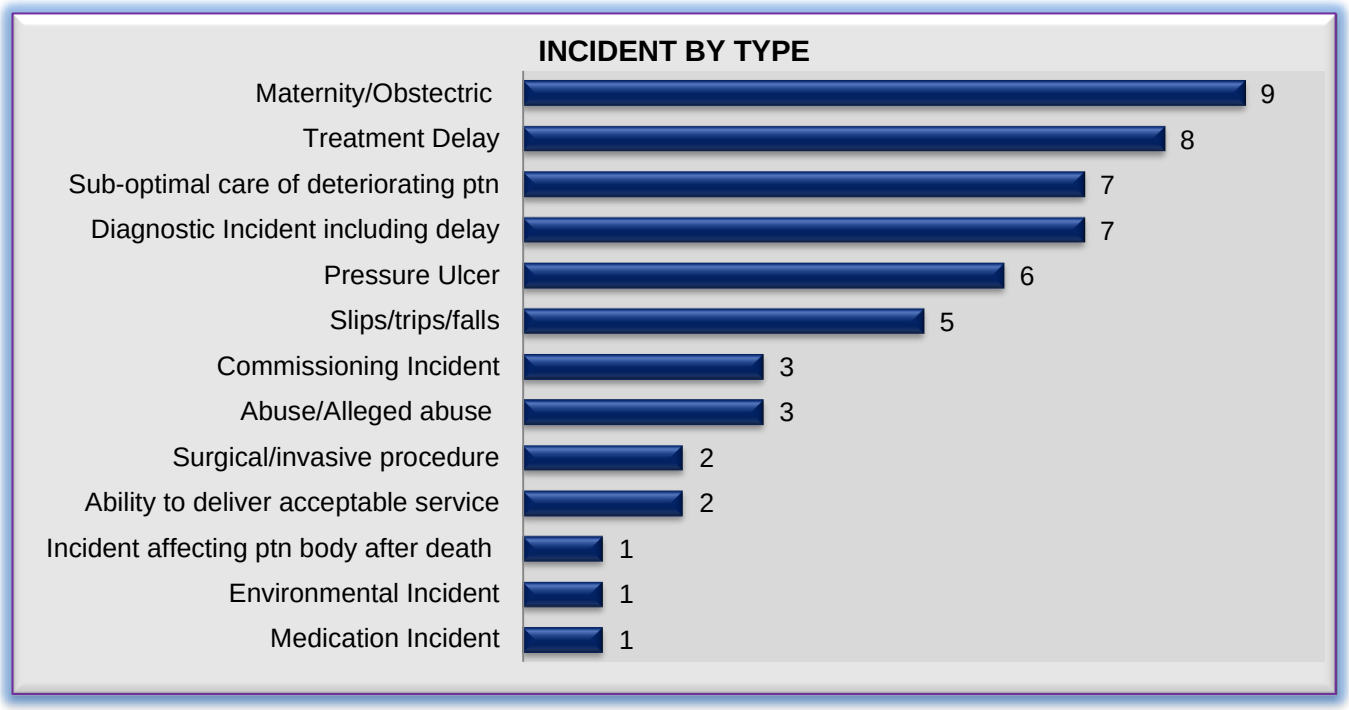
The remaining focus of this report will provide analysis of the CCG main providers and highest reporting organisations, The Rotherham Foundation Trust (TRFT) and Rotherham Doncaster and South Humber NHS Foundation Trust (RDaSH).

5. SERIOUS INCIDENTS REPORTED BY THE ROTHERHAM FOUNDATION TRUST

TRFT reported 70 incidents in total, 15 cases were de-logged after further investigation revealed that there were no acts or omissions in care which caused or contributed towards the outcome. Fifty five incidents were reviewed under the CCG SI process.

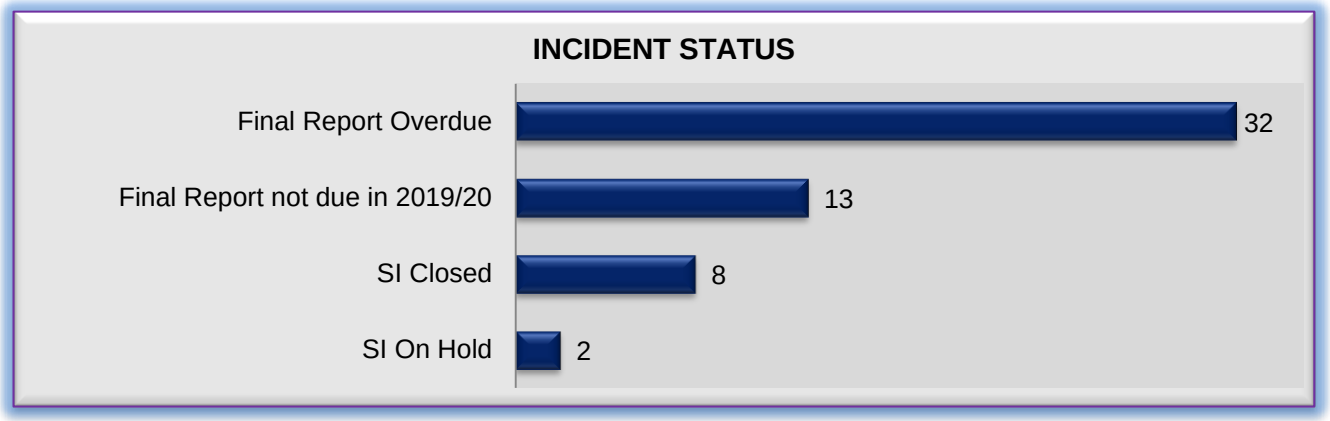
5.1 Incident By Type

Graph 2: As shown in graph 2 below the highest reportable recurring themed SI in this reporting period is Maternity / Obstetric.



5.2 End of Year Incident Status

Graph 3: Of the 55 incidents reported 8 cases were closed, 2 maternity incident on hold due to Healthcare Safety Investigation Branch***** (HSIB) The 32 on-going cases that came within the timeframe for receipt of the Final Report within this reporting period were overdue and no extension granted, this issue has been escalated to the CCG/TRFT Contract Quality Meeting. The timeframe for receipt of the remaining 13 Final Reports were outside this reporting period.



5.3 Comparison by Year

Graph 4: Below shows the comparison, by type, of all incidents that went through the SI process between this 2019/20 reporting period and the previous 2018/19 reporting period, highlighting where there has been no change, increase or reduction in occurrences.

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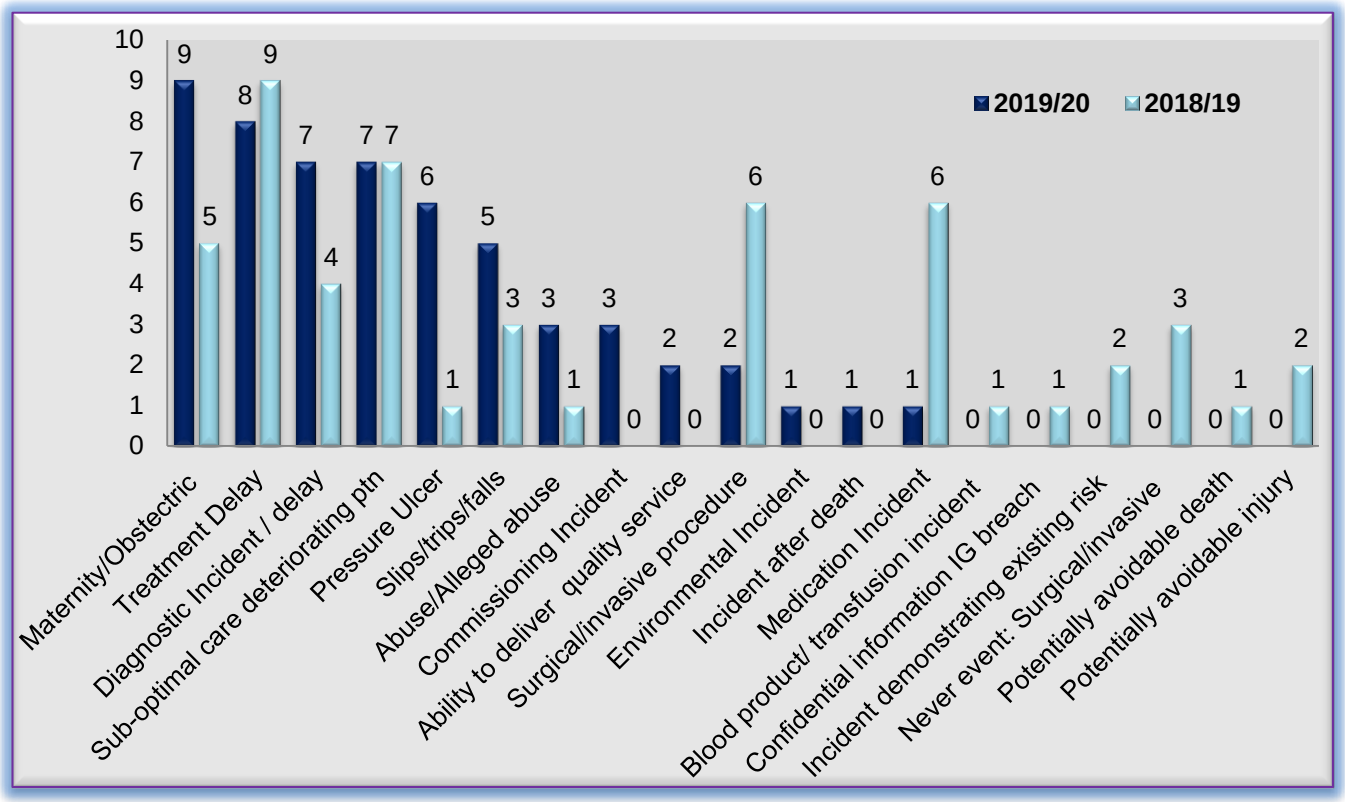


Maternity / Obstetrics

Where applicable the investigation is undertaken by HSIB on behalf of TRFT, HSIB do give recommendations but do not include an action plan, for this reporting period 2 of the 9 cases came under the criteria. The CCG are aware of the increase in these incidents and are assured by TRFT a thorough investigation is undertaken looking to identify themes and implement recommendations through robust action plans with the aim to reduce the number of occurrences. For HSIB cases TRFT develop a separate action plan for each incident based on the findings of their investigation.

HSIB: The National Maternity Safety Ambition, launched in November 2015, aims to halve the rates of stillbirths, neonatal and maternal deaths, and brain injuries that occur soon after birth, by 2025. This strategy was updated in November 2017 with a new national action plan called Safer Maternity Care, which set out additional measures to improve the rigour and quality of investigations into term stillbirths, serious brain injuries to babies and deaths of mothers and babies. https://www.hsib.org.uk/maternity/

Pressure Ulcers

TRFT have developed robust processes to address Pressure Ulcers, an internal panel meet for reviewing all pressure ulcers and is attend by the Head of Quality at the CCG. Training and support mechanisms for frontline staff, internal sharing of organisational learning and monitored and evaluated action plans have been implemented. Until the incidents have been through the full SI process the information is not available for this reporting period to confirm if these cases were avoidable or unavoidable.

Diagnostic / Treatment Delay / Suboptimal Care

TRFT are working towards the accurate management of patients following the decision to undertake diagnostics, to develop a teaching package to be delivered to all medical staff around the need to ensure accurate clinical data is entered onto all diagnostic request forms. Detailed guidance to be written for general surgical. To re-educate teams with regards to documentation standards and to audit clinical documentation to ensure that it adheres to national standards to ensure education results in improved practice. Findings presented as a point of learning & reflection to prevent recurrence. Under new arrangements all action plans will be shared with the CCG via TRFT Patient Safety team at 6 monthly intervals for assurance.

Slips/Trips/Falls

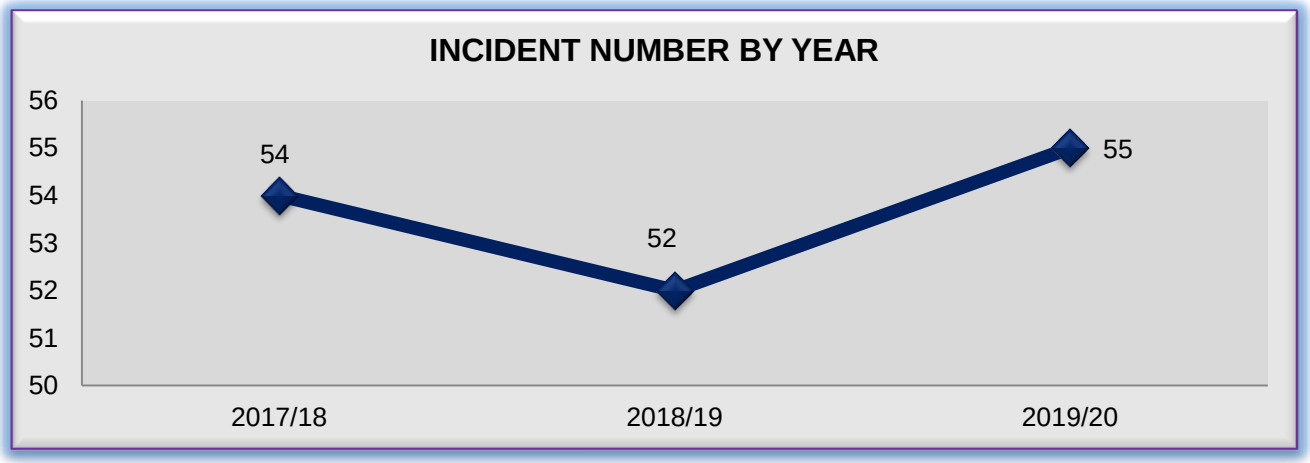
In line with Trust Policy, where a patient is assessed as being at risk of falls, fall preventative measures must be put into place to reduce the risk of falls. This is monitored through the completion of the monthly Patient Safety Thermometer data. All clinical areas now have a Falls Champion in place whose role is to help reduce avoidable falls resulting in harm and to lead on falls reduction developments within their own speciality areas. The Trust Falls Group will continue to promote good practice to reduce the number of falls across the Trust. The Fall Group has created a substantial action plan including recommendations from the National Audit of Inpatient Falls: Falls and fragility Fracture Audit Programme, which the Trust has taken part in, with the aim to reduce the number of occurrences in the future.

Abuse / Alleged Abuse

TRFT now undertake daily huddles to review previous day's admissions and a weekly safeguarding meeting attended by external partners and safeguarding team member to support with queries, training and supervision. Meetings are recorded, actions logged and RAG rated to ensure completion. The safeguarding team attend the Divisional Clinical Governance meeting to ensure any changes to practice are approved and actioned. All statutory services involved where appropriate. These actions have further been strengthened due to an increase and theme identified in regards to young children and Non-Accidental Injuries (NAI). The SI process has been aligned with the Department of Health's Working Together (2018) compliance and now has a robust system in place. (Appendix 1)

5.4 Number of Incidents By Year

Graph 5: Identifies the total number of incidents that went through the SI process over the last 3 reporting periods. It is clear from the three sets of data that the numbers are almost the same albeit the type of incident does vary, as identified in graph 4 above.

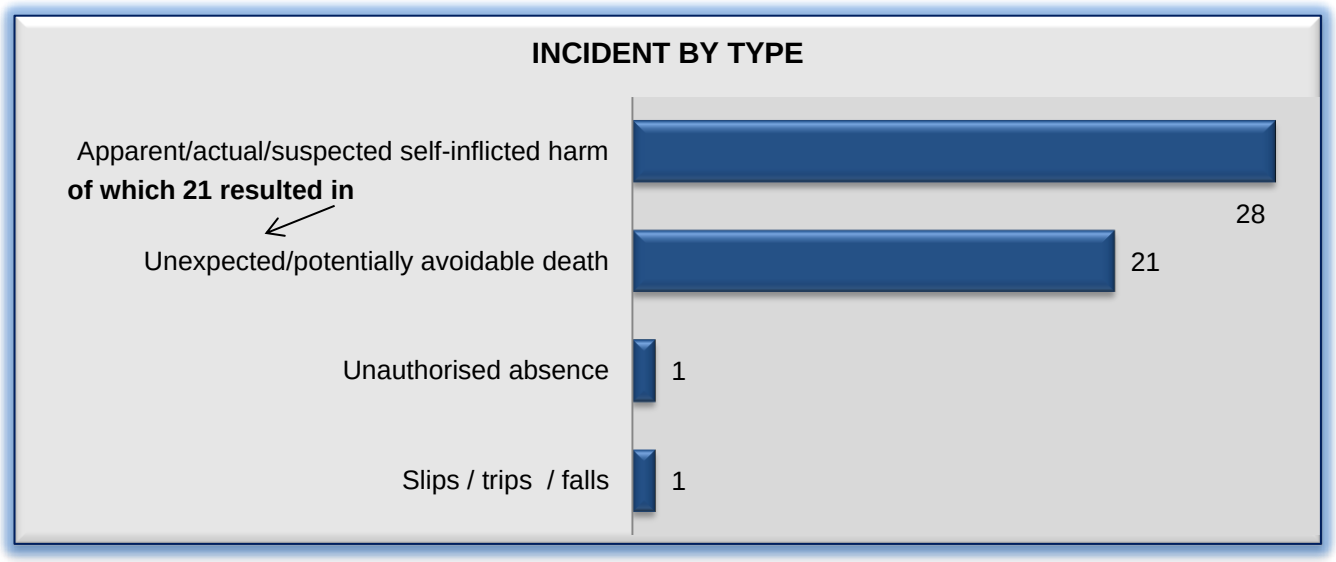


6. SERIOUS INCIDENTS & NEVER EVENTS REPORTED BY ROTHERHAM, DONCASTER & SOUTH HUMBER NHS FOUNDATION TRUST

RDaSH reported 30 incidents all of which were reviewed under the SI process.

6.1 Incidents by Type

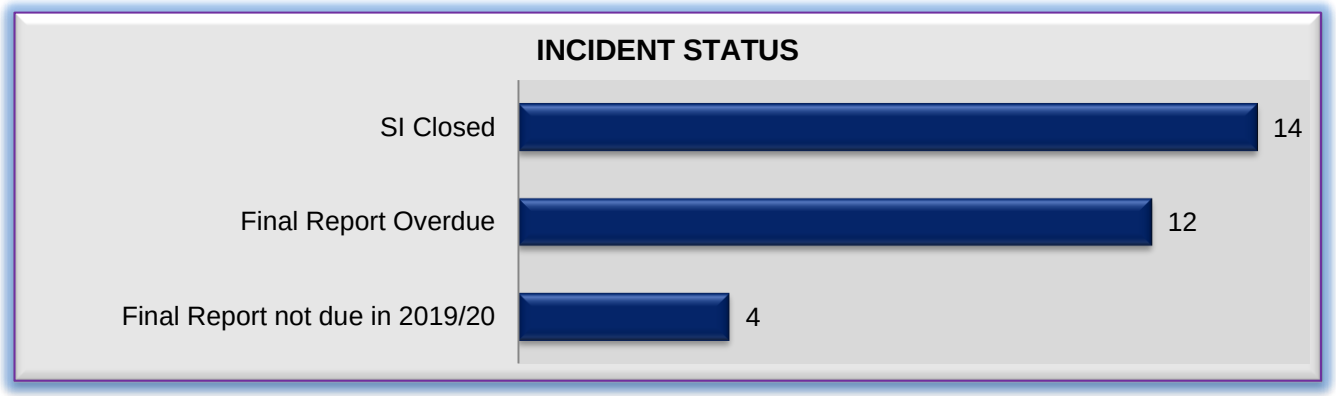
Graph 6: Apparent / actual / suspected self-inflicted harm is the highest reportable recurring themed SI with RDaSH reporting 28 incidents under this category. Analysis of these cases identified an outcome of 'unexpected/potentially avoidable death' for 21 of the 28 incidents.



Within the identified category for this provider, unexpected potentially avoidable death relating to suicide is mainly a continual theme. The CCG remains committed to supporting measures in reducing these incidents relating to suicides. Members of the CCG attend and contribute to both a multi-agency Suicide Prevention Operational Group monthly and Suicide Prevention & Self Harm Wider Group Meeting quarterly.

6.2 End of Year Status

Graph 7: The status of the 30 incidents at the end of the reporting period, 26 cases came within the recommended timeframe for closure, 14 were closed, the remaining 12 that came within the timeframe for receipt of the Final Report within this reporting period were overdue, an issue which is escalated to the CCG/RDaSH Contract Quality Meeting. The timeframe for receipt of the remaining 4 Final Reports were outside this reporting period.



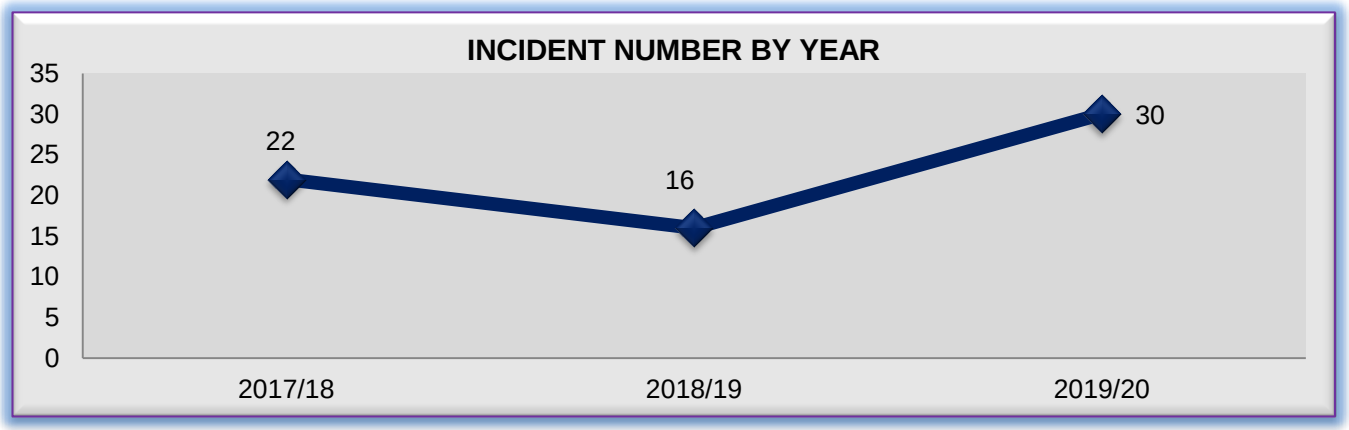
RDaSH will address SI through actions/recommendations:

- All access assessments should indicate patient centred risk management strategies and individualised crisis and contingency plan
- Address delivery of training requirements
- Review and audit of assessments and correspondence
- Review of the system and process of the management and triaging of referrals
- Ensure that all processes are robust and all records are saved onto the clinical system
- Safeguarding to be considered in all incidents as appropriate
- To ensure through managers that physical health assessments are completed, reviewed annually and plans developed for all patients
- Discuss actions/recommendations with all service and locality managers/staff
- Share learning

RDaSH provide assurance to the CCG that they are committed to patient safety and will ensure that all SI are thoroughly investigated, actions addressed, lessons learned and shared.

6.3 Number of Incidents by Year

Graph 8: The total number of incidents that went through the SI process over the last 3 reporting periods. The reason as to why the number of incidents has increased in this reporting period is due mainly to the increase in suspected suicide and are being fully explored through the outcome of actions and the suicide prevention work.



Suicide Prevention is high on the NHS Rotherham CCG agenda:

- RCCG along with partner agencies have systematic measures in place to ensure all suicides are reported in a timely manner to relevant services to allow procedures to be implemented and move forward at pace.
- RCCG representative attend a Suicide Prevention Operational Group meeting, held every six weeks to review real time data, discuss cases, actions and support which need to be put in place for the wider community.
- Since the launch of the cross-government 'Suicide Prevention Strategy' in 2012 a Suicide Prevention & Self Harm Wider Group Meeting is held quarterly, this multi-agency group are tasked to implement this plan, which outlines the actions Rotherham organisations are taking to prevent suicides.

AMPARO is the new suicide liaison service operational across Rotherham offering timely support following a suspected suicide. This service is supported by partners of the Rotherham Suicide Prevention and Self Harm Group: RCCG, RMBC, SYP, TRFT & RDaSH.

7. COMMISSIONER AIMS AND OBJECTIVES FOR PATIENT SAFETY AND QUALITY

- Continue developing collaborative approaches to sharing learning from SIs across CCGs, regulators and providers.
- Continue to aim to reduce the most reportable incident.
- Maintain Commissioner oversight of quality and safety of providers, during a period of change for CCGs, regulators and providers.
- Sustain oversight of and continue to develop measures for primary care around quality assurance
- Collaborative working with commissioning and contracting functions within the CCG

8. CONCLUSION

Both TRFT and RDaSH our 2 main providers work in an open, honest and transparent culture in the reporting and investigating of SI and NE, working multi-agency and involving families where necessary. Robust incident reporting and investigation processes allied with an open, honest and mature learning culture remain an important component of delivering safe health care and improving outcomes. Learning following an incident is essential to improve practice and prevent similar incidents occurring again:

- Solutions to address SI root causes that may be relevant to other teams, services and Provider organisations
- Identification of the components of best practice that reduced the potential impact of the SI and how they were developed and supported
- Lessons from conducting the investigation that may improve the management of investigations in the future
- Documentation of the identification of the risks, the extent to which they have been reduced and how this is measured and monitored
- Identification of any relevant staffing issues e.g. skill mix, recruitment, induction and training that may prevent further incidents
- Identification of any safeguarding lapse will be shared with the appropriate RMBC Safeguarding teams and Safeguarding Boards to ensure Safeguarding remains a priority and continues to be everyone's business. This will ensure local collaborative multiagency working is a driver for sharing lessons, increased knowledge and improved outcomes.

Commissioners play a vital role in ensuring that organisations have these processes in place and that learning as a result of adverse incidents is identified, shared and embedded in practice.

9. FUTURE PLANNING & NEXT STEPS

- NHS Rotherham CCG SI Committee has put patient safety and reduction of harm at the forefront of its aims. This will be achieved through the implementation and quality monitoring of agreed action plans and learning outcomes.
- NHS Rotherham CCG continued robust scrutiny and quality monitoring will be paramount and will continue to support their providers, to be open and transparent in their incident reporting and without fear of blame.
- NHS Rotherham CCG will continue to encourage sharing the learning with colleagues across the health and social care network to improve training and education and to play our part in the prevention and reduction of serious incidents.
- NHS Rotherham CCG will closely work and challenge providers in relation to supporting continued improvements in quality of service and incident recording, monitoring, and learning.
- Commissioners play a vital role in ensuring that organisations have these processes in place and that learning as a result of adverse incidents is identified and embedded in

practice. The SI & NE Committee will continue to work with providers to support continual improvement through the analysis of themes and trends and sharing of learning and best practice.

- NHS Rotherham CCG will review the SI Process to reflect changes to the introduction of The Patient safety Incident Response Framework (PSIRF) adhering currently to NHS structures and National Commissioning Board Serious Incident Framework March 2015. (Appendix 2)
- NHS Rotherham CCG will review bi-annually the Terms of References for the Serious Incident & Never Event Committee. (Appendix 3)

APPENDIX 1 - SERIOUS INCIDENT (SI) & NEVER EVENT (NE) MANAGEMENT PROCESS INTERLINKING WITH SAFEGUARDING PROCESS

Serious Incidents (SI) in health care are adverse events, where the consequences are so significant or the potential for learning is so great, that a heightened level of response is justified and expected.

Never Events (NE) are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers.

NHS Rotherham Clinical Commissioning Group (the CCG) has systematic measures in place to ensure serious incidents requiring investigation are identified correctly, managed appropriately, investigated thoroughly by the reporting providers and learned from to prevent the likelihood of similar incidents happening again. The CCG update Governing Body monthly on the number and types of incidents.

Incidents are performance managed in accordance with the:

NHSE Serious Incident Framework (NHS England 2015)
https://improvement.nhs.uk/resources/serious-incident-framework/

Never Events Policy and Framework
https://improvement.nhs.uk/resources/never-events-policy-and-framework/

Conversely Serious Incidents that have a safeguarding challenge need to also be considered by the multi-agency safeguarding partnership.

Safeguarding Practice Reviews are set out in national statutory guidance (Working Together 2018). The responsibility for how the system learns the lessons from serious child safeguarding incidents lies at a national level with the Child Safeguarding Practice Review Panel (the Panel) and at local level with the safeguarding partners.

The Child Safeguarding Practice Review Panel considers all notifications of serious incidents and together with partners agrees the most effective way forward in order to learn lesson. Lessons can be multi or single agency, depending on the situation being considered.

Child Safeguarding Practice Review Panel is:

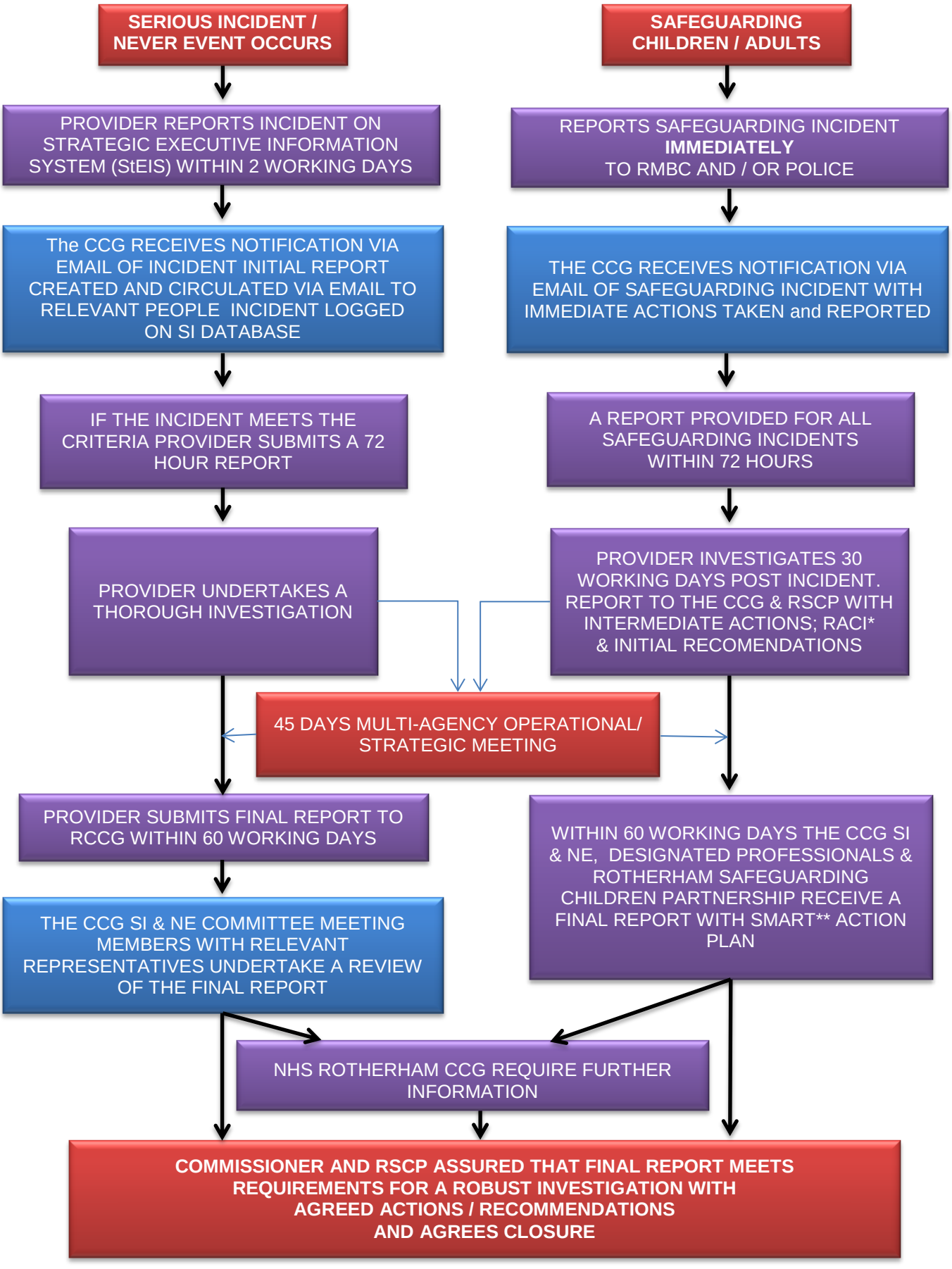
- Responsible for identifying and overseeing the review of serious child safeguarding cases which, in its view, raise issues that are complex or of national importance.
- The Panel must decide whether it is appropriate to commission a national review of a case or cases
- The Panel must set up a pool of potential reviewers who can undertake national reviews, a list of whom must be publicly available.

KEY:

RASCI*
Responsible - (Doer) - The team assigned to do the work
Accountable - (Buck stops here) - The team making the final decision with ultimate ownership
Supporting - (Here to help) - The Team that will support the quality assurance functions including ensuring there is timely reporting, investigation and learning and action plan implementation undertaken by the provider in response to serious incidents
Consulted - (In the Loop) - The team that must be consulted before a decision or action is taken
Informed - (For Your Information) - The team which must be informed that a decision or action has been taken

SMART**
Specific - Specify area for improvement.
Measurable - Quantify or at least suggest an indicator of progress.
Assignable - Specify who will do it.
Realistic - State what results can realistically be achieved, given available resources.
Time-related - Specify when the action(s) will be achieved.

NHS ROTHERHAM CLINICAL COMMISSIONING GROUP (RCCG) SERIOUS INCIDENT (SI) MANAGEMENT PROCESS INTEGRATING SAFEGUARDING INCIDENTS



APPENDIX 2 – SI & NE PROCESS

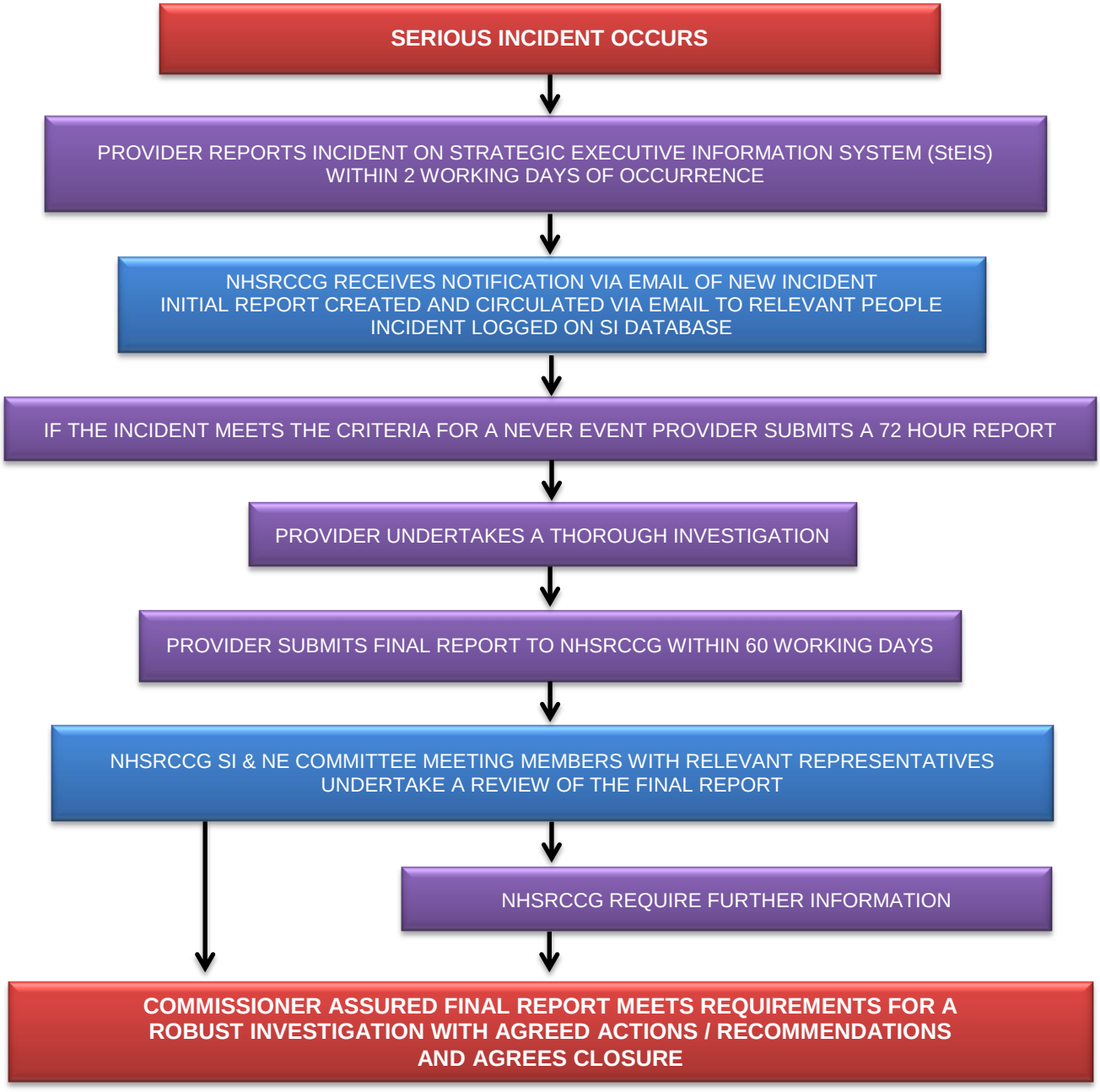
Serious Incidents (SI) in health care are adverse events, where the consequences are so significant or the potential for learning is so great, that a heightened level of response is justified. **Never Events** (NE) are serious incidents that are entirely preventable as guidance, or safety recommendations providing strong systemic protective barriers, are available at a national level, and should have been implemented by all healthcare providers. NHS Rotherham Clinical Commissioning Group (NHSRCCG) has systematic measures in place to ensure serious incidents requiring investigation are identified correctly, managed appropriately, investigated thoroughly by the reporting providers and learned from to prevent the likelihood of similar incidents happening again. NHSRCCG update Governing Body monthly on the number and type of incidents. Incidents will be performance managed in accordance with the:

NHSE Serious Incident Framework (NHS England 2015)

https://improvement.nhs.uk/resources/serious-incident-framework/

Never Events Policy and Framework

https://improvement.nhs.uk/resources/never-events-policy-and-framework/



APPENDIX 3 – SI & NE TERMS OF REFERENCE

Contact Details:			
Lead O.E. / Clinician:	Chief Nurse	**Lead Officer:**	Chief Nurse
Purpose:			
To provide a robust process for the performance management of Serious incidents (SI) and Never Events (NE) reported by providers of NHS services commissioned by NHS Rotherham Clinical Commissioning Group (RCCG)			
Responsibilities:			
• To ensure SI and NE are reported appropriately via the Strategic Executive Information System (StEIS) NHS England's web-based serious incident management system, through which providers record incidents • To ensure NHS England & NHS Improvement (NHSE&I) guidance is followed with regard to performance management of SI and NE • To review, challenge and critically analyse all Serious Incidents and Never Events as reported via StEIS • To identify trends and risks, reporting issues of concerns to appropriate committees and quality meetings • To ensure the development of a monitoring process by which progress against actions and recommendations can be assured • To be assured that where appropriate reporting to other professional bodies/organisations or regulatory authority has occurred • To directly report and provide assurance to RCCG Governing Body and Audit, Quality & Assurance Committee (AQuA) • To escalate good practice, concerns, unresolved and urgent issues etc. to AQuA, Contract Quality and Performance Groups as appropriate against quality schedules • To provide assurance to NHSE&I to demonstrate appropriate, robust performance management processes including NE decisions and closures • To review extension requests from providers where further time is required to complete investigations and reports • To receive updates where extensions have been granted • To request further information in relation to Final Reports from providers where appropriate / necessary reviewing is required prior to closure within the 20 days' notice timescale			
Chair:			
Head of Clinical Quality			
Deputy Chair:			
Representative from GP Commissioning Executive			
Core membership:			
• Head of Clinical Quality • Representatives from GP Commissioning Executive • Provider representatives • Co-ordinator • Administrator			
Co-opted members:			
• Contract Managers • Infection Prevention Control Lead • Experts in Various Clinical Fields as appropriate			
Deputising:			
Members to elect deputies if unable to attend			
Quorum:			
A minimum of 3 clinical members			

Accountability:
AQuA
Frequency of meetings:
Bi-monthly
Order of business:
Declarations of Interest at the start of meeting. Items for escalation at the end of the meeting, clearly identifying why and where to.
Agenda deadlines:
Paper deadline 10 working days prior to the meeting. Final papers circulated 7 working days prior to meeting
Minutes:
Minutes circulated to membership and AQuA
Administration:
Administration Officer / Co-ordinator
Attendance:
Members are expected to attend 75% of meetings, to be audited on an annual rolling basis
Review Date:
February 2020
Review Due:
February 2022 or when national guidance indicates otherwise
Named Membership List:
Appendix 1

APPENDIX 1

Named Membership List:	
Head of Clinical Quality Representatives from GP Commissioning Executive Representatives from GP Commissioning Executive Representatives from GP Commissioning Executive Co-ordinator Administrator	Kirsty Leahy Dr Jason Page Dr Anand Barmade Dr Phil Birks Lesley McNeill Jayne Watson
Named Co-opted members:	
Contract Managers Experts in Various Clinical Fields as appropriate	As appropriate As appropriate

APPENDIX 4 - GLOSSARY

AQuA	Audit, Quality & Assurance Committee
DH	Department of Health
GB	Governing Body
HSIB	Healthcare Safety Investigation Branch
NE	Never Event
NHSE&I	NHS England & NHS Improvement
CCG	NHS Rotherham Clinical Commissioning Group
NPSA	National Patient Safety Agency
RCA	Root Cause Analysis
RCCG	NHS Rotherham Clinical Commissioning Group
RDaSH	Rotherham, Doncaster and South Humber NHS Foundation Trust
RMBC	Rotherham Metropolitan Borough Council
SI	Serious Incident
StEIS	Strategic Executive Information System
SYP	South Yorkshire Police
TRFT	The Rotherham NHS Foundation Trust