NHS
Coastal West Sussex
Clinical Commissioning Group

Policy and Procedures for all services commissioned by Coastal West Sussex Clinical Commissioning Group on the reporting of Patient Safety Incidents and Serious Incidents

Compliance with all CCG policies, procedures, protocols, guidelines, guidance and standards is a condition of employment. Breach of policy may result in disciplinary action.

Version	Date Issued	Details	Brief Summary of Change	Author
0.1	July 2014	New Policy		Head of Quality & Nursing CWS CCG
0.2	October 2015	Revision	Revised to reflect NHS England Serious Incident Framework April 2015	Interim Head of Quality & Nursing CWS CCG

For more information on the status of this policy, please contact: Head of Quality & Nursing	
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Responsibility for Review	Head of Quality & Nursing
Contributors	Quality & Patient Safety Teams
Audience	CCG employees & commissioned service providers

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Reporting Patient Safety Incidents and Serious Incidents

1. Introduction

1.1 In organisations as large and complex as the NHS, things will sometimes go wrong. This policy is to inform the providers of commissioned services of Coastal West Sussex Clinical Commissioning Group's (CWS CCG) expectations of managing Patient Safety Incidents and Serious Incidents.

2. Serious Incident Framework

2.1 The revised Serious Incident Framework published in April 2015 builds on previous guidance that introduced a systematic process for responding to serious incidents in NHS-funded care. It replaces, the National Patient Safety Agency (NPSA) National Framework for Reporting and Learning from Serious Incidents Requiring Investigation (2010) and NHS England's Serious Incident Framework (March 2013).

2.2 The framework takes account of the changes within the NHS landscape and acknowledges the increasing importance of taking a whole-system approach, where cooperation, partnership working, thorough investigation and analytical thinking is applied to ensure organisations identify and learn what went wrong, how it went wrong and what can be done to minimise the risk of the incident happening again.

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

2.3 Aggregate Incidents: In order to learn from trends and themes it is essential to have an established process for reporting aggregate incidents as SIs. There is no single definition of an aggregate incident but commonly they are incidents were a pattern, trend or theme has emerged. This could be an accumulation of several incidents or a cluster of incidents and complaints.

3. Patient Safety Incidents

3.1 Each provider is responsible for ensuring the safety of patients whilst on their premises and/or under the care of their staff and departments and/or throughout the discharge process. CWS CCG expects each provider to have robust risk management systems in place including risk assessment, risk register and established incident reporting system which directly informs the National Reporting and Learning Service (NRLS).

3.2 In addition other agencies may require to be informed such as Care Quality Commission, Health Protection Agency, RIDDOR, SHOT, Police, Human Tissue Authority. Some incidents may require sharing of information with Safeguarding Adults or Children's Teams in accordance with the pan Sussex procedures for Safeguarding Adults and Children.

4. Serious Incidents

4.1 The NHS England Serious Incident Framework (revised April 2015) describes serious incidents as:

"…events in healthcare 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 on patient safety or an organisations ability to deliver ongoing healthcare".

Serious incidents can be isolated, single events or multiple linked or unlinked events signaling systemic failures within a commissioning or health system.

5. Never Events

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

5.2 The Never Events list 2015/16
The following never events list is the list that all organisations providing care should use. It is applicable for all incidents that occur on or after 1 April 2015.

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

Further detail is available at:

- http://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/04/never-evnts-pol-framwrk-apr2.pdf
- http://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/03/never-evnts-list-15-162.pdf
- http://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/03/nepf-faqs2.pdf

6. Serious Incident (SI) reporting

6.1 Serious incidents must be reported by the Provider to the Patient Safety team at Brighton and Hove CCG (host service for patient safety for Sussex) bhccg.sisussex@nhs.net without delay and no later than 2 working days after the incident is identified. Incidents falling into any of the categories below should be reported immediately to Coastal West Sussex CCG and the patient safety team. Reporting should be by both telephone and electronically:

- Incidents which activate the Provider or Commissioner Major incident Plan
- Incidents which are likely to be of significant public concern
- Incidents which will give rise to significant media interest or will be of significance to other agencies.
- Never Events

6.2 Out of hours the CWS CCG Director on call should be contacted.

Further guidance from NHS England can be found at:
http://www.england.nhs.uk/ourwork/patientsafety/

7. Being Open & the Duty Of Candour

7.1 It is the expectation of CWS CCG that that the principles of openness and honesty as outlined in the NHS Being Open Guidance and the NHS contractual Duty of Candour is applied in discussions with all those involved. This includes staff, patients, victims and perpetrators and their families and carers.

8. Reporting onto the Strategic Executive Information System (STEIS)

8.1 If an incident is agreed to be a serious incident, the incident will be recorded and entered onto STEIS by the provider completing as much of the detail as is possible at the time of entry.

8.2 SI's occurring in Primary Care will be logged on STEIS by the NHS England South East team.

8.3 If the Provider does not have access to STEIS (e.g. independent providers who provide NHS funded care) the Patient Safety Team at Brighton and Hove CCG should be informed via the generic email address bhccg.sisussex@nhs.net who will request the provider to complete a STEIS form and return it so the patient safety team can upload this to the STEIS system.

9. Investigating an incident or serious incident

9.1 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.

9.2 There is a requirement to provide a 72 hour report/update for each SI. This should be submitted to the Brighton and Hove CCG Patient safety team.

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

9.4 The Brighton and Hove CCG Patient Safety Team will monitor that investigations of serious incidents are completed and submitted to the pan Sussex Serious Incident Scrutiny Panel within the agreed timescale of 60 working days.
Request for extensions to report submission deadline will be considered, but the rationale for this must be clearly outlined e.g. new information relevant to the investigation that requires consideration and further investigation.

9.5 There is a requirement to provide a 72 hour report/update for each SI. This should be submitted to the Brighton and Hove CCG Patient safety team.

9.6 In the event of a formal request to suspend the investigation from the Police or Coroner, Commissioners can apply a 'Stop the clock' process. The date for completion of the investigation and submission of the final report will be reviewed and agreed once the investigation can be recommenced.

10. Closure of incidents and serious incidents

10.1 All serious incidents will be reviewed by the pan Sussex Serious Incident Scrutiny Panel, which meets on a fortnightly basis. The panel requires each organisation to;

- Identify a root cause to the incident
- Demonstrate being open with the patient and or relative
- Learning from the incident
- Recommendations to prevent recurrence with a robust action plan to demonstrate how the recommendations will be embedded in the organisation.

10.2 Written feedback from the pan Sussex Serious Incident Scrutiny Panel will be provided to the relevant organisation.

10.3 In certain circumstances the panel may keep the SI open and request further detail from the provider to enable closure. All providers are welcome to attend the pan Sussex Serious Incident Scrutiny Panel, when their SIs are being reviewed. Arrangement of this is through the patient safety team at Brighton and Hove CCG.

10.4 Membership of the pan Sussex Serious Incident Scrutiny Panel is:

- Chair (Head of Quality) – rotational from each participating CCG
- Quality Assurance Managers (or nominated representatives)from:
- Eastbourne, Hailsham and Seaford CCG
- Hastings and Rother CCG

- High Weald, Lewes and Havens CCG
- Coastal West Sussex CCG
- Crawley CCG
- Horsham and Mid Sussex CCG
- Brighton & Hove CCG
- Patient Safety Manager (hosted by Brighton & Hove CCG)
- Patient Safety Officer (hosted by Brighton & Hove CCG)

10.5 Any clarification required related to this policy should be sought from the Head of Quality and Nursing at CWS CCG.