NHS
Brighton and Hove
Clinical Commissioning Group

Policy and Procedures for Reporting and Managing Incidents and Serious Incidents

This document sets out the processes and procedures for the reporting and management of incidents and Serious Incidents (including near-misses), both clinical and non-clinical, in relation to the CCG and the services it commissions.

DOCUMENT CONTROL

Reference Number	**Version**	**Status**	**Executive Sponsor**
	8	Draft	Allison Cannon
Amendments to the 2016/17 policy	Addition of East Surrey CCG to the list of CCGs which have delegated responsibility for management of serious incidents to the B&H hosted Patient Safety team Specific reference to NHS England currently retaining responsibility for managing incidents and SIs for Primary Care Updated details of Occ Health service Updated details in Section 10 to reflect CCG governance review changes Updated Terms of Reference for the Serious Incident Scrutiny Group (Appendix 4)		
Document objectives: To provide guidance to CCG staff on reporting and managing incidents, and to provide the framework for reporting and managing serious incidents (SIs) for services commissioned by the CCG			
Intended Recipients: All CCG staff			
Approved by	Tbc		
Date of Issue	13/09/17		
Review Date	01/04/19		
Contact for Review	Ian Wilson – Assistant Director of Clinical Quality		

To be read in conjunction with the following CCG policies:

- Emergency Plan
- Freedom To Speak Up Policy
- Complaints Policy
- Claims Policy
- Fire Safety Policy
- Risk Management Policy
- Infection Control Policy
- Child & Adult Safeguarding Policies
- Staff Induction and Training Policies

CONTENTS

1 Introduction and Purpose 4

2. Scope 4

3. Definitions 5

4. Type of Incidents 5

5. Serious incidents 7

6. Never events 9

7. Requirements 9

8. Policy Statement 10

9. Supporting organisational structures 11

10. Accountability and Responsibility for Policy & Implementation 11

11. Communication of Policy – Method and Responsibility 11

Appendix 1: CCG incident reporting form 12

Appendix 2: Incident Grading Matrix 15

Appendix 3: Examples of Serious Incidents for all settings 16

Appendix 4: Terms of Reference for Scrutiny panel 17

NHS
Brighton and Hove
Clinical Commissioning Group

1 Introduction and Purpose

1.1 In organisations as large and complex as the NHS, things will sometimes go wrong. Brighton & Hove CCG (BHCCG) is committed to comply with the legislation and standards that require organisations to have a procedure in place for the reporting, investigation and management of all incidents allowing the organisation to learn, share valuable lessons and continually improve systems and processes.

1.2 Incident reporting is a fundamental aspect of risk management, the aim of which is to collect information about adverse incidents, including near misses, to facilitate wider organisational learning.

1.3 Brighton & Hove CCG endeavours to commission high quality services by embedding risk management, including incident reporting, into service specifications and contracts for all its commissioned services.

2 Scope

2.1 This policy details how to report all incidents and near-misses whether clinical or non-clinical, including serious incidents and notifiable incidents. It applies to incidents that involve commissioned services, as well as for the CCG, i.e. for patients, carers, visitors, staff, premises, property, other assets, data, or any other aspect of the organisation.

2.2 All CCG incidents should be reported onto the Safeguard incident reporting software system following completion of an incident form (see Appendix 1). Forms can be accessed via BH CCG's staff intranet website. All incident forms should be completed using the Incident Grading Matrix (see Appendix 2).

2.3 Commissioned services will report and record incidents on their own incident reporting systems.

2.4 All serious incidents are logged on a national database system called STEIS (Strategic Executive Information System). CCGs have designated responsibility for approving closure of serious incidents for commissioned service providers. Serious incidents occurring in Sussex are managed by the Patient Safety Team hosted by B&H CCG, which provides this service on behalf of the Sussex CCGs as well as East Surrey CCG.

2.5 Incidents occurring in Primary Care service should be reported by the provider directly to the NHS England Area Team. BHCCG had delegated commissioning responsibilities from April 2017; however at time of writing this does not include management of incidents and serious incidents.

2.6 Incidents occurring in other independent providers that provide NHS services, but not directly commissioned by the CCG, are reported and recorded by the individual

organisation, in accordance with their incident reporting policy. Incidents deemed to be serious incidents will be reported by the provider (if they have their own STEIS account), or the CCG where the service is located on behalf of the independent provider.

2.7 The CCG and all service providers providing NHS care are expected to comply with the NHS England Serious Incident Framework (updated March 2015).

3 Definitions

3.1 **Incident:** Any event or circumstance arising that could have or did lead to unintended or unexpected harm, loss or damage to BHCCG commissioned services, patients, carers, visitors, staff, other members of the public, premises, property, other assets, information, or any other aspect of the organisation. They can involve any number of different factors, e.g. injury, damage, loss, fire, theft, violence, abuse, accidents, ill health, disruption to services etc.

3.2 **Near Miss:** An incident that did not lead to harm, loss or damage but had serious potential to do so, where lessons can be learnt to implement changes in procedures, processes and systems, for example a prevented clinical/patient safety incident.

4 Types of Incidents

4.1 Health & Safety Incident: An unplanned and uncontrolled event that has led to or could have caused injury, ill health, harm to persons, damage to equipment or loss. These should be reported to the BHCCG Corporate team and an incident form completed and added to the Safeguard system as outlined in section 2.2 above. Examples of health and safety incidents include health compromise or illness directly work related, e.g. slip/trip/fall, unsafe exposure to substances hazardous to health, infection, poisoning, musculoskeletal injury, etc.

If immediate urgent medical attention is needed, the person/s affected should attend the Accident and Emergency Department as soon as possible - the details of the health professional attending to the person should be recorded on the relevant section of the incident form.

The person's Line Manager or the Directorate Head should arrange Occupational Health follow up for staff as soon as possible where appropriate, at:

Occupational Health Department,
Jevington J2
Brighton General Hospital,
Elm Grove,
Brighton,
East Sussex
BN2 3EW
(01273) 242282,
Fax (01273) 242167

Some accidents at work constitute an Injury or Dangerous Occurrence reportable under RIDDOR. If so, the Directorate Head should report the incident to the Health & Safety Executive (HSE) via: http://www.riddor.gov.uk

4.2 Buildings Incident: Where an incident occurs due to defects and failures in BHCCG Estates and Facilities

4.3 COSHH (Control of Substances Hazardous to Health): Staff experiencing an incident associated with substances hazardous to health must report it to their Department Head immediately, who will risk assess the situation and will immediately arrange an Occupational Health assessment.

4.4 Medical Devices and Community Equipment Incidents: Managers should report all medical devices related incidents to the relevant regulatory body and ensure that any devices involved are isolated for inspection. Such incidents are most likely to be reported by the CCG's CHC team

4.5 Violence/Abuse/Discrimination:
Violence/Abuse: On receipt of a report of physical/verbal assault or bullying, the Directorate Manager will immediately complete the NHS Security Management Service "Report of a Physical assault on NHS Staff" form for review and reporting onwards to the NHS Security Management Service. In such instances it may be necessary for the person involved to inform the police of the incident immediately – if so, the crime number should be recorded on the Safeguard incident form.

All incidents of discrimination are reportable, including social, racial, religious, sexual, ethnic or age-related discrimination, etc. On receipt of an incident report detailing an incident of racism, the Directorate Manager (or other relevant person) will report the incident to the Local Authority's Racial Harassment Forum, which co-ordinates responses to racist incidents within Sussex, via the following link:

http://www.brighton-hove.gov.uk/content/council-and-democracy/equality/racist-and-religiously-motivated-incidents

4.6 Fire Incident: Any incident involving a fire or a near miss serious incident

4.7 Security Incident (including Information Governance breaches): Any incident where a breach or a lapse of security is the dominating factor, e.g. theft or vandalism, premises window left open overnight, or data security incidents, e.g. missing health records, theft of a PC or unauthorised disclosure of patient identifiable information. Any data security or information governance incidents must be reported to the BHCCG Information Governance Manager and an incident form completed and logged on the Safeguard system. Incidents will be graded in accordance with the IG toolkit. IG incidents will be routinely reviewed at the CCG Information Governance Group meetings. All other security incidents should be reported to BHCCG Corporate team as soon as possible after the incident has occurred. Where fraud is suspected, the local Counter Fraud Specialist service should be informed as soon as possible. Incidents of suspected theft or vandalism should also be reported to the police – in such cases, the crime number should be recorded on the incident form.

4.8 Patient Safety Incident: Any unintended or unexpected incident that could have or did lead to harm (e.g. injury, suffering, disability or death – physical, psychological or social) for one or more persons receiving BHCCG commissioned/NHS-funded healthcare, e.g. an occurrence, procedure or intervention which has or could have given rise to actual injury, or to an unexpected or unwanted effect. All patient safety incidents will be assessed to see if it meets the criteria for a Serious Incident. For the CCG, this is most likely to be applicable for the CHC team.

4.9 Medication Incidents: The CCG Medicines Management & Quality team provides advice and support to service providers for managing and reporting medication

incidents, including notification to the National Reporting and Learning System (NRLS).
In the event of the CCG being notified of a controlled drugs (CD) incident, this will be escalated to the Controlled Drugs (CDs) Accountable Officer for Surrey & Sussex based at the NHS England Area Team.

4.10 Infection Control Incident: MRSA Bacteraemia/Clostridium Difficile and outbreaks. Incidences of community acquired MRSA bacteraemia and Clostridium Difficile are reported to the BHCCG Quality and Patient Safety team via the surveillance mechanism in place. A Post Infection Review (PIR) is coordinated by the CCGs Infection Control Specialist Nurse for MRSA blood stream infections allocated to the CCG, in line with national requirements. For Clostridium Difficile incidences, a root cause analysis (RCA) is conducted by the service provider where the incidence has been reported.

5 Serious Incidents (SIs)

In broad terms, serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare.
The occurrence of a serious incident demonstrates weaknesses in a system or process that need to be addressed to prevent future incidents leading to avoidable death or serious harm to patients or staff, future incidents of abuse to patients or staff, or future significant reputational damage to the organisations involved. Serious incidents therefore require investigation in order to identify the factors that contributed towards the incident occurring and the fundamental issues (or root causes) that underpinned these. Serious incidents can be isolated, single events or multiple linked or unlinked events signalling systemic failures within a commissioning or health system.

There is no definitive list of events/incidents that constitute a serious incident and lists should not be created locally as this can lead to inconsistent or inappropriate management of incidents. However, examples of possible serious incidents are illustrated in Appendix 3.

5.1 Serious Incident (SI) reporting

STAGE 1 – Initial reporting within the CCG

- When it is suspected that an incident may fulfil the criteria of an SI the BH CCG Quality & Patient Safety team should be contacted and given a summary of the incident. The incident should also be reported to the appropriate BHCCG senior manager and the Corporate and Communications team, if there is potential for significant media interest. The Communications team will inform the Area Team Communications department and BH CCG Executive Team as required.

- Out of hours, Serious Incidents should be reported to the BHCCG on-call Director. The BH CCG on-call Director will liaise with NHS England on-call Director as appropriate.

STAGE 2 – Reporting onto the national STEIS database

- If a CCG incident is agreed to be a serious incident, the incident will be recorded and entered onto STEIS by the BHCCG-hosted Patient Safety Team, completing as much of the detail as is possible at the time of entry.

- All SIs should be entered onto STEIS no later than two working days after the organisation becomes aware of the incident.

- SIs occurring in Primary Care will be logged on STEIS by NHS England.

STAGE 3 – Investigating an incident or serious incident

Investigation of incidents and serious incidents, attributed either to the CCG, commissioned services or independent providers of NHS care, are carried out in accordance with the National Patient Safety Agency (NPSA) and NHS England framework for managing serious incidents. The usual method of investigation is a Root Cause Analysis.

Where a serious incident is also subject to investigation via the Safeguarding process (for children and adults at risk), the CCG will work together with the Local Authority and Area Team to ensure a thorough investigation is concluded that meets the requirements for both Safeguarding and Serious Incident investigation processes.

The BHCCG Patient Safety Team will monitor that investigations of serious incidents are completed and submitted to the CCG within agreed timescales, i.e. 60 working days from the date submitted on STEIS.

STAGE 4 – closure of incidents and serious incidents

- All SIs reported submitted to the BHCCG Patient Safety Team will be reviewed initially by the Patient Safety Manager, prior to submitting to the pan-Sussex Serious Incident Scrutiny Group, which meets on a fortnightly basis - see appendix 4 for Terms of Reference of the group .

- Since the removal of grading of incidents in the NHSE Serious Incident Framework (2015) the Serious Incident Scrutiny Group approves closure or otherwise of all serious incidents commissioned by CCGs. Serious incidents in services commissioned by NHS England (e.g. secure and forensic mental health) will be forwarded to NHS England for scrutiny and closure.

- Formal written feedback from the scrutiny panel (including requests for further information to enable closure) is given via the BHCCG Patient Safety Team to the service provider's patient safety and/or governance leads.

- SIs given conditional closure status by the SI scrutiny group can be closed by the respective CCG Heads of Quality (or delegated Quality lead) following a satisfactory response to the SI panel feedback. SIs given a 'kept open' status are submitted back to the SI scrutiny panel for further scrutiny following receipt of additional information.

- Extensions to submission deadlines of investigations reports may be granted for any delay in the investigation which is outside of the organisations control. Examples include:

- Police investigation.
- Safeguarding investigation.
- Awaiting statements or reports from individuals not employed by the Provider organisation.
- Awaiting external investigation reports
- Extensive investigation required
- Complexities around implementing the Being Open policy

6 Never Events

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

NHS England has defined 14 types of incidents as never events in 2015/15 (reduced from 25 in 2014/15), as described in the following link:

http://www.england.nhs.uk/ourwork/patientsafety/never-events

It is not envisaged that the CCG will be required to report never events, as these apply to front-line services.

7 Requirements

7.1 NHS England

BHCCG will inform NHS England of any exceptional Serious Incidents, including those with potential significant media interest and/or press enquiries from national media. This enables NHS England to offer advice and support in managing the incident, ensures that ministers and other relevant parties are briefed as appropriate and that the NHS is prepared to deal with enquiries from staff, patients, members of the public and other stakeholders.

7.2 National Reporting and Learning System

Patient safety incidents should continue to be reported to the National Reporting and Learning System (NRLS), in order to share lessons learned both locally and nationally, and informs the national safety alert mechanism.

7.3 NHS Litigation Authority (NHSLA)

The NHSLA Risk Management Standard requires providers to hold an approved document for the management of risks associated with all internally and externally reportable incidents, to include the reporting process for all incidents/near misses, involving staff, patients and others, along with the process for reporting to external agencies, the process for full and open communication with those directly involved in the incident and with other organisations e.g. neighbouring NHS trusts, other stakeholders, etc, and the process for monitoring the effectiveness of all of the above.

7.4 NHS Protect

NHS Protect provides national leadership for NHS anti-crime work by applying a strategic, coordinated, intelligence-led and evidence based approach and works in partnership with the NHS, DH, NHS England and key stakeholders including the police, Crown Prosecution Service and local authorities to take action against those who commit offences against the NHS. A Local Security Management Specialist (LSMS) – accredited by NHS Protect will work with BH CCG to establish a safe and secure environment that has systems and policies in place to protect NHS staff from violence,

harassment and abuse; safeguard NHS property and assets from theft or criminal damage. The Counter Fraud Security Management Specialist (CFSMS) will lead investigations into serious, complex and/or organised cases of fraud, bribery and corruption.

7.5 NHS Information Governance (IG) Toolkit

The IG toolkit requires BHCCG to have documented incident control and investigation procedures that are accessible to all staff. IG incidents are to be managed by the CCG IG manager. After receipt of the completed incident form, the details will be logged into the Information Governance Toolkit Incident Reporting Tool by the IG Manager and an initial assessment will be obtained. If the incident is assessed at Level 1 or below on the tool, the incident will be managed by the usual incident process as detailed in this policy. If assessed at Level 2 or above on the tool it is then automatically reported to the Information Commissioner's Office and DH via the tool and the SI process will be followed.

8 Culture

The organisation can learn many important lessons through an open approach, which would not otherwise be learned where blame is apportioned or staff feel under threat through incident reporting. BHCCG promotes a just, fair and responsible culture that fosters learning and improvement whilst encouraging accountability. BHCCG is committed to an open and fair culture, promoting a non-punitive approach to the investigation of incidents reported. The Incident Reporting Policy and Procedures is not primarily concerned with disciplinary procedures. BHCCG recognises that a root cause analysis approach to investigating incidents focusses on systems processes and failures that allow errors to happen, and identifies lessons learned to enable improvements to be made that eliminate (or prevent as far as possible) the incident or error from re-occurring.

Staff reporting and involved in incidents are assured that any investigations will be carried out fairly, without prejudice and with the aim of identifying and correcting underlying causes to prevent recurrence. They will not be subject to disciplinary action or suffer any material loss or disadvantage unless they have been negligent in their acts or omissions or willfully failed to comply with professional standards and codes of practice.

9 Supporting Organisational Structures

The contact points within BHCCG for incident reporting for the above are as follows:

- Clinical/ patient safety and Safeguarding incidents/near misses – Quality & Patient Safety team
- Non clinical incidents – Corporate Business team and/or Quality & Patient Safety team
- Non-clinical risk management issues – Planning & Delivery team
- Health and Safety incidents/near misses – Corporate team
- Ulysses Risk Management System Administration – Planning & Delivery team
- Complaints – Complaints Manager, Corporate team
- Information Governance incidents – Information Governance Manager, Corporate team and Quality team

10 Accountability and Governance

10.1 Chief Accountable Officer
The Chief Accountable Officer of BHCCG has ultimate accountability for ensuring that effective systems of incident reporting, investigation and action are in place within the organisation.

10.2 Chief Nurse/Director of Quality
The Chief Nurse/Director of Quality has executive responsibility for ensuring the policy is followed.

10.3 BHCCG-hosted Patient Safety Team
The CCG Patient Safety Team Manager will manage the hosted Sussex-wide SI service, overseen by the BHCCG Quality and Patient Safety Lead. The CCG Quality and Patient Safety team will support staff to complete incident forms when needed.

10.4 Information Governance Manager
The Information Governance Manager will be copied into all incident reports relating to data security or information governance (IG) incidents. A quarterly Information Governance Committee will oversee all IG incidents reported, and monitor all actions are completed.

10.5 Quality and Safety Committee
Monthly reports on SIs (including any new serious incidents reported and investigations submitted to the fortnightly Serious Incident Scrutiny Group) will be submitted to the CCG's Commissioning Operation Meeting prior to submission to the Quality and Safety Committee.

10.6 Contractual Meetings with Providers
Assurance of providers' compliance with incident reporting, and implementing lessons from serious incidents, takes place via quality review meetings, with escalation processes in place either to individual providers contract meetings or the NHSE-led Quality Surveillance Group.

11 Communication and Staff Training of Policy

The Incident Reporting and Management of Incidents Policy and Procedures will be provided to all new staff as part of the BHCCG induction policy. The Incident Reporting and Management of Incidents Policy and Procedures will be integral to the BHCCG Mandatory Training programme. Department Heads must ensure that all relevant staff within their department have seen and follow the policy.

NHS
Brighton and Hove
Clinical Commissioning Group

Appendix 1 – Incident Report Form

Please read the Brighton and Hove CCG Policy and Procedures for the Reporting of Incidents for further information about completing this form

You should ensure that this form contains FACTS AND NOT OPINION.

Serious incidents must be reported immediately, regardless of the time of day.

Date of incident:	
Time of incident:	
Organisation involved:	
Location where the incident occurred:	

Who/what was involved:

Member of staff ☐ / Patient ☐ / Visitor ☐ / Contractor ☐ / Equipment ☐

Other ☐ *(please describe – for example theft, breach of confidential information):*

Please provide the name and contact details of the person or persons involved with the incident (if any):

Did the incident involve:

Accident (e.g. slip, trip or fall) ☐ / Physical assault ☐ / Verbal abuse ☐

Other ☐ *(please state):*

Was the incident:

An actual event ☐ / A near miss ☐

What happened:			
What harm was caused (actual and/or potential)?			
Describe any immediate action taken to protect and/or improve patient/visitor/staff safety			
What, if any, follow up action was taken to alleviate harm and/or prevent a reoccurrence			
Please provide the name and contact details of any witnesses to the incident			
Were the police called? Yes ☐ No ☐			
Did Police attend? Yes ☐ No ☐			
Crime Reference No. (if applicable)		**Date**	
Please provide details of any ongoing action plan			
If an investigation has been undertaken in respect of this incident, what was the outcome? *Was Root Cause Analysis (RCA) used?*			
Please specify whether information regarding this incident has, or will be reported to any other agency or body, e.g. Caldicott Guardian, Information Commission Office, Health & Safety Executive etc.			

Grade of incident

	Consequence				
Likelihood	Negligible 1	Minor 2	Moderate 3	Major 4	Catastrophic 5
Certain 5	LOW 5	LOW 10	MODERATE 15	VERY HIGH 20	VERY HIGH 25
Likely 4	LOW 4	LOW 8	MODERATE 12	HIGH 16	VERY HIGH 20
Possible 3	VERY LOW 3	LOW 6	MODERATE 9	HIGH 12	HIGH 15
Unlikely 2	VERY LOW 2	VERY LOW 4	LOW 6	MODERATE 8	HIGH 10
Rare 1	VERY LOW 1	VERY LOW 2	LOW 3	MODERATE 4	HIGH 5

Overall grade of incident	VERY LOW	LOW	MODERATE	HIGH	VERY HIGH
(please tick)					

Your name and job title .....

Signed……..

Date .....

Appendix 2: Incident Grading Matrix

Risk Scoring:

Consider 2 aspects:

1. Likelihood of the risk occurring

Versus:

2. Impact of the risk occurring

Once you have decided upon the Likelihood and Impact of the risk that you are assessing, use the Risk Scoring Matrix to cross-reference these two aspects and determine the Risk Score.

e.g. If you decide that the Likelihood of the risk occurring is 'Unlikely' (2) and the Impact is 'Major' (4), then the Risk Score is Moderate (8)

It is important to record how you arrive at your score, e.g. 2 x 4 = 8.

	Impact:				
	Negligible 1	**Minor 2**	**Moderate 3**	**Major 4**	**Catastrophic 5**
Potential impact on patients, staff, visitors, contractors, others:					
	No real harm physically or psychologically. Minor non-compliance with standards. Minor cuts/bruises.	***Temporary/low harm*** up to 1 month (physical or psychological). Staff sickness < 3 days. Single failure to meet national and/or internal standards or follow protocol. Includes healthcare associated infection.	***Semi-permanent/ moderate*** harm (up to 1 year). Physical or psychological, but full recovery anticipated long term. Repeated failures to meet national and/or internal standards. Includes healthcare associated infection.	***Permanent/severe*** harm, ie, loss of body part, misdiagnosis, poor prognosis, RIDDOR reportable injury. Failure to meet professional and national standards.	***Unexpected avoidable death/s***, suicide/homicide, multiple fatalities. Gross failure to meet professional standards. Absolute failure to meet national standards.
Potential impact on organization and resource implications:					
	Minimal impact. No service disruption. No real risk of public concern/complaint. Negligible financial loss (consider theft, damaged equipment, compensation).	Some risk of property damage (broken chairs, windows, room closure). Some loss of user/patient confidence, small risk of user complaint. Extended length of hospital stay < 2 days. Increased level of care > 8 days. Litigation > £50k	MHRA reportable. Staff sickness > 3 days. RIDDOR reportable. Moderate loss of service user confidence. Local adverse publicity. Probable complaint maybe adverse publicity. Significant damage – requiring ward/service closure. Extended length of hospital stay > 2 days. Increased level of care > 8-15 days. Litigation > £50 - £500k	HSE Investigation. Inspection by Healthcare Commission, Public Inquiry, serious complaint anticipated. Staff sickness > 20 days. Breach of legislation or formal regulation. Public outrage. Loss of public confidence. Temporary service closure. Extended length of hospital stay > 15 days. Increased level of care >115 days. Litigation >£500k-£1m	Criminal prosecution. Extended service closure. Loss of essential service and contingency failure. Increased frequency of inspections (HSE, Healthcare Commission). Permanent removal of service. National adverse publicity &severe loss of public confidence. Litigation >£1m
Number of persons affected:					
	N/A	1-2	3-15 ie, toxic gas emission, violent incident, poor standard of hygiene – D&V outbreak	-50 ie, lost specimens, Hostage situation, D&V outbreak with ward closure	> 50 ie, vaccination errors, cervical screening concerns – failure to recall
Likelihood:					
Rare: Hazard is not expected to occur	LOW 1 *Green*	LOW 2 *Green*	MODERATE 3 *Yellow*	HIGH 4 *Amber*	HIGH 5 *Amber*
Unlikely: Hazard occurs infrequently, but remains a possibility	LOW 2 *Green*	LOW 4 *Green*	MODERATE 6 *Yellow*	HIGH 8 *Amber*	HIGH 10 *Amber*
Possible: Hazard may occur occasionally, ie, once or twice a year	LOW 3 *Green*	MODERATE 6 *Yellow*	HIGH 9 *Amber*	HIGH 12 *Amber*	HIGH 15 *Amber*
Likely: Hazard will probably occur. We know from our experience that the hazard does present itself from time to time	MODERATE 4 *Yellow*	HIGH 8 *Amber*	HIGH 12 *Amber*	VERY HIGH 16 *Red*	VERY HIGH 20 *Red*
Certain: Hazard occurs frequently. It is a constant threat, or is custom and practice, ie, daily, weekly, monthly	MODERATE 5 *Yellow*	HIGH 10 *Amber*	HIGH 15 *Amber*	VERY HIGH 20 *Red*	VERY HIGH 25 *Red*

Appendix 3:

Examples of Serious Incidents for All settings (Not exhaustive, intended as a guide only)

- Serious incidents involving patients e.g. operation on wrong limb, screening errors, serious drug errors (including medical gases e.g. oxygen)
- Unexpected patient death on NHS premises in unusual or suspicious circumstances.
- Any situation whereby death causes significant media interest.
- Serious injury, injury resulting in permanent harm, or unexpected death involving patients, a member of staff, visitor, contractor or another person to whom the organisation owes a duty of care.
- Suicide or homicide committed by a patient with or without mental health problems, including service users who may have been discharged into the community but are still under the care of mental health services.
- Serious damage to NHS property e.g. through flood, fire or criminal activity.
- Outbreak of significant HCAI where there are 2 or more (epidemiologically) linked cases of a similar nature e.g. Clostridium difficile. Outbreaks of minor self limiting illnesses do not need to be reported as SUIs unless there is a significant impact on service provision or a significant impact on an individual patient.
- An increase in the observed incidence of cases over the expected within a given time period. (HPA 2003)
- All HCAI related deaths where MRSA or Clostridium difficile has been mentioned in part 1 of the death certificate (even if it was a secondary cause).
- Major health risk e.g. outbreak of infection such as Salmonella, Legionella.
- Chemical, biological, radiological or nuclear incidents (CBRN incidents).
- Large scale theft, fraud, large confidentiality breaches or major litigation.
- Suspension of health professional because of concerns about professional conduct, practice or criminal activity.
- Incidents affecting large numbers of people.
- Death, potentially life threatening injury, or permanent impairment of health or development through abuse, neglect or serious sexual assault.
- Any loss or breach of confidentially where person/patient or service user's are identified. This can be paper documents, paper files, or electronic data which is person identifiable.

Appendix 4 – Terms of Reference for the pan-Sussex SI Scrutiny Group

Sussex and East Surrey Clinical Commissioning Groups
Serious Incidents Scrutiny Group (SISG)

Terms of Reference 2017-2018/19

Overall purpose:

To review serious incident (SI) investigation reports for NHS providers (to include independent organisations providing NHS-funded care commissioned by CCGs) across Sussex and East Surrey CCGs as reported on STEIS (Strategic Executive Information System). The group enables individual CCGs to discharge their responsibility for closure of serious incidents as described in the NHS England Serious Incident Framework (updated March 2015).

Aims & Objectives:

- To improve quality and patient safety in a standardised way, by using a planned and robust approach to scrutiny of providers' investigation reports
- To ensure organisational learning and ongoing quality improvement is evidenced by providers
- To identify and action any emerging themes from SI investigations
- To ensure parity of SI closure for all providers
- To provide assurance to the CCGs' Quality Committees and Governing Bodies of each participating CCG
- To ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting lawfully on their behalf) in general in relation to care and treatment, in line with Duty of Candour legislation/CQC Regulation 20
- To ensure individuals affected and/or their families are proactively involved in any serious incident investigations, as part of Being Open requirements
- Provide economies of scale through central processing of administrative and clinical quality assurance reviews via the STP Patient Safety Team.

This process will be managed by the STP Patient Safety team, which is hosted by Brighton and Hove Clinical Commissioning Group, as clarified in a signed Service Level Agreement, on behalf of the following CCGs:

- Brighton & Hove
- Coastal West Sussex
- Crawley
- High Weald Lewes Havens
- Horsham & Mid-Sussex
- Eastbourne, Hailsham & Seaford
- Hastings & Rother
- East Surrey

The scrutiny group will adhere to the Sussex CCG's Incident Reporting and Management policies, which will align to the NHS England Serious Incident Framework (April 2015) and

the National Patient Safety Agency National Framework for Reporting and Learning from Serious Incidents Requiring Investigation (2010).

Membership:

A core group of representative members are required which includes the following:

- STP Quality Senior Leadership team
- Quality Managers across the STP team
- Patient Safety Team Manager (hosted service)
- Patient Safety Team Officer (hosted service) or nominated administrator

Following alignment of quality teams and functions across the STP, there is agreement that attendance from representatives of every CCG is not required for panel meetings. This arrangement marks a change to the previous terms of reference. However there is a recognition that 'coordinating CCG' responsibilities remain with named STP Quality leads. Therefore there is still a requirement for Quality leads of their respective providers to provide a view on closure (or otherwise) for individual serious incident reports where they (or a nominated deputy) are not in attendance at a panel meeting.

Providers are invited to attend scrutiny group meetings, by exception, where it has been identified as beneficial for the panel. This may include particularly complex cases where specialist knowledge from the provider can support panel decisions. The STP Quality Senior Leadership Team/Panel Chair will be responsible for requesting provider attendance with support from the Patient Safety Manager following first line triage, which may indicate provider attendance.

Quoracy

For the scrutiny panel to remain quorate there will be a requirement for a minimum of 2 members of the STP Quality Senior Leadership Team, one of whom will be the Chair. A minimum of 4 members from the STP-wide quality team is required for a panel meeting.

Members will need to have a sufficient level of seniority in the clinical commissioning groups and have sufficient knowledge (or represent the views of other relevant clinicians outside the group) to aid effective decision making.

The Patient Safety Manager may seek specialist opinion from clinical and non-clinical experts (e.g. adult and child safeguarding, infection prevention and control or I.T.) for certain categories of serious incidents.

Public health incident reports will be sent to the Public Health England for review and comment prior to submission to the SISG. It is the responsibility of the meeting chair to ensure appropriate expert opinion has been sought and received at the beginning of the meeting.

If a member of the group has been directly involved as either an investigator or contributor in a RCA investigation, this would be deemed a conflict of interest and that person will not have involvement with the decision to close the incident.

Frequency of meetings

The group meets on a fortnightly basis. This may be more or less frequent in response to the number of reports from organisations, always with the aims of timely review of closure of SIs in line with national standards.

There may be occasions when an extraordinary meeting may be convened e.g. for a high profile incident, a homicide review, or when a high volume of SI reports have exceeded their submission date and require closure.

Submission and Standard Documentation

All SI reports and action plans submitted to the Patient Safety Team will be submitted:

1) With a Standard SI closure Submission Form front sheet attached
2) On an approved template following the NPSA format
3) Fully anonymised*
4) With any requested amendments (following 1st line triage or panel review) *in a different coloured font or highlighted.*

* Providers are advised to be able to offer an identifiable copy for patients and families on request.

Closure criteria:

Submitted SI reports received by the Patient Safety Team will be quality assured ("1st line triage") by the Patient Safety Manager. This provides an opportunity for clarification or questions to assist the panel in decision making and improve the likelihood of closure of a report on first panel review.

An SI will be closed when evidence of the following has been submitted:

- A comprehensive, objective, analytical report of the incident
- Duty of Candour legislation followed and clearly demonstrated
- Clear and robust investigation process and RCA methodology followed
- Service/care delivery issues accurately identified and root cause identification (or clear rationale if no root cause is identified).
- The learning identified for each root cause and significant service/care delivery issue
- A SMART* action plan that covers all identified learning including responsible individuals (by role) and timescales.
- Evidence that the final report has been scrutinised via the provider governance process, and authorised at an appropriate senior level
- The final report should be submitted in a format that can be wholly understood by patients, families and carers alike. All medical terminology and abbreviations should be fully explained either in the sub text (footer) or in a glossary. An easy read version should be made available for any patients with a learning disability, Braille version for any patients who are registered blind and evidence that an interpreter has been considered if a language barrier is identified.

**Specific Measurable Achievable Relevant Time-bound*

An SI may be approved for closure without all of the above criteria being met. Where the panel advises changes should be made to a report (for instance, re-wording that would benefit a family or suggested re-phrasing of a root cause), this is captured as feedback for the provider in the panel minutes.

Following SI closure via the scrutiny panel, it is the responsibility of the coordinating CCG to gain assurance that action plans have been implemented via contracted quality review meetings with their respective provider.

Downgrading an incident

If following the submission of the final investigation report, the members of the SISG agree that the SI does not meet the SI criteria, a 'downgrade' of the incident can be agreed and the incident can be removed from STEIS. The Serious Incident Framework can be found via the following link:

https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/04/serious-incidnt-framwrk-upd2.pdf

An incident may also be downgraded prior to reaching the Serious Incident Scrutiny Group. If this is requested by a provider or the Patient Safety Team Manager in advance of the scrutiny panel, the STP Quality lead for the coordinating CCG will receive the request in writing and respond within ten working days. The Patient Safety Team will then provide the response in writing to the provider within two days of receipt of the response. The Patient Safety Manager may decline the request and direct the report for full panel scrutiny if it is felt to require in-depth consideration.

Administration

A closure report will be produced for each provider following the scrutiny panel. This will be forwarded by the Patient Safety Team officer or their deputy to the Panel Chair within five working days. The Chair will respond within three working days to agree or request amendments to the minutes.
Providers will receive the report with actions and comments within fourteen days of closure panel unless there are exceptional circumstances.

A standardised proforma is used for the purpose of recording outcomes from the meeting, to include the following:

- STEIS No.
- Incident
- Location/Trust
- Closed – Yes/No
- Conditional Closure – Yes/No
- If no, action to take, by whom etc.

In the event that the SI is '*conditionally'* closed, the provider will be informed of the further information/assurance required in order to close the SI. The SISG Chair will request a response date. When the assurance has been received, this will be communicated to the provider lead commissioner, to agree final closure. The response to this submission will be sent by email to the Patient Safety Team to be communicated to the provider, no later than two weeks following receipt. In order to minimise the risk of a backlog of SIs occurring, conditional closure decisions will only be made in exceptional circumstances.

If a report is '*kept open'* the provider will be informed of the further information/assurance required in order to close the SI. The SISG Chair will request a response date. When the assurance has been received the report will be re-presented to the next available scrutiny panel at which the increased assurance will be reviewed. (As above, amendments must be highlighted/in a different coloured font to enable the changes to be easily identified).

Meetings will be planned at least six months in advance by the Patient Safety Officer. They will circulate the meeting agenda (with the SI reports to be reviewed embedded) two weeks in advance of each meeting.

Minute taking/actions will be co-ordinated by the Patient Safety Officer. In the absence of the PSO the Patient Safety Manager will record the minutes/actions.

Effective From:

November 1st 2017

Review Date:

April 2019

Responsible Director:

Allison Cannon

To be read in conjunction with:

DOH Serious Incident Framework updated March 2015

DOH Never Events Framework updated March 2015

B&H CCG Incident Reporting Policy

Version History:

Date	
11 February 2016	**SISG panel agreed Soline Jerram Director sign off**
03 March 2017	**Draft to HoQs**
06 April 2017	**SISG panel agreed Soline Jerram Director sign off**
24 August 2017	**Amendment – SISG panel agreed Soline Jerram Director sign off**