Item Number: 11.2

NHS VALE OF YORK CLINICAL COMMISSIONING GROUP

GOVERNING BODY MEETING

Vale of York Clinical Commissioning Group

Meeting Date: 4 April 2013

Report Sponsor:	**Report Author:**
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1. Title of Paper: Serious Incident Policy

2. Strategic Objectives supported by this paper

In exercising its functions the CCG will have a general duty to act with a view to securing continuous improvements in the quality of services for patients and in outcomes, with particular regard to clinical effectiveness, safety and patient experience. Serious incident management is an integral part of this duty.

3. Executive Summary

This policy sets out the roles, responsibilities and accountability in relation to response, management and conclusion of Serious Incidents, occurring in the CCG or in services commissioned by Vale of York Clinical Commissioning Group (VoY CCG).

The policy sets out the arrangements to be followed by commissioned services, VoY CCG and NHS North Yorkshire and Humber Commissioning Support Unit (NYHCSU) who are contracted to manage the process for this area of work on behalf of VoY CCG.

The purpose of the Policy is to provide VoY CCG and VoY CCG's commissioned services and NHS NYHCSU with a working procedure for managing, monitoring and learning from Serious Incidents to improve patient safety.

4. Evidence Base

- Patient safety data and background information, http://www.nrls.npsa.nhs.uk/patient-safety-data/
- NHS Commissioning Board (2013) Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework
- National Patient Safety Agency (2009). Data Quality Standards. Guidance for organisations reporting to the reporting and learning system. (www.nrls.npsa.nhs.uk/)
- Department of Health (2009) Being open: communicating patient safety incidents with patients, their families and carers.
- Department of Health (2007) Building a safer NHS for patients: Implementing an organisation with a memory
- Department of Health (2006) Safety first: a report for patients, clinicians and healthcare managers.

5. Risks relating to proposals in this paper

Not applicable

6. Any statutory / regulatory / legal / NHS Constitution implications

The CCG has to put in place effective systems and processes to proactively identify early warning of ailing services, monitoring and acting on patient feedback, identify quality including safety issues and secure continuous improvements in the quality of services provided. This policy supports the CCG in working toward these duties.

7. Equality Impact Assessment

Not applicable

8. Any related work with stakeholders or communications plan

The policy has been developed in partnership with the Scarborough and Ryedale, Hambleton, Richmondshire, and Whitby, and Harrogate and Rural District CCGs. Work with provider organisations is an ongoing process.

9. Recommendations / Action Required

The Governing Body is asked to approve this policy .

10. Assurance

Serious incident policies are included in all provider contracts and related matters are monitored through the monthly Quality and Performance Committee in the CCG, and the Contract Management Board structures.

Vale of York
Clinical Commissioning Group

Vale of York Clinical Commissioning Group Serious Incident Policy

Policy Number: **Title:** Serious Incident Policy
Author: Liz Vickerstaff, Quality Lead, North Yorkshire and the Humber Commissioning Support Unit
Review Date: Feb 2014 (may be brought forward depending upon any subsequent advice from Department of Health and or the NHS Commissioning Board which materially affects current content)
Version: **v1.1** (includes amendments from VoY CCG Quality and Performance Committee)

Contents

Introduction

Vale of York Clinical Commissioning Group (NHS VoY CCG) is committed to providing the best possible service to its patients, clients and staff. NHS VoY CCG recognises that, on occasions, serious incidents (SIs) or near misses will occur and that it is important to identify causes and to ensure that lessons are learnt to prevent recurrence.

Learning from incidents is an important function of NHS VoY CCGs commitment to the safety of its patients, staff and the general public. Modern healthcare is a complex and at times high risk activity where serious incidents or near misses may occur. Promoting patient safety by reducing error is a key priority for the NHS, supported by the establishment of the National Patient Safety Agency (NPSA).

NHS VOY CCG has a duty to receive information on Serious Incidents from NHS organisations within its boundaries to both identify learning opportunities for improving patient safety and to ensure that NHS organisations have robust arrangements in place to identify and investigate SIs to prevent recurrence.

The principle definition of an SI is something out of the ordinary or unexpected, with the potential to cause serious harm, and/or likely to attract public and media interest that occurs on NHS premises or in the provision of an NHS or a commissioned service. SIs are not exclusively clinical issues, for example, an equipment failure may have consequences which could result in an SI.

NHS VOY CCG will be informed of SIs that have occurred within any of its commissioned services listed below:

- York Teaching Hospitals NHS Foundation Trust
- Leeds and York Partnership NHS Foundation Trust
- Tees Esk and Wear Valley
- Yorkshire Ambulance Service
- Any other provider of commissioned services reporting on STEIS

This policy sets out the requirements in relation of how to respond to a Serious Incident and provides the tool for investigation. This policy sets out the arrangements to be followed by commissioned services and the CCG, to:

- Promptly and fully report serious incidents
- Effectively manage serious incidents so as to minimise harm and damage.
- Thoroughly and systematically investigate and analyse serious incidents
- Identify learning from serious incidents and share that learning as appropriate
- Take actions and put in place measure to minimise the risk of recurrence
- Report to the NHS VOY CCG Board and NHS Commissioning Board, Area Team (NHS CB AT) as required

NHS VOY CCG will work closely with the NHS CB AT, other NHS organisations, the Department of Health and other organisations to manage serious incidents minimise risk and in so doing help prevent recurrence across the NHS. NHS North Yorkshire and Humber Commissioning Support Unit (NHS NY&H CSU) is contracted to deliver this area of work for NHS VOY CCG.

Role, responsibility and accountability

NHS VOY CCG has a responsibility to ensure there is a robust performance management process in place that meets NHS CB AT requirements as well as provides clear guidance on the identification, investigation and feedback of an SI. Part of this responsibility is to ensure commissioned services report SIs electronically on the Strategic Executive Information System (STEIS) and for this requirement to form part of the contract between NHS VOY CCG and the commissioned service. NHS VOY CCG also has a duty to comply with NHS CB AT SI Procedure (formerly Y&HSHA procedure version 6 (October 2010) until further update received. It is the responsibility of the NHS NY&H CSU on behalf of the CCG, to ensure this process is executed. The CCG will remain accountable for ensuring there is a robust process and the commissioned service are accountable for delivering this process.

Policy Statement

NHS VOY CCG recognises that in a service as large and as complex as the NHS things will sometimes go wrong. When they do, the NHS VOY CCG supports the view that the response should not focus on blame and retribution, but of professional accountability and organisational learning with the aim of encouraging participation in the overall process and supporting staff, rather than exposing them to recrimination.

NHS VOY CCG is committed to developing an open and fair culture and to encouraging a willingness to admit mistakes without fear of punitive measures.

Purpose

The purpose of the Policy is to provide NHS VOY CCG, all commissioned services and NHS NY&H CSU employees with a working procedure for managing SIs to improve patient and staff safety.

The objective of this policy is to provide:

- A written description of the procedure
- Areas of responsibility
- Accountability
- Internal and external communication guidance
- Serious Incident classification
- Methods for investigation processes
- Learning from incidents

Scope

This policy and associated tools for investigation is for use by NHS VOY CCG employees, all commissioned services and NHS NY&H CSU staff.

For the purpose of this policy an NHS patient is defined as a person receiving care or treatment under the NHS Act 1977.

The responsibilities of this document apply to NHS VOY CCG, all commissioned services and NHS NY&H CSU staff, who should make themselves aware of their responsibilities in this document as part of their duties to report incidents. An SI can be declared in relation to any member of staff, patient or member of the public who comes into contact with any service commissioned or provided by the NHS VOY CCG.

Culture

NHS VOY CCG is actively engaged in promoting and developing a safety culture where staff have a constant and active awareness of the potential for things to go wrong both internally and with commissioned providers. Through the development of this culture, NHS VOY CCG are able to acknowledge mistakes, learn from them and take action to put things right with the opportunity to learn from the SI and improve patient safety.

Having a safety culture encourages a working environment where many components are taken into account and recognised as contributing to an SI or to the events leading up to it. It is recognised that the causes of any SI frequently extend far beyond the actions of the individual staff involved, and are often out of their control. While human error might immediately precede an SI, in a technically and socially complex system like healthcare, there are usually entrenched systemic factors at work. NHS VOY CCG is committed to using root cause analysis, during the investigation of SIs and requires providers to use this technique when investigating SIs.

Being Open

A commitment to improving communication between NHS VOY CCG and patients who have been harmed is integral to NHS VOY CCG's strategy to improve patient safety.

NHS VOY CCG expects all providers to demonstrate "being open" principles which involve acknowledging, apologising and explaining what happened to patients and/or their carers who have been involved in a patient safety incident.

What is a Serious Incident (SI)

A serious incident may be defined as an incident where a patient, member of staff, or member of the public has suffered serious injury, major permanent harm, unexpected death, or where there is cluster/pattern of incidents or actions by NHS

staff which have caused or are likely to cause significant public concern. Where a patient/member of staff raises an issue about an NHS organisation direct to the media, it will be for the provider to determine in conjunction with the Commissioners integrated governance team whether this has substance and should therefore be reported as an SI.

'Near misses' may also constitute SIs, where the contributory causes are serious and under different circumstances they may have led to serious injury, major permanent harm, or unexpected death, but no actual harm resulted on that occasion. A possible example is that of a system failure, the result of which is incorrect/delayed diagnosis. This may not have any serious consequences for some patients, but for others could lead to the wrong treatment/serious delay in treatment and ultimately to death.

A full list of definitions of serious incidents requiring investigation can be found at Appendix 1.

The National Patient Safety Agency (NPSA) has implemented a core list of Never Events which are listed in Appendix 2. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. If a Never Event does occur it must be reported immediately as a serious incident.

Information Governance SIs i.e. loss of data; patient or staff personal details should be reported in line with the Department of Health (DH) Digital Information Policy January 2009: Checklist for reporting, managing and Investigating Information Governance Serious Untoward Incidents. The DH Information Governance Risk Assessment tool should be used for categorising the incident.
All incidents rated as 1-5 on the Information Governance Risk Assessment tool must be categorised as SIs and reported as per this policy.

Reporting a Serious Incident

Who should report SIs?

All commissioned providers are required to report SIs to NHS VOY CCG using the STEIS system. The reporting process for commissioned providers can be found at Appendix 3.

For SI's which are declared by the NHS VOY CCG itself, these are reported directly on STEIS by NHS NY&HCSU Quality team. Please see Appendix 4, Service Specification

NHS VOY CCG is automatically informed via e-mail of an SI when a STEIS record is completed by a provider organisation. This e-mail contains a link to securely log into STEIS to view the incident details.

Investigation of a Serious Incident

The Lead for the area will ensure the establishment and co-ordination of an investigation team to thoroughly investigate the SI and to ensure objectivity using Root Cause Analysis (RCA) tools.

The team will be led by a nominated manager fully trained in incident investigation and analysis. All staff involved in the incident will be asked to participate in the investigation.

The Investigation team will support organisational learning through root cause analysis and will:

- Ensure the incident is logged on the national reporting system (STEIS)
- The SI must be logged on STEIS by the appropriate person within 24 hours.
- Establish a set of Terms of Reference for the investigation
- Ensure that all proper records are obtained and kept secure, including the copying of Medical Records prior to their leaving the site of the incident
- Ensure there is adequate support to staff affected by the SI
- Ensure that there is a thorough investigation of serious or repeated incidents so that causation factors (root causes) can be identified
- Complete investigations and the investigation report so that it can be reviewed by the SI panel within 12 weeks of the incident date
- Report the SI summary, investigation report including root causes and lessons learnt to the relevant committees in line with the investigation terms of reference
- Identify which committee or team is responsible for providing an update on actions taken following the SI investigation
- Update the STEIS system as appropriate
- Identify how lessons will be shared within the team, directorate/service

NH&Y CSU Quality team will:

- Monitor that SIs are logged onto the STEIS system appropriately
- Acknowledge receipt of SIs received via the STEIS system to providers within two working days, conformation of the patient / clients GP details and a deadline for receipt of the investigation report and action plan
- Maintain up-to-date electronic and paper based records of all Serious Incidents pertaining to the NHS VOY CCG and commissioned services
- Provide specialist advice to support the SI process
- Ensure or advise that SIs are reported to the relevant professional bodies
- Negotiate requests for extensions of investigation reports with providers
- Forward SI reports to the nominated reviewer
- Organise the SI panel meetings
- Ensure feedback is provided following review of investigation reports
- Produce quarterly SI data for both NHS VOY CCG and NHS CB AT

All SI investigation reports are reviewed and discussed at the SI panel. The SI Panel is a collaborative group drawn from HaRD, VoY, SR and HRW CCGs. The SI panel:

- Receive, critique and provide feedback on the SI report
- Maintain a system to receive assurance that action plans resulting from SI reports have been followed up and adequately completed within the timescales indicated in the SI report
- implementation of action plans and assurance on SI reports received
- Identify learning points
- Monitor the implementation of this policy, including reporting timescales, quality of reporting, feedback to providers, performance management responsibilities, dissemination of lessons learned and assurance on actions taken
- Ensure SIs are closed on STEIS when it is satisfied the investigation and action plan are adequate or when it has sufficient assurance that actions have been completed

The sharing of lessons learnt post-investigation is a critical part of incident management. Following a review of the SI, the Lead will ensure that procedures are adopted or altered to reflect the lessons learnt from such Incidents. The Lead Director and Investigation Officer will ensure that such procedures are disseminated to all departments through the appropriate means e.g. local networks, through team meetings, inclusion in appropriate newsletters, all in anonymised form. Lessons will be shared across organisational boundaries through local networks.

If as a result of the initial enquiry disciplinary action is considered necessary, advice will be sought from the Director of Human Resources. The NPSA has a simple-to-use on-line Incident Decision Tree, which, depending on the nature of the incident and the amount of information gathered, usually takes 30 to 60 minutes to work through and provides information on whether to suspend/remove a member of staff whose conduct is under suspicion as part of an SI and be used in parallel with the Root Cause Analysis.

The Executive lead for Serious Incidents within VoY CCG will have a duty to report regularly to the VoY CCG Quality and Performance Committee and will escalate matters to the wider membership and Governing Body as appropriate.

Never Events

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Please see Appendix 2 for a full list of core never events.

Local reporting and management processes will underpin the implementation of the Never Events Policy. This will provide the impetus to increase patient safety through greater transparency and accountability when serious patient safety incidents occur and will inform new ways in which local commissioners can act as a lever for safer care.

Provider reporting of Never Events to the NHS VOY CCG should form part of existing contract arrangements for reporting of SIs.

The NHS CB AT (formerly SHA) SI Procedure supports NHS VOY CCG in their performance management of Never Events and will provide interventions with providers

The role of the NHS Commissioning Board, Area Team

NHS VOY CCG and its provider organisations report the SI to NHS CB AT electronically on STEIS as soon as practically possible (at the latest within one working day). Reports should be anonymised of identifiable information.

- NHS CB AT are automatically alerted when an SI is reported via the STEIS system. In some circumstances NHS CB AT may require immediate assurance depending on the seriousness and complexity of the SI.
- In exceptional circumstances, NHS CB AT may alert other Trusts in Yorkshire and the Humber or throughout the country. A list of agencies is included in the NHS CB AT (formerly SHA) Procedure. NHS CB AT will also lead on informing relevant networks if there are serious concerns about the actions of an individual health professional and s/he is considered likely to be seeking work with other employers who would be unaware of the concerns.
- Out of hours, the provider should contact NHS CB AT on-call manager if the SI is of an exceptional nature, for example, requiring immediate investigation by the Police/HSE and/or likely to attract media attention, e.g. a fire on NHS premises causing major service disruption. The SI should be formally reported on STEIS the next working day.
- Where a SI involves more than one NHS organisation (e.g. a patient affected by system failures both in an acute hospital and in primary care), a decision should be made jointly by the organisations concerned about where the frequency/severity of the problem(s) appears to have been greatest, if necessary referring to NHS VOY CCG and NY&HCSU or NHS CB AT for advice. A single investigation report and action plan will be submitted by the reporting organisation.
- In the interest of patient safety, NHS CB AT will inform the CQC of “highly significant” SIs such as those which are likely to generate significant learning, possibly require consideration by the Care Quality Commission Investigations Department as indicative of system failure and are subject to national or a high level of local media interest. Where NHS CB AT decides to notify the CQC of such an incident the relevant organisation will be informed of this first.

NHS CB AT will continue to performance manage SIs involving the safeguarding of children as outlined in Working Together to Safeguard Children, DH, 2010. This

will be done through the Safeguarding Team Designated Nurses who are employed by the four CCGs in North Yorkshire collectively, (HRWCCG, HaRDCCG, VoYCCG, SRCCG) and these cases will be kept open until the action plans have been fully implemented.

NHS CB AT will performance manage SIs reported by commissioned services of NHS VOY CCG where there are potential issues/concerns about the commissioning of services.

NHS CB AT will hold NHS VOY CCG to account in respect of their performance management of SIs and requires NHS VOY CCG to prepare quarterly reports on SI management. Reports will be compiled, agreed and ratified with NHS VOY CCG by NHS NY&H CSU **prior to** the CSU submitting reports to NHS CB AT on behalf of NHS VOY CCG.

Learning from SIs within the region will also be shared nationally through the NPSA (or other bodies) as appropriate and the NHS CB AT will ensure that the learning from key inquiries at national level is implemented within the North Yorkshire and the Humber.

Safeguarding Children

Under 'Working Together to Safeguard Children: Every Child Matters, 2009/10 it states that 'the SHA's role is to performance manage and support the development of NHS arrangements to safeguard and promote the welfare of children and young people. This role is relocated to NHS CB.

For clarity, incidents relating to safeguarding children should be reported if they fall within the criteria set below:

- Any case where there is prima facie evidence (i.e. initial indications) that a child has sustained a potentially life-threatening injury which may be through abuse or neglect or serious sexual abuse, or sustained serious and permanent impairment of health or development through abuse or neglect.

- A prima facie case where a child dies (including death by Suicide) and abuse or neglect is known or suspected to be a factor in the child's death and there will be a serious case review (SCR). ('Working Together', 2006).

The policy for performance managing NHS involvement in serious safeguarding children cases (version two, March 2010) is managed by the NHS CBAT (formerly SHA) and is updated accordingly with any national policy amendments.

NHS CB AT will continue to performance manage SIs involving the safeguarding of children as outlined in Working Together to Safeguard Children, DH, 2006. This will be done through the NHS VOY CCG SI process (see Appendix 4, Section 1.2 p22 of this document) and these cases will be kept open until the action plans have been fully implemented.

Safeguarding Adults

Use of Adult Psychiatric Wards for Children Under 16
Any incident involving children under 16 who are admitted to adult mental health beds requires reporting on STEIS by the commissioning organisation. A category called 'Admission of under 16s to Acute Mental Health Ward' has been added to STEIS and requires details of how the child will be moved to appropriate accommodation within 48 hours. The definitive date is the child's date of birth.

Incidents Involving National Screening Programmes

SIs linked to screening programmes should also be reported to the Quality Assurance Reference Centre (QARC) within five working days. For the most serious of incidents the QARC should be informed immediately and a member of the QARC team should be involved in the incident investigation.
This is done via the Screening Lead at the NHS CB AT.

Further details on the management of incidents within the breast screening programme are available at:
www.cancerscreening.nhs.uk/breastscreen/publications/pm-09.html

Further details on the management of incidents within the cervical screening programme are available at:
http://www.cancerscreening.nhs.uk/cervical/publications/pm-07.html

Breaches of Confidentiality Involving Person Identifiable Data (PID), Including Data Loss

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 and be reported as a SI in the usual way. NHS CB AT has a role in notifying the Department of Health (DH) of certain data loss incidents, depending on the severity.

Process for Reporting SIs That Falls In Category of Health Care Associated Infections (HCAI)

Incidents where a HCAI is the primary cause of death should be reported as a SI. Other cases which should be reported as a SI include: clusters of HCAIs, outbreaks which result in ward closures, recurrent incidences within the same unit and those which result in adverse media interest.

Incidents Relating to Health and Safety, Drug Errors, Equipment Failure and Waste

For incidents related to health and safety, the NHS VOY CCG will take advice from the approved Health and Safety Specialists within the CSU who will advise whether it is necessary to inform the Health and Safety Executive (HSE) and whether the area involved needs to be isolated until an HSE Inspector has visited.

Any SI involving a drug error must include the name of the drug and the details of the error when reported on STEIS.

For SIs involving defective 'products' (i.e. drugs, equipment, etc), the item(s) must be isolated and retained (where this has not already occurred for the purposes of a police investigation) and the relevant staff should be contacted, The NHS VOY CCG has a duty to report defects in medicinal products, buildings and plant, and other medical and non-medical equipment and supplies to the relevant external authorities, currently the Medicines and Healthcare Products Regulatory Agency (MHRA) and/or the Health and Safety Executive.

For SIs relating to waste the appointed team for waste at the Local Authority should be involved in all investigations following accident or incident that requires reference to waste legislation. Contact with the relevant team at the Local Authority must be made through the Facilities department.

Midwifery Service Incidents

Where the NHS VOY CCG is performance managing a midwifery SI, it is responsible for obtaining clinical advice either form a supervisor of midwives independent of the service in question or directly from the LSA Midwifery Officer.

Patients in Receipt of Mental Health Services

For SIs reported involving patient/s in receipt of mental health services the details of the section of the Mental Health Act the patient is under (if applicable) should be included on STEIS along with confirmation if the patient is a formal or informal patient.

Accountable Officer Role (AO)

Incidents that are considered to be serious enough should be reported as an organisational Serious Incident. The AO should establish a risk assessment process for determining the seriousness of an incident or concern.

Whichever route or system is used to identify the issue or concern, the AO will need to initiate an investigation. The extent and scope of the investigation will be determined based on the initial facts presented, although there will need to be some flexibility to the scope as additional facts emerge. A risk assessed approach should be taken by the AO for the investigation of incidents reported such as accidental spills, irreconcilable CD register balances of exceptionally small quantities or one-off prescriptions for quantities in excess of prescribing recommendations.

Further details of risk assessment processes within healthcare settings can be found on the National Patient Safety Agency (NPSA) website.

www.nrls.npsa.nhs.uk/resources/patient-safetytopics/
risk-assessment-management/

Patients in Receipt of Substance Misuse Services

Where the cause of death of a substance misuse service user is a direct result of their substance misuse, the reporting organisation should report this as an unexpected death on STEIS/, unless there is evidence that Suicide was intended i.e. a Suicide note, in which case it should be reported as a Suicide.

Sharing Lessons Learned

NHS VOY CCG will endeavour to work in partnership with provider and co-commissioning organisations to share transferable lessons learnt from serious incidents. This will enable a wider impact when implementing actions to improve the quality and safety of services provided both locally and nationally.

NHS VOY CCG will also ensure that learning from serious incidents is shared with other NHS organisations in Yorkshire and the Humber and nationally where appropriate.

Freedom of Information Act 2000

NHS VOY CCG will inform NHS CB AT of any requests for information regarding serious incidents submitted to them under the Freedom of Information Act 2000. NY&H CSU provide this service on behalf of NHS VOY CCG

Reviewing the Serious Incident Policy & Procedure

The practicality and appropriateness of this Policy and Procedure will be reviewed at least annually.

The Policy and Procedure may also require alteration from time to time in response to any future guidance from the Department of Health or other agencies.

Appendix 1 - Criteria for Reporting Serious Incidents

- the death of a person currently in receipt of NHS care where the death is suicide, as a result of a homicide or is likely to be of public concern, e.g. of particular concern is any such death occurring on NHS premises or potentially high profile patient suicides involving bridges and railway lines .

- death or serious injury to a child which results in a Part 8 review under the Children Act 1989 in which health has a major role.

- homicide or serious injury of a member of staff (including independent contractors) in the course of their NHS duties.

- the death or serious injury of a patient which is alleged to be at the hands of another patient or a member of the public while on NHS premises.

- serious injury of a person currently in receipt of NHS care such as deliberate self harm, accidental injury or injury inflicted by another person.

- incidents which involve concerns regarding the actions of NHS staff (including independent contractors) which is likely to lead to the involvement of the criminal justice system. This may include fraudulent behaviour, actions resulting in harm to patients.

- serious fires or other serious damage which occurs on health service premises. Of particular concern would be any fire which resulted in the death or serious injury of patients or staff and/or would result in the major diVoYuption of service provision.

- patients detained under the Mental Health Act 1983 who abscond from mental health/learning disability services who present a serious risk to themselves and/or to others. Of particular concern are those patients who abscond from medium secure or specialist forensic services, those who are likely to pose a risk to the public, attract media attention and/or who commit an offence while at large.

- any incident involving a serious outbreak of infectious diseases in hospital or the wider community (eg food poisoning, MRSA etc.), the transmission of infectious disease from an NHS staff member to a patient or any incident involving an HIV or Hepatitis B infected health care worker.

- any instance of staff or patients being poisoned in the course of receiving treatment or as a direct result of NHS employment.

- the unplanned release of substances into the environment likely to cause a substantial hazard to the public (e.g. toxic gas, infected clinical material etc).

- serious chemical or microbiological contamination incidents

- any incident which is attracting significant media attention is likely to become high profile and/or is likely to be of public concern.

- a pattern emerging that is causing local concern such as a high number of complaints regarding a member of staff, a particular service and/or hospital that may warrant further investigation and action

- theft of computers or laptops which contain patient sensitive data

- This list is not exhaustive but should help in clarifying under what circumstances an incident should be reported. Senior Managers on Call will need to exercise personal judgement when considering whether or not the incident is a Serious Incident. Senior Managers on Call and Directors with responsibility for the service will also need to make the final decision about whether or not the incident is of sufficient severity and/or focus of public concern to warrant reporting.

- If a SI escalates into a major incident the procedure detailed in the Major Incident Plan must be implemented immediately.

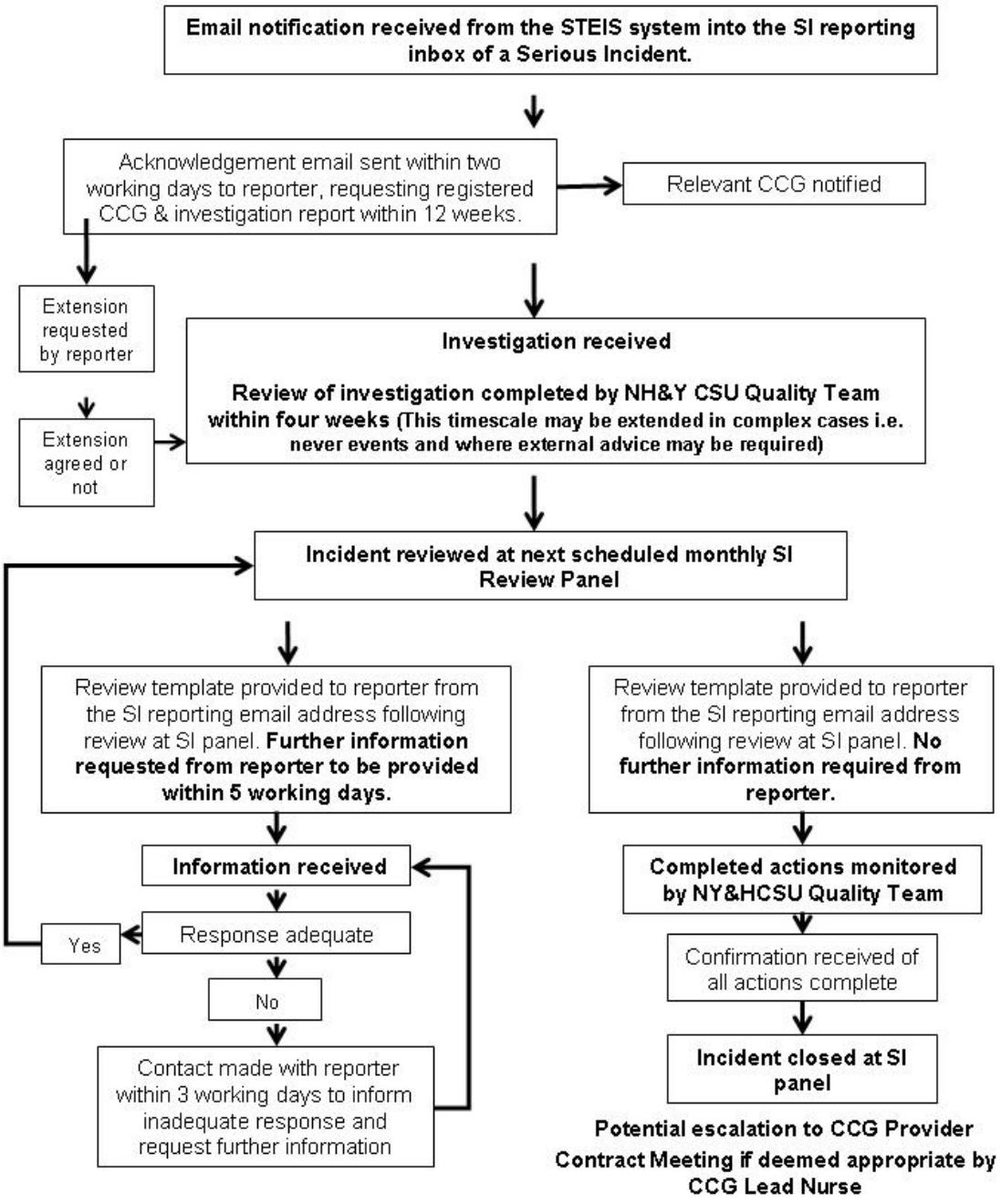
Appendix 2 - Core list of Never Events

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 or HLA-incompatible Organs
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

Appendix 3

Commissioned Services Reporting Process

****all communication to be sent via SI reporting e-mail address:**
nyyccgssi@nhs.net



Appendix 4. Serious Incident Report Submission – Extension Requests

Provider organisations are required to report Serious Incidents (SI) within two working days, once identified. As per SHA Procedure (v 6 Oct 2010) and NPSA Good Practice (2010) the date of SI occurrence is the date from which the 12 week deadline is taken (SHA Procedure p7 6.3), for a report into SI to be completed and submitted. Organisations are requested to use SHA tool "Strategic Executive Information System (StEIS) to log SIs, and are required to keep commissioners informed as per contractual arrangements.

SIs should be fully investigated by the provider using nationally recognised tools and a report with action plan signed off by a director, submitted to the commissioner no later than 12 weeks from the date of occurrence of the SI.

It is expected that SI reports will be submitted within the 12 week timeframe.

When the provider recognises they may need to ask for an extension to a known deadline date, requests **MUST BE** formally requested via the SI Inbox.

It is acknowledged that on occasion, some SIs investigations cannot be completed within 12 weeks. An interim report **will always** be required to be submitted at the initial 12 week deadline. The provider must request an extension for the final report submission.

SIs which are not identified immediately and may not achieve the 12 week investigation deadline from the date of the incident occurrence, the provider must request an extension with a proposed realistic deadline for report submission. A date will be negotiated and agreed by the CSU Quality Manager on behalf of the CCG

Coroner/inquest investigations often benefit from completed SI Investigations and Coroners will often await SI investigation reports. On occasion the SI investigation completion may be held up by the Coroner/inquest investigation. In these circumstances, an interim SI report will be required in the initial 12 week deadline

All extension requests **MUST BE** formally requested via the SI Inbox. The extension requested should be a realistic timeframe, to avoid the potential for repeated requests for extensions. Extensions will be agreed on a case by case basis, and may include:

- Police investigation
- Coroners investigation requiring completion prior to SI report completion
- Where one or more members of staff are unavailable for a prolonged period whose information is important to the SI investigation.
- Other situations on case by case basis, where the CSU Quality Manager will liaise with CCG Quality Lead.

In all these circumstances, an interim SI report will be required in the initial 12 week deadline.

In conclusion, providers are expected to complete SI investigations and submit reports to the SI Inbox within the 12 week deadline. SIs reported, reports submitted and number of extensions requested will be monitored through the contract management board.