London Ambulance Service NHS Trust

Serious Incident Policy and Procedure

DOCUMENT PROFILE and CONTROL.

Purpose of the document: To define the Trust's reporting process for Serious Incidents.

Sponsor Department: Governance and Assurance

Author/Reviewer: Director of Corporate Affairs. To be reviewed by March 2018.

Document Status: Final

Amendment History			
Date	*Version	Author/Contributor	Amendment Details
01/04/15	5.1	IG Manager	Document Profile and Control update and new Implementation Plan template added.
16/2/2015	4.2	Director of Corporate Affairs	Document update
12/06/2012	4.1	IG Manager	Document Profile and Control update
12/06/2012	4.0	Assistant Director of Corporate Services	Approved
08/05/2012	3.2	IG Manager	Monitoring section added, formatting changed, and updates to Document Profile and Control
30/03/2012	3.1	Assistant Director of Corporate Services	Updated with ADG comments
23/03/2012	2.3	Assistant Director of Corporate Services	Re-draft
03/03/2012	2.1 & 2.2	Assistant Director of Corporate Services	Re-draft
15/04/2010	1.1	Head of Patient Experiences, Head of Governance, Director of Corporate Services	Formatting, revised document content
02/2007	0.1		First draft

***Version Control Note:** All documents in development are indicated by minor versions i.e. 0.1; 0.2 etc. The first version of a document to be approved for release is given major version 1.0. Upon review the first version of a revised document is given the designation 1.1, the second 1.2 etc. until the revised version is approved, whereupon it becomes version 2.0. The system continues in numerical order each time a document is reviewed and approved.

Published on:	Date	By	Dept
The Pulse	01/04/15 (v5.1)	Governance Administrator	G&A
The Pulse	15/06/12	Governance Coordinator	Governance and Compliance
LAS Website	01/04/15 (v5.1)	Governance Administrator	G&A
LAS Website	15/06/12	Governance Coordinator	Governance and Compliance
The Pulse	14/05/10	Records Manager	GCT
LAS Website	14/05/10	Records Manager	GCT
Announced on:	**Date**	**By**	**Dept**
The RIB	07/04/15	IG Manager	G&A
The RIB	19/06/12	Information Governance Manager	Governance and Compliance
The RIB	05/10	Records Manager	GCT

For Approval By	Date Approved	Version
Senior Management Team	25/03/15	5.0
Associate Directors Group	27/03/12	3.0
Chief Executive	08/07	
Ratified by (if appropriate):		
SMG	14/05/12	4.0
Agreed by Trust Board (If appropriate):		
	25/05/10	2.0

Equality Analysis completed on	By
03/03/2012	Assistant Director Corporate of Services
17/05/10	Head of Patient Experiences
Staff side reviewed on	**By**

Links to Related documents or references providing additional information		
Ref. No.	**Title**	**Version**
TP/034	Being Open Policy	
TP/004	Complaints and Feedback Policy	
H&S011	Incident Reporting Procedure	
TP/035	Risk Identification and Assessment Procedure	
TP/054	Investigation and Learning from Incidents, PALs, Complaints and Claims Policy	
TP/024	Managing Patient Confidentiality when Dealing with the Media	
HR/025	Management Policy Statement on Staff Responsibilities Regarding Communication	
TP/003	Policy Statement of Duties to Patients	
TP/049	Risk Register Procedure	
TP/005	Risk Management Policy and Strategy	
H&S018	Stress Management Policy	
HR/003	Whistleblowing Policy & Procedure	
LA 52	Incident Report Form	
LA 277	Notification of High Risk - Register	
LA 042	Crew safety assault report forms	
	NHS Commissioning Board – now NHS England: *Serious Incident Framework, March 2013* *http://www.england.nhs.uk/wp-content/uploads/2013/03/sif-guide.pdf*	

	Checklist Guidance for Reporting, Managing and Investigating Information Governance Serious Incidents Requiring Investigation 1st June 2013: Health and Social Care information Centre *Version 2.0* *https://www.igt.hscic.gov.uk/KnowledgeBaseNew/HSCIC%20IG%20SIRI%20%20Checklist%20Guidance%20V2%200%201st%20June%202013.pdf*	
	Local Authority Social Services & NHS Complaints (England) Regulations (2009) - *http://www.opsi.gov.uk/si/si2009/uksi_20090309_en_1*	
	Regulation 20: the Duty of Candour *The Health and Social Care Act 2008 (Regulated Activities (Regulations 2014) will come fully into force on 1 April 2015.* *http://www.cqc.org.uk/sites/default/files/20141120_doc_fppf_final_nhs_provider_guidance_v1-0.pdf*	
	CQC Fundamental Standards of Care *http://www.cqc.org.uk/content/regulations-service-providers-and-managers* *With effect from 1 April 2015*	
	References to the resources provided by the National Patient Safety Agency have been removed as the NPSA ceased to exist on April 1st 2012. When a link to the archived documents is published it will be included in the Policy.	

SECTION 1.0

1. Introduction

1.1 The London Ambulance Service NHS Trust (LAS) manages in excess of 1.7 million 999 calls and attends more than 1 million patients every year. The vast majority of patients receive very high standards of care. We recognise however that sometimes things do go wrong and it is therefore important that such incidents are reported and managed effectively and that we learn and improve as an organisation.

1.2 This policy and procedure is based on NHS England's Serious Incident Framework 2013.

1.3 Making services safe for patients is fundamental to the provision of high-quality care and it is essential that the LAS has sound and robust systems in place for staff to report when patients have, or could have been, harmed. Open and honest reporting demonstrates a commitment to patients and their safety and is a mark of "high reliability". The focus on reporting should be on analysing the root cause of the incident because serious incidents yield important lessons about changing process to reduce risk. It is only through active learning and service improvement from serious incidents that the benefits of experience are actually realised.

1.4 Serious incidents requiring investigation in healthcare are rare, but when they do occur, everyone must make sure that there are systematic measures in place to respond to them. These measures must protect patients and ensure that robust investigations are carried out, which result in organisations learning from serious incidents to minimise the risk of the incident happening again.[1]

[1] Serious Incident Framework March 2013 NHS Commissioning Board – now NHS England

1.5 As a provider of NHS-funded care the principal accountability of the LAS is to patients and their families and carers. The first consideration following a serious incident is the care of the patient, to secure their health and welfare and mitigate any further risk. Patients and/or their families or carers must be fully involved in the response to the serious incident.

1.6 The Trust is registered with the Care Quality Commission (CQC) and is required to notify the CQC about events that indicate or may indicate risks to compliance with registration requirements, and this includes reporting serious incidents as defined in the CQC guidance and the Fundamental Standards of Care.[2]

2. Scope

The focus of the Serious Incident Policy and Procedure is to ensure robust systems and processes are in place to identify, investigate and report in an open and transparent manner where a serious incident has occurred and to learn from this thereby mitigating future risk.

This policy and procedure should be read and implemented in conjunction with a number of other Trust policies detailed on page 4.

3. Objectives

The purpose of this policy and procedure is to enable the LAS and its staff to:

- Understand what constitutes a Serious Incident (SI)
- Respond quickly and appropriately to an SI
- Take a consistent approach to the management of such incidents
- Act in an open and transparent way
- Involve and fully inform service users, stakeholders and staff, taking account of cultural belief systems
- Manage cases where poor practice is identified as a contributory factor in accordance with the Trust's workforce policies
- Learn from all incidents and prevent recurrence as far as reasonably practicable.
- Address the lessons to be learnt from such incidents recognising that the majority of incidents occur because of failure in systems rather than individual practice.
- Share any learning across the health and social care economy.

[2] The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

4. Responsibilities

4.1. The **Trust Board** will have overall responsibility for ensuring that SIs are investigated, reported and managed, and lessons learnt and implemented, and meet the requirements of the regulatory Duty of Candour.

4.2. The **Medical Director** will be responsible for reporting an overview of any SI investigations to the Trust Board.

4.3. The **Director of Corporate Affairs** will be responsible for ensuring there are robust systems and processes in place for the review, investigation and reporting of SIs.

4.4. The **Quality Governance Committee** will be responsible for providing assurance to the Trust Board.

4.5. The **Clinical Safety, Development and Effectiveness Committee** will review SIs, themes, actions and lessons learnt, and will establish links to Inquests, Preventing Future Deaths Coroners' reports, safeguarding reviews/reports, and complaints and incidents, and will report and provide assurance to the Quality Governance Committee.

4.6. The **Executive Management Team** will have oversight of the SI process and will review contentious and high profile reports to ensure any associated risks are managed and mitigated.

4.7. The **Senior Management Team (SMT)** will monitor progress against recommendations and associated actions from completed SIs on the SI tracker and will oversee the implementation of SI action plans to ensure these are implemented and risks are being mitigated. The SMT will also review linked/associated risks against the corporate risk register.

4.8. The **Serious Incident Group** (SIG) will be responsible for implementing the SI policy and procedure through the consideration, grading, declaration, investigation and reporting of serious incidents. The group will allocate executive and senior management leads, if appropriate an expert with specialist skills, an investigating officer and family liaison officer(if appropriate) to each SI and will monitor progress with the investigation through to reporting and submission of the report to commissioners.

4.9. The **Head of Governance and Assurance** has day to day management responsibility for the SI policy and process and will manage the SI tracker and action plan, escalating these to directors as and when required. They will also be the link person with commissioners and other NHS providers with regard to the investigation and management of SIs and SI actions.

4.10. **The Director of Communications** will be responsible for media relations and liaison with other relevant agencies in this respect.

4.11. The **Head of Legal Services** is responsible for notifying the National Health Service Litigation Authority (NHSLA), and will liaise with HM Coroners and legal representatives when an inquest has been held and the SI policy and procedure has been invoked, and, when appropriate, the LAS' motor insurer.

4.12. The **Governance and Assurance team** will take the responsibility for facilitating the investigation and drafting the final report, and for supporting LAS staff involved in the SI process, including those providing statements or undertaking the investigation.

4.13. The **Head of Health, Safety and Risk** has responsibility for informing the Health & Safety Executive of an incident that falls within the jurisdiction of that agency.

4.14. The **Head of Quality, Governance and Assurance – Control Services** and **the Quality, Governance and Assurance Managers – Sector Services**, will lead on the investigation of Serious Incidents (SI) when appropriate; regularly reviewing incident and SI action plans to provide assurance for Performance and Assurance committees;

4.15. The **Head of Safeguarding** has responsibility for informing social services of any safeguarding incidents that are considered by the Trust to be an SI.

4.16. **Local Managers** are responsible for documenting events prior to reporting the incident up to the relevant Assistant Director of Operations (ADO) / or line manager.

4.17. **All** members of staff are responsible for reporting any incident that may be a cause of concern.

5. Definitions

5.1. A **Serious Incident** is an incident that has occurred during NHS funded healthcare which resulted in one or more of the following:

- Unexpected or avoidable death of one or more patients, staff, visitors or any person that is affected by the Trust's undertaking;

- Serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm (including incidents graded under the NPSA definition of severe harm);

- A scenario that prevents, or threatens to prevent, a provider organisation's ability to continue to deliver healthcare services, for example, actual or potential loss of personal/ organisational information, damage to property, reputation or the environment, IT failure;

- Allegations of abuse (subject to appropriate HR policies);

- Adverse media coverage or public concern about healthcare or the organisation;

- A never event – a serious, largely preventable patient safety incident that should never occur if the available preventative measures are in place. (Appendix 4)

5.2. Serious Incidents are not exclusively clinical issues, for example a breach of information governance, a technology systems failure, ambulance vehicle fire, or a road traffic accident incident involving a Trust vehicle, may have consequences that make it an SI, subject to London Ambulance Service Health and Safety Policy and procedures

5.3. A 'near miss' and any identified emerging trends which constitute a significant risk are included. However, excluded from this definition are adverse outcomes reasonably associated with routine NHS activity.

5.4. **Severe Harm:** a patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.

5.5. **Prolonged pain and/or psychological harm** – pain or harm that a servicer user has experienced, or is likely to experience, for a continuous period of 28 days or more.

5.6. **Permanent harm** – permanent lessening of bodily functions, including sensory, motor, physiological or intellectual.

5.7. **Being Open** – open communication of patient safety incidents that result in harm or the death of a patient while receiving healthcare.

5.8. **Duty of Candour** - a regulatory duty, enforceable by the Care Quality Commission, that requires NHS provider organisations to be open and transparent with the "relevant person" (as defined in the regulation[3]) when certain incidents occur in relation to the care and treatment provided to people who use services in the carrying on of a regulated activity.

5.9. **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.

5.10. **Unexpected death** – where natural causes are not suspected the organisation should investigate to determine if the incident contributed to the unexpected death.

6. Responsibility for identifying and reporting an incident that may be serious

6.1. Every member of staff has a responsibility to report any incident that may be a cause of concern. Staff should immediately bring to the attention of their line manager, or any manager if the line manager is not available, any incident that they have observed or been involved in if it has given cause for concern.

6.2. It is essential that concerns are reported without delay and staff should also use the LA52 incident reporting procedure which is managed by the Health, Safety & Risk Department. The incident reports are reviewed to confirm the grading is accurate and if required the incident will be escalated as a potential Serious Incident, reported through PotentialSUINotification@lond-amb.nhs.uk (see Appendix 2) to the Governance and Assurance department.

6.3. An SI may be identified from a wide variety of sources throughout the Trust, including patient safety incidents reported internally, daily operational reports, safeguarding concerns, patient feedback from complaints, a problematic Inquest, a Regulation 28 Preventing Future Deaths recommendation, or a legal claim against the Trust, staff safety incidents, and IM&T failure, or a reputational concern.

This is a list of examples based on current LAS experience.

6.4. In instances where a local manager has been made aware of a serious incident, this should be reported to the relevant ADO or line/senior manager and by using the email facility PotentialSUINotification@lond-amb.nhs.uk. An LA52 incident report should also be completed, the incident graded (Appendix 2), and the form sent immediately to the Governance and Assurance department. All supporting documentation and evidence should be provided as soon as possible and on request.

6.5. If an incident of concern becomes apparent in the Control Room as it occurs, all relevant details of the incident must be recorded on the Call Receipt Form, using the electronic call logs. The incident must be reported through the management structure and reported via the dedicated email facility cited. An LA52 incident report should be completed, the incident graded (Appendix 1), and the form sent to the Governance and Assurance department with supporting documentation and evidence as above.

6.6. In the case of safeguarding children incidents, the named professional will liaise with the London Safeguarding Children Board and other relevant agencies in accordance with the requirements of NHS England (London).

6.7. Those incidents involving vulnerable adults the named professional will liaise with any relevant agencies in accordance with the Care Act 2014.

6.8. In all cases, notification via the email facility should be made within 24 hours or the next normal business day, with an LA52 incident report completed, graded (Appendix 1) and sent to the Governance and Assurance department within 5 working days.

7. Immediate Management of the Incident

7.1. The first priority for the Trust is to ensure that the needs of individuals affected by the incident are attended to including any urgent clinical care which may reduce the harmful impact. A safe environment should be re-established, all equipment or

[3] ''Relevant person'' means the service user or a person acting lawfully on their behalf as defined in Regulation 20

medication retained and isolated, and relevant documentation copied and secured to preserve evidence and facilitate investigation and learning. If there is a suggestion that a criminal offence has been committed, the police should be contacted. Early consideration must be given to the provision of information and support to patients, relatives and carers and staff involved in the incident, including information regarding support systems which are available to patients/ relatives/visitor/contractors.

8. Serious Incident Group

8.1. The dedicated email facility will auto-forward to members of the Serious Incident Group (SIG) which comprises of executive directors, senior operational management, the Heads of Legal Services and Governance and Assurance, a communications manager, and governance support.

8.2. The SIG will meet weekly to review pending and newly reported potential serious incidents. The executive directors on the group may determine in between meetings whether an incident meets the criteria and will request this is declared and the investigation started. The severity and circumstance of a potential incident may also dictate if a meeting has to be called between scheduled meetings.

8.3. The Head of Governance and Assurance and their department are responsible for compiling the supporting documentation and preparing a brief summary of events. This information will be placed on a secure designated intranet folder accessible only to members of SIG and nominated officers.

8.4. At least three of the following senior managers will constitute a quorum for the Trust's Serious Incident Group and come to a decision as to declaration of the incident as an SI:

- Medical director
- Director of Nursing and Quality
- Director of Paramedic Education and Development
- Director of Corporate Affairs
- Director or nominated Deputy Director of Operations
- Head of Governance and Assurance or the Head of Legal Services

8.5. The SIG will review the information available about the incident and determine the severity using the grading matrix (Appendix 1) to determine whether the incident meets the threshold for declaration. A Serious Incident (SI), with a score of 15 and above will be reported onto the Strategic Executive Information System (STEIS) website. Key to the decision-making process will be whether the incident meets the criteria set out in section 5, Definitions.

8.6. Each declared SI will be allocated to an executive and a senior management lead, an investigating officer and, for a patient safety incident, a family liaison officer (FLO). A member of the Governance and Assurance team will coordinate the investigation and reporting process.

8.7. In the case of an information security or information governance incident, the Trust's Caldicott Guardian and the designated Senior Information Risk Owner (SIRO) must be involved in the SIG. The Information Security Manager is responsible for IT forensic investigation and determining the physical and electronic evidence to be gathered as part of the Incident Investigation, as defined in the LAS IT Forensic Readiness Policy.

8.8. The appropriate technical resources from IM&T are responsible for monitoring any damage from a security incident and that it is repaired or mitigated and that the vulnerability is eliminated or minimised where possible.

8.9. The SIG will determine if a widespread LAS communication is required, the content of the communication, and how best to distribute the communication. The assessment matrix in relation to data loss incidents is set out at Appendix 3.

8.10. When requested the named professional will arrange for a senior Safeguarding practitioner, via liaison with the Safeguarding Lead at NHS England (London) or any other appropriate agency, to attend the SIG.

8.11. The SIG may also decide to invite an external advisor, for example a senior manager from another ambulance or NHS provider organisation, or from a clinical commissioning group (CCG) to assist and advise the SIG.

8.12. In the case of a patient safety incident and in compliance with the regulatory Duty of Candour, the SIG will appoint a representative to act as point of contact to enable a regular flow of information on behalf of the Trust to patient(s) and/or relatives except in cases when it is decided by the SIG not to be necessary or appropriate; or, in joint agency cases, where it is agreed that another responsible body will undertake this role.

8.13. The Head of Governance and Assurance will maintain a record of each incident considered at the SIG and the outcome and decision reached.

8.14. An SI investigation should not be confused with an investigation conducted under the LAS Disciplinary Procedure. If, as a consequence of the SI investigation, a disciplinary issue is identified, a separate investigation will be undertaken in accordance with the LAS Disciplinary Procedure.

8.15. Where an SI is not declared but the SIG consider it to be serious and warrant investigation, the Head of Governance and Assurance will be responsible for ensuring that an investigation is undertaken by the appropriate designated senior manager thereby ensuring compliance with the Investigation of Incidents, Complaints and Claims Policy, TP054.

8.16. Where the same issue (incident) is the subject of a complaint, regard must be given to the Local Authority Social Services & NHS Complaints Regulations (2009) and there should be close liaison with the Head of Patient Experiences (or their delegate) accordingly. (See 11.12/13)

9. Reporting Serious Incidents

9.1. The Trust Board will receive details of incidents being investigated under the SI policy and procedure at the next formal meeting following declaration of the SI. In the event that an incident is [so severe or is] likely to attract media attention before that meeting, the Trust Board will be notified by email by a member of the executive management team (EMT).

9.2. The Medical Director will report an overview of any SI investigations in Part I of the Trust Board meeting, however the Trust reserves the right to discuss sensitive

and confidential matters relating to the incident in the Part II meeting.

9.3. The Quality Governance Committee will oversee the SI process and outcomes and will provide assurance to the Trust Board.

9.4. The Clinical Safety, Development and Effectiveness committee (CSDEC) will review themes and trend information, in conjunction with other risk information such as complaints, Inquests and claims, and will seek assurance on the action taken, lessons learned and where improvements have been made. This group will provide assurance to the Quality Governance Committee.

9.5. The Senior Management Team (SMT) will be responsible for monitoring the SI tracker to ensure progress is being made with investigations and reporting within the recommended timelines of 45/60 days and will escalate to the executive management team or relevant director as required.

9.6. The SMT will be responsible for monitoring progress with actions to address recommendations in SI reports and for reviewing the themes and trends report prior to its review by the CSDEC.

10. External Agencies

10.1. The Trust is committed to cooperating fully with external agencies when they declare an SI which directly or indirectly involves the Trust and will share information, providing that relevant statutory responsibilities (Data Protection, etc.) are being met in the process. The Trust will also involve and include other agencies as appropriate, e.g. if a Trust employee reports a criminal offence then the Police should be contacted immediately. The investigation lead will liaise with the agencies involved to agree who will conduct the investigation. This is in line with the Memorandum of Understanding which includes, in the event of patient safety incidents (unexpected death or serious harm), a protocol for liaison and effective communications between the NHS and the Police.

11. Other Notification Responsibilities

11.1. Within 2 working days of an SI being declared, the Head of Governance and Assurance should report through the electronic Strategic Executive Information System (STEIS) in the format required by the system. The STEIS record should be updated within 3 working days if the situation changes significantly after the initial report.

11.2. The Head of Governance and Assurance will be responsible for updating the risk management system and informing Communications, Legal Services, Patient Experiences, and Health, Safety & Risk when an SI is declared.

11.3. Following declaration of an SI all identified personnel will be informed within 24 hours of the incident occurring, where contactable, via a local management representative who will ensure the appropriate debriefing and support for all staff involved.

11.4. The Head of Health, Safety & Risk is responsible for notification of serious patient safety incidents leading to severe harm or death within the recommended timescales to the National Reporting and Learning System via the Trust risk management system in order to comply with CQC registration requirements.

11.5. On agreement from the relevant senior manager, the Head of Health, Safety & Risk should inform the Health & Safety Executive of an incident that falls within the jurisdiction of that agency.

11.6. The Head of Legal Services is responsible for notifying the National Health Service Litigation Authority (NHSLA) in respect to an SI relating to a claim.

11.7. The Head of Legal Services is responsible for notifying the relevant Coroner where a death has occurred.

11.8. The Director of Corporate Affairs will be responsible for informing the NHS Trust Development Authority of a Grade 2 SI.

11.9. Where there may be a direct consequence for patient safety the Director of Corporate Affairs will notify the Care Quality Commission.

11.10. In the case of a data loss incident, the Head of Governance and

Assurance will ensure notification to the Information Commissioner and any other relevant agencies in accordance with Department of Health and NHS England guidance.

11.11. In the case of a safeguarding incident, the named professional will notify the local Safeguarding Board and any other appropriate agencies.

11.12. The Trust has a legal obligation to keep a complainant informed of progress and to send a written response as soon as reasonably practical after completing the investigation. The Trust will aim to do so within a target of 45/60 days from the date of the incident being declared a Serious Incident.

11.13. Whilst the SI report will usually serve as the substantive response to a complaint, consideration will be given, in liaison with the complainant, as to whether a simplified version should be made available in line with the format used in complaints management. This will be the responsibility of the lead officer in close liaison with Patient Experiences at the time the draft report is finalised.

12. Media Relations

12.1. The Director of Communications will be responsible for media relations and liaison with other relevant agencies [in this respect].

12.2. The Director of Communications or their nominated lead will liaise with the Head of Governance and Assurance and the appointed family liaison officer and agree arrangements for informing the patient(s) involved and/or relative(s) if any information relating to an SI is to be released to the media, where practical to do so. This will usually be undertaken by an appointed representative. There may be occasions when this may not be practical for example where contact has not yet been made with the patient/family, or where the release of information is in response to the patient/family disclosing details to the media but where an approach to the Trust has not been made.

12.3. No member of staff will provide statements to the media independently of this process and should refer to the *Policy Statement on staff*

responsibilities regarding communication (HR/025) and other relevant Trust policies include the *Policy Statement of Duties to Patients* (TP/003) and *Managing Patient Confidentiality when Dealing with the Media* (TP/024).

13. Being Open

13.1. *"Research studies have shown that patients accept something has gone wrong when they are told about it promptly, fully and compassionately. This open approach minimises the trauma they feel."* ('Seven Steps to Patient Safety' NPSA 2003).

13.2. The Trust is committed to being open with patients who have been unintentionally harmed. 'Being Open' involves acknowledging, apologising and explaining when things go wrong as well as conducting a thorough investigation into the incident and offering reassurance that lessons learned will help prevent a similar incident recurring. The LAS *Being Open* policy has been developed in line with the NPSA guidance.

14. Duty of Candour

14.1. The Governance and Assurance department will coordinate implementation of the Duty of Candour in the management of serious incidents and will provide support to those staff involved in carrying this out.

14.2. The Health, Safety and Risk department will coordinate implementation of the Duty of Candour in all patient safety incidents graded moderate/severe where these are not being managed as SIs and will provide support to those staff involved in carrying this out.

14.3. The Legal Services department will coordinate implementation of the Duty of Candour in the management of inquests to ensure that legal support is provided to those staff who may be called to give evidence at the inquest.

14.4 As soon as is reasonably practicable after the notifiable[4] safety incident has occurred we have a duty to notify the relevant person and provide reasonable support to them in

relation to the incident.

14.5 The responsible department will identify a family liaison officer (FLO) in discussion with those leading on the investigation of the incident.

14.6 The FLO will give an account of the incident, which, to the best of the Trust's knowledge, is true of the facts that are known at the time of the incident.

14.7 The FLO will advise the relevant person of the investigation process and any other enquiries that are being undertaken as appropriate and will offer an apology. This will then be followed up in writing, and an update given on progress with the investigation.

14.8 The FLO will be responsible, with support from the Governance and Assurance department, for SIs; or with support from Legal Services if death has occurred and there will be an inquest; or with support from the Health, Safety and Risk department for other notifiable incidents not declared as an SI; for keeping a written record of all communication with the relevant person.

14.9 The Governance and Assurance department will provide details of the outcome of the investigation with the relevant person, should they wish to receive this. This will apply to Safety and Risk-led investigations also.

14.10 The Governance and Assurance department will provide a copy of the SI report for those staff involved in the incident, and/or interviewed for the SI investigation, should they wish to receive this.

15. Administrative Management

15.1. The Governance and Assurance department will have responsibility for the administrative management of declared Serious Incidents.

15.2. Details of the progress of the investigation will be updated on STEIS by the Head of

[4] Notifiable patient safety incident to include moderate harm, severe harm, death, prolonged psychological harm as described in Regulation 20

Governance and Assurance or delegated manager. In the event that further information during the course of the investigation leading to re-consideration of the grading of the incident, this should be discussed with the lead commissioner who will agree whether the incident can be downgraded and removed from STEIS.

15.3. In the event that the investigation is likely to take longer than 45/60 days to complete and report due to circumstances such as seeking statements from staff or requesting information from another organisation, the Trust can request an extension to the reporting period. The Head of Governance and Assurance will be responsible for making this request.

15.4. Each serious incident declared will have a unique reference number from STEIS and on the local risk management system. This will be maintained by the Governance and Assurance department throughout the investigation and for the final report.

15.5. Weekly progress reports will be provided to the SIG against the SI tracker on the progress of the investigation and individual leads will receive progress updates for their SIs.

15.6. The Governance and Assurance department will co-ordinate the investigation process and will draw on expertise from around the Trust and any external agency to undertake the investigation and produce a report and recommendations.

15.7. The Governance and Assurance department will ensure that the patient(s) and other involved or interested parties affected by the incident are informed at the earliest opportunity and in advance of any public announcement, taking into account the circumstances. They will ensure that contact with a patient/family is maintained, recording each contact and all the information that is provided to the patients, carers, relatives and families of those involved during and after the SI investigation in line with the Duty of Candour.

15.8. The Governance and Assurance department will liaise with the ADO or relevant senior manager to identify a nominated representative from the local management team who will provide regular feedback and support to any staff

involved.

15.9. The Governance and Assurance department will liaise with other agencies to agree arrangements where a joint investigation is being undertaken. Agreements for sharing the final reports which have been led by other organisations will be explicit in the terms of reference at the beginning of the investigation.

15.10. Appendix 2 details the investigation process and should be followed in all SI investigations.

15.11. The SIG will monitor progress, maintain a strategic overview and assist the management of the investigation and dissemination of the outcome(s).

15.12. The review of the draft and then sign off on the final investigation report is the responsibility of the executive and senior management leads for each SI and it is their responsibility to ensure the report addresses the terms of reference and identifies outcomes, recommendations and actions to mitigate any future risk. This activity is coordinated by the Governance and Assurance department.

15.13. The Director of Communications or nominated officer will be party to the final review and report and will advise the SIG, EMT and the Trust Board on media handling where this is required.

15.14. The implementation of actions to address recommendations within each SI will be monitored by the Senior Management Team.

15.15. The report and action plan will be sent to the lead Commissioner within 45 working days from declaration of the serious incident.

15.16. Where possible, and with the authorisation of all parties involved (including the patient/authorised representative) anonymised versions of the final report will be published on the Trust's website, subject to [familiar] reporting restrictions, e.g. those imposed by the Courts or where a criminal matter is under investigation by the police and is subject to legal proceedings.

16. A Special investigation team

16.1. Some serious incidents will require independent investigation from outside the Trust and this will be determined on the point of declaration of the SI.

16.2. Incidents involving clinical matters will require the inclusion of appropriate senior clinical staff delegated by the Medical Director or nominated Deputy who are not associated with that aspect of the service under scrutiny.

16.3. Where legal matters are raised in the initial report, the Trust's legal advisors should be consulted. Similarly, where there may be an insurance matter then the Trust may choose to consult with the appropriate insurer.

16.4. Decisions also need to be taken at this stage on the level of support required for all involved in what is often a traumatic and stressful process. The need for Involvement of the Police and/or the Health and Safety Executive, in accordance with the draft Memorandum of Understanding, must be considered.

16.5. Terms of reference for the investigation must be produced in writing. The investigating panel should be the minimum size necessary to do the job, but this will depend on the breadth and scope of the enquiry set out in the Terms of Reference, and the need to co-ordinate with other agencies.

16.6. In the case of safeguarding incidents, the named professional will liaise with relevant agencies and in consultation with the SIG, consider the appointment of an external practitioner to act as Investigating Manager.

17. Implementing agreed action measures.

17.1. The Senior Management Team (SMT) will oversee the implementation of the recommended actions and the changes to practice.

17.2. Monitoring to ensure implementation of any agreed actions will be undertaken by the appropriate group from the following: the Information Governance Group for information governance and security incidents principally; and the Clinical Safety, Development &

Effectiveness for patient safety incidents; EMT for staff safety incidents.

17.3. The Quality Governance Committee will receive reports and assurance from the committees in 17.2 above and will provide assurance to the Trust Board.

17.4. Feedback on implementation of any recommended actions will be provided to the patient/family by the Investigation lead or an individual nominated by the SIG.

17.5. In the event that, following an SI, concurrent and related investigations are ongoing (e.g. disciplinary investigation), such investigations will not normally delay the report being made available to patient/family. The decision to release the report should be made by the executive lead in consultation with HR.

18. Audit

18.1. The LAS commits to monitor compliance with this policy and procedure and to ensure that the audit cycle is completed with learning identified and implemented when an SI is declared. An annual audit will be completed by the Governance & Assurance department and presented to the Clinical Safety, Development and Effectiveness committee as evidence of lessons learnt and improvements made to the quality of care provided to patients.

19. Supporting staff

It is recognised that being involved in an incident, complaint or claim which is under investigation may be an incredibly stressful experience.

19.1. It is the duty of the manager of any staff member involved in an investigation to support that staff member and to ensure that they are aware of other sources of support which they may access. The ADO or Senior Manager is responsible for ensuring that this information has been communicated in the case of more serious incidents or complaints.

19.2 The LAS provides a number of staff support mechanisms such as LINC, and external counselling to which staff members may self-refer.

19.3 Managers who have concerns about a staff member's fitness to work may wish to formally refer the individual to the Occupational Health Service for advice and a possible recommended course of action.

19.3 Staff may wish to seek the advice of any professional organisation of which they are a member.

20. Policy Review

The Policy will be reviewed by the SMT. The Clinical Safety, Development & Effectiveness Committee will note the policy and it will then be endorsed by the Quality Governance Committee.

IMPLEMENTATION PLAN				
Intended Audience	All LAS Staff			
Dissemination	Available to all staff on the Pulse and to the public on the LAS website.			
Communications	Revised Policy and Procedure to be announced in the RIB and a link provided to the document.			
Training	The Trust provides Root Cause Analysis training sessions. Where an investigation needs to use Root Cause Analysis an appropriately trained multi-disciplinary team will be appointed. Training for the Family Liaison Officer role is being developed and will be available to those staff nominated for the role.			
Monitoring:				
Aspect to be monitored	**Frequency of monitoring** **AND** **Tool used**	**Individual/ team responsible for carrying out monitoring** **AND** **Committee/ group where results are**	**Committee/ group responsible for monitoring outcomes/ recommendations**	**How learning will take place**

		reported		
List aspects/ Key elements of the policy/ procedure that will be monitored, *e.g., training records, employment checks, etc*	***How often will this take place and What tool will be used,*** *e.g., annual audit of x, quarterly report/statistical analysis of x, annual inspection of x, etc*	***Who is responsible for carrying this out?*** ***Title of individual/team that will do this, and Name of Group/committee where the results will be reported,*** *e.g., Head of Legal Service will report results to the Learning from Experience Group, Clinical Audit and Research Unit will report results to the Quality Committee*	***Who monitors outcomes/ recommendations?*** ***Name of Higher level group/committee that will monitor outcomes/ recommendations,*** *e.g., Trust Board, Audit Committee, RCAG, Quality Committee, Clinical Safety and Effectiveness Committee*	***Describe how learning will take place for relevant areas,*** *e.g., dissemination of findings and action to be taken where change to practice is required*

Appendix 1

Incident Grading Matrix

Table 1 Impact Score

Instructions

1. Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.

2. Use Table 1 to determine the impact score (I) for the potential adverse outcome(s) relevant to the risk being evaluated.

3. Use Table 2 to determine the likelihood score (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.

4. Use Table 3 to calculate: I (Impact) x L (Likelihood) = R (risk score)

5. Identify the level at which the risk will be managed, assign priorities for remedial action and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings.

NB: Using the Trust's risk management schema, consideration should be given to inclusion of an identified risk in the Trust's Risk Register at the appropriate level.

- Choose the most appropriate domain for the identified risk from the left hand side of the table
- Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

Table 1

	Impact score (severity levels) and examples of descriptors				
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**

Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood Score (L)

What is the likelihood of the consequence occurring? The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood Score	1	2	3	4	5
Descriptor	**Rare**	**Unlikely**	**Possible**	**Likely**	**Almost certain**
Frequency	Not expected to Occur annually.	Expected to occur at least annually.	Expected to occur at least every 6 months.	Expected to occur at least monthly.	Expected to occur at least weekly.
Probability	< 1%	1-5%	6-25%	25-60%	>60%
	Will only occur in exceptional circumstances.	Unlikely to occur.	Reasonable chance of occurring.	Likely to occur.	More likely to occur than not.

Table 3 Risk Score = Impact x Likelihood (I x L)

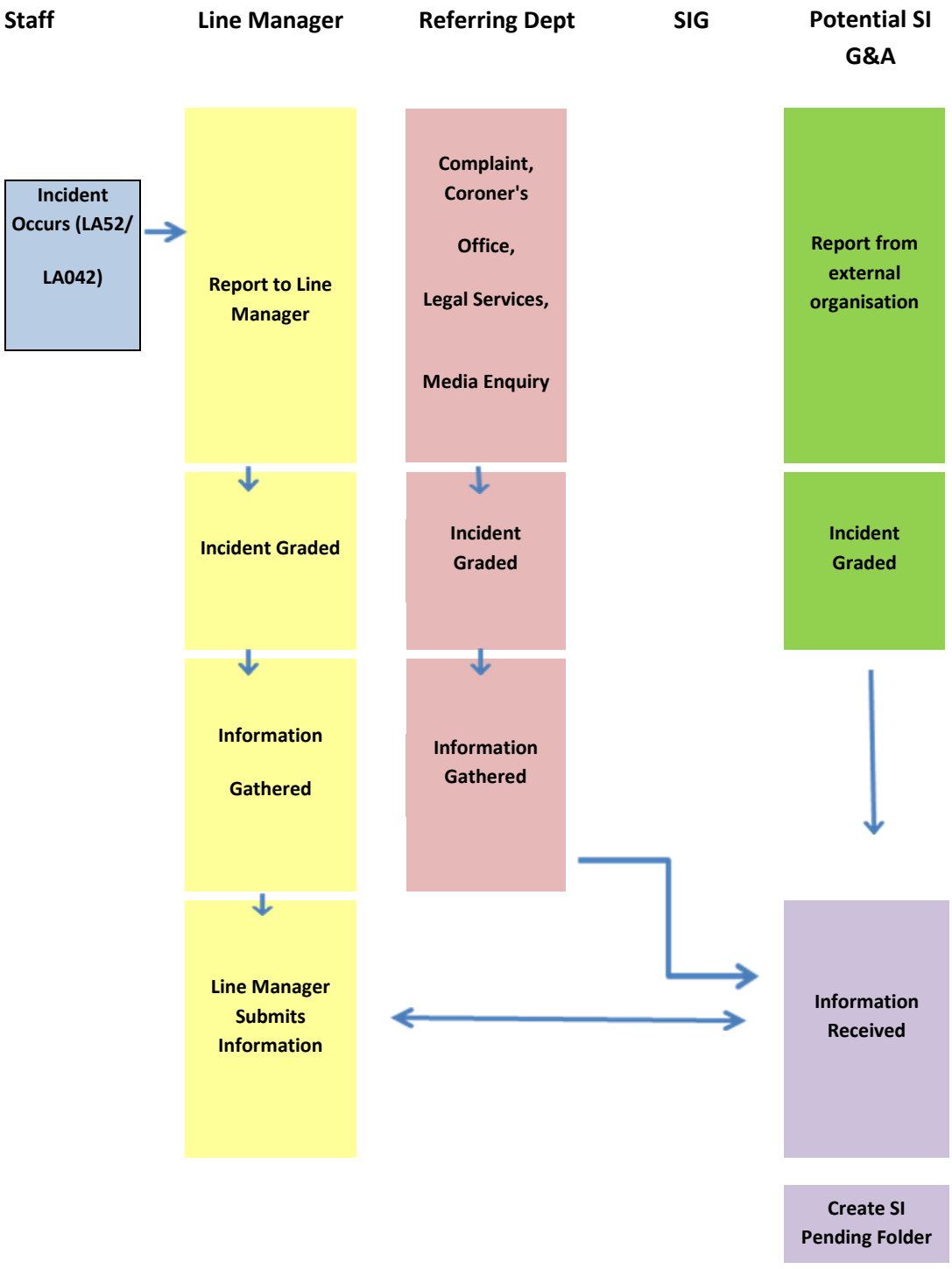
	Likelihood Score				
Impact Score	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

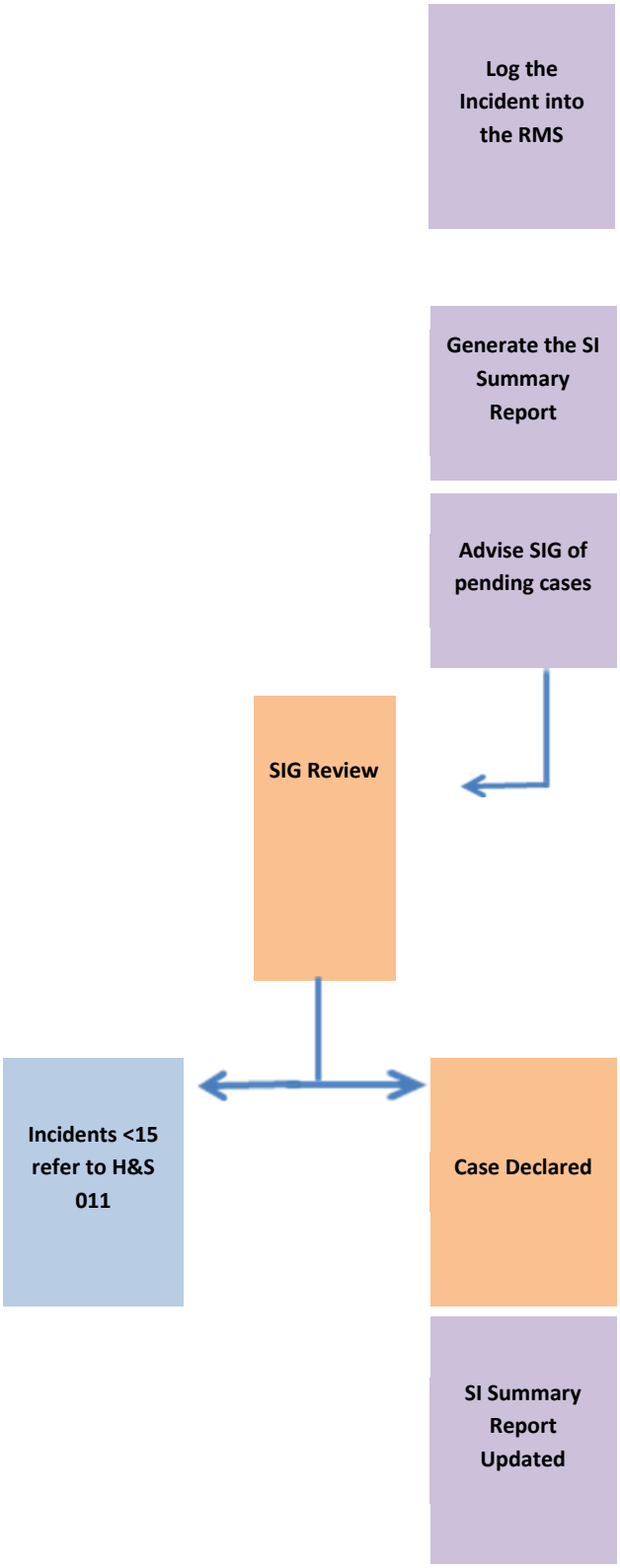
For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

	1-3	Low risk
	4-6	Moderate risk
	8-12	Significant risk
	15-25	High risk

Appendix 2

Workflow of Management Process




Log the Incident into the RMS
Governance & Assurance log the incident into the **Incidents** module of the Risk Management System (RMS).
Update the Folder with the RMS Reference Number
Generate the SI Summary Report
Governance & Assurance generate the SI Summary Report and save into the Pending Folder.
Advise SIG of pending cases
Governance & Assurance email SIG of pending cases along with the SI Progress report (Friday afternoon)
SIG Review
Weekly SIG meeting to discuss pending incidents
SIG decides on declaration and provides the SI Risk Scoring, specifies Terms of Reference and nominates executive and SMT lead for the investigation
Incidents <15 refer to H&S 011
Case Declared
Governance and Assurance upload the incident to STEIS within 2 working days of SIG declaration, recording the STEIS reference and report due date into risk management system.
SI Summary Report Updated
SIG provides TOR for declared cases
SI Summary Report updated to reflect decision
Transferred from Pending to Declared Folder

Investigation team	SIG identifies Investigation team and confirms family liaison plan.

Investigation Process

SIG	Potential SI/G&A	Policy/Guidance
	Round table planning meeting	Head of Governance and Assurance or G&A lead liaise with other departments and interested parties.
	Risk Assessment Investigation Plan Milestones	Review the documentation Perform a Risk Assessment & check the Risk Register Prepare an investigation plan - collate statements & arrange interviews Discuss, agree and confirm timescales
	Root Cause Analysis Investigation	Gather information, conduct interviews, etc Map information Identify Care and Service Delivery Problems Analyse the information & identify Root Causes
	G&A team Challenge and Confirm	Progress report and review
	Draft report	SMT lead to review and comment and respond to G&A
	Governance & Assurance	Circulate draft report for comment and review to all interested parties. Response required within 3 working days.
	Director sponsoring report	Executive and SMT leads review final draft and provides feedback to G&A on actions necessary to complete the report. G&A update the SI Tracker for the Weekly Progress report

	Senior Management Team	SMT reviews at least monthly and tasks individuals with the responsibility for implementing action plans. Progress with implementation will be monitored by SMT. Exception reports will be provided to EMT and individual Directors.
	Submit Report to lead Commissioners **Update SI Tracker**	The Head of Governance and Assurance submits the final approved report. G&A update the SI Tracker for the Weekly Progress Rpt & move the SI folder to 'Closed' folder
	CSU Feedback	The HoGA meets with the CSU on a monthly basis to discuss their feedback on completed reports and to provide updates on action plan progress.
Monthly review at SMT	**Review Action Plan**	Action plans are monitored at least monthly at an SMT meeting. Escalation to EMT if action plans aren't progressing to time.
	Monitor Implementation	The HoGA is responsible for ensuring that action plans are complete and up to date for Clinical Safety, Development & Effectiveness Committee
	Action Plans Completed	Completed action plans are archived. Lessons learned and progress on action plans is included in a quarterly report to the Clinical Safety, development & Effectiveness committee. Annual audit of implementation and effectiveness included in the annual review and report.

Resources and Guidance for investigations are available in the secure Serious Incident folder.

Appendix 3

Data loss risk matrix

A score of 3 – 5 indicates that a Serious Incident should be declared to the Information Commissioner

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

Appendix 4

Never Events 2014/15[5]

Never Events	Threshold	Method of Measurement	Never Event Consequence (per occurrence)	Applicability	Applicable Service Category
SURGICAL					
Wrong site surgery	>0	Review of reports submitted To NRLS/Serious Incidents Reports and monthly Service Quality Performance Report	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure or episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	All Healthcare Premises	A S
Wrong implant/prosthesis	>0	Review of reports submitted to NRLA/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure or episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	All Healthcare Premises	A S
Retained foreign object post-operation	>0	Review of reports submitted to NRLS/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure or episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	All Healthcare Premises	A S

[5] LAS Contract Requirements 2014/15 – note that not all apply to Ambulance Services

MEDICATION					
Wrongly prepared high-risk injectable medication	>0	Review of reports submitted to NRLS/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure or episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	All Healthcare Premises	All except PT
Maladministration of potassium-containing solutions	>0	Review of reports submitted to NRLS/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure of episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	All Healthcare Settings	A
Wrong route administration chemotherapy	>0	Review of reports submitted to NRLS/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure of episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	All Healthcare Premises	A CR
Wrong route administration of oral/enteral treatment	>0	Review of reports submitted to NRLS/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure of episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in	All Healthcare Settings	All except PT

			consequence of the Never Event		

Intravenous administration of epidural medication	>0	Review of reports submitted to NRLS/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure of episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	All Healthcare Premises	All except PT, Ph
Maladministration of insulin	>0	Review of reports submitted to NRLS/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure of episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	All Healthcare Settings	All except PT
Overdose of midazolam during conscious sedation	>0	Review of reports submitted to NRLS/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure of episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	All Healthcare Premises	A S
Opioid overdose of an opioid-naïve Service User	>0	Review of reports submitted to NRLS/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure of episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	All Healthcare Settings	All except PT

Inappropriate administration of daily oral methotrexate	>0	Review of reports submitted to NRLS/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure of episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	All Healthcare Settings	All except PT
MENTAL HEALTH					
Suicide using non-collapsible rails	>0	Review of reports submitted to NRLS/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure of episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	All mental health inpatient premises	MH MHSS
Escape of a transferred prisoner	>0	Review of reports submitted to NRLS/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure of episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	All medium and high secure mental health inpatient premises	MH MHSS
GENERAL HEALTHCARE					
Falls from unrestricted windows	>0	Review of reports submitted to NRLS/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure of episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	All Healthcare Premises	All except AM, PT, Ph
Entrapment in bedrails	>0	Review of reports submitted to NRLS/Serious Incidents reports and monthly Service	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure of episode (or, where	All adult inpatient premises	A MH MHSS

		Quality Performance Report	these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event		
Transfusion of ABO incompatible blood components	>0	Review of reports submitted to NRLS/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure of episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	All Healthcare Premises	A&E A AM CR R SM S U
Transplantation of ABO incompatible organs as a result of error	>0	Review of reports submitted to NRLS/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure of episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	All Healthcare Premises	A
Misplaced naso- or oro-gastric tubes	>0	Review of reports submitted to NRLS/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure of episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any	All Healthcare Premises	All except PT, Ph

			corrective procedure or necessary care in consequence of the Never Event		
Wrong gas administered	>0	Review of reports submitted to NRLS/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure of episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	All Healthcare Premises	All except PT, Ph, CH
Failure to monitor and respond to oxygen saturation	>0	Review of reports submitted to NRLS/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure of episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	All Healthcare Premises	All except PT
Air embolism	>0	Review of reports submitted to NRLS/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure of episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	All Healthcare Premises	All except PT
Misidentification of Service Users	>0	Review of reports submitted to NRLS/Serious Incidents reports and monthly Service	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure of episode (or, where	All Healthcare Premises	All

		Quality Performance Report	these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event		
Severe scalding of Service Users	>0	Review of reports submitted to NRLS/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure of episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	All Healthcare Premises	All
MATERNITY					
Maternal death due to post-partum haemorrhage after elective caesarean section	>0	Review of reports submitted to NRLS/Serious Incidents reports and monthly Service Quality Performance Report	In accordance with Never Events Guidance, recovery by the Responsible Commissioner of the costs to that Commissioner of the procedure of episode (or, where these cannot be accurately established, £2,000) plus any additional charges incurred by that Commissioner (whether under this Contract or otherwise) for any corrective procedure or necessary care in consequence of the Never Event	All Healthcare Premises	A