Creating a healthier Hull

NHS
Hull Clinical Commissioning Group

SERIOUS INCIDENT POLICY

August 2016

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Date Issued:	November 2016
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Policy Title:	Serious Incident Policy	
Supersedes: (Please List)	Incident Reporting Policy	
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Consultation:		

POLICY AMENDMENTS

Amendments to the Policy will be issued from time to time. A new amendment history will be issued with each change.

New Version Number	Issued by	Nature of Amendment	Approved by & Date	Date on Intranet
1.0	HULL CCG			
1.1	YHCS	Updates from new NHS England national framework for Serious Incidents 2015		

CONTENTS

1 INTRODUCTION

NHS Hull Clinical Commissioning Group (NHS Hull CCG) is committed to providing the best possible service to its patients, clients and staff. NHS Hull 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.

Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified. Serious Incidents include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm - including those where the injury required treatment to prevent death or serious harm, abuse, Never Events, incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services.

Learning from Serious Incidents is an important function of NHS Hull 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 national guidance from NHS England.

NHS Hull CCG has a duty to receive information on Serious Incidents from NHS organisations within its boundaries as well as affecting its patients treated out of area, 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.

NHS Hull CCG will be informed of SIs in line with the NHS Serious Incident National Framework (March 2015) that have occurred within any of its commissioned services listed below:

- Hull and East Yorkshire Hospitals NHS Trust
- Humber NHS Foundation Trust
- CHCP Hull
- Spire
- Yorkshire Ambulance Service
- Independent (including GP practices) and Private Providers, commissioned to provide NHS services for the CCGs population, including NHS commissioned placements and service provision in care homes.

- Any other provider of NHS commissioned services affecting the patient population of NHS Hull CCG

- SI in services that fall under NHS Hull CCG's responsibility under the co-commissioning agenda.

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 Hull CCG Board and NHS England as required

NHS Hull CCGs will work closely with NHS England, the Department of Health and other organisations to manage serious incidents, minimise risk and in so doing help prevent recurrence across the NHS. External organisations contracted to support delivery of this area of work for NHS Hull CCG will be referred to as associated team with lead for Serious Incident service.

The policy also outlines management of Incidents, which are of a less serious nature, but require monitoring and management to promote a culture of safety in NHS commissioned services.

2 DEFINITION

Serious Incidents in the NHS include:

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

  - Unexpected or avoidable death8 of one or more people. This includes
    - suicide/self-inflicted death; and
    - homicide by a person in receipt of mental health care within the recent past
  - Unexpected or avoidable injury to one or more people that has resulted in serious harm
  - Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent:
    - the death of the service user, or
    - serious harm

- Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where:

- healthcare did not take appropriate action/intervention to safeguard against such abuse occurring, or
- where abuse occurred during the provision of NHS-funded care.

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

An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:

- Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues.
- Property damage.
- Security breach/concern.
- Incidents in population-wide healthcare activities like screening13 and immunisation programmes where the potential for harm may extend to a large population.
- Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS).
- Systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/ unit closure or suspension of services).
- Activation of Major Incident Plan (by provider, commissioner or relevant agency).
- Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation.

Near Misses

A 'near miss' should be classified as a serious incident based on an assessment of risk that considers:

- The likelihood of the incident occurring again if current systems/process remain unchanged, and
- The potential for harm to staff, patients, and the organisation should the incident occur again.

This does not mean that every 'near miss' should be reported as a serious incident but, where there is a significant existing risk of system failure and serious harm, the serious incident process should be used to understand and mitigate that risk.

It is required that all incidents which are categorised as SIs within the Serious Incidents Framework (2015) will be reported as SIs. Providers may categorise or

describe incidents internally, with differing titles, but are required to report all incidents which fit the criteria of a Serious Incident.

NHS England updated a core list of Never Events which are listed in Appendix 1. Never Events are Serious incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services. 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.

Incident – An incident is any event or circumstance that could or did lead to unintended or unexpected harm, loss or damage to one or more patients, members of staff, visitors, other persons or property, but does not constitute a Serious Incident.

Concern – Occurrence which gives cause for concern by patient, member of public, health or other care worker, which does not constitute an incident, but where collectively, can form a body of evidence for commissioners.

3 ENGAGEMENT

This policy has been developed by Lead Nurses, GPs and clinical and managerial staff in NHS Hull CCG, NHS NLCCG, NHS NEL CCG, NHS ERY CCG and NHS England NYH&H AT. The National Framework for Serious Incidents (2015) on which this policy is based, has been circulated to all hospital, ambulance and community providers.

4 IMPACT ANALYSES

4.1 Equality

In developing this policy, an analysis of the impact on Equality has been undertaken. As a result of performing the analysis, the policy, project or function does not appear to have any adverse effects on people who share Protected Characteristics and no further actions are recommended at this stage.

NHS Hull CCG promotes a culture of Equality and Diversity within its organisation and actively monitors themes arising from incidents for any potential discriminatory activity.

4.2 Sustainability

The Sustainability Impact Assessment identifies two positive impacts in relation to this policy or the CCG's sustainability themes. These relate to teleconferencing and electronic documentation and meeting management.

4.3 Bribery Act 2010

There are the following requirements to the provisions of the Bribery Act 2010 within this policy.

"Never Event" Serious Incidents

Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers.

Each Never Event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event. Never Events include incidents such as:

- wrong site surgery
- retained instrument post operation
- wrong route administration of chemotherapy

Where a patient pathway error has been identified as a Never Event, the commissioner is not required to pay for the care delivered for the episode of the patients care in relation to the Never Event. Commissioners are able to decide to waive these contractual terms depending on individual circumstances, applying the principles of proportionality and taking into account previous performance and the Provider's response to the Never Event occurring. This decision should be taken in discussion with the Provider, although the default should be to recover costs.

Never Events are clearly defined in the Revised Never Events Policy and Framework (2015) and NHS providers are required to declare these on Strategic Executive Information System (STEIS).

All Serious Incidents, including Never Events are reported to the CCG on a monthly basis and where necessary, funds recouped for Never Event occurrence.

Organisational Integrity
Organisations undertaking NHS services are required to declare Serious Incidents and Incidents. Organisations also investigate Serious Incidents and Incidents using internal investigators.
These requirements present a very low level of risk to the CCG in relation to potential bribery.

5 SCOPE

This policy and associated tools for investigation is for use by NHS Hull CCG employees, all commissioned services and associated team with lead for Serious Incident service staff.
For the purpose of this policy an NHS patient is defined as a person receiving care or treatment under the NHS Act 1977, and described in Serious Incident Framework (2015) as "patient in receipt of NHS-funded care".

The responsibilities of this document apply to NHS Hull CCG, all commissioned services and associated team with lead for Serious Incident service 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 Hull CCG.

6 POLICY PURPOSE & AIMS

The purpose of the Policy is to provide NHS Hull CCG and all their commissioned services 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

7 ROLES / RESPONSIBILITIES / DUTIES

NHS Hull CCG has a responsibility to ensure there is a robust performance management process in place that meets NHS England 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 Hull CCG and the commissioned service. NHS Hull CCG also has a duty to comply with NHS England Serious Incidents Framework March 2015. It is the responsibility of the associated team with lead for Serious Incident service 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 in line with the Serious Incidents Framework 2015.

8 IMPLEMENTATION

8.1 SERIOUS INCIDENTS

8.1.1 Culture

NHS Hull 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 Hull CCG is 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 Hull CCG is committed to using root cause analysis, during the investigation of SIs and requires providers to use this technique when investigating SIs.

8.1.2 Duty of Candour – Being Open
A commitment to improving communication between NHS Hull CCG and patients who have been harmed is integral to NHS Hull CCG's strategy to improve patient safety.

NHS Hull CCG expects all providers to demonstrate a Duty of Candour, based on recommendations made by Francis (2013) and in line with principle of "Being Open" which involve acknowledging, apologising and explaining what happened to patients and/or their carers who have been involved in a patient safety incident, whether or not the patient or their representative have asked for this information.

This is also a national contractual requirement for all providers of NHS services under the NHS standard contract, as well as one of the fundamental standards applied by the Care Quality Commission (2015).

8.1.3 Reporting a Serious Incident
Who should report SIs?
All commissioned providers are required to report SIs to NHS Hull CCG using the STEIS system. The reporting process for commissioned providers can be found at Appendix 3.
Providers are required to demonstrate an internal governance process which ensures Serious Incidents are reported on STEIS within 2 working days of the SI being identified from within the organisation, or to the organisation by an external organisation.

For SI's which are declared by the NHS Hull CCG should be reported directly on STEIS by the Patient Safety Lead or their delegate.

NHS Hull 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. Hull CCG may require immediate assurance from the provider depending on the seriousness and complexity of the SI, a 72 hour report can be requested by the commissioner from the provider.

8.1.4 Investigation of a Serious Incident

The Patient Safety 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 investigation will be led by a nominated manager fully trained in incident investigation and analysis and sufficiently removed from the incident itself so as to be able to conduct an objective investigation. 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 within 2 working days.
- 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 provide report within 60 working days of the incident date, so the SI can be reviewed by the SI panel, following RCA review by associated team with lead for Serious Incident service.
- 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 and organisation

The Patient Safety Lead with lead for the Serious Incident service 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, confirmation of the patient's/client's GP details and a deadline for receipt of the investigation report and action plan
- Maintain up-to-date electronic records of all Serious Incidents pertaining to the NHS Hull 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 between providers and the CCG. It is the responsibility of the CCG to authorise extensions
- Provide expert clinical and managerial review of all SIs and where appropriate seek external expert review (ie Midwifery SIs).

- Organise the SI panel meetings
- Ensure feedback is provided following review of investigation reports
- Produce quarterly SI data for both NHS Hull CCG and NHS England (ie for Contract Management).

All SI investigation reports are reviewed and discussed at the SI panel. The SI panel is collaborative group drawn from NHS Hull and NHS ERY CCGs.

The SI panel will:

- Receive, critique and provide feedback on the SI report including opinion on the SIs submitted if there is a safeguarding adults issue that requires an alert to made to the safeguarding team.
- Maintain a transparent and open system to assure quality of Root Cause Analysis, and 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.
- Seek assurance of the completion of Implementation of action plans and that learning has been embedded.
- Identify learning points and be assured of sharing of learning.
- Monitor the implementation of this policy, including reporting timescales, quality of reporting, and feedback to providers, performance management responsibilities, dissemination of lessons learned and assurance on actions taken.
- Ensure SIs are closed on STEIS when the CCG is satisfied the investigation has established all the root causes and actions are captured in appropriate detail on the action plan.
- Work in conjunction with the CCG Communications service where a media response is required.

The sharing of lessons learnt post-investigation is a critical part of serious incident management. Following a review of the SI, the Lead will ensure that procedures are adopted or altered to reflect the lessons learnt from Serious Incidents. The Patient Safety Lead 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.

Serious Incidents Reports are provided regularly to the Hull CCG Quality and Performance committee. This committee will escalate matters to the wider membership and Council of Members as appropriate.

Also see section 8.1.18– Sharing Lessons Learnt.

8.1.5 Never Events

Never Events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. Each Never Event type has the potential to cause serious patient harm or death. However,

serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event.

Local reporting and management processes will underpin the implementation of the Never Events Framework. 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 NHS Hull CCG forms part of existing contract arrangements for reporting of SIs.

The NHS England Framework supports NHS Hull CCG in their performance management of Never Events and will provide interventions with providers, where this is appropriate to the role of NHS England.

8.1.6 The role of NHS England

NHS England has a direct commissioning role as well as a role in leading and enabling the commissioning system. As part of the latter role, NHS England maintains oversight and surveillance of serious incident management within NHS-funded care and assures that CCGs have systems in place to appropriately manage serious incidents in the care they commission. They are responsible for reviewing trends, analysing quality and identifying issues of concern. They have a responsibility for providing the wider system with intelligence gained through their role as direct commissioners and leaders of the commissioning system. NHS England must maintain mechanisms to support this function, including exploiting opportunities provided by their involvement and participation in local and regional Quality Surveillance Groups.

In certain circumstances (for example with many incidents relating to mental health homicide) NHS England may be required to lead a local, regional or national response (including the commissioning of an independent incident investigation) depending on the circumstances of the case.

- NHS England are automatically alerted when an SI is reported via the STEIS system. In some circumstances NHS England may require immediate assurance depending on the seriousness and complexity of the SI.
- In exceptional circumstances, NHS England may alert other Trusts in Yorkshire and the Humber or throughout the country. NHS England 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 England 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 Hull CCG and associated team with lead for Serious Incident service or NHS England for advice. A single investigation report and action plan will be submitted by the reporting organisation.

- In the interest of patient safety, NHS England will inform the CQC of "highly significant" SIs such as those which are likely to generate significant interest and 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 England decides to notify the CQC of such an incident the relevant organisation will be informed of this first and this action does not negate the organisation from reporting to the CQC where appropriate.

NHS England will continue to performance manage SIs involving the safeguarding of children as outlined in Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework (March 2013) This will be done through the Safeguarding Team Designated Nurses who are employed across the NHS Hull CCG and NHS ERY CCG and NHS England. Cases will be kept open until the action plans have been fully implemented.

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

8.1.7 Safeguarding Adults and Children

The new Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework published on 21 March 2013 makes clear that regardless of the individual circumstances, both commissioner and provider organisations should:

- Ensure that the Local Safeguarding Adult boards (LSABs) and Local Safeguarding Children Boards (LSCBs) have been notified of relevant incidents and agree arrangements for the management of Serious Case Reviews / Lessons Learnt Reviews, Domestic Homicide Reviews and other non-statutory reviews, depending on circumstances; including action planning and learning from incidents. All actions should be consistent with the local multi-agency safeguarding protocol and policies
- Ensure robust communication between safeguarding boards, commissioners, regulators and providers. There should not be duplication of investigations and action planning within the health care provider organisations where external bodies, such as safeguarding boards, are carrying out these activities and health care organisations are assured that actions are satisfactorily in hand and that there are robust process for ensuring any outcomes from the external investigation will be communicated and acted upon; SIs must be reported on STEIS to ensure health element of SI is

reported and evidence of action implementation is submitted to commissioner.

- Ensure understanding of, and apply, reporting and liaison requirements with regard to agencies such as the Police, Public Health England, Health and Safety Executive (HSE), Coroner, Education Partners, Local Authority partners, Local Midwifery Supervising Authority or Medicines and Healthcare products Regulatory Agency (MHRA)
- Ensure incidents are reported to the appropriate regulatory and healthcare bodies, including the CQC and, for patient safety incidents, the National Reporting and Learning System
- Ensure that all SIs are considered by the provider in relation to whether there has been a possible incident of abuse or neglect as defined by the "No Secret's - Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse" (DH 2000), and an alert is raised as appropriate.
- Hull CCG will produce quarterly reports for Hull SAB on all SIs that have safeguarding adults implications

Under the statutory guidance Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children published March 2015, NHS England has a statutory duty to safeguard and promote the welfare of children. It will also be accountable for the services it directly commissions. The NHS Commissioning Board will also lead and define improvements in safeguarding practice and impact/outcomes, and should also ensure that there are effective mechanisms for LSCBs and Health and Wellbeing Boards to raise concerns about the engagement and leadership of the local NHS in relation to safeguarding children & adults.

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

(a) abuse or neglect of a child is known or suspected; and
(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child. ('Working Together' 2015)

NHS England is responsible for ensuring that the health commissioning system as a whole is working effectively to safeguard and promote the welfare of children. It is also accountable for the services it directly commissions, including health care services in the under-18 secure estate and in police custody.

NHS England also leads and defines improvement in safeguarding practice and outcomes and should also ensure that there are effective mechanisms for LSCBs and health and wellbeing boards to raise concerns about the engagement and leadership of the local NHS.
NHS Hull CCG as the commissioner of local health services is responsible for safeguarding quality assurance through contractual arrangements with all provider organisations.

The Designated Professionals for Adults and for Children are employed by NHS Hull CCG and provide the CCG and NHS England with professional support and advice in relation to relevant SI's.

The administrative records of SIs linked with safeguarding investigations will be processed through the NHS Hull CCG SI management process via the associated team with lead for Serious Incident service and these cases will be kept open until the action plans have been fully implemented.

8.1.8 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.

8.1.9 Incidents Involving National Screening Programmes

SIs linked to screening programmes should also be reported to NHS England within two working days. For the most serious of incidents NHS England should be informed immediately and a member of the Public Health team should be involved in the incident investigation.

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 bowel screening programme are available at: http://www.cancerscreening.nhs.uk/bowel/index.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

8.1.10 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 England has a role in notifying the Department of Health (DH) of certain data loss incidents, depending on the severity and in line with recommendations of Caldicott Review (2013).

8.1.11 Process for Reporting SIs that Fall into Category of Pressure Damage

Patients who are in receipt of NHS commissioned care, in hospital and community settings who experience pressure damage, should be assessed appropriately using nationally recognised assessment and care management tools. Patients should be initially and appropriately assessed within 8 hours of admission or at their first

planned visit within the community setting (EPUAP, 2015). Where pressure damage occurs and the assessment identifies that there have been any acts or omissions in care contributing to the development of the pressure damage, any neglect of the patient or any safeguarding alerts the incident must be reported as a Serious Incident in line with SI Framework (2015)
Provider organisations who do not have STEIS log on, can report the SI to HULLCCG.SeriousIncidents@nhs.net

A report will be uploaded on behalf of the organisation, and guidance given by associated team with lead for Serious Incident service.

8.1.12 Process for Reporting SIs That Fall into Category of Health Care Associated Infections (HCAI)

It is required that MRSA and C.difficile deaths will be subject to a Post Infection Review (PIR, April 2013). These cases will be managed elsewhere and do not require to be reported as SIs.

Incidents where a HCAI is on Part 1 of death certificate should be reported as a SI. Other HCAI which should be considered for reporting as a SI include:

- Clusters or recurrences of HCAIs which are not being managed via PIR or other HCAI process.
- Unusual outbreaks in care settings
- Incidents which result in adverse media interest.

Services will ensure engagement with NHS England Public Health teams where appropriate and for all outbreaks in non-NHS care settings.

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

For incidents related to health and safety, the NHS Hull CCG approved Health and Safety Specialists 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, Medication and Drug related errors which result in serious harm or death, or are considered “near misses” should be reported as SIs by the provider. NHS Hull 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.

8.1.14 Midwifery Service Incidents
Where NHS Hull CCG is performance managing a midwifery SI, they are responsible for ensuring that clinical advice is obtained either from a supervisor of midwives independent of the service in question or directly from the LSA Midwifery Officer.

8.1.15 Patients in Receipt of Mental Health Services
For SIs reported involving patients 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.

8.1.16 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.

8.1.17 Patients in Receipt of Substance Misuse Services
In NHS commissioned 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.
Where patients are in receipt of care commissioning by non-NHS commissioners, such as Local Authority commissioned Drug and Alcohol Services, these are not required to be reported on STEIS, but managed through that commissioning organisations processes.

8.1.18 Sharing Lessons Learned
NHS Hull CCG will work in partnership with, and support 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. Provider organisations will be expected to lead and implement changes to improve patient safety in line with recommendations of Francis (2013) and NHS CB (2012) Compassion in Practice (2012), provide evidence of impact on lessons learnt and quality improvement with staff. NHS Hull CCG will work with NHS England in order

that learning from serious incidents is shared with other NHS organisations in Yorkshire and the Humber and nationally where appropriate.
Also see Section 8.1.5 - Investigation of a Serious Incident

9 TRAINING & AWARENESS

Staff will be made aware of the policy through the staff induction process, when directed to review policies and procedures of the organisation. The policy will be held on the Intranet.
Staff involved with the monitoring, management and review of Serious Incidents, Incidents and Concerns will receive Root Cause Analysis training using nationally approved tools.

10 MONITORING & AUDIT

A monthly review of all Serious Incidents will be held by the associated team with lead for Serious Incident service and collaboratively involve Hull & ER CCGs.

11 POLICY REVIEW

This policy will be reviewed every two years. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation/guidance, and as instructed by the senior manager responsible for this policy.

12 REFERENCES

Putting Patients First: The NHS England Business Plan for 2013/14 – 2015/16
Recommendations and Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Feb 2013)
NHS Commissioning Board (March 2015) Serious Incident Framework
Working Together to Safeguard Children
https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/419595/Working_Together_to_Safeguard_Children.pdf,
Guidance on the reporting and monitoring arrangements and post infection review process for MRSA bloodstream infections (April 2013)
http://www.England.nhs.uk/wp-content/uploads/2013/03/pir-guidance.pdf
Department of Health (2013) Information: To Share or not to Share Government Response to the Caldicott Review
www.nrls.npsa.nhs.uk/resources/patient-safety-topics/
Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework (March 2013)
Department of Health (2012) Compassion in Practice
National framework for reporting and learning from serious incidents requiring investigation (2010)
http://www.nrls.npsa.nhs.uk/resources/?entryid45=75173
NPSA (2009) Being Open Policy
National Health Services Act 1977.

Health and Social Care Information Centre (hscic) (February 2015) Checklist Guidance for the Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation.

NHS England (2013/14 update) The Never Events List
NHS England (Sept 2014) Twelve Hour Breach of the AE Standard Guide
NHS England (November 2014) Safer Staffing Guide Care Contact Time

13 ASSOCIATED DOCUMENTATION

No other associated documentation.

APPENDICES

Appendix 1 - Core list of Never Events

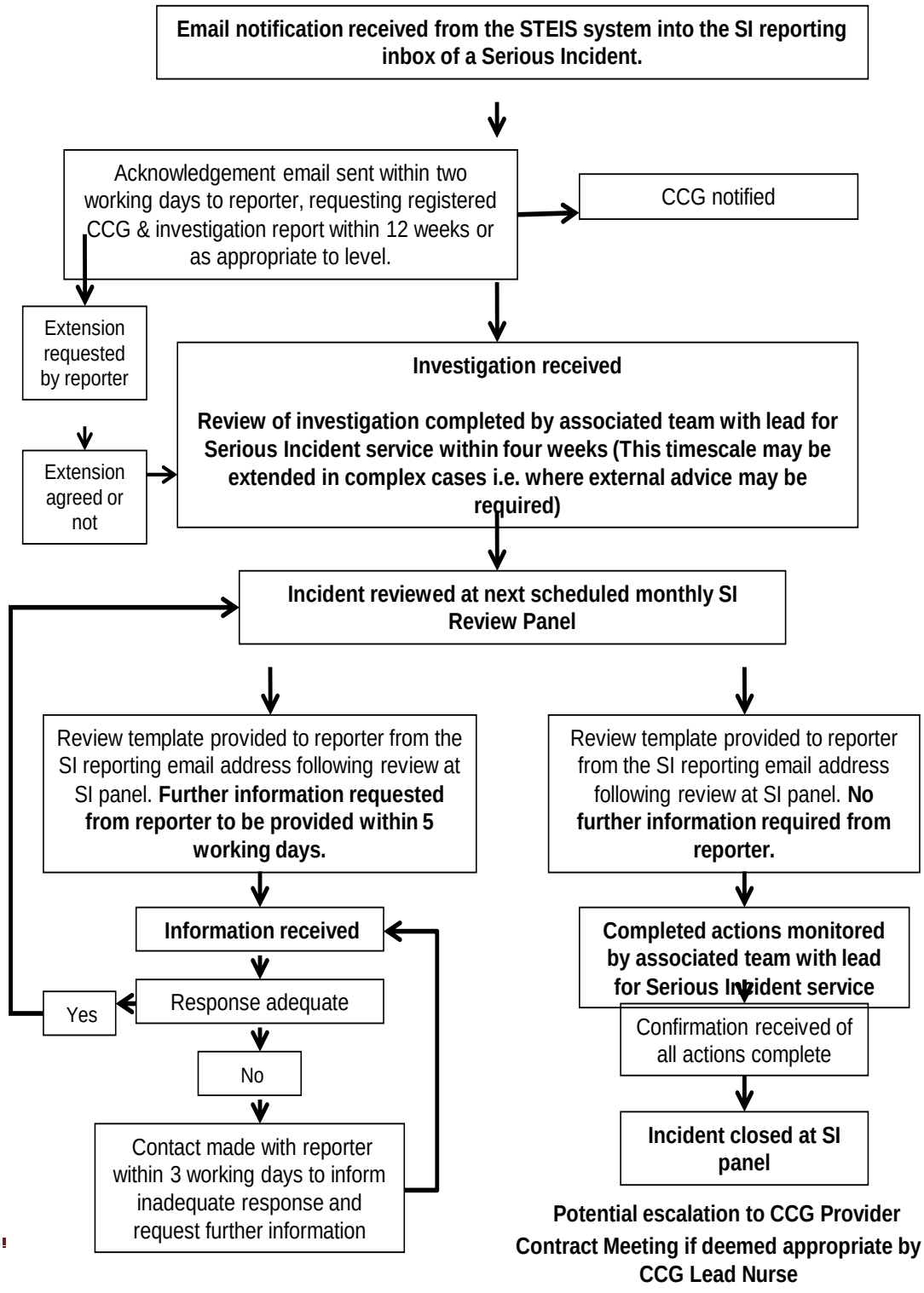
1. Wrong site surgery
2. Wrong implant/prosthesis
3. Retained foreign object post-procedure
4. Mis – selection of a strong potassium containing solution
5. Wrong route administration of medication
6. Overdose of Insulin due to abbreviations or incorrect device
7. Overdose of methotrexate for non-cancer treatment
8. Mis – selection of high strength midazolam during conscious sedation
9. Failure to install functional collapsible shower or curtain rails
10. Falls from poorly restricted windows
11. Chest or neck entrapment in bedrails
12. Transfusion or transplantation of ABO-incompatible blood components or organs
13. Misplaced naso- or oro-gastric tubes
14. Scalding of patients

Appendix 2

Commissioned Services Reporting Process

****all communication to be sent via SI reporting e-mail address:**

HULLCCG.SeriousIncidents@nhs.net



Potential escalation to CCG Provider Contract Meeting if deemed appropriate by CCG Lead Nurse

Appendix 3

Serious Incident Report Submission – Extension Requests

Provider organisations are required to report Serious Incidents (SI) within two working days, once identified. As per Framework for SIs (March 2015) the date of SI's discovery by the organisation is the date from which the deadline is taken for a report into SI to be completed and submitted. Organisations are requested to use "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 within12 weeks, from the date of organisation's awareness 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 expected the provider will make request for extension deadline well ahead of the due date. Repeated extension requests made within last 4 weeks of the due date for the report will be challenged by the commissioner.

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.

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
- Coroner's 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 associated team with lead for Serious Incident service will liaise with relevant CCG Lead.

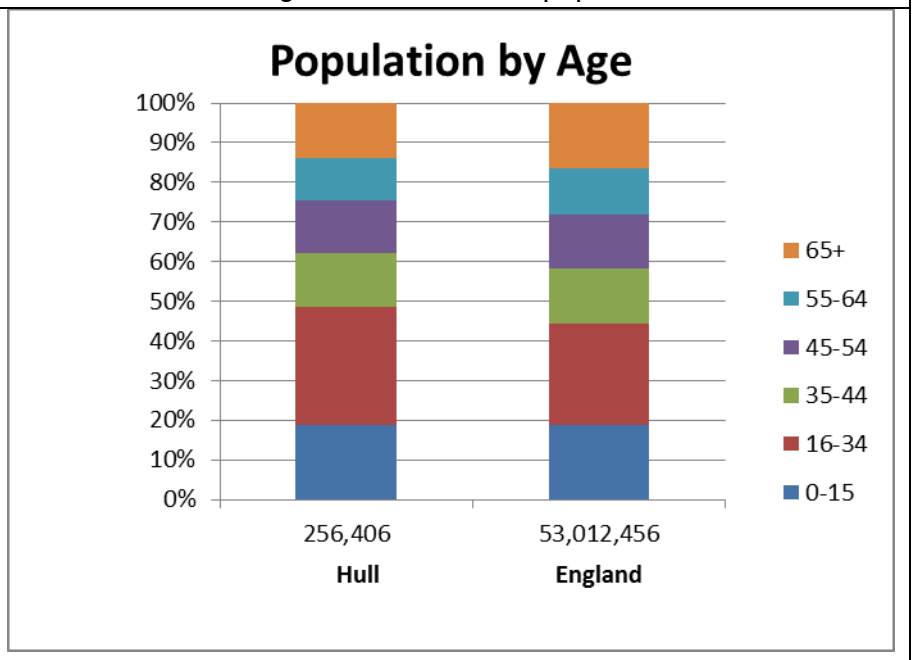
In all these circumstances, an interim SI report will be required in the initial 12 week deadline.

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 SI Panel and the contract management board.

Equality Impact Assessment:

Equality Impact Analysis:	
Policy / Project / Function:	Serious Incident Policy August 2016
Date of Analysis:	26 September 2016
This Equality Impact Analysis was completed by: **(Name and Department)**	Kate Memluks, Quality Lead, Quality
What are the aims and intended **effects of this policy, project or** **function ?**	This policy aims to ensure that all serious incidents are reported and investigated to ensure lessons are learnt. All commissioned services and providers are affected as well as Hull CCG staff and Hull GP surgeries.

Please list any other policies that are related to or referred to as part of this analysis	• Incident Policy • Being Open Policy
Who does the policy, project or function affect ? Please Tick ✔	Employees ✓ Service Users ✓ Members of the Public Other (List Below) ✔ Hull GP surgery staff. NHS providers commissioned by Hull CCG

Equality Impact Analysis: Local Profile/Demography of the Groups affected (population figures) Relevant data can be found in the attached Knowledge Management Toolkit	
General	There are 57 GP practices in the Hull area which spans 7,154 hectares and, as a city, has relatively tight geographical boundaries with most of the 'leafy suburb' areas outside Hull's boundaries in East Riding of Yorkshire. As a result, Hull has a relatively high deprivation score, as measured by the Index of Multiple Deprivation 2010, with Hull ranked as the 10th most deprived local authority out of 326 (bottom 4%). The resident population of Hull is 256,406 based on the 2011 Census data and 265,369 residents based on estimates from the local GP registration file as at October 2011. This equates to approximately 37 residents per hectare. The Joint Strategic Needs Assessment (JSNA) identifies considerable inequalities in health between Hull and England, and between populations within Hull.
Age	 Compared to England, Hull has lower percentages of residents aged 10-19 years and 55+ years, but slightly higher percentages aged under 5, 20-34 years and 45-54 years. There is a relatively large difference between Hull and England for the age group 20-34

	years, due to Hull's colleges and Universities. There were 2,869 live births occurring to Hull residents in 2001, but this has increased steadily to 3,771 for 2010. The number of deaths occurring to Hull residents has decreased from 2,571 to 2,310 between 2001 and 2010. ONS estimated the resident population to be 243,596 in 2001 compared to 260,424 residents based on the GP registration file, with the difference between these estimates narrowing over time. So, whilst it is difficult to quantify the exact increase in Hull's population, it has increased over recent years. Between 2010 and 2030, ONS estimate that Hull's population will increase from 266,100 to 311,900 residents, an increase of 17%. The figure above shows the population of Hull (2011 Census Data).
Race	The percentage of the population from Black and Minority Ethnic (BME) groups has increased substantially since 2001. For the 2001 Census, it was estimated that 3.3% of Hull's population was not White British or White Irish, whereas Census data shows that this figure increased to 10.2% for 2011. There is no single BME group in Hull with much higher percentages compared to other groups. The 2011 census data shows: White British - 89.7% White Other - 4.4% Mixed – 1.3% Asian - 2.5% Black - 1.2% Other – 0.8%
Sex	The gender split in Hull is approximately 50.1% men and 49.9% women. For 2008-2010, life expectancy in Hull was 75.7 years for

<table>
<tr><td></td><td>men and 80.2 years for women compared to 78.6 years and 82.6 years for men and women respectively in England.</td></tr>
<tr><td>Gender reassignment</td><td>No local information provided.</td></tr>
<tr><td>Disability</td><td>According to the 2011 Census, it is estimated that approximately 19.7% of the Hull population lives with a long term health problem or disability compared with 17.6% for England. This information can be broken down further (Source: Projecting Older People Population Information System and Projecting Adult Needs and Service Information) to include learning disabilities, physical disabilities, hearing impairments and visual impairments, as follows:
<table>
<tr><th>2012 Estimates</th><th>Hull</th></tr>
<tr><td>Learning Disability (Age 18 – 64)</td><td>4,078</td></tr>
<tr><td>Learning Disability (Age 65 and over)</td><td>762</td></tr>
<tr><td>Physical Disability – Moderate (Age 18 – 64)</td><td>12,222</td></tr>
<tr><td>Physical Disability – Serious (Age 18 – 64)</td><td>3,491</td></tr>
<tr><td>Visual Impairment (Age 18 – 64)</td><td>108</td></tr>
<tr><td>Visual Impairment (Age 65 and over)</td><td>3,263</td></tr>
<tr><td>Hearing Impairment – Moderate or Severe (Age 18 – 64)</td><td>5,765</td></tr>
<tr><td>Hearing Impairment – Moderate or Severe (Age 65 and over)</td><td>15,707</td></tr>
<tr><td>Hearing Impairment – Profound (Age 18 – 64)</td><td>49</td></tr>
<tr><td>Hearing Impairment – Profound (Age 65 and over)</td><td>402</td></tr>
</table></td></tr>
</table>

<table>
<tr><td>Sexual Orientation</td><td>There are no local statistics for how many Lesbian, Gay or Bisexual (LGB) people live within Hull however, nationally, the Government estimates that 5% of the population are lesbian, gay, bi and transgender communities.</td></tr>
<tr><td>Religion, faith and belief</td><td>According to the 2011 Census, 54.9% of the population have identified themselves as Christian and 3.1% of the population is made up of other religions. The remainder of the population did not state anything (7.2%) or stated ‘no religion’ (34.8%).
<table>
<tr><th>Religion</th><th>2011</th></tr>
<tr><td>Christian</td><td>54.9%</td></tr>
<tr><td>Buddhist</td><td>0.3%</td></tr>
<tr><td>Hindu</td><td>0.2%</td></tr>
<tr><td>Jewish</td><td>0.1%</td></tr>
<tr><td>Muslim</td><td>2.1%</td></tr>
<tr><td>Sikh</td><td>0.1%</td></tr>
<tr><td>Other Religion</td><td>0.3%</td></tr>
<tr><td>No Religion</td><td>34.8%</td></tr>
<tr><td>Religion Not Stated</td><td>7.2%</td></tr>
</table></td></tr>
<tr><td>Marriage and civil partnership</td><td>This protected characteristic generally only applies in the workplace. Data from the Office of National Statistics covering the period 2008-2010 indicates that there were 18,049 Civil Partnerships in England and Wales during this three-year period – 52% men and 48% women.</td></tr>
<tr><td>Pregnancy and maternity</td><td>There were 2,869 live births occurring to Hull residents in 2001, but this has increased steadily to 3,771 for 2010.</td></tr>
</table>

Equality Impact Analysis:

Is any Equality Data available relating to the use or **implementation of this policy, project or function ?** Equality data is internal or external information that may indicate how the activity being analysed can affect different groups of people who share the nine *Protected Characteristics* – referred to hereafter as *'Equality Groups'.* Examples of *Equality Data* include: (this list is not definitive) 1: Application success rates *Equality Groups* 2: Complaints by *Equality Groups* 3: Service usage and withdrawal of services by *Equality Groups* 4: Grievances or decisions upheld and dismissed by *Equality Groups*	Yes employee data has been used to support the monitoring of the impact of this policy in the future. The employee data is not included due to the low number of CCG employees and concern around anonymity. No ☐ Where you have answered yes, please incorporate this data when performing the *Equality Impact Assessment Test* (the next section of this document).
List any Consultation e.g. with employees, service users, Unions or members of the public that has taken place in the development or implementation of this policy, project or function	Consultation has taken place both locally and nationally with Trade Unions and staff • Health and Safety Group. • Social Partnership Forum • Integrated Audit and Governance Committee

Promoting Inclusivity How does the project, service or function contribute towards our aims of eliminating discrimination and promoting equality and diversity within our organisation	This Policy does not directly promote inclusivity, but ensures all employees are treated in the same way.

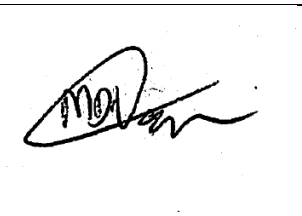
Equality Impact Assessment Test:				
What impact will the implementation of this policy, project or function have on employees, service users or other people who share characteristics protected by *The Equality Act 2010* ?				
Protected Characteristic:	**No Impact:**	**Positive Impact:**	**Negative Impact:**	**Evidence of impact and if applicable, justification where a *Genuine Determining Reason* exists**
Gender (Men and Women)	✓			Considered – neutral impact
Race (All Racial Groups)	✓			As the policy is written in English there is a potential impact on employees whose first language is not English and therefore may struggle reading the policy. However this potential impact is minimised due to the development of the 'portal' facilities detailed in the action plan and an expectation that employees should be able to comprehend all policy documents.
Disability (Mental and Physical)	✓			Considered – neutral impact

Religion or Belief	✓			Considered – neutral impact
Sexual Orientation **(Heterosexual, Homosexual and Bisexual)**	✓			Considered – neutral impact
Pregnancy and Maternity	✓			Considered – neutral impact
Transgender	✓			Considered – neutral impact
Marital Status	✓			Considered – neutral impact
Age	✓			Considered – neutral impact

Action Planning:				
As a result of performing this analysis, what actions are proposed to remove or reduce any risks of adverse outcomes identified on employees, service users or other people who share characteristics protected by *The Equality Act 2010* ?				
Identified Risk:	**Recommended Actions:**	**Responsible Lead:**	**Completion Date:**	**Review Date:**
As the policy is written in English there is a potential impact on employees whose first language is not English and therefore may struggle reading the policy.	The CCGs Communication Team has developed the 'portal' to signpost individuals to alternative formats. As of January 15 there have been no requests for information in alternative formats, however this will be monitored.	CCG Communications	April 2016	Next policy review

Equality Impact Findings:	
Analysis Rating:	**GREEN** - As a result of performing the analysis, the policy, project or function does not appear to have any adverse effects on people who share *Protected Characteristics* and no further actions are recommended at this stage.
Red – Stop and remove the policy	**Red:** As a result of performing the analysis, it is evident that a risk of discrimination exists (direct, indirect, unintentional or otherwise) to one or more of the nine groups of people who share *Protected Characteristics.* It is recommended that the use of the policy be suspended until further work or analysis is performed.
Red Amber – Continue the policy	As a result of performing the analysis, it is evident that a risk of discrimination exists (direct, indirect, unintentional or otherwise) to one or more of the nine groups of people who share *Protected Characteristics.* However, a genuine determining reason may exist that could legitimise or justify the use of this policy and further professional advice should be taken.
Amber – Adjust the Policy	As a result of performing the analysis, it is evident that a risk of discrimination (as described above) exists and this risk may be removed or reduced by implementing the actions detailed within the *Action Planning* section of this document.
Green – No major change	As a result of performing the analysis, the policy, project or function does not appear to have any adverse effects on people who share *Protected Characteristics* and no further actions are recommended at this stage.

Brief Summary/Further comments	As a result of performing the analysis, the policy, project or function does not appear to have any adverse effects on people who share *Protected Characteristics* and no further actions are recommended at this stage.

Signatures	
Other Comments	
Confirmed by (manager): (Name and Title)	
Date:	October 2016