Bexley Clinical Commissioning Group

ENCLOSURE: F

Agenda Item: 08/13

Governing Body (Public) Meeting

DATE: 28th February 2013

Title	**Incidents and Serious Incident Policy**
Recommended action for the Governing Body	That the Governing Body: **Approve** the Incidents and Serious Incidents Policy as laid out in the attached report
Executive Summary	Management of Serious Incidents has been repatriated from NHS London, we have agreed to work with colleagues in Bromley and Greenwich to maximise the learning from SI incidents and reporting. This policy is designed to ensure that Incidents and Serious incidents are acted upon and lessons learned BBG CCGs are committed to identifying, managing and minimising all risks to its commissioned service users, staff and visitors through the framework of corporate and clinical governance. It is a mandatory requirement for health care organisations to have in place incident reporting policies and procedures. This is part of good risk management standard specified by the National Health Service Litigation Authority (NHSLA). This document sets out how all incidents (including SIs) will be identified, reported by staff, and managed within commissioning and provider organisations. Serious incidents in healthcare are uncommon but when they occur the National Health Service (NHS) has a responsibility to ensure there are systematic measures in place for safeguarding people, property, NHS resources and reputation. This includes responsibility to learn from these incidents to minimise the risk of them happening again BBG CCGs role relating to serious incidents is to ensure that the appropriate management is in place across the system in the service commissioned by the CCG.
Which objective	**Patients:** Improve the health and wellbeing of

does this paper support?		people in Bexley in partnership with our key stakeholders	✓
	People:	Empower our staff to make BCCG the most successful CCG in (south) London	
	Pounds:	Delivering on all of our statutory duties and become an effective, efficient and economical organisation	
	Process:	Commission safe, sustainable and equitable services in line with the operating framework and which improves outcomes and patient experience	✓

Organisational implications	Key Risks (corporate and/or clinical)	This report provides assurance that around the processes and procedures in place for ensuring the quality and safety of commissioned services in respect of serious incidents
	Equality and Diversity	No Equality and Diversity issues identified
	Patient impact	This policy sets out the process for managing Serious Incidents and Never events across the BBG and ensuring that learning from experience minimise the risk of reoccurrence
	Financial	Additional Resourcing
	Legal Issues	
	NHS constitution	This paper supports the pledges as set out in the NHS constitution.
Consultation (Public, member or other)	With Directors of Quality across BBG CCGs	
Audit (Considered / Approved by Other Committees / Groups)		
Communications Plan		
Author	Interim Serious Incidents Manager	

	Clinical Lead	Executive Sponsor Simon Evans-Evans
Date	12/02/13	

Bromley Clinical Commissioning Group

Bexley Clinical Commissioning Group

Greenwich Clinical Commissioning Group

Incidents and Serious Incidents Policy

April 2013

POLICY NUMBER		**VERSION: 1**
APPROVAL/RATIFYING COMMITTEE/S		
IMPLEMENTATION DATE		April 2013
NEXT REVIEW DATE		

ACCOUNTABLE DIRECTORS/ Clinical Lead:

Sonia Colwill – Bromley

Simon Evan-Evans – Bexley

Nicola Havutcu – Greenwich

POLICY AUTHOR:

Kashmir Sidhu Interim Serious Incidents Manager

Record of Amendments

Date of Amendment	Version No	Comments

Linked Documents:

Policies relating to the documents linked below will be available via each of the above CCGs

Being Open when Patients are Harmed

Whistleblowing

Confidentiality Policy and Procedure

Safeguarding

Secondary Use of Protecting Patient Identifiable data

Health and Safety

Accident and Incident reporting management

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BBG CCGS

Incident and Serious Incident Policy

1 Introduction

NHS funded organisations providing care in England need to demonstrate accountability for effective governance and learning following incidents and Serious Incidents (SIs). BBG CCGs seeks to work closely with all provider organisations as well as commissioning staff members to ensure all incidents are reported and managed appropriately.

BBG CCGs is committed to identifying, managing and minimising all risks to its commissioned service users, staff and visitors through the framework of corporate and clinical governance. It is a mandatory requirement for health care organisations to have in place incident reporting policies and procedures. This is part of good risk management standard specified by the National Health Service Litigation Authority (NHSLA).

This document sets out how all incidents (including SIs) will be identified, reported by staff, and managed within commissioning and provider organisations.
Serious incidents in healthcare are uncommon but when they occur the National Health Service (NHS) has a responsibility to ensure there are systematic measures in place for safeguarding people, property, NHS resources and reputation. This includes responsibility to learn from these incidents to minimise the risk of them happening again1.

BBG CCGs role relating to serious incidents is to ensure that the appropriate management is in place across the system in the service commissioned by the CCG.

In order to provide national consistency in the definition of a serious incident and clear roles, responsibilities and timescales for completing Serious Incident investigations, the National Patient Safety Agency (NPSA) launched the first release of a National Framework for Reporting and Learning from Serious Incidents Requiring Investigation (SIRIs) in March 2010. This framework and the accompanying Information Resource to Support Reporting of Serious Incidents must be read in conjunction with this policy this can be found on the NPSA website or by using the link http://www.nrls.npsa.nhs.uk/resources/?EntryId45=75173

BBG CCGs has adopted this framework in full and expects those commissioning on behalf of the CCG or providing NHS funded care commissioned by the CCG to adhere to the guidance contained in the framework. This policy provides some additional information as an addendum to the national framework that specifically applies to all organisations in London.
In line with the national framework, events previously known as Serious Untoward Incidents (SUIs) will be known as Serious Incidents (SIs).

The NPSA is developing a national Serious Incident Management System (SIMS) to replace the current serious incident reporting system, STEIS. NHS Service Providers will report serious incidents on STEIS.

BBG CCGs takes responsibility for the closure of SIs in NHS organisations from NHS London from [date].

1.1 Scope

This policy is applicable to all NHS-funded services commissioned by BBG CCGs unless that service is commissioned by a number of CCGs where the lead CCG's policy will be used. This includes for instance Hospitals, 111 Providers, Nursing Homes. There are no services, which are commissioned by BBG CCGs, or for whom BBG CCGs is the lead commissioner, which is exempt from the need to comply with this policy.

1.2 Equality Impact Assessment

The CCG has a commitment to ensuring that no person is treated in a less favourable manner than another on grounds of their personal characteristics nor is placed at a disadvantage by the application of conditions or requirements which cannot be shown to be justifiable.

The Equalities Act of 2010 identifies 9 protected characterises: age, disability, gender re-assignment, marriage and civil partnership, pregnancy and maternity, race, religion and belief, sex and sexual orientation. This policy applies to all groups equally.

2 Roles and Responsibilities

2.1 Chief Officer

Accountable Officer and Chief Officer of the service has ultimate responsibility for ensuring that the organisation has the necessary management systems in place to enable the effective management and implementation of all risk management and governance systems.

2.2 Director of Quality (or equivalent)

Executive Lead for Quality and Safety. Accountable for an effective process for managing SIs.

2.3 Head of Quality and Clinical Governance (or equivalent)

Responsible for day to day management of incidents and SIs reportable by the organisation and for the monitoring of summary reports for provider organisation which will be submitted to appropriate BBG CCGs forums.

2.4 Quality & Safety Team/Serious Incidents Manager (or equivalent)

The team will undertake analysis of Incident and SI themes and organisation performance, based on timeliness of submission, report completeness and reporting levels. Team members will liaise with relevant staff in organisations to help them improve their processes and learn from events.

2.5 Expert Leads

The role of the Expert Lead is to review relevant SI alerts and identify any areas that need to be addressed as part of the investigation. When the SI report is completed, their role is to review the report and identify whether it has addressed all the issues and is suitable for closure. An example of an expert lead would be a specialist in infection control, maternity, mental health, the medicines management lead, finance or IT specialist.

2.6 Contract Managers and Commissioning Leads

To make explicit reference to incident and SI reporting in contracts with all provider commissioned services; in particular the expectations regarding SI reporting and management, the incident and SI indicators to receive for monitoring purposes and the process for performance management of these indicators. The Contract Managers and Commissioning Leads are also responsible for ensuring that lessons learned from incidents and SIs influence the quality and safety standards for care pathway and service development.

3 Definitions

3.1 Incident

An incident is described as “any event which has given rise to potential or actual harm or injury, to patient dissatisfaction or to damage/ loss of property” (Ref: NHS Executive). This definition includes patient/ service user injury, fire, theft, vandalism, assault and employee accident and near misses. It includes incidents resulting from negligent acts, deliberate or unforeseen

3.2 Near miss

An incident that had the potential to cause harm but was prevented

3.3 Non-Clinical incidents

an unplanned or unexpected event in which a member of staff/contractor or the public has been, or could have been injured, killed, or suffer mental trauma, or led to loss or damage to equipment or property, or other financial loss. For example:

- A member of staff hurts his/her back
- A member of staff subject to verbal abuse
- A member of the public falls in the car park
- A member of staff suffers a needle stick injury
- Fire on work premises
- Theft loss or damage to organisation or personal property

3.4 Patient Safety Incident

Any unintended or unexpected event that could have or did lead to harm on Organisation premises where NHS funded care is provided, including a patient’s own home or anywhere in the community. For example:

- Delayed treatment that has or could have caused harm

- Diagnostic results not communicated or lost
- Record Keeping – poor recording, incomplete, failure to document
- Procedures carried out incorrectly or incorrect procedure applied to an individual
- Patients' notes lost, unavailable, incomplete
- The wrong medication is prescribed, administered, missed or lost
- Patient falls
- Absconsion from (non) secure settings
- Inappropriate/unsafe patient discharge
- Confidentiality breach
- Staff shortages
- Faulty Equipment – medical such as feeding pump, syringe driver, catheter.

3.5 Serious Incidents

A serious incident requiring investigation is defined as an incident that occurred in relation to

NHS-funded services and care resulting in one of the following:

- Unexpected or avoidable death of one or more patients, staff, visitors or members of the public.
- Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent
- harm or will shorten life expectancy or result in prolonged pain or psychological harm (this
- Includes incidents graded under the NPSA definition of severe harm).
- A scenario that prevents or threatens to prevent a provider organisation's ability to continue
- to deliver healthcare services, for example, actual or potential loss of
- personal/organisational information, damage to property, reputation or the environment, or
- IT failure.
- Allegations of abuse.
- Potential or actual adverse media coverage or public concern about the organisation or the wider NHS.
- Is a death in custody e.g. prison, probation hostels and immigration detention Accommodation and includes expected deaths. Guidance on clinical reviews undertaken in those circumstances and the responsibilities of the NHS are available on www.dh.gov.uk/socialcare (navigate to prison health) or from the regional health and social care justice team.
- One of the core set of NPSA 'Never Events' as updated on an annual basis and currently including:

1. wrong site surgery
2. wrong implant/prosthesis
3. retained foreign object post-operation

4. wrongly prepared high-risk injectable medication
5. maladministration of potassium-containing solutions
6. wrong route administration of chemotherapy
7. wrong route administration of oral/enteral treatment
8. intravenous administration of epidural medication
9. maladministration of Insulin
10. overdose of midazolam during conscious sedation
11. opioid overdose of an opioid-naïve patient
12. inappropriate administration of daily oral methotrexate
13. suicide using non-collapsible rails
14. escape of a transferred prisoner
15. falls from unrestricted windows
16. entrapment in bedrails
17. transfusion of ABO-incompatible blood components
18. transplantation of ABO-incompatible organs as a result of error
19. misplaced naso- or oro-gastric tubes
20. wrong gas administered
21. failure to monitor and respond to oxygen saturation
22. air embolism
23. misidentification of patients
24. severe scalding of patients
25. Maternal death due to post partum haemorrhage after elective Caesarean section.

The definition of SIs requiring investigation extends beyond those which affect patients directly, and includes incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare. All serious patient safety incidents should be reported to the NPSA, and to modifiable partner organisations, as detailed in the information resource that supports this policy (found on the NPSA website at http://www.nrls.npsa.nhs.uk/resources/?entryid45=75173.

Organisations are advised to err on the side of caution. Advice can be sought from the commissioner of the service and or the clinical quality and patient safety team at BBG CCGs. All SIs should be reported to The Quality & Safety Team/Serious Incidents Manager as soon as possible (as below). The team can provide advice on the management of SIs and can be contacted by telephone during normal office hours see schedule 1. For Grade 3 SIs a call should be made immediately should this occur out of hours the NCB. should be called.

Excluded from this definition are adverse outcomes reasonably associated with routine NHS activity such as major surgical procedures or radiotherapy treatment. A no harm event in relation to any of the above should also be recorded by NHS provider organisations and potential aggregated trends and clusters analysed using root cause analysis. Any emerging trends, which

constitute a significant risk in any of the above categories, should be reported using this policy. All Serious incidents should be graded by the provider in line with the national framework subject to local arrangements (see appendix 1).

3.6 Never Events

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. CCGs are required to publicly report the incidence of Never Events in commissioned providers identifying frequency and type with a summary of actions implemented.

3.7 Service Provider

A service provider is an organisation who is commissioned to provide NHS funded care for instance a General Practice, a 111 or Out of Hours Provider, or an Acute Trust.

4 Incidents

4.1 Managing the incident

In all instances, the first priority for the organisation where the incident occurs is to ensure the needs of individuals affected by the incident are attended to, including any urgent clinical care which may reduce the harmful impact.

A safe environment should be re-established, all equipment or medication retained and isolated, and relevant documentation copied and secured to preserve evidence and facilitate investigation and learning. If there is a suggestion that a criminal offence has been committed, the provider organisation should contact the police.*

The organisation should give early consideration to the provision of information and support to patients, relatives and carers and staff involved in the incident, including information regarding support systems which are available to patients/ relatives/visitor/contractors. The organisation should follow guidance provided in their local *Being Open* policy.

Provider organisations are responsible for risk assessing and managing all incidents and triggering the escalation of reports from serious incidents. They must also manage the reporting to HSE as appropriate of Health and Safety Incidents and to NRLS for Patient Safety Incidents. Provider organisations must have systems and processes for collecting, collating and analysis of data on all incidents and lessons learned.

4.2 Monitoring of Incidents

Analysis of the types and trends from reports shall be provided to BBG CCGs by all providers. As a minimum, incident and SI figures and trends should be monitored on a quarterly basis within contract monitoring and / or quality assurance meetings with

providers of commissioned services. Note: SI figures and trends monitoring is in addition to acting immediately following being notified of an SI, as detailed in appendix 3

Within these monitoring meetings, commissioning managers / leads will want to be assured of the following:

- Incidents and SIs are being identified and reported.
- SI investigation reports are being submitted within the appropriate working days timeframe (see appendix 2).
- Incidents and SIs have been thoroughly investigated and root causes identified.
- Providers have been working with related services and / or partner agencies involved in the incident when investigating root causes and sharing incident information with related services and / or partner agencies involved so that they can investigate their involvement.
- Providers have considered the involvement of services that refer patients into their care when investigating root causes. Services such as, and especially considering, primary care out of hours GP services and NHS 111 service, should be informed of the incident as soon as possible so they can investigate their involvement, particularly including the patients transition between services.
- Patients and / or relatives and carers have been considered and involved, where appropriate, throughout the different stages of the incident / SI lifecycle.
- Actions have been taken and lessons have been learnt to prevent recurrence of the incident / SI.
- Lessons have been shared with services that may also be at risk of seeing such incidents / SIs occur.
- Analysis of trends and patterns of incidents and SIs occurring and what actions have been taken to address any concerns arising from this analysis.

Evidence of such can take the form of:

- Training log / programme showing that staff are aware of the types of incidents that may occur and that they received this training, for example at induction / refresher training.
- Numbers of incidents reported by type of incident and severity of incident. For larger organisations, a breakdown of incident types by service line is strongly recommended.
- Minutes of „learning from experience“ groups or equivalent where discussions have taken place about investigations, actions, linked working and lessons learned.

(This is not an exhaustive list.)

As a result, lessons learned and analysis of trends and patterns of incidents and SIs occurring should then be used to influence the quality and safety standards for care pathway and service development.

4.3 CCG reporting on incidents

BBG CCGs will include information on incidents and serious incidents reported by provider commissioned services within the quality report to the Board on a quarterly and annual basis.
The reports will include:

- Numbers of incidents and SIs reported
- Number of SI investigation reports submitted within the 45 working days timeframe
- Comparative information available overtime and by provider type
- Trends, themes and concerns
- Developments in the quality improvements activities resulting from trends, themes and concerns analysis
- Training and education
- Audits
- Pathway / service redesigns
- Challenges, risks and concerns to be addressed

5 Procedure for reporting and investigating Serious Incidents

5.1 Reporting on STEIS

All organisations providing care commissioned by BBG CCGs, including Foundation Organisations (FTs) and 111 Providers must use the Strategic Executive Information System (STEIS) to report SIs until the new SIM system is in place. They must be reported as soon as possible after the incident is detected and no later than two working days of the incident being identified. The report must not contain any patient or staff identifiable data and the description should be concise (fewer than 60 words).

For grading of incidents, reference should be made to the National Framework for Reporting and Learning from Serious Incidents Requiring Investigation (Appendix 1).

Where an SI occurs, it should be reported to the BBG CCG as soon after the event as possible by telephone: See schedule 1. When the event happens during normal office hours the call should be made on that working day; where the event happens outside of these hours it should be as early as possible on the next working day. Where a Grade 3 SI event occurs a call should be immediately made to the on call commissioner [number for on call commissioner] and followed by a call to the Quality and Safety Team in office hours the next working day.

The STEIS record must be updated as the situation changes, which could be weeks or months after the original incident. It is important that BBG CCG is ready to deal effectively with any resulting media and public interest. An email must be sent with the STEIS number in subject line to: indicate Bromley/Bexley/Greenwich when the STEIS record is updated.

5.2 Submission of Final Reports for Serious Incidents

Grade 1 reports and action plans must be submitted within 45 working days. Grade 2 reports and action plans (with the exception of reported homicides) must be submitted within 60 working days. All provider organisations must submit their final report to the BBG CCG using the generic email address. The due date and grade will be recorded in the case summary section of the STEIS record. It is the responsibility of the Quality and Safety lead in the provider organisation to provide the report on or before the due date.

Within BBG CCGs on receipt of the final report the Quality & Safety Team/Serious Incidents Manager/serious Incidents Manager, with input from an Expert Lead where relevant, will review the report and decide if it is appropriate for closure.

5.3 Serious Incident Report Format

As a minimum SI reports should include the following:

- Incident date
- Incident description
- Actual effect on patient/service
- Involvement and support of patients and relatives
- Clear, fact based chronology of events leading up to the incident
- Care and Service Delivery problems
- Contributory Factors
- Root Causes
- Lessons Learned
- Action Plan (containing the minimum requirements listed below)
- Evidence of Board level sign off before submission (including name, designation and date reviewed)
- Anonymised for patient and staff involved in the incident

In relation to organisations submitting reports to BBG CCGs, on receipt of the report BBG CCGs will review its content and structure against the above criteria. BBG CCGs requires 100% compliance and will provide feedback on compliance to organisations on a quarterly basis. The criteria relating to anonymity will be incorporated into the evaluation and feedback to organisations.

5.4 Criteria for Accepting a Report of a Serious Incident

If an organisational report does not meet the above criteria for submission, then the report will not be accepted. The Quality & Safety Team/Serious Incidents Manager will provide the reason for non-acceptance and the organisation will have to revise the report and re-submit as soon as possible. No extension will be granted to account for the period of revision and it will be recorded as overdue. Only when the report meets the criteria will it be accepted.

5.5 Action Plan

BBG CCGs recommends use of the NPSA Action Plan template which can be found on the NHS Commissioning Boards website which includes the NPSA National Framework for Reporting and Learning from Serious Incidents

These are the minimum requirements for an action plan:

- every recommendation must have a clearly articulated action
- a responsible person (job title only) must be identified for each action point
- there are dates for proposed completion of actions
- description of the form of evidence that will be available to confirm completion

A SMART approach to action planning is recommended. That is, the actions should be: Specific, Measurable, Attainable, Relevant and Time-bound.

5.6 Monitoring of Action Plans

Minimum data sets for reporting by providers to the CCG are found at appendix 3.

In relation to Never Events and incidents involving an independent investigation or inquiry, BBG CCGs will monitor action plans until evidence is provided that each action point has been implemented. In addition, there may be other grade 2 incidents where BBG CCGs will monitor action plans such as incidents of high public interest.

For other categories of incident the monitoring and the implementation of action plans will be as part of regular quality review meetings.

6 Specialist Report Templates and Investigation Aids

For some types of incident there are individual reporting templates and investigation aids which can be used. There is a report template for Grade 3 and 4 pressure ulcers.

Regarding Infection Control (IC), there are currently two popular and tested tools. These are the NPSA Infection Control Tool, Learning through action to reduce infection and the DH Data Gathering Tool for Clostridium difficile infection (CDI) and MRSA.

The NPSA IC Tool can be submitted to BBG CCGs as a report for those investigations that are judged to be uncomplicated, however a more detailed report would need to be submitted should the incident require a comprehensive investigation.

The Department of Health Clostridium difficile (C. difficile) and MRSA (methicillin-resistant staphylococcus aureus) Data Gathering Tool provides a good methodology for gathering information when undertaking a root cause analysis (RCA) relating to Infection Control incidents however organisations will need to consider using the NPSA RCA Investigation Report Template as a final report.
Investigation aids are also available for:

- Intrapartum-related Perinatal Deaths
- Information Governance SIs

All these templates and investigation aids can all be found on the BBG CCGs website.

7 De-escalation Requests

BBG CCGs recognise that organisations may report SIs based on limited information which on further investigation does not meet the criteria for an SI. In such cases the organisation should request de-escalation from BBG CCGs. In relation to organisations submitting reports to BBG CCGs, requests for SIs to be de-escalated should be sent to see Schedule 1. When an organisation makes a request for de-escalation it must account for why the incident does not warrant further investigation under the SI process. BBG CCGs will review the de-escalation request and inform the organisation of its decision within ten working days.

As de-escalation on STEIS means the record is deleted from the system, BBG CCGs may take the decision to close the SI without a report rather than de-escalate it, in which case this will be noted on the comments section of the STEIS record.

BBG CCGs may decide that the SI should not be de-escalated and a full SI report is required.

8 Extension of Submission Period

It is recognised that in certain circumstances organisations will find it impossible to complete a final report within the national framework timescales. Generally, this will be due to:

- enforced compliance with the timetable of an external agency, such as a Coroner, Health and Safety Executive, Local Children's Safeguarding Board
- investigation of highly specialised and multi-organisation incidents, such as those involving a national screening programme.

In such cases an extension can be requested by organisations. In relation to organisations submitting reports to BBG CCGs, requests for extensions should be communicated to see schedule 1 and must include the reason for the extension and the extension period required.

Following review by the Quality & Patient Safety Team, an extension may be granted. This will start from the day on which the SI report was due for submission. The organisation will be informed of the decision once it has been made.

Organisations can also request extensions to the report submission deadline for other reasons, but there must be a compelling reason, for example, new information coming to light during the course of the investigation, requiring the terms of reference to be altered. In such cases, again the request for extensions should be communicated to see schedule 1, and must include the reason for the extension. Following review by the Quality & Safety Team/Serious Incidents Manager, an

extension of one month will usually be granted. This will start from the day on which the SI report was due for submission.

The organisation will be informed of the decision once it has been made. No further extensions can be requested. Any request for an extension must be made prior to the due date of the final report, otherwise an extension can not be granted and the report will be recorded as overdue for submission.

9 Coroner's Verdicts

Some incidents involving patient deaths need to have a verdict from a coroner. Where this is the case, the SI final report should be submitted within the appropriate timescale, and not delayed in order to incorporate the coroner's verdict. It must be made clear in the report that a coroner's verdict is awaited and as a result the report will not be closed by BBG CCGs. Once the verdict is available, the organisation must send a summary of the verdict (not the coroner's report) (to be confirmed), using the SI further Information form, available on the BBG CCGs website.

If the coroner's verdict does not present any issues not already covered in the SI final report then it will be closed (assuming it satisfies the criteria for closing an SI). If the verdict presents issues not covered in the final report, then the organisation will be required to revise the SI report in order to incorporate these issues and to re-submit it to BBG CCGs.

10 Performance Expectations

BBG CCGs expects the following in relation to SI performance:

- All SIs to be reported on STEIS within 2 working days of discovering the incident.
  The reason for any delays should be clearly communicated on the STEIS alert.
- All SI reports to be submitted within the appropriate deadline depending on the grade of SI, or an extension to be requested if there is a compelling reason why this cannot be achieved
- All reports meet the report content criteria

BBG CCGs will have oversight of all SIs in Bromley/Bexley/Greenwich and will produce Borough wide analysis on themes and trends from SIs. This information will be published see schedule 1. BBG CCGs aims to complete the review of SI final reports within 20 days of receipt.

As a minimum, incident and SI figures and trends should be monitored on a quarterly basis within contract monitoring and / or quality assurance meetings with providers of commissioned services.

11 Freedom of Information (FOI) Requests

Serious incidents are increasingly becoming the subject of Freedom of Information (FOI) requests.
Legally BBG CCGs is obliged to consider the disclosure of this information when it is requested. Since it is information that concerns individual organisations, it is important organisations have the opportunity to comment on what is intended to be provided to requestors.

This will most commonly be requests for the number of incidents reported by organisations and for types of incidents. Organisations do provide a description of an incident when they report it on STEIS; however, those descriptions may not be appropriate for release due to the clinical or technical terminology.

On STEIS the 'Line being taken by the organisation' should be used to provide a brief description of the incident that organisations accept may be released in the event of an FOI request. This should be written so that it is comprehensible to a lay person that is without acronyms or highly clinical or technical terminology. Providing this description should not delay reporting on STEIS in the event of an incident. The organisation does not have to complete the 'Line taken…' box immediately.

In the event of an FOI request the Quality & Safety Team/Serious Incidents Manager will contact those organisations likely to be affected by the request and inform them that incidents within a given period may be subject to release. Organisations will then have five working days to ensure that their data is accurate prior to the release. If the 'Line taken' box has not been completed by this time NHSL will have to assume that the contents of the description box are suitable for release. It will not be possible to extend this deadline.

The incident category that is entered onto STEIS will be the category BBG CCGs may have to report in the event of an FOI request. Therefore, it is important that organisations ensure that they are satisfied that STEIS is accurate and up to date. If, for example, a coroner's verdict has ruled that a suspected suicide was actually due to some other unexpected circumstances it is the responsibility of the organisation to update STEIS accordingly.

Organisations should be aware that all information relating to serious incidents including investigation reports could be subject to a request for disclosure under the Freedom of Information Act. Therefore, organisations are advised to ensure that reports are suitably anonymised.

12 Serious Incidents special categories

12.1 Maternity

The following incidents should be reported as SIs and these STEIS codes used:
Maternal death

A maternal death is defined as any death which occurs during or within one year of pregnancy, ectopic pregnancy or abortion which is directly or indirectly related to these conditions.

Intrauterine death (antenatal)
Any intrauterine death at 24 weeks and above where service or clinical factors might have contributed.

Intra partum death (during labour)
Unexpected intra partum death during labour regardless of gestational age where service or clinical factors might have contributed.

Unexpected Neonatal Death
Unexpected death of a baby aged 0-28 days. The requirement is to report unexpected death where the death of a neonate was not anticipated as a significant possibility 24 hours before the death or where there was a similarly unexpected collapse leading to or precipitating the events that led to the death.

If in doubt about whether or not the death is unexpected, the designated paediatrician responsible for unexpected deaths should be consulted. In such cases, the incident should be reported until the available evidence enables a decision to be made.

Unexpected admission to NICU (Neonatal Intensive Care Unit)
Infants > 37 completed weeks of gestation that have a sudden and unexpected collapse following delivery or in the early postnatal period of a previously well infant requiring intensive care (positive pressure ventilatory support).

Maternal unplanned admission to ITU
An unexpected admission to ITU during pregnancy or within 28 days of delivery.

Suspension of maternity services
Any time a decision is made to suspend the full service even if suspension is subsequently not possible. The Local Supervisory Authority expects to be informed when any part of a maternity service is suspended.

Post partum haemorrhage (PPH)
1. In hospital maternal death from post partum haemorrhage after elective caesarean section
(Never Event)
2. Unplanned admission to HDU/ITU following post partum haemorrhage
3. Unplanned hysterectomy/uterine artery embolisation

4. If significant care or service issues were identified which contributed to the PPH.

12.2 Information security incidents (see appendix 2)

The requirement for reporting information governance (IG) SIs in Bromley/Bexley/Greenwich will be consistent with the guidance in the National Framework for Reporting and Learning from Serious Incidents Requiring Investigation.

BBG CCGs has a duty to escalate to the Department of Health Business Unit, details of all IG Sis graded as level 3 or above. To enable this to happen, when a level 3 or above IG SI is reported, a checklist for completion will be emailed to the organisation SI lead. This must be completed and returned to the email address on the form within 72 hours of the SI being reported on STEIS. The form can be found on the CCG's website.

The reporting of SIs relating to breaches of confidentiality involving person identifiable data and data losses should be reported in accordance with Department of Health Gateway letter 9571 dated 29 February 2008 and refer to the definitions and risk assessment methods contained in Annex B (see Appendix 2). BBG CCGs will utilise the risk assessment matrix in the DH guidance to determine the level of seriousness applied to the incident. A quarterly report of such incidents will be published on its website in accordance with the Gateway letter.

Further to this all SIs involving data losses and breaches in confidentiality should be published in the annual reports of all service provider organisations in accordance with Department of Health Gateway letter 9912 of 20 May 2008 utilising the format at Annex A of the gateway letter.

13 Review of Policy

In line with the organisations key documents policy this policy will be reviewed no later than 3 years from the date of original circulation

14 References

There is extensive guidance, national frameworks and resources available on what to report, manage and monitor including:

Patient Safety NHS Commissioning Board
http://www.commissioningboard.nhs.uk/ourwork/patientsafety/

National framework for reporting and learning from serious incidents requiring investigation: http://www.nrls.npsa.nhs.uk/resources/?entryid45=75173

Information resource to support the reporting of serious incidents:
http://www.nrls.npsa.nhs.uk/resources/?entryid45=75173

NHS London reporting serious incidents: http://www.london.nhs.uk/publications/tools-and-resources/reporting-serious-incidents

Never events framework: http://www.london.nhs.uk/publications/tools-and-resources/reporting-serious-incidents

Safeguarding children serious case review policy: http://www.london.nhs.uk/publications/tools-and-resources/reporting-serious-incidents

Clinical Governance and Safeguarding Adults – An Integrated Process: http://www.nmcuk.org/Documents/Safeguarding/England/Clinical%20governance%20and%20adult%20safeguarding.pdf

NPSA Three Levels of Root Cause Analysis (RCA) investigation guidance: http://www.nrls.npsa.nhs.uk/resources/?entryid45=75355

Root Cause Analysis (RCA) investigation: http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/?entryid45=59901

Root Cause Analysis (RCA) investigation guidance: http://www.nrls.npsa.nhs.uk/resources/?entryid45=75355

Root Cause Analysis (RCA) investigation reporting writing templates: http://www.nrls.npsa.nhs.uk/resources/?entryid45=75419

Patient safety resources: http://www.nrls.npsa.nhs.uk/resources/

Checklist for reporting, managing and investigating information governance serious untoward incidents: http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_111498

NPSA Undertaking a Clinical Review Following a Death in Custody guidance: http://www.ppo.gov.uk/docs/clinical_guidance_pcts_undertaking_clinical_review_july_09.pdf

National Reporting and Learning Service (NRLS): http://www.nrls.npsa.nhs.uk/

National Patient Safety Agency: http://www.npsa.nhs.uk/

Appendix 1 Grading of Serious Incidents

Table 1: Grading of serious incidents

Grade 0

Action required

Notification only - it is unclear if a serious incident has occurred.

The provider organisation must update the PCT/SHA with further information within three working days of a grade 0 incident being notified.

If within three working days it is found not to be a serious incident, it can be downgraded with the agreement of the accountable SHA/PCT.

If a serious incident has occurred it will be regraded as a grade 1 or 2

Grade 1

Action required	Monitoring required Local monitoring	Examples of cases
Commissioning PCTs will monitor the case and report findings, recommendations and associated action plans to the SHA. SHA will monitor progress on a quarterly basis with PCT unless earlier discussion is required or the serious incident is regraded. **Comprehensive Investigation Root Cause Analysis (RCA) required (level 2 Investigation)** **See Appendix C**	• The PCT and/or SHA will close the incident when it is satisfied the investigation, recommendations and action plan are satisfactory, and local monitoring arrangements are in place and working efficiently. • Publish incident details within Annual Reports **Timescales:** Up to **45 working days/9 weeks** from the date the incident is notified to the PCT/SHA.	• Mental Health – deaths in the community* • HCAI outbreaks • Avoidable/unexplained death • Mental health – attempted suicides as inpatients* • Ambulance services missing target for arrival resulting in death/severe harm to patient • Data loss and information security (DH Criteria level 2, see Information Resource) • Grade 3 pressure ulcer develops • Poor discharge planning causes harm to patient **See Information Resource Tool**

Grade 2

Action required	Monitoring required SHA/PCT monitoring	Examples of cases
Case will be monitored by the SHA/PCT/LA in conjunction with the provider organisation. The SHA will review findings, recommendations and associated action plans. For Never Events, the commissioning PCT will be obliged to monitor overall numbers and actions and report these in its annual reporting arrangements **Comprehensive Investigation (RCA level 2 investigation)** (as above) or **Independent Investigation (RCA level 3 Investigation)*** **See Appendix C**	• Incidents leading to an independent investigation or inquiry or those considered high risk will continue to be monitored by the SHA/PCT or Local Authority until evidence is provided that each action point has been implemented. Incidents involving adult or child abuse are referred to local safeguarding arrangements • Publish quarterly reports **Timescales:** For Independent Investigations allow up to **26 weeks/6 months** for completion of investigation. Extensions can be granted on an individual case-by-case basis by the SHA/PCT.	• Maternal deaths • Inpatient suicides (including following absconsion)* • Child protection • Data loss and information security (DH Criteria level 3-5) • Never Events • Accusation of physical misconduct or harm is made • Homicides following recent contact with mental health services* **See Information Resource Tool** * Mental Health incidents should refer to DH guidance: *Independent investigation of adverse events in mental health services*[14]

Appendix 2 Personably identifiable data

Annex B of DH Gateway Letter 9571 (29/2/08) REPORTING SERIOUS (UNTOWARD) INCIDENTS (SIs) RELATING TO ACTUAL OR POTENTIAL BREACHES OF CONFIDENTIALITY INVOLVING PERSON IDENTIFIABLE DATA (PID), INCLUDING DATA LOSS.

It is essential that all SIs that occur at a trust are reported appropriately and handled effectively. This document covers the reporting arrangements and describes the actions that need to be taken in terms of communication and follow up when a serious incident occurs.
Trusts should ensure that any existing policies for dealing with SIs are updated to reflect these arrangements.

Definition of a serious incident in relation to personal identifiable data
There is no simple definition of a serious incident. What may at first appear to be of minor importance may, on further investigation, be found to be serious and vice versa. As a guide, any incident involving the actual or potential loss of personal information that could lead to identity fraud or have other significant impact on individuals should be considered as serious.

Immediate response to serious incident
The Trust should have robust policies in place to ensure that appropriate senior staff are notified immediately of all incidents involving data loss or breaches of confidentiality. Where incidents occur out of hours, the Trust should have arrangements in place to ensure on-call directors or other nominated individuals are informed of the incident and take action to inform the appropriate contacts.

Assessing the severity of the incident
The immediate response to the incident and the escalation process for reporting and investigating this will vary according to the severity of the incident. Risk assessment methods commonly categorise incidents according to the likely consequences, with the most serious being categorised as a 5, e.g. an incident should be categorised at the highest level that applies when considering the characteristics and risks of the incident.

SI level 1			SI level 2		
0	1	2	3	4	5
No significant reflection on any individual or body. Media interest very unlikely.	Damage to an individual's reputation. Possible media interest e.g. celebrity involved	Damage to a team's reputation. Some local media interest that may not go public	Damage to a service's reputation. Low key local media coverage.	Damage to an organisation's reputation. Local media coverage.	Damage to NHS reputation. National media coverage.
Minor breech of confidentiality. Only a single individual affected.	Potentially serious breach. Less than five people affected or risk assessed as low e.g. files were encrypted.	Serious potential breach and risk assessed high e.g. unencrypted clinical records lost. Up to 20 people affected.	Serious breach of confidentiality e.g. up to 100 people affected.	Serious breach with either particular sensitivity e.g. sexual health details or up to 1000 people affected.	Serious breach with potential for ID theft or over 1000 people affected.

Informing patients

Appendix 2: Personally identifiable data

Consideration should always be given to informing patients when person identifiable information about them has been lost or inappropriately placed in the public domain. Where there is any risk of identity theft it is strongly recommended that this is done.

Appendix 3 Monitoring of Serious Incidents as part of Quality Reviews

Table 1: incident and serious incident minimum monitoring requirements

For each Serious incident (SI):	For incidents reported:
• Receive notification of SI occurring and immediate actions taken • Receive SI investigation report including Root Cause Analysis (RCA) within 45 working days • Receive action plan to prevent recurrence • Receive evidence of liaising with relevant services and / or partner organisation also involved in the SI • Receive evidence of disseminating lessons learned • Receive assurance / evidence of progress against action plan	• Receive numbers of incidents reported • Receive assurance that incidents have been investigated and root causes identified • Receive assurance that action has been taken to prevent recurrence • Receive assurance of liaising with related services and / or partner organisations involved in the incident • Receive assurance that lessons learned have been disseminated

BBG CCGs also look to receive theme and trend analysis to review and identify patterns and areas of concern. This should be reported on, at least, at a quarterly and annual basis to allow for timely action to correct areas of concern.
It is intended that intelligence gained from incidents and SIs will be used to influence and inform quality and patient safety standards for care pathway development, service specifications and contract monitoring.

BBG CCGs will monitor and guide the management of incidents and SIs, and where appropriate, provide support to provider organisations.

Appendix 4. Criteria for receiving reports

	SI Management Grid	SI Manager to Complete	Options*	Comments
1	STEIS Number		Insert STEIS number	
2	Type of Incident		see list of PSM codes	
3	Grade of incident		1 or 2	
4	Incident Description		poor, acceptable or good	
5	Evidence of the principles of Being Open applied in this case.		yes, no or n/a	
6	Executive Sign Off		yes or no	
7	Template used		see list below	
8	Type of investigation undertaken		traditional, RCA	
9	RCA methodology. Have they articulated an appropriate methodology for the investigation, and have they used it?		poor, acceptable or good	
10	Identification of reasonable/appropriate C/S Delivery Problems		poor, acceptable or good	
11	Identification of reasonable Contributory Factors		poor, acceptable or good	
12	Identification of reasonable Root Causes		poor, acceptable, good or NA	
13	Identification of appropriate Recommendations		poor, acceptable or good	
14	Identification of appropriate actions within SMART action plan		poor, acceptable or good	
15	How is the trust Sharing the Learning		free text	
16	Comments (Area for improvement / notable Practice)		free text	
17	Can the SI be closed based on this report?		yes or no	
18	If no, record below the action that is required from the trust. Your response will be copied and sent to the trust.			

Template used: concise, comprehensive, PU, IC, suspension of maternity service, IUD, other, none	Action required from Trust:

Categories to be used when completing incident type on Evaluation Tool			
Headings	**Use Prefix**	**Main Category**	**Sub Category**
Acute	AC	Complication of procedure	Expand briefly
	AC	Consent	Expand briefly
	AC	Cytology	Expand briefly
	AC	Delay in Diagnosis	
	AC	AC FADP Failure to act on deteriorating patient includes detecting complications	
	AC	Pathology	Expand briefly
	AC	Radiology	Expand briefly
		Radiotherapy	Expand briefly
	AC	Retained instrument NE	site and instrument
	AC	Retained swab / needle/clip unplanned	
	AC	unexpected death	

	AC	Wrong site surgery NE	specify site
	AC		type
	AC	AC 1hr trolley wait	
Child	C	Death	
	C	Injury	
	C	Protection issues	
Confidential data	CD	loss electronic	
	CD	loss paper	
Infection Control	IC	Outbreak/ Death / other - but describe please	Organism type-MRSA Cdiff / TB etc. Number patients involved pts.
IT	IT	System failure	
	IT	virus	
Maternity	MAT	PPH	
	MAT	IUD	
	MAT	Maternal Death	
Medication	MD	C D (controlled drug procedures etc.	Name of drug route +IV:IM : Oral :NG:IT: SC
	MD	Prescr / Disp / Administration	
Mental Health	MH	Absconsion	specify section if relevant
	MH	Assault by	pt on pt on staff/ staff on staff
	MH	Attempted suicide	location i.e. in patient/ community
	MH	Suicide	Hospital Community
	MH	Unexpected Death	Hospital Community

	MH	Self Harm	
	MH	Homicide	
Non Clinical	NC	Assault -not MH	
	NC	Equipment failure	
	NC	Estates / Buildings	type e.g. CSSD Boilers
	NC	Fire	type e.g. asbestos
	NC	Fraud	site
	NC	Theft	Type
	NC	Security	
Professional	P	Allegation	sexual fraud / criminal
	P	Poor practice	Nursing / Medical /AHP
	P	Unregistered professional	
POVA	POVA	Abuse	
	POVA	Failure of national guidance	
	POVA	Failure to care / death	
Prison	PR	Death in Custody	Suicide / natural causes
	PR	Delay in treatment	Type
Screening	SC	Any other please specify	
	SC	Cervical	
	SC	Diabetic retinopathy	
	SC	Neonatal Spot	
Tissue viability	TV	Pressure sore grade	
Falls	F	Fall Patient	

Criteria for Evaluating Reports

4. Incident Description

Poor =	Incomplete or unclear description
Acceptable =	A reasonable description outlining most of the key features
Good =	Clear, concise description of the incident and the outcome, detailing all the key features

9. RCA Methodology - Have they articulated an appropriate methodology for the investigation, and have they used it?

Poor =	There is minimal description of the intended RCA methodology and little evidence throughout the report that it has been implemented.
Acceptable =	There is some description of the intended RCA methodology and some evidence throughout the report that it has been implemented.
Good =	There is a clear description of the intended RCA methodology and clear evidence throughout the report that it has been implemented to a good standard.

10. Identification of reasonable/appropriate C/S Delivery Problems

Poor =	A number of Care/Service delivery problems not identified from the Timeline
Acceptable =	Most of the Care/Service Delivery problems have been identified from the Timeline
Good =	All of the Care /Service Delivery problems have been identified from the Timeline

11. Identification of Contributory Factors

Poor =	It is obvious that they have not used the Contributory factors framework
Acceptable =	It is apparent that they have used the Contributory factors framework however it appears that they may have applied it to the entire incident rather than each C/S delivery problem.
Good =	There is evidence that they have applied the Contributory factors framework appropriately throughout the analysis stage.

12. Identification of reasonable/appropriate Root Causes

Poor =	There is inappropriate or non identification of the Root Cause.
Acceptable =	There is appropriate identification of the Root Cause however it is not evident that this has been derived from the Contributory Factors Taxonomy.
Good =	There is appropriate identification of the Root Cause and it is evident that this has been derived from the Contributory Factors Taxonomy (If no RCA mark as N/A)

13. Identification of appropriate Recommendations

Poor =	The Recommendations do not follow a logical step in terms of addressing the issues raised in the Contributory Factors Section and Root Cause.

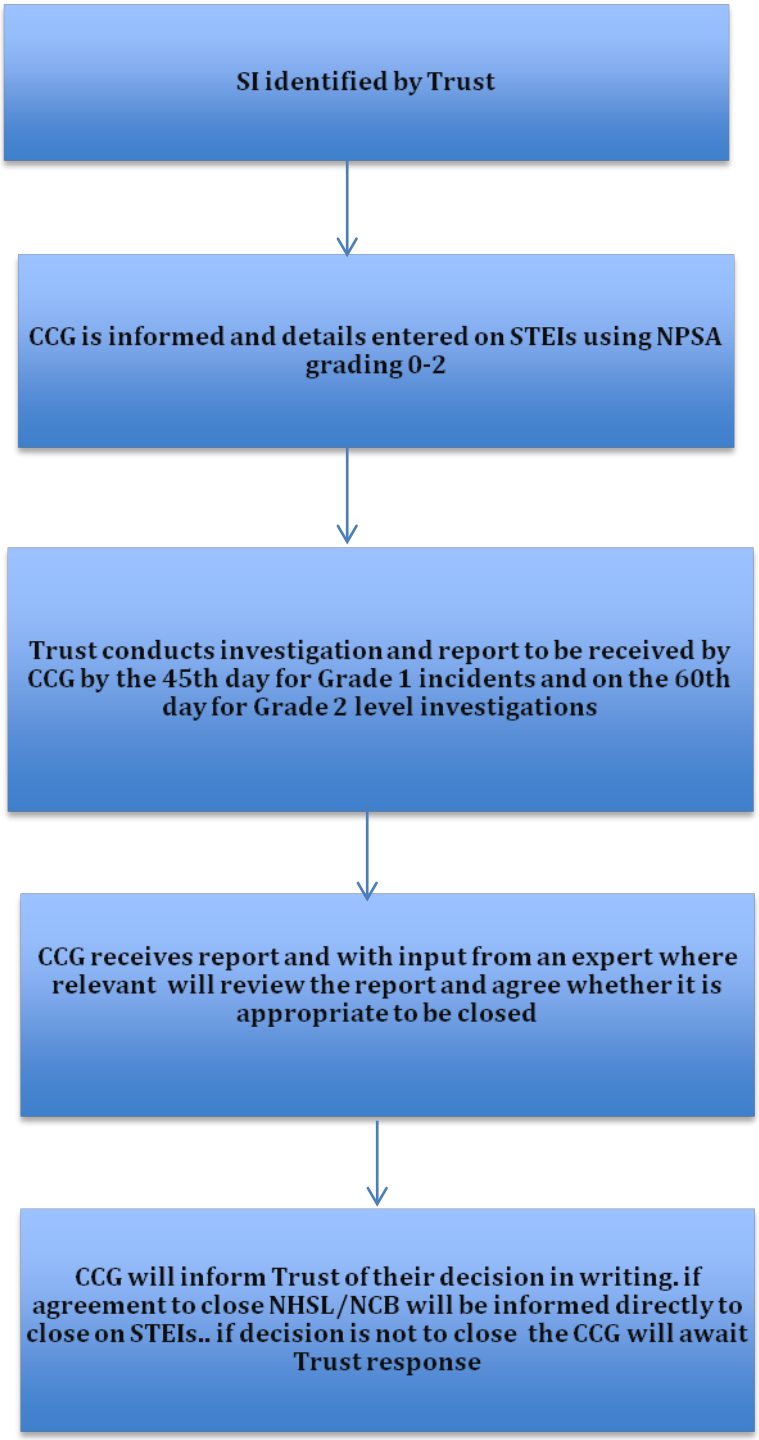
Acceptable =	The Recommendations follow a logical step in terms of addressing some of the issues raised in the Contributory Factors Section and Root Causes.
Good =	The Recommendations follow a logical step in terms of addressing all the issues raised in the Contributory Factors Section and Root Causes.

14. Identification of appropriate actions within a SMART action plan

Poor =	The Actions do not directly flow from the Recommendations and do not appear to have strength in minimising the possibility of the incident recurring. They are all weak actions. The Action plan template is poor
Acceptable =	The Actions directly flow from the Recommendations and appear to have a reasonable level of strength/reliability in minimising the possibility of the incident recurring. There is a mixture of both weak and strong actions and the action plan template is of a reasonable standard.
Good =	There are robust Actions that directly flow from the Recommendations and appear to have strength in minimising the possibility of the incident recurring. Their action plan includes both moderate and strong actions and the template is of a good standard

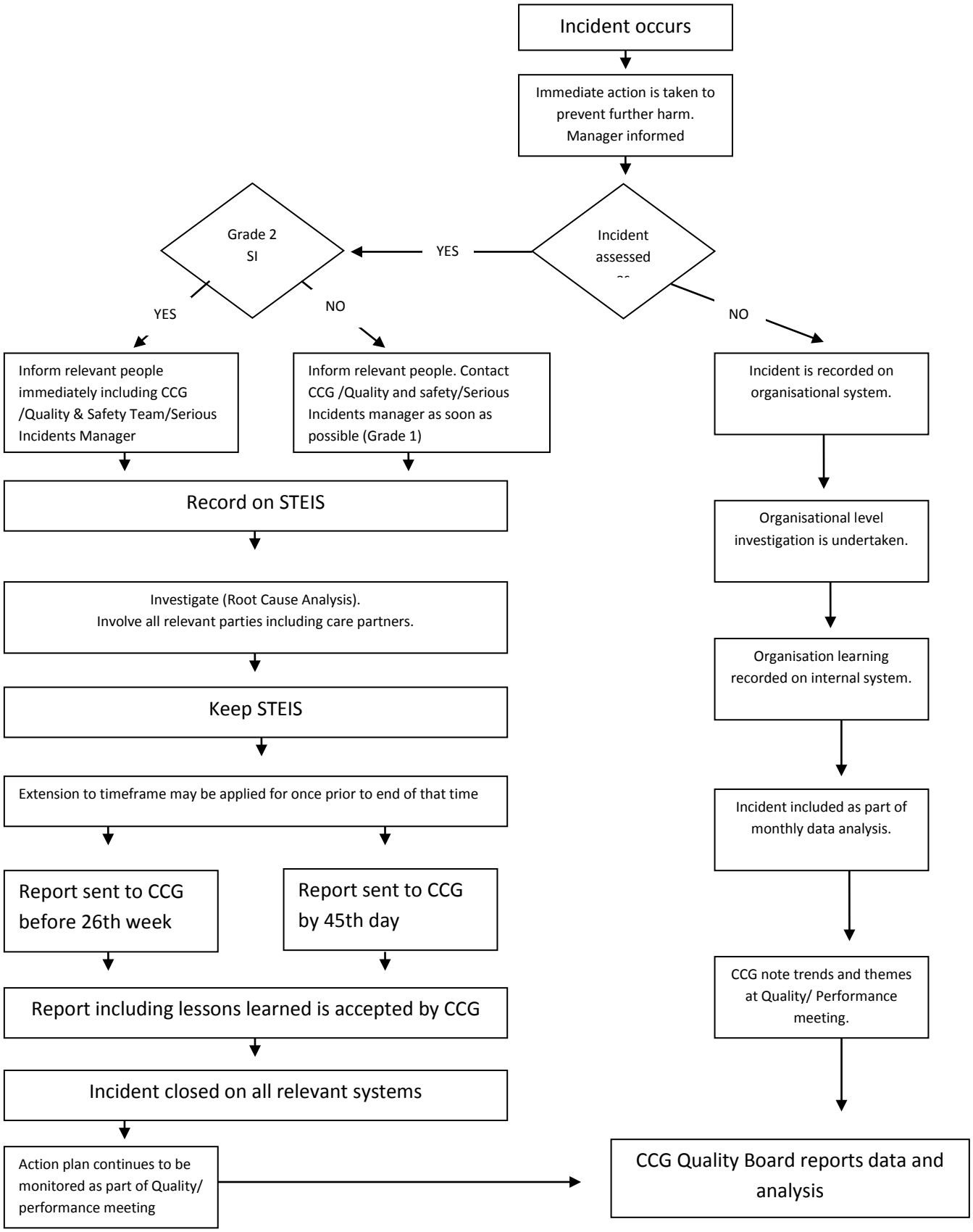
Appendix 5 Process for reporting serious incidents to BBG

Process for reporting Serious Incidents to BBG CCGs for all NHS Organisations commissioned Including Foundation Trusts



The above process applies to all services commissioned by Bromley, Baxley and Greenwich Clinical Commissioning Groups.

Appendix 6: Incident reporting and monitoring process map



Appendix 6: Incident reporting and monitoring process map

Schedule 1

The following contact details relate to each individual Clinical Commissioning group within the Bromley Bexley and Greenwich area. Please convey all information to the appropriate person.

Bromley	
Person to contact including email details	
Telephone numbers	
Fax number safe haven	
Email address for all queries relating to Sis including notification	

Bexley	
Person to contact including email details	
Telephone numbers	
Fax number safe haven	
Email address for all queries relating to Sis including notification	

Greenwich	
Person to contact including email details	
Telephone numbers	
Fax number safe haven	
Email address for all queries relating to Sis including notification	