Surrey Heath
Clinical Commissioning Group

Agenda item 15
Attachment 9

COVER SHEET : Governing Body Meeting in Public 5 February 2019 - Part 1

Title of paper	**Serious Incident (SI) Policy**
Date	28th January 2019
Exec Lead	Edmund Cartwright, Interim Director of Quality and Nursing

Purpose	To Approve	X
	To Consider	
	To Note	x

Summary of purpose and scope of report
The CCG Serious Incident policy has been reviewed to reflect the changes that have been made to the national 'Serious Incident Framework' March 2015 published by NHS England, this updates the National Patient Safety Agency (NPSA)'s 2010 National Framework for Reporting and Learning from Serious Incidents Requiring Investigation to reflect new responsibilities but does not fundamentally alter existing principles therein. The main changes to the policy are: • It reflects the 'Duty of Candour' within the NHS Standard Contract (from April 2014) • Appendix E has been updated with new websites. The Quality and Clinical Governance Committee recommends approval of this updated policy.

RECOMMENDATIONS	To note the recommendation of the Quality & Clinical Governance Committee and ratify the decision to approve this policy.

IMPLICATIONS
Quality & Safety/ Patient Engagement/ Impact on patient services:
This policy is a key safety policy and is core activity for the CCG. The policy ensures the CCG is compliant with relevant law and national guidance.
Equality / Human Rights / Privacy impact analysis
Surrey Heath CCG aims to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the Human Rights Act 1998 and promotes equal opportunities for all. This document has been assessed to ensure that no employee receives less favourable treatment on grounds of their gender, sexual orientation, marital status, race, religion, age, ethnic origin, nationality, or disability.
Financial and resource implications
None identified
Risk

All risks identified to the quality of services commissioned are recorded and monitored through the Clinical Risk Register. This is reviewed through the Quality and Clinical Governance Committee.
1. Legal
None – the policy has been reviewed to ensure compliance.

Governance and reporting		
Committee name	**Date discussed**	**Outcome**
Quality and Clinical Governance Committee	16th January 2019.	Agreed.

Serious Incident (SI) Policy

Document Control Sheet

Policy Number:	024
Version:	6
Approved by	Quality and Clinical Governance Committee xx
Name of originator/author:	Head of Quality
Date issued:	Last review Sept 2014
Effective date for current version	Jan 2019
Next review date:	September 2019

Version control

Date	Update/ change	By Who
September 2014	Review to include current processes and legislation.	Anas Salah, Clinical Quality Officer, CSU South
July 2015	Review to align with updated national framework issued March 2015	Julie Comer, Quality and Patient Experience Manager
May 2017	Review to include current processes and legislation.	Karen Hampton Head of Quality
January 2019	Reviewed for compliance and reflective of best practice	Deborah Seago Head of Quality

Equality Analysis

This Policy is applicable to the Governing Body, every member of staff within the SH CCG (SHCCG) and those who work on behalf of the CCG. This document has been assessed for equality impact on the protected groups, as set out in the Equality Act 2010. This document demonstrates SHCCG's commitment to create a positive culture of respect for all individuals, including staff, patients, their families and carers as well as community partners.
The intention is, as required by the Equality Act 2010, to identify, remove or minimise discriminatory practice in the ten named protected characteristics of age, disability, sex, gender reassignment, pregnancy and maternity, race, sexual orientation, religion or belief, and marriage and civil partnership. It is also intended to use the Human Rights Act 1998 and to promote positive practice and value the diversity of all individuals and communities.
An equality impact assessment has been completed and included in Appendix G

If you have identified a potential discriminatory impact of this procedural document, please contact SH CCG, SH House, Knoll Road, Camberley, Surrey GU15 3HD. Telephone 01276 707697

1. Introduction and Scope

1.1. Surrey Heath Clinical Commissioning Group (SH CCG) is accountable and responsible for the effective performance management of provider serious incidents (SIs) as part of their duties under the Health and Social Care Act 2012 to continuously improve the quality of services.

1.2. Providers of NHS care are required, as part of their registration requirements with the Care Quality Commission (CQC) and Monitor (and any subsequent regulatory body) and via their contracts with commissioners, to provide a safe standard of care. It is known that at times the provision of care may not reach the standard required and providers are obliged to notify both their regulators and commissioners. There are specific regulatory and contractual requirements for reporting adverse events and those events that fall within the SI criteria. This policy relates to all such incidents defined as a SI.

1.3. This policy should be read in conjunction with NHS England 'Serious Incident Framework' March 2015 and considers 'The Future of Patient Safety Investigation' reflected in the NHS Improvement (2018) documentation and considers new responsibilities but does not fundamentally alter existing principles therein.

1.4. Any serious incident involving an independent contractor (General Practitioner, Pharmacist, Optometrist, and Dentist) must be reported to, and will be performance

managed by the relevant NHS England area team. Surrey Heath CCG can support independent contractors in identifying and reporting incidents appropriately.

2. Policy statement

2.1 It is the duty of Surrey Heath CCG to establish and maintain robust arrangements for monitoring and performance managing SIs and Never Events reported by services commissioned by the CCG. A serious incident occurring in a service hosted by the CCG or within the CCG's own departments, should be reported internally via line managers, and escalated to the Operational Leadership Team (OLT), then reported externally to relevant parties e.g. NHS England, Adults and Children's Safeguarding Leads,and formally entered onto the national SI database StEIS.

2.2 The policy is a living document and will be reviewed and in line with specified review dates or in response to changes in national or local guidance.

2.3 SIs in healthcare are relatively rare but, when they do occur, the immediate response must protect patients and ensure that robust investigations are carried out, which result in organisations learning from serious incidents to minimise the risk of the incident happening again. See Appendix A for related national standards and processes for reporting and managing SIs.

2.4 Surrey Heath CCG will seek assurance from providers through contractual mechanisms that they have robust policies and procedures in place to manage SIs and carry out detailed investigations. In addition the provider will be required to apply the principles of 'being open' and adhere to a 'Duty of Candour' within the NHS Standard Contract (from April 2014) ensuring that patients and relatives, where applicable, are informed of the adverse event and the resulting investigation report is shared with them. The duty of candour is a legal requirement with Care Quality Commission actively able to take enforcement action in response to breaches.

2.5 In addition commissioners will seek assurances that providers have reported SIs appropriately externally to their regulators, and where relevant to other bodies such as other providers and commissioners, NHS Litigation Authority, the Police, Health and Safety Executive, Medicines and Healthcare products Regulatory Agency, Radiation Protection Advisor, Information Commissioner's Office, NHS England, Public Health England, Local Supervising Authority Midwifery Officer, Local Authority Safeguarding Adult and Safeguarding Children Boards, Local Authority Designated Officer (LADO), HM Coroner.

2.6 Requirements for providers reporting to external bodies are set out in more detail in the 'Serious Incident Framework' March 2015. (see also Appendix C addendum 3)

2.7 On rare occasions there may also be a requirement to report to a professional regulatory body such as, the General Medical Council (GMC), Nursing and Midwifery Council (NMC)

and the Health and Care Professions Council (**HCPC**) who Allied Health Professionals (AHP)s are regulated by, if professional competence is considered to be in doubt.

2.8 Where more than one provider or commissioner is involved in a serious incident all parties must agree which organisation will act as lead investigator and coordinate the multiagency report. The organisation where the SI occurred usually has overall responsibility for the investigation, production of a written report and implementation of subsequent action plans. Lead commissioners are responsible for monitoring the management of SIs reported by providers of NHS funded care. Where a SI spans more than one NHS provider or organisation, the local commissioners will work together to facilitate a multi-agency review, agree who will be the coordinating author of the report and agree which commissioner will assume the lead performance management role (see Appendix B).

2.9 By the nature of the Surrey Heath CCG geographical location, there is an interface with more than one NHS England Area Team (AT). Where there is any doubt about the performance management and sign off process of a specific Serious Incident, the patient safety team of the relevant AT should be consulted in order to seek clarification. It is accepted that there may be subtle variation in different AT processes.

3 What is a serious Incident?

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

There is no definitive list of events/incidents that constitute a serious incident and lists should not be created locally as this can lead to inconsistent or inappropriate management of incidents. Where lists are created there is a tendency to not appropriately investigate things that are not on the list even when they should be investigated, and equally a tendency to undertake full investigations of incidents where that may not be warranted simply because they seem to fit a description of an incident on a list.

The definition below sets out circumstances in which a serious incident must be declared. Every incident must be considered on a case-by-case basis using the description below. Inevitably, there will be borderline cases that rely on the judgement of the people involved

3.1 Serious Incidents in the NHS include:

Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:

Unexpected or avoidable death[1] 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[2]

Unexpected or avoidable injury to one or more people that has resulted in serious harm;

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 occurring[3]; or
- where abuse occurred during the provision of NHS-funded care.

This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS funded care caused/contributed towards the incident

3.2 A Never Event

All Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death. See Never Events Policy and Framework for the national definition and further information (See appendix D)

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:

[1] Caused or contributed to by weaknesses in care/service delivery (including lapses/acts and/or omission) as opposed to a death which occurs as a direct result of the natural course of the patient's illness or underlying condition where this was managed in accordance with best practice.

[2] This includes those in receipt of care within the last 6 months but this is a guide and each case should be considered individually - it may be appropriate to declare a serious incident for a homicide by a person discharged from mental health care more than 6 months previously.

[3] This may include failure to take a complete history, gather information from which to base care plan/treatment, assess mental capacity and/or seek consent to treatment, or fail to share information when to do so would be in the best interest of the client in an effort to prevent further abuse by a third party and/or to follow policy on safer recruitment.

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[4]); or

Activation of Major Incident Plan (by provider, commissioner or relevant agency)[5]

Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation

4 Roles and Responsibilities

Providers of NHS services

4.1.1 Providers are contractually obliged by Surrey Heath CCG to adhere to national and local SI processes.

4.1.2 Providers are contractually required to adhere to SI notification and reporting timescales as stipulated in their NHS contracts, including being open and Duty of Candour requirements.

4.1.3 Providers must record on StEIS within 2 working days of the SI being identified. An initial review (characteristically termed a '72 hour review') should be undertaken and uploaded onto the StEIS system by the provider. This should be completed within 3 working days of the incident being identified.

4.1.4 Providers are contractually obliged to undertake a SI investigation to the national standard as specified by the National Patient Safety Agency, NHS England or

[4] It is recognised that in some cases ward closure may be the safest/ most responsible action to take but in order to identify problems in service/care delivery , contributing factors and fundamental issues which need to be resolved an investigation must be undertaken

[5] For further information relating to emergency preparedness, resilience and response, visit: http://www.england.nhs.uk/ourwork/eprr/

Department of Health, including board level responsibility to investigate and respond to SI's, identify trends and share / embed learning.

4.1.5 Under the terms of the national NHS contract a provider may forfeit payment for an episode of care if a never event occurs.

4.1.6 Surrey Heath CCG expects that Providers will alert commissioners of any concerns about their ability to meet national and local requirements as soon as possible. SI management will also be regularly reviewed at contract or quality meetings between provider and commissioner.

4.2 Surrey Heath Clinical Commissioning Group (The CCG)

4.2.1 The CCG Director of Quality and Nursing will act as the designated officer to lead on patient safety and the management of provider SIs.

4.2.2 The CCG, as commissioner of a service will ensure, via contract managers, that the provider is formally required to report all SIs and ensure 'being open' and the Duty of Candour are stipulated.

4.2.3 The CCG will undertake, or contract a third party to undertake, the performance management of those providers where they hold the lead contract role.

4.2.4 The CCG at its discretion may grant a provider an extension to 60 day contractual deadline for receipt of an investigation report, if the provider is considered by the CCG to have a valid reason for the additional time needed. 'Stop the clock' arrangements should only be applied in very exceptional circumstances, for example in respect of SIs that are also subject to safeguarding investigations and processes.

4.2.5 Where the CCG is an associate to a contract, they will seek assurances from the lead commissioner that SI processes are robust and providers are appropriately held to account.

4.2.6 The CCG will ensure each report is reviewed by the quality team, clinical lead and patients GP to reflect that we have reviewed all the Surrey Heath resident populations SI's working with the lead commissioners and actively participating in commissioner led SI review panels with providers. If additional assurances need to be sought from the provider the StEIS report should be annotated 'further action required'.

4.2.7 The CCG will attend providers SI Panel meetings led by the Host commissioners to feedback the review of the Investigation reports and monitor action plans.

4.2.8 The CCG will ensure that 'lessons learned' from SIs are disseminated widely between providers and commissioners

4.2.9 Due to the inexperience with SIs of a small provider, or because of the complexity of a case with multiple providers, the CCG may require to be directly involvement in the

investigation process, or commission a skilled individual from the CSU to do so on their behalf.

4.2.10 The CCG constituent practices may require support with a significant event audit (SEA) or root cause analysis (RCA). NHS England has responsibility for SIs within independent contractors. However, the CCG may choose to designate a CCG manager to support the general practice in the production of a report to meet NHS England's requirements.

4.2.11 The CCG may have cause to declare a SI relating to its own internal systems and processes. In such circumstances the CCG will designate a manager, independent of the department concerned, to carry out an internal investigation and provide a written report for the CCG Committee. Where required a specific CCG senior officer may be directly involved such as: the designated Caldicott Guardian, Senior Information Risk Officer (SIRO) or Accountable Officer. To avoid any conflict of interest, such internal SIs will be 'signed off' by NHS England area team (AT).

4.2.12 As a result of recurrent events, or significant concerns, the CCG will consider engaging an independent expert external investigator. Costs to be divided by agreement between all commissioners.

4.2.13 The CCG will report SI activity to a designated Committee and ensure significant concerns, such as never events, are shared with the CCG Governing Body. Please refer to the terms of reference of CCG Committee with oversight of SIs included.

4.3 NHS England Area Teams

4.3.1 NHS England Area Teams (AT) supervise local SI management processes and ensure that Surrey Heath CCG have appropriate systems and processes in place to hold providers to account and promote improvements in patient safety.

4.3.2 Mental Health Homicide investigations, will be supervised and coordinated by NHS England who will commission an independent external review of the provider investigation where deemed necessary to be discussed on a case by case basis with NHS England.

4.3.3 Domestic Homicide investigations will be coordinated by the local Community Safety Partnership (CSP) led by the relevant local authority. Representation on the review panel will be sought from each agency involved, including from Surrey Heath CCG. NHS England will require assurance that appropriate actions are in place prior to closure of the SI.

5 Governance

5.1 Both commissioning and provider organisations, whether in primary, secondary or tertiary care, are accountable for effective governance and learning following a serious

incident. The precise split of responsibilities varies with the type of providers and commissioner, and the particular circumstances of the serious incident. Overarching governance principles and considerations for managing SIs are more fully described in the 'Serious Incident Framework' March 2015.

5.2 Particular attention should be paid to ensuring that, where host commissioning arrangements are in place across several CCGs, there are suitably robust governance processes to enable sufficient assurance to be gained.

5.3 The Surrey Heath CCG Quality and Clinical Governance committee has delegated responsibility for oversight of serious incidents as detailed in the committee's terms of reference.

6. Specialist SIs

For certain types of SI additional individuals and subject specialists should receive notifications and provide expert scrutiny of a provider's investigation report before closure is sanctioned by Surrey Heath CCG

6.1. *Never event* -SIs additional circulation of notification to the following:

CCG Accountable Officer

CCG Director of Nursing and Quality

CCG Chief Financial Officer

CCG 'on call' Director

CCG Communications Manager

CCG relevant subject specialist / clinical lead where indicated

6.2. *Information governance* (IG) SIs additional circulation of notification to the following:

IG Officer for CCG
CCG Caldicott Guardian if patient identifiable data involved

Please refer to information governance policy

6.3. *Health Care associated infections* (HCAI) additional circulation of notification to the following:

Infection prevention and control specialist

6.4. Safeguarding Adults

Designated Nurse Safeguarding Adults

6.5. Safeguarding children

Designated Nurse Safeguarding Children

6.6. Issues likely to be of interest to the media

CCG Communications manager

6.7. Domestic Homicides

Surrey Heath CCG Accountable Officer or Director of Nursing and Quality, to discuss review / requirement for internal management reviews with NHS England AT and relevant Community Safety Partnership and designated adult safeguarding lead.

6.8. Mental Health Homicides

Surrey Heath CCG Accountable Officer or Director of Nursing and Quality to discuss review / requirement for independent external review with NHS England

7. Escalation processes

7.1. Surrey Heath CCG (The CCG) Accountable Officer and senior team should always be aware of significant patient safety issues prior to any queries being raised by the media. Rule of 'no surprises'.

7.2. New SI notifications to be available in the CCG NHS net accounts within 12 hours of provider declaration.

7.3. For never events notification also to be made verbally, either provider to contact Surrey Heath CCG Director of Nursing and Quality direct.

7.4. If a provider does not adhere to the contractual timescales for SI reporting or provision of a report to the required standard, the CCG Accountable Officer and Contract Manager to be informed in writing.

7.5. Where a provider persistently fails to adhere to contractual requirements, the CCG Contract manager will discuss with the CCG and issue an initial letter of concern, using additional contract levers as required in order to improve provider performance.

7.6. In exceptional circumstances the CCG Accountable Officer may be required to meet with provider Chief Executive Officer in order to instigate improvements.

7.7. Where a Coroner has issued a Prevention of Future Death Report, previously known as Rule 43 letter, to a provider highlighting deficits in their service that relates to a SI

being performance managed by the CCG, the Director of Nursing and Quality at the CCG will be immediately informed as soon as the report has been issued.

8. Closure of SI cases

8.1. Principles of good practice are contained within the Serious Incident Framework 2015. The serious incident investigation should be of good quality underpinned by clear terms of reference. It should also demonstrate the application of robust investigative methodologies with resultant recommendations which link back to the findings.

8.2. Closure of an incident marks the completion of the investigation process only. Commissioners should close incidents on receipt of the final investigation report and action plan if they are satisfied that the requirements outlined within the serious incident framework are fulfilled. Incidents can be closed before all preventative actions have been implemented and reviewed for efficacy, particularly if actions are continuous or long term. Mechanisms must be in place for monitoring implementation of long term/on-going actions. Cases can be re-opened where there is a requirement to do so i.e. upon receipt of new information. Prior to the closure of a serious incident Surrey Heath CCG (The CCG) shall ensure the following:

8.1.1 An appropriate investigation that identifies findings, based on root causes and recommendations;

8.1.2 A satisfactory action plan with action points to address each root cause recommendation(s) and with a named lead and timescale for implementation;

8.1.3 Lessons learned, including partners or stakeholders with whom the learning has been shared;

8.1.4 Full completion of the StEIS record covering the above points e.g. date investigation completed, population of RCA/Lessons learned field;

8.1.5 A summary of each never event for inclusion in the CCG annual report arrangements.

8.1.6 Surrey Heath CCG (The CCG) should have a specific process for SI reviews to ensure appropriate consideration of provider reports-documented at 4.2.6. For some providers where the commissioner is fully assured about the provider's SI processes and robustness of investigation a virtual panel may be sufficient. For other providers a round table debate about the case with representation from other interested commissioners may be more appropriate.

8.1.7 For specialist SIs an expert in the topic should be included on the CCG review panel to ensure all facets of the case have been appropriately addressed.

9 Monitoring themes and trends

9.1 Surrey Heath CCG (Lead CCG) in collaboration with other CCG's will undertake to monitor providers for recurrent incidents, particular themes and trends among the SI cases under performance management.

9.2 Key areas of note will be reported to Quality and Clinical Governance Committee (QCGC) and to the Governing Body (GB) via the quality report.

9.3 Where particular trends or themes are identified the CCG, working collaboratively with the Lead commissioner, will determine what additional action is required for assurance to determine what additional action is required to obtain additional assurances direct from the provider. The relevant contract manager may need to be engaged in this process in order to ensure the appropriate contract sanctions are applied where necessary.

10. Learning from serious incidents

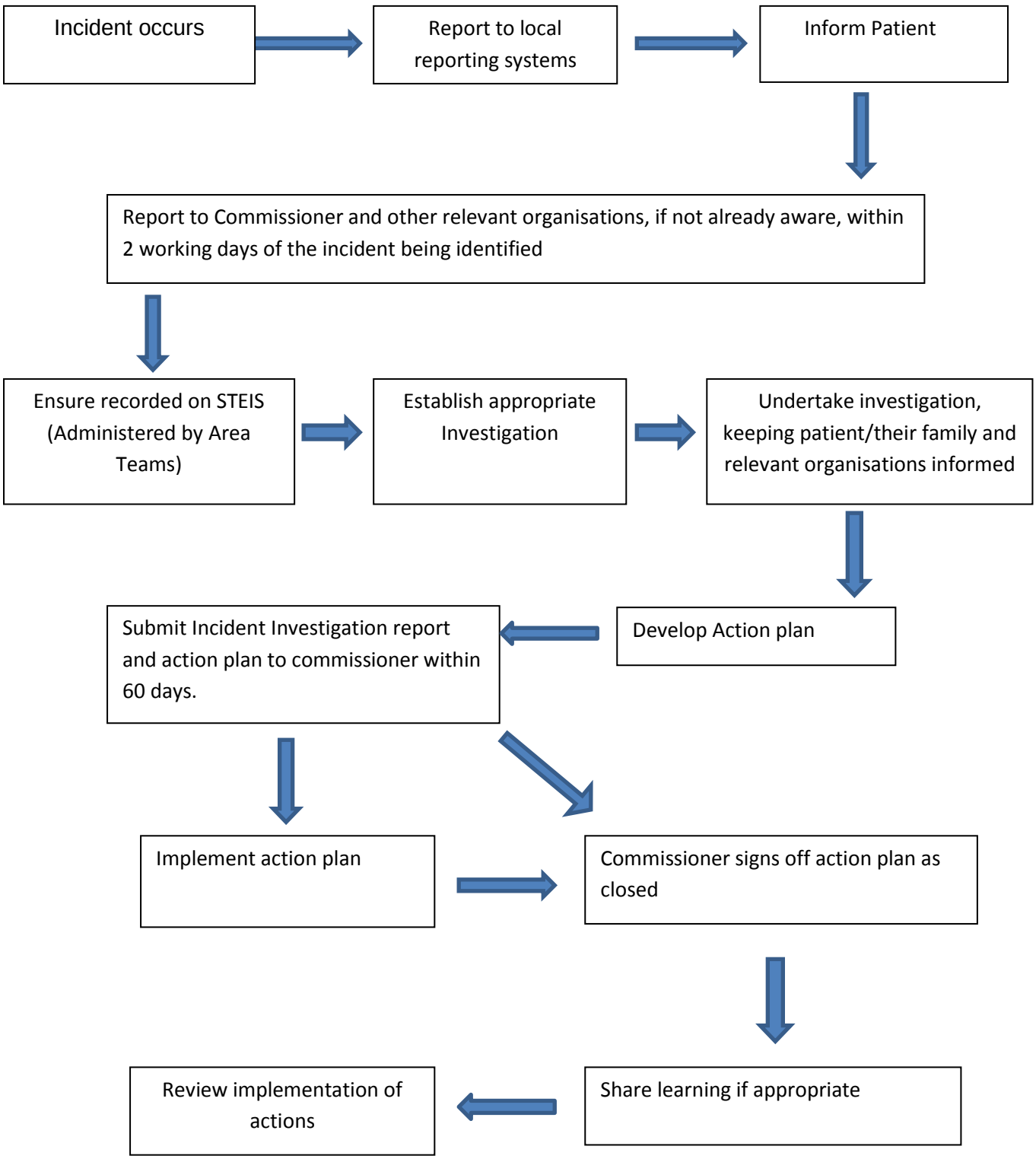
10.1 Surrey Heath CCG (Lead CCG) is committed to learning from serious incidents and sharing patient safety information across the local health economy. In every multiagency forum, the CCG will take the opportunity to share information, in an anonymised format, with colleagues, in order to reduce the risk of similar adverse event.

10.2 The CCG will work collaboratively and actively participate in learning events in order to ensure key messages, relating to patient safety, are shared as broadly as possible.

Intelligence gained from SIs will be used to influence contract monitoring, quality and safety standards for care pathway development and service specifications.

Surrey Heath Clinical Commissioning Group

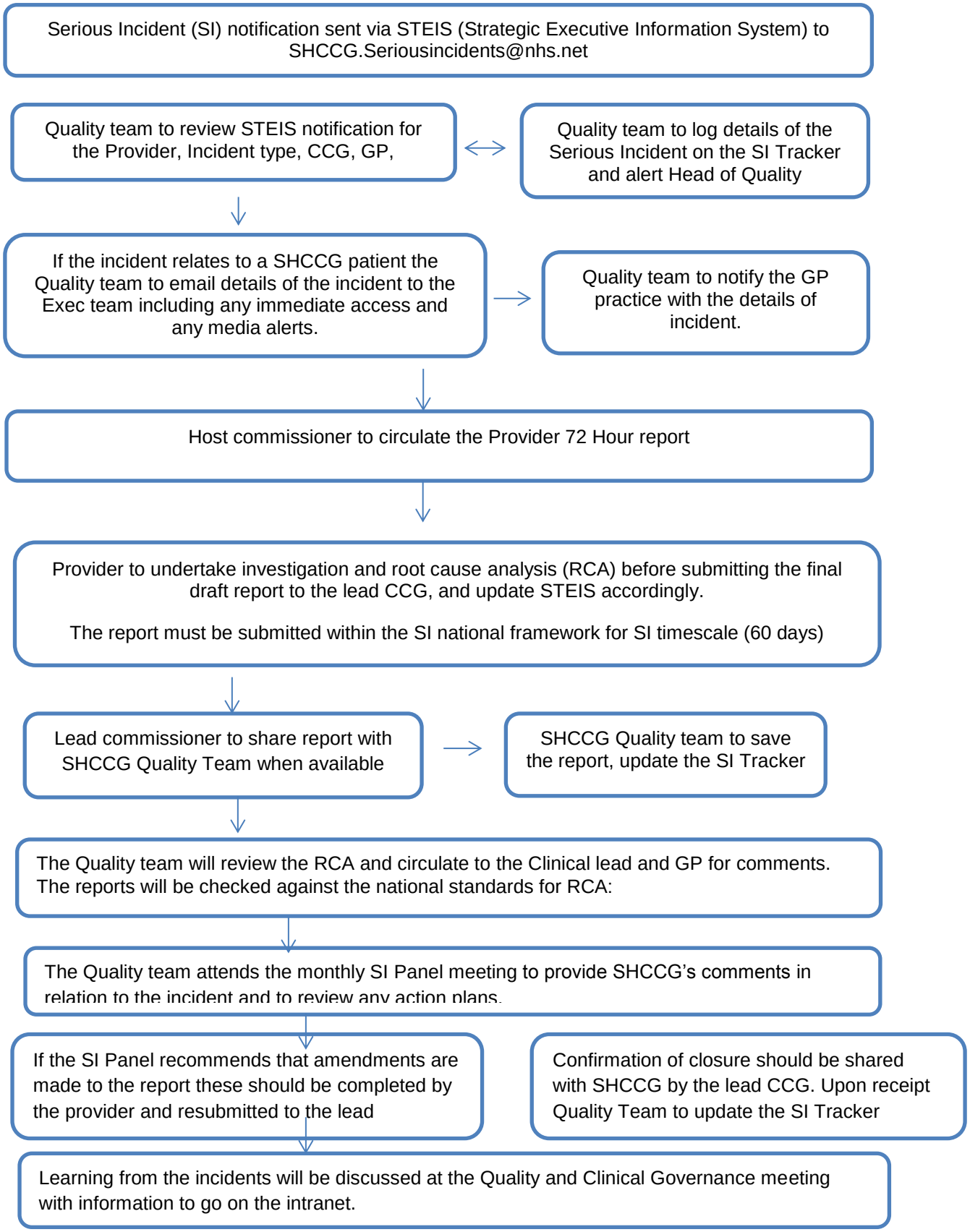
Steps to be taken when a serious incident occurs (simplified flowchart)



Appendix B

NHS Surrey Heath Clinical Commissioning Group

Process for managing Serious Incidents for Commissioned Services



NHS Surrey Heath Clinical Commissioning Group

Serious Incident Reporting Document

Created by U10C on 15/09/2015 at 15:28:58

Organisation reporting SI on STEIS:	NHS Surrey Heath CCG	Log No:	2015/30032
Region (Geography):	South East	Status:	Ongoing
CCG/CSU:		Commissioner leading oversight of investigation:	
BF/wd Date:	14/11/2015	Organisation leading investigation	NHS Surrey Heath CCG

When, Where & Your Details

Date of Incident:	15/09/2015	Reporter Name:	
Time of Incident:		Reporter Job Title:	
Site of Incident:		Reporter Tel. No.:	
Location of Incident:	Please Select	Reporter Email:	
Date Incident Identified:			

Who

Care Sector:	Please Select	Type of Patient at time of inciden	Please Select

		t:	
Clinical Area:	Please Select - more than one ar	Gender:	Please Select
Date of Birth (dd/mm/yyyy, N/A or Not Known):		Ethnic Group:	Please Select
Patient's GP Practice:		Legal Status of patient at time of incident:	Please Select

What Happened?			
Reason for Reporting:	Please Select		
Type of Incident:	Please select		
Where is patient at time of reporting:	Please Select	Never Event:	Please Select
Internal Investigation Required:	Please Select	Expected investigation Completion	Read Only This will be calculated 60 days from date report submitted

		date (excluding externally led investigations):	
Independent Required:	○ Yes ◉ No ○ Unknown ○ Pending Review	Expected date of Completion	
Non-health led investigation required	Please Select	Expected date of Completion	
Description of what happened:			
Immediate action taken:			
Patient family / victims family informed?	○ Yes ○ No ○ Not applicable ○ Obtaining contact details ○ Yes ○ No ○ Not applicable		
Patient (s) informed?			
Duty of Candour comments - include Steps taken to involve and			

support those affected (including patient(s), victims, families, staff):			
Media Interest:	○ Yes ○ No	Line being taken by Trust/CCG:	
Externally reportable:	○ Yes ○ No	Externally reportable to:	Please Select - more than one can be selected
Have relevant organisations been notified:	○ Yes ○ No ○ Ongoing		

Trust / Commissioner File			
Provider Lead:		Provider Lead Tel No.:	
Commissioner Lead:		CCG Lead Tel No.:	
Current File Holder:		BF/wd Date:	14/11/2015
Date Internal Investigation Report and action plan submitted:			
Date Independent Investigation Report submitted (where applicable):			

Correspondence History:	
Comments / further action required:	
Has an extension been agreed:	Yes No
State reason for extension	
State agreed extension date	

Key Findings (i.e. fundamental issues/root causes) and recommendations	
Key findings (i.e. fundamental/root causes) and recommendations:	
How will lessons be disseminated to interested parties:	
Plan for monitoring action plan in place:	Yes No
Date Closed by commissioner:	

Modified Date and Time	By
15/09/2015 15:28	U10C

NOTES:

For use by all organisations contracted to provide NHS care without direct access to the national SIRI database StEIS. (Strategic Executive Information System) All SIRI reports *must* be submitted to the Commissioners in accordance with contractual requirements, in order to be added to the national database as soon as practicable.

For 'Never Events' the provider is required to notify commissioners of the event immediately by telephone to the on call director: during working hours between 8 am and 4 pm (01276707697) and out of working hours Mobile: 07010063245.

In the case of a Never event, the Commissioner may choose to collect the required data verbally without the requirement for the Provider to submit a report form also. This will be confirmed at the point of notification of the never event to the Commissioner.

Please e-mail form, either password protected or from NHS Net to NHS Net accounts to:

SHCCG.SeriousIncidents@nhs.net

(StEIS proforma as at: **September 2015**)

Addendum 1
Type of Incident

Please select one of the following options
Note: 'in receipt' applies to receipt of mental health services

Abscond
Accident whilst in hospital
Admission of under 16s to adult mental health ward
Admission of under 18s to adult mental health ward
Adverse media coverage of public concern about the organisation or the wider NHS
Allegation against HC non-professional
Allegation against HC professional
Allegation against HC professional (assault)
Allegation against HC Professional (fraud)

Ambulance accident – Road Traffic Collision
Ambulance Accidental Injury
Ambulance Delay
Ambulance (general)
Assault by inpatient (in receipt)
Assault by inpatient (not in receipt)
Assault by outpatient (in receipt)
Assault by outpatient (not in receipt)
Assault (unknown assailant)
Attempted Homicide by Inpatient (in receipt)
Attempted Homicide by Inpatient (not in receipt)
Attempted Homicide by Outpatient (in receipt)
Attempted Homicide by Outpatient (not in receipt)
Bogus Health Workers
Chemical Incident
Child Abuse (family)
Child Abuse (institutional)
Child Abuse (multiple)
Child Death
Child Serious Injury
Communi cable Disease and Infection Issue
Communication Issue
Confidential Information Leak
Critical Care Transfer
C.Diff & Health Care Acquired Infections
Death in Custody
Death on GP Premises
Delayed Diagnosis
Dentistry
Drug incident (Chemotherapy)
Drug incident (general)
Drug incident (insulin)
Escape
Failure to act upon test results
Failure to obtain consent
Fire (accidental)
Fire (non-accidental)
Health and Safety
Hep B Infected HC Professional
HIV infected HC Professional
Home Oxygen
Homicide by inpatient (in receipt)
Homicide by inpatient (not in receipt)
Homicide by outpatient (in receipt)
Homicide by outpatient (not in receipt)
Hospital equipment failure
Hospital Transfer Issue
Infected Health Care Worker
Maternity Service
Maternity Services – Intrapartum death
Maternity Services – Intrauterine death
Maternity Services – Maternal death
Maternity Services – Maternal unplanned admission to ITU
Maternity Services – Suspension of Maternity Services
Maternity Services – Unexpected admission to NICU (Neonatal intensive care unit)
Maternity Services – Unexpected neonatal death
Medical equipment failure
Mental Health Act – Class A incident
Mental Health Act – Class B incident
Mental Health Act – Class C incident
MRSA Bacteraemia
New category
NHS Direct Incident
Other
Out patient appointment delay
Post Mortem
Premature Discharge
Pressure Ulcer Grade 4
Prisoner in receipt of care

Radiology/Scanning incident
Safeguarding Vulnerable Adult
Safeguarding Vulnerable Child
Screening Issues
Security Threat
Serious incident by inpatient (in receipt)
Serious incident by inpatient (not in receipt)
Serious incident by outpatient (in receipt)
Serious incident by outpatient (not in receipt)
Serious self inflicted injury Inpatient
Serious self inflicted injury Outpatient
Slips/Trips/Falls
Sub-optimal care of the deteriorating patient
Suicide
Suicide by Inpatient (in receipt)
Suicide by Inpatient (not in receipt)
Suicide by Outpatient (in receipt)
Suicide by Outpatient (not in receipt)
Surgical Error
Suspected Suicide
Test Incident (do not use for live incidents)
Transfusion incident
Unexpected Death of Community Patient (in receipt)
Unexpected Death of Community Patient (not in receipt)
Unexpected Death of Inpatient (in receipt)
Unexpected Death of Inpatient (not in receipt)
Unexpected Death of Outpatient (in receipt)
Unexpected Death of Outpatient (not in receipt)
Venous Thromboembolism (VTE)
Ward Closure
Ward / Unit Closure
Wrong site surgery

Addendum 2

Type of Patient:

Select <u>one</u> of the following options:

A&E Patient

Ambulance Patient

Community Patient

Day Patient

GP Patient

Home patient

Residential Care Patient/Client

Out Patient

In Patient Planned

In Patient Unplanned

None

Addendum 3

Externally reportable to:

List on the form all those organisations being informed by you, the Provider, directly or indirectly, about the incident being reported. Select as many of the following options as required:

Centre for Communicable Disease Control

Care Quality Commission

Confidential Inquiries

Coroner

Department of Health

Environmental Health

Food Standards Agency

Health Authority

Health and Safety Executive

Home Office

Information Commissioner

Medical Devices Agency

Medicines Control Agency

Monitor

National Patient Safety Agency

NHS Estates

NHS Litigation Authority

Police

CCG (Clinical Commissioning Group)

Professional Regulatory Bodies (e.g. GMC UKCC etc)

Public Health Laboratory Service

Serious Hazards of Transfusion (SHOT)

NONE

Definitions

Abuse: A violation of an individual's human and civil rights by any other person or persons: a single or repeated act. Abuse could be physical, verbal, psychological, emotional, financial or sexual. Abuse can occur in any relationship and may result in significant harm to, or exploitation of, the person subjected to it. Abuse can result due to 'inflicting harm' or 'by failing to act to prevent harm'. Abuse may be by an act of neglect or an omission to protect a vulnerable individual.

Accountable Officer:
The individual ultimately accountable for ensuring that the statutory obligations of the CCG are met and those public funds are utilised appropriately.

Adverse event or incident:
An event or circumstance which could have resulted, or did result in unnecessary damage, loss or harm such as physical or mental injury to a patient, staff, visitors or members of the public.

Caldicott Guardian:
A Caldicott Guardian has the responsibility for ensuring the protection and appropriate use of patient identifiable information within an NHS organisation, which may be accessed during the incident reporting process. If an information governance breach has occurred the Caldicott guardian will seek assurances that all appropriate actions have been instigated.

Clinical Commissioning Group (CCG):
Clinically-led organisation, created by the Health and Social Care Act 2012 that commissions NHS-funded healthcare on behalf of its local patient population. CCGs will not commission primary care or specialised services.

Commissioning Support Unit:
An organisation set up to support CCGs in their management of provider contracts delivering expertise and economies of scale. They are accountable to the CCGs through service level agreements and service specifications but without statutory accountability.

Executive Nurse / Quality Lead - Clinical Commissioning Group:
Responsible for quality elements of provider contracts and associated contract monitoring. Accountable for providing assurance to the CCG in relation to the management of adverse events in providers and the robustness of actions taken to improve quality of services to patients.

Near Miss:
A near miss is an incident that had the potential to cause harm but was prevented either by mechanical or human intervention.

Never Events:
Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. Never events are patient safety incidents that are preventable

because there are existing national guidance or safety recommendations, which if followed, would have prevented the incident from occurring.

Incidents are considered to be never events if:

The incident either resulted in severe harm or death or had the potential to cause severe harm or death

There is evidence that the never event has occurred in the past and is a known source of risk

Core Never Event list as at 2015/2016:

Surgical

- Wrong site surgery
- Wrong implant/ prosthesis

Retained foreign object post procedure

Medication

- Mis-selection of a strong potassium-containing solution
- Wrong route administration of chemotherapy
- Wrong route administration of oral/enteral treatment
- Intravenous administration of epidural medication
- Overdose of Insulin due to abbreviations or incorrect device
- Mis -selection of high strength midazolam during conscious sedation
- Overdose of methotrexate for non-cancer treatment

Mental Health

- Failure to install functional collapsible shower or curtain rails

General

- Falls from poorly restricted windows
- Chest or neck entrapment in bedrails

Transfusion or transplantation of ABO-incompatible blood components or organs

Misplaced naso- or oro-gastric tubes

Scalding of patients

Prevention of Future Death Reports previously known as Rule 43:

The Chief Coroner assumed responsibility for Prevention of Future Death Reports (previously known as Rule 43 reports) following implementation of powers under the Coroners and Justice Act 2009 in July 2013, strengthening and elevating 'Rule 43' provision to primary legislation. HM Coroner can issue a report where s/he has concerns that an organisation's omissions or commissions contributed to the death of an individual or

individuals. The recipient of the report has 56 days to respond to the Coroner detailing any actions which have been or will be taken to prevent another death in similar circumstances. As inquests are held in public the application of 'Rule 43' can result in adverse publicity for a provider of NHS Services and should trigger a commissioner to seek additional assurance from the provider about actions being taken.

Root Cause Analysis (RCA):
Root cause analysis (RCA) is a method of problem solving that tries to identify the most basic cause or causes of faults or problems along with the contributory factors, rather than stopping at the most obvious, in the context of the environment in which an incident happened.

Safeguarding:
Ensuring that people live free from harm, abuse (in all its forms) and neglect and, in doing so, protecting their health, wellbeing and human rights. For children, safeguarding work focuses more on care and development; for adults, on empowerment, independence and choice.

Serious Incident:
A serious incident is, in general terms, an event or circumstance which could have resulted, or did result in significant unexpected damage, loss or harm to a patient, staff, visitors or members of the public and/or unintended outcomes of a commissioned service. Serious incident are not limited to clinical incidents. Any incident that caused significant disruption to a service or considerable damage to an organisation's reputation could also be classified as a Serious Incident Requiring Investigation (SIRI). The definition extends to potential incidents (near misses) as well as actual incidents.

- Unexpected or avoidable death or sever harm of one or more patients, staff or members of the public;
- A never event – all never events are defined as serious incidents although not all never events necessarily result in severe harm or death; *[See appendix C]*
- A scenario that prevents, or threatens to prevent, an organisation's ability to continue to deliver healthcare services, including data loss, property damage, or incidents in population programmes like screening and immunization where harm potentially may extend to a large population;
- Allegations, or incidents, of physical abuse and sexual assault or abuse;

And/or

- Loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation.

Strategic Executive Information System (StEIS):
Part of a Department of Health database (UNIFY) specifically for SIRIs. Each NHS provider, commissioner and commissioning support unit has a unique password to the system. NHS England Local Area Teams are the gatekeepers to the system. Some organisations contracted to provide NHS care do not have direct access to StEIS and the relevant CCG or CSU will have to report SIRIs on their behalf. .

Unexpected Death: Where natural causes are not believed to be the cause of death. Such incidents should be investigated to determine whether any adverse events contributed to the unexpected death.

Working Day:
Days that exclude weekends and bank holidays

NHS
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Clinical Commissioning Group

National and local documents associated with this policy

Serious Incident Framework March 2015
https://improvement.nhs.uk/documents/920/serious-incidnt-framwrk.pdf

Never events policy framework. Department of Health October 2012
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213046/never-events-policy-framework-update-to-policy.pdf

The 'Never Events' List 2015/2016
https://www.england.nhs.uk/wp-content/uploads/2015/03/never-evnts-list-15-16.pdf

NHS England – patient safety
http://www.england.nhs.uk/ourwork/patientsafety/

NPSA Being Open resources
http://www.nrls.npsa.nhs.uk/beingopen/

NPSA Being Open framework 2009
http://www.nrls.npsa.nhs.uk/beingopen/?entryid45=837266

Root Cause Analysis (RCA) investigation guidance
http://www.nrls.npsa.nhs.uk/resources/?entryid45=75355&q=0%c2%acRCA%c2%ac

Post Infection Review (PIR) for Methicillin-Resistant *Staphylococcus aureus* (MRSA)
https://improvement.nhs.uk/resources/mrsa-guidance-post-infection-review/

Managing Incidents in the NHS Screening Programmes (March 2015)
https://www.gov.uk/government/publications/managing-safety-incidents-in-nhs-screening-programmess

Checklist Guidance for Reporting, Managing and Investigating Information Governance Serious Incidents Requiring Investigation June 2015
https://www.igt.hscic.gov.uk/resources/HSCIC%20SIRI%20Reporting%20and%20Checklist%20Guidance.pdf

Domestic homicide review online learning for frontline practitioners.
https://www.gov.uk/conducting-a-domestic-homicide-review-online-learning

https://www.gov.uk/government/collections/domestic-homicide-review

https://www.gov.uk/government/publications/revised-statutory-guidance-for-the-conduct-of-domestic-homicide-reviews

An update to the 2012 NHS South of England Process for Reporting and Learning from Serious Incidents
https://www.england.nhs.uk/south/wp-content/uploads/sites/6/2015/01/how-to-guide-ss-at-incident-reporting.pdf

Appendix F

NHS
Surrey Heath
Clinical Commissioning Group

Serious Incident (SI) 72 Hour Report

SIRI Reference Number: **(local internal ID system)**	
STEIS Identification Number: **(National database log number)**	
Date/Time/Location of Incident including hospital / ward / team level information	
Incident type	
Description of incident including reason for admission and diagnosis (for mental health please include Mental Health Act status and date of referral and last contact)	
Details of any police or media involvement/interest	
Details of contact with or planned contact patient/family or carers	
Immediate actions taken including actions to mitigate any further risk	
Details of other organisations/individuals notified	
Lead Commissioner	
Report completed by	
Designation	
Date / time report completed	

Please insert below a brief chronology of key events:-

Appendix G

NHS
Surrey Heath
Clinical Commissioning Group

Analysing the Impact on Equality

1. Title of policy/ programme/ framework being analysed **Serious incidents Policy**
2. Please state the aims and objectives of this work and the *intended equality outcomes*. How is this proposal linked to the organisation's business plan and strategic equality objectives? **To Support the SH CCG in managing SI's, and to standards closure process.**
3. Who is likely to be affected? e.g. staff, patients, service users, carers **None**
4. What evidence do you have of the potential impact (positive and negative)? **Step one: Gather evidence** - List the main sources of evidence (including full references) reviewed to determine impact on each equality group or protected characteristic. This can include national research, census data, Joint Strategic Needs Assessment (JSNA), surveys, reports, research interviews, focus groups, engagement with stakeholders. **Step two: Consider the impact** – On the basis of the evidence and findings from engagement activity, what is the impact of your work on each equality group/ protected characteristic? Identify whether the evidence shows potential for differential impact, if so state whether positive or negative and for which groups. This could be barriers to access, or different levels of needs, experiences or health outcomes. Identify how you will mitigate any negative impacts. Also how you will include certain protected groups in services or expand their participation in public life. How do the proposals impact on elimination of discrimination, harassment and victimization, advance the equality of opportunity and promote good relations between groups? **None**
4.1 Disability (Consider attitudinal, physical and social barriers) None
4.2 Sex (Impact on men and women, potential link to carers below) None
4.3 Race (Consider different ethnic groups, nationalities, Roma Gypsies, Irish Travellers, language barriers, cultural differences). None
4.4 Age (Consider across age ranges, on old and younger people. This can include safeguarding, consent and child welfare).

4.5 Gender reassignment (Consider impact on transgender and transsexual people. This can include issues such as privacy of data and harassment). None
4.6 Sexual orientation (This will include lesbian, gay and bi-sexual people as well as heterosexual people). None
4.7 Religion or belief (Consider impact on people with different religions, beliefs or no belief) None
4.8 Marriage and Civil Partnership None
4.9 Pregnancy and maternity (This can include impact on working arrangements, part-time working, infant caring responsibilities). None
4.10 Carers (This can include impact on part-time working, shift-patterns, general caring responsibilities, access to health services, 'by association' protection under equality legislation)**.** None
4.11 Additional significant evidence Give details of any evidence on other groups experiencing disadvantage and barriers to access due to: • socio-economic status • location (e.g. living in areas of multiple deprivation) • resident status (migrants) • multiple discrimination • homelessness
5 Action planning for improvement Please give an outline of the key action points based on any gaps, challenges and opportunities you have identified. An Action Plan template is appended for specific action planning.
Sign off
Name and signature of person who carried out this analysis
Date analysis completed
Name and signature of responsible Director
Date analysis was approved by responsible Director