The Newcastle upon Tyne Hospitals NHS Foundation Trust

Serious Untoward Incidents (SUIs) Reporting and Management Policy

Effective: October 2011 Review: October 2013

1. Introduction

n the event of a Serious Untoward Incident (SUI) occurring within the Newcastle upon Tyne Hospitals NHS Foundation Trust the incident should be reported to the Commissioners at the NHS North of Tyne. After reporting the incident the Trust is responsible for the investigation and response to the Commissioners. In addition the incident will be reported to the regulator Monitor as part of the monthly Governance report. The investigation and subsequent response should comprise a detailed report which includes a description of the incident, a root cause analysis of the events that led to the incident, an action plan to address the issues identified, a summary of lessons learned from the investigation and details of the anticipated approach to dissemination of the lessons learned. The aim of the process is to ensure that action is taken to identify, minimise and manage risk, whilst sharing learning identified as a result of the investigation and thereby improving the quality of services and delivery of care.

2. Purpose

2.1 The purpose of a SUI investigation is to examine all of the events in detail and to place them in the context of the system in which they operated, with the aim of learning lessons and reducing the possibility of a similar incident occurring in the future. A SUI investigation is an established method which seeks to understand what went wrong in a particular incident and to identify ways of remedying problems for the future. The primary aim is not to apportion blame or identify liability. SUI reviews would usually be carried out as soon as practicable after the events occurred in order to maximise the learning from the event.

2.2 All SUIs should be reported to the Commissioners. The role of the Commissioners in dealing with SUIs is to ensure that

- action is taken where necessary to improve clinical quality and patient safety
- lessons are learned in order to minimise the risk of a similar incident occurring in the future
- learning is shared across the wider health community, locally and nationally.

2.3 The attached procedure (Appendix 1) outlines the steps to be taken for the reporting and management of SUIs. This has been formulated to comply with the Commissioners' requirements and to sit alongside the Trust's Management and Reporting of Accidents and Incidents Policy. The document sets out roles, responsibilities and timescales for action. The purpose of the document is to ensure that serious incidents are managed and investigated in a coordinated, timely and thorough manner within a supportive environment.

3. Policy Statement

The Newcastle upon Tyne Hospitals NHS Foundation Trust is committed to the reporting of SUIs to identify and learn from sources of error and risk which may lead to damage, loss or harm, complaint or legal claim for negligence and to comply with the requirements of Monitor, NHS North Of Tyne, Care Quality Commission and National Health Service (NHS) Litigation Authority.

4. SUI Classification and Investigation

4.1 The process for classifying an incident as serious has been determined below:
All potential SUIs will be brought to the attention of the Director of Quality & Effectiveness or designate in their absence via the Clinical Governance and Risk Department.

- the Director of Quality & Effectiveness will consult with two Board Directors for a decision on whether a given incident should be classified as a SUI. Where the incident involves a clinical circumstance one of the Directors must be the Medical Director or the Director of Nursing and Patient Services
- out of hours all potential SUIs should be reported to the on call Medical Director, who will discuss with a Board Director as necessary
- where agreement on the status of an incident cannot be achieved with the designated Board Directors, a case discussion will take place with relevant stakeholders and agreement reached
- when the Board Directors agree that an incident should be classified as a SUI they will agree the Responsible Director and determine the Lead Investigator
- the Responsible Director will inform the Chief Executive that an incident has been classified as a SUI
- the decision whether or not to determine an incident a SUI, with reasons, will be recorded by the Director of Quality & Effectiveness.

4.2 The investigation of a SUI will be undertaken by a named individual with the time, ability, authority and experience to commit to leading a SUI investigation on behalf of the Newcastle upon Tyne Hospitals NHS Foundation Trust. Lead Investigators will be given latitude to conduct the investigation. However, guidance and support will be available on the required structure and format of the investigation and final report.

4.3 All breaches of the investigation/report submission deadlines will be notified to the Corporate Governance Committee.

4.4 Directorate Managers/Heads of Department have a duty to implement local systems to ensure that staff comply with the SUI policy and procedure. In particular that:

- relevant staff are aware of the SUI policy and procedure
- potential SUIs are identified on a timely basis
- incident forms are completed and submitted promptly

- there are effective systems for communication and management of SUIs out of hours
- implementation of actions are monitored on a regular basis until the action plan has been achieved.

4.5 All members of staff have an important role in identifying, assessing and managing risk. To support staff in this role the Newcastle upon Tyne NHS Foundation Trust Board has endorsed a Being Open Policy, the aim of which is to encourage a culture of openness and willingness to admit mistakes**.** At the heart of this policy is the desire to learn from events and situations in order to improve practices, systems and processes on a continual basis. Where necessary, changes to systems and care pathways will be made to enable this.

4.6 Where an investigation results in Police inquiries a single point of contact will be established.

4.7 It is the duty of every employer to ensure, as far as is reasonably practicable, the health, safety and welfare of employees. This, together with the duty of care and cooperation imposed on each employee, requires that all serious incidents or near misses which do or could potentially result in harm should be reported to the appropriate level of management within the Trust, initially via the electronic incident reporting system or on a paper incident form, available to all wards and departments. An employee's duty to report applies even if they are not directly or potentially affected.

4.8 All employees within the Trust must understand what may constitute a serious incident or near miss and the processes for reporting and investigating such events.

5. Equality and Diversity Statement

The Newcastle upon Tyne NHS Foundation Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

6. References

The following documents have been referred to within this policy:

- Being Open Policy
- Management and Reporting of Accidents and Incidents Policy.

7. Consultation

The content of this policy has been discussed with relevant stakeholders and agreed by the Corporate Governance Committee, prior to final ratification.

8. Ratification

This policy has been ratified by the Trust Clinical Policy Group and disseminated by the Clinical Governance and Risk Department.

9. Audit of Policy

Assessment of compliance with this policy will be the responsibility of the Corporate Governance Committee, who will review on a quarterly basis.

Author: Director of Quality & Effectiveness

Appendix 1

The Newcastle upon Tyne NHS Foundation Trust

Procedure for the Reporting and Management of Serious Untoward Incidents (SUIS)

1. Introduction

1.1 The aim of this procedure is to ensure that SUIs are properly investigated, that actions are taken to improve clinical quality and that lessons are learned in order to minimise the risk of similar incidents occurring in the future.

1.2 It must be noted that the Trust has a responsibility to work with relevant statutory bodies such as the Police and the Health and Safety Executive. The procedure to notify the Commissioners of serious untoward incidents does not supersede the normal legal requirements to notify other agencies (listed in Appendix 2) of certain incidents.

1.3 Reporting an incident to the Commissioners does not remove any responsibility to comply with national guidance issued by Monitor, Department of Health or other organisations such as the NHS Litigation Authority, Care Quality Commission, National Patient Safety Agency, NHS Estates or Medicines and Healthcare Products Regulatory Agency (MHRA). In such circumstances the procedures in this document should be followed in conjunction with national guidance. Should a child die or be seriously injured and non-accidental injury be suspected, then all local child protection procedures must be followed.

1.4 Managers should be aware of Department of Health guidance that exempts details of individual SUI reports under either or both sections 31(2) and section 40 (2 and 3) of the Freedom of Information Act 2000.

2. Definition of a SUI

2.1 For the purpose of this procedure, a SUI is any incident on Trust premises, or elsewhere whilst in NHS-funded or NHS regulated care involving;

- patients, relatives or visitors
- staff
- contractors, equipment, building or property

which may or has:

- caused death (including suicide) or serious injury or was life threatening, including screening and immunisation/radiation errors and equipment failures or where the outcome requires life-saving intervention, major surgical or medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm

- caused serious disruption to services, including systems used or required to deliver patient or system user care, e.g. PAS, PACS, results reporting systems or potential loss of organisational information
- caused significant damage to the reputation of the Trust or its staff
- been classified as a serious offence involving an individual in receipt of mental health or learning disability services
- been confirmed as a death of a patient due to health care acquired infection including MRSA and Clostridium difficile confirmed by notification on Parts 1 and/or 2 of the death certificate
- invoked the emergency plan
- involved patients detained under the Mental Health Act 1983 who abscond from health services and who present a serious risk to themselves and/or others
- resulted in serious case review within the 'Protection of Vulnerable Adults' scheme
- the actual or potential loss of personal information that could lead to identity fraud or have other significant impact on individuals
- admission of a child under 16 years of age to an adult psychiatric ward
- adverse media coverage or public concern about the organisation or the wider NHS.
- one of the core set of 'Never Events' as updated on an annual basis and currently including:
    - wrong site surgery,
    - wrong implant or prosthesis
    - retained foreign body or instrument post-operation,
    - death or serious harm as a result of wrongly prepared high risk injectable medication
    - death or serious harm as a result of maladministration of potassium-containing solution
    - death or serious harm as a result of wrong route administration of chemotherapy,
    - death or serious harm as a result of wrong route administration of oral/enteral treatment
    - death or serious harm as a result of intravenous administration of epidural medication
    - death or serious harm as a result of maladministration of insulin
    - death or serious harm as a result of overdose of midazolam during conscious sedation
    - death or serious harm as a result of opioid overdose of an opiod-naïve patient
    - death or serious harm as a result of falls from unrestricted windows
    - death or serious harm as a result of entrapment in bed rails
    - death or serious harm as a result of transfusion of ABO-incompatible blood components
    - death or serious harm as a result of transplantation of ABO or HLA incompatible organs
    - death or serious harm as a result of misplaced nasogastric or orogastric tube not detected prior to use

- death or serious harm death as a result of the administration of the wrong gas or failure to administer the correct gas at all through a line designed for oxygen in a healthcare facility
- death or serious harm as a result of failure to monitor and respond to oxygen saturation
- death or serious harm as a result of air embolism
- death or serious harm as a result of misidentification of patients
- inpatient suicide using non-collapsible rails,
- escape from within the secure perimeter of medium or high security mental health services by patients who are transferred prisoners,
- death or serious harm as a result of a patient being scalded by water used for washing or bathing
- in-hospital maternal death from postpartum haemorrhage after elective caesarean section,
- daily administration of oral methotrexate for non-cancer treatment pr provision of oral methotrexate for non-cancer treatment with the instruction to take daily

2.2 Incidents in Maternity Services which cause serious concern relating to maternity care or midwifery practice should also be reported to the Local Supervising Authority Midwifery Officer. Any incident involving the following issues in maternity services should be reported to the PCT in addition to the Centre for Maternal and Child Enquiries:

- unexpected intrapartum still birth
- unexpected maternal or neonatal death including cot death in hospital
- serious birth trauma to the baby, for example, scalpel wound at caesarean section or skull fracture at instrumental delivery
- baby abduction.

Adverse outcomes reasonably associated with routine NHS activity are excluded from this procedure.

3. Immediate Action to be taken following an Incident

3.1 It is an overriding responsibility of all employees to take immediate action at the scene of an incident to minimise injury and/or obtain appropriate treatment for individuals. Employees should consider what immediate action may be required to prevent further injury. Employees should have regard for their own health and safety at such times and should summon assistance whenever appropriate.

3.2 Individual employees, volunteers, contractors or students must report to their supervisor or head of department, as soon as practicable, any incident they have witnessed or been involved in.

3.3 Before reporting is commenced, some incidents will require prompt and specific action to deal with the problem. For example:

Patient Related Incidents

Where the incident relates to an inpatient, the patient's Medical Consultant must be informed as soon as possible. The Consultant will be expected to advise the patient (or where applicable the patient's relatives) of the circumstances of the incident and offer a reassurance that a full investigation will be undertaken. A full, contemporaneous record of the information provided to the patient/patient's relatives regarding the incident should be documented in the health records by the Consultant.

Information incidents

Where the incident relates to data loss or breach of confidentiality the appropriate senior staff should be notified immediately. The immediate response to the incident and the escalation process for reporting and investigating this will vary according to the severity of the incident.

0	1	2	3	4	5
No significant reflection on any individual or body. Media interest very unlikely.	Damage to an individual's reputation. Possible media interest e.g. celebrity involved.	Damage to a team's reputation. Some local media interest that may not go public.	Damage to a service's reputation. Low key local 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. Fewer than 5 people affected or risk assessed as low, e.g. files encrypted.	Serious potential breach & risk assessed as high e.g. unencrypted clinical records lost. Up to 20 people affected.	Serious breach of confidentiality e.g. 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.

Reporting to NHS North of Tyne Commissioners

The Trust should report all information incidents rated as 1-5 to the Commissioners through the usual channels, including the following information:

- a short description of the incident including the actions taken to recover the data and whether the incident has been resolved
- details of the type of data involves and sensitivity
- details of how the information was held: paper, memory stick, laptop, etc.
- details of any safeguards such as encryption that would mitigate risk
- details of the number of individuals whose information is at risk
- whether a) the individuals concerned have been informed, b) a decision has been taken not to inform or c) this has not yet been decided
- whether the Caldicott Guardian has been informed
- whether a) the Information Commissioner has been informed, a decision has been made not to inform or c) this has not yet been decided
- whether the police have been involved
- whether the SUI is in the public domain and the extent of any media interest and/or publication

- confirmation that appropriate & documented incident management procedures are being followed
- whether the reputation of an individual, team, or organisation is at risk
- that disciplinary action will be invoked where appropriate following the investigation.

Reporting to the Commissioners should be undertaken as soon as practically possible (and no later than 24 hours of the incident in the working week).

Equipment Related Incidents

- Where equipment is involved in an incident (e.g. syringe driver, dialysis machine) the equipment and all consumables (e.g. lines or other disposables) should be isolated and marked 'UNDER INVESTIGATION DO NOT USE'. The equipment should be retained in a secure location pending further instructions. Further guidance is available in the Management of Medical Devices Policy and the Policy for the Management and Reporting of Accidents and Incidents.

Staff Related Incidents

- consider what support staff on duty may require after the initial scene has been made safe (e.g. additional staffing, counselling or support from Occupation Health or Human Resources)
- consider if arrangements need to be made for leave of absence to be granted.

Screening incidents

- actual or possible failure of the screening service that has consequences for the clinical management of patients e.g. loss of test results, failure to detect cancers, incorrect notification of results to a patient or groups of patients.

- the screening programmes which are covered are:- breast cancer, cervical screening , bowel cancer, diabetic retinopathy, abdominal aortic aneurysm, fetal anomaly, infectious diseases in pregnancy, sickle cell and thalassaemia, newborn blood spot, newborn hearing and newborn and Infant Physical Examination.

- Incidents involving the Cervical Screening Programme (NHSCSP) should be handled in accordance with the protocol documented in Interim Guidelines for Managing Incidents in the NHS Cervical Screening Programme" NHSCSP Publication No 11. Dec 2010

4. Reporting a Suspected SUI

Directorate Managers/Heads of Department must ensure that the Director of Quality and Effectiveness via Clinical Governance and Risk Department is informed as soon as possible by telephone where a SUI is suspected. Where the incident occurs out of hours the on call Medical Director should be informed of the incident by the Patient Services Coordinator.

Out of hours, the on call Medical Director may decide that if the SUI is of an exceptional nature, for example, requiring immediate investigation by the Police/HSE and/or likely to attract media attention, such as in the case of a major fire on NHS premises causing severe service disruption that the PCT on-call manager should be notified. This will be a verbal report with the agreement of the Chief Executive or nominated deputy. A decision as to whether to formally report the SUI to the Commissioners will be made on the first working day after the incident has occurred.

The Directorate Manager/Head of Department will be responsible for contacting the Clinical Governance and Risk Department on the first working day following the incident to report the circumstances of the event and seek further guidance if so required.

The Directorate Manager/Head of Department is responsible for ensuring the completion of the incident report.

It may be that a potential SUI has been identified via local reviews of the incident reports. Directorate Management Teams will be responsible for ensuring that there are local procedures in place for the prompt review of incidents to ensure the identification of a potential SUI on a timely basis.

The Clinical Governance and Risk Department will alert the Director of Quality & Effectiveness (or designate in their absence) of the potential SUI immediately following receipt of the verbal notification from the Directorate Manager/Head of Department.

5. Determining a Serious Untoward Incident

The Director of Quality & Effectiveness (or designate) will consult with two Board Directors for a decision on whether the given incident should be classified as a SUI. Where the incident involves a clinical circumstance, one of the Board Directors must be the Medical Director or the Director of Nursing and Patient Services.

Where there is a difference in opinion between the two Board Directors, they will discuss the incident and reach a decision on the future management with the Chief Executive. The decision of the Board Directors, and the reasons for this, must be recorded on the notification form by the Director of Quality & Effectiveness.

Where an incident is declared a SUI, the Board Directors will determine who will act as the responsible Board Director. The Responsible Board Director will normally be the Director for the area where the incident occurred. The Responsible Board Director will commission the investigation and formally appoint the Lead Investigator. In the event that a decision is made that an incident should be referred to the Police a single initial point of contact between the Trust and the Police will be determined by the Responsible Board Director.

The Responsible Board Director will maintain communication with the Chief Executive on the management and investigation of the SUI.

In cases where the HSE/Police or other enforcement agencies are involved, these organisations may initiate their own investigation and request interviews with and information from Trust staff. The Board Directors will agree who will act as the Trust Coordinator in such instances.

6. Helpline Arrangements

There will be occasions when an incident will necessitate the establishment of a helpline. The Procedure for Establishment of a Public Telephone Helpline should be utilised in such circumstances.

Where the issue affects more than one organisation, agreement will need to be reached as to who will manage the helpline in order to avoid confusion.

7. External Notification of SUIs to NHS North of Tyne

The Clinical Governance and Risk Department will be responsible for notifying the commissioners of all SUIs. Initial notification will be via completion of the computerised notification form on STEIS (Strategic, Electronic, Incident Reporting System) as soon as practically possible (within 24 hours of the incident during the working week). The Risk Management Team will act as the liaison link between the Trust and the Commissioners during all stages of the incident investigation process. The Trust will keep the Commissioners informed of any significant developments in internal/external investigations, as appropriate.

8. External Notification of SUIs to Stakeholders

Appendix 2 contains details of external stakeholders who should be considered prior to the commencement of the investigation. It will be the Lead Investigator's responsibility supported by the Risk Management and Safety Manager to ensure that all relevant stakeholders are notified of the incident. A record of the stakeholders who have been notified must be retained as part of the SUI investigation.

9. Internal Notification of SUIs

Following receipt of the initial notification of a SUI the Risk Management Team will be responsible for preparing a summary of the incident along with details of immediate action taken, date, time and location of incident (Appendix 3). The above summary must comply with the Caldicott principles and will not refer to patients by name, (or staff if the incident relates to a member of staff), or any other identifiable information.

10. Investigation Process

The Lead Investigator will be responsible for establishing the investigation team, ensuring that all the relevant disciplines and departments are represented. If the Lead Investigator believes that an external expert is required, the decision to commission external help should always be referred to the Board Directors who declared the SUI. The reason for instructing an external expert must be documented

in the SUI file. The Board Directors will consider the degree of error and seriousness of outcome when debating whether to commission an external review.

The criteria that may result in commissioning an external review include:

- where on balance, a criminal charge is unlikely to follow, but could do so
- where there is a strong suggestion of clinical error
- where the effect of the error is to significantly harm the patient, or where the patient has died
- where the potential political ramifications are of national level
- when there is a reasonable belief that the action may be malicious and the Police have been informed.

When the investigation of a SUI is carried out, it is not in itself a management investigation into any individual(s). The focus of a SUI investigation is to establish what happened. This might then constitute a prima facie case for a management investigation to be undertaken. As a result of this investigation a number of courses of action may follow; these will be determined by the results of the management investigation. Managers should refer to "Incidents, Accidents and the Trust Disciplinary Process - Guidelines for Managers, Clinical Directors and Employees", available on the Trust Intranet. In this process it will be the role of the relevant Board Director to supervise the management investigation and the role of the Human Resources Department to advise and support this process as required.

Staff need support following any incident; however the more serious the incident, the more support is normally required. Being involved in an incident can be stressful for the individual, the team and the service. It is important that individuals should not feel isolated when involved in an incident. The Lead Investigator will ensure that adequate support mechanisms have been made available to staff. This may include referral to the Occupational Health department.

Although the Lead Investigator will have latitude to determine the conduct of the investigation and will be mandated to ensure that a single coordinated, multidisciplinary investigation takes place, they are expected to meet a number of essential requirements. This includes:

- a root cause analysis of incident
- completion of chronology/time line of events
- collation of staff statements
- ensuring there is timely and sympathetic liaison with the patient/patient's relatives and staff during the course of the investigation (refer to the Trust's Being Open Policy)
- overseeing liaison with external stakeholders such as MHRA, HSE, NHS Estates, NHS North of Tyne
- conducting exploratory interviews
- analysis of evidence
- formulation of recommendations
- compilation of report with action plan (see Appendix 4 for template)
- debriefing of staff after the investigation.

The Lead Investigator has a responsibility to:

- make all necessary decisions to manage the incident effectively
- identify and communicate with all necessary parties in an efficient and methodical manner
- analyse the incident and the way it was handled and make recommendations for future implementation.

In respect of clinical incidents, the Lead Investigator will ensure that medical records are secured. Where records are required for the purposes of an external investigation, e.g. an inquest, criminal investigation or investigation by external experts, the Lead Investigator will ensure that copies are made and retained on the hospital site.

12. Communication

If an incident is likely to result in media coverage, effective communication with staff is paramount. The timing and the extent of any information issued will be decided by the Chief Executive or nominated deputy.

The Lead Investigator will ensure that where necessary a member of staff is identified to act as liaison link with the family/patient throughout the investigation. A record should be maintained of all such communications.

The Chief Executive or nominated deputy will be responsible for overseeing the responses to all press enquiries and the preparation of press statements.

SUI investigation reports must be submitted within a defined time scale from the incident being reported to STEIS, dependant on the grading of the incident. The Trust will be notified by the Commissioners of the date the report is due. Where an investigation is unlikely to be completed within the set time frame, the Lead Investigator will be expected to provide an interim report for submission to the PCT, summarising the progress to date. The Risk Management Team will advise the Lead Investigator of the date by which the interim report is required.

13. Completion of Report

On conclusion of the investigation, the Lead Investigator will forward the completed report and supporting SUI file to the Clinical Governance and Risk Department.

The Director of Quality & Effectiveness will review the completed report to ensure that the incident has been properly investigated, that there is a clear and timely action plan and that the report complies with the PCT's requirements.

The Responsible Director will be responsible for agreeing the report and action plan. The Responsible Director will review actions in the report to identify those that need to be implemented widely.

Once the report has been agreed and accepted by the Responsible Director, this will be sent to the Chief Executive for final agreement prior to being sent to the Commissioners.

The SUI central file will be archived in the Clinical Governance and Risk Department. The Risk Management Team will be responsible for advising the Lead Investigator and Responsible Director when the commissioners have agreed closure of the file.

14. Monitoring

On a monthly basis the Director of Quality & Effectiveness will provide the Medical Director with an updated monitoring chart which will show the progress against each SUI investigation. Investigations that are not completed within 20 working days of the submission date will be flagged as amber and those not completed within 10 working days will be flagged as red.

The Director of Quality & Effectiveness will be responsible for reporting details of learning points resulting from SUI investigations to the Clinical Risk Group. On both a quarterly and annual basis the Director of Quality & Effectiveness will provide the Corporate Governance Committee with a performance report summarising the number of SUIs reported to the Commissioners and numbers closed.

The Trust is committed to ensuring that lessons are learned in order to minimise the risk of similar incidents occurring in the future.

15. Review

The Director of Quality & Effectiveness will be responsible for reviewing the SUI procedure every two years.

16. References

Being Open Policy
Management of Medical Devices Policy
Policy and Procedure for the Establishment of a Helpline
Policy for the Management and Reporting of Accidents and Incidents.

Author: Director of Quality & Effectiveness

Key Stakeholders Checklist

- ❑ Coroner (0191 2777280 in office hours. Out of hours via Police)

- ❑ Counter Fraud and Security Management Service (02078 954631)

- ❑ Department of Health (Customer Service Centre 02072104850 in office hours)
  - Strategic Health Authority (0191 2106400)

- ❑ Public Health (0191 2116175 office hours)

- ❑ Food Standards Agency (0207276800 office hours or 02072708960 emergencies only or www.food.gov.uk/foodindustry/regulation/foodfeedform

- ❑ Care Quality Commission (Ionising Radiation (Medical Exposure) Regulations 2000) (02074489039, or http://www.cqc.org.uk)

- ❑ Health and Safety Executive (0845 3450055)
  - RIDDOR (0845 300 9923 or www.hse.gov.uk/riddor/online.htm)

- ❑ Medicines and Healthcare Products Regulatory Agency (MHRA) (02070842000 in office hours or 02072103000 or info@mhra.gsi.gov.uk)

- ❑ National Patient Safety Agency (NPSA) (02079279500 or enquiries@npsa.nhs.uk)

- ❑ NHS Estates
  - Fire code – reporting of fire incidents (www.efm.ic.nhs.uk)
  - Buildings and non-medical equipment defect and failure reporting (Trust Estates Helpline 259100

- ❑ NHS Litigation Authority (riskmanagement@nhsla.com)

- ❑ Police (Public Protection Unit 0191 2146555)

- ❑ NHS North of Tyne Commissioners (0191 217 2565)
  e-mail: sui.northoftyne@nhs.net

- ❑ Professional Regulatory Bodies
  General Medical Council 0845 3578001, www.gmc-uk.org;
  Nursing & Midwifery Council 02076377181 or www.nmc-uk.org)

- ❑ Public Health Laboratory Service (Extension 21076 in office hours; out of hours via switchboard)

- ❑ Serious Hazards of Transfusion (SHOT) (0161 2514208 or www.shotuk.org)

- ❑ Social Services
  Child Protection: in office hours 0191 2772500
  Vulnerable Adults: in office hours 0191 2772077 /2772555
  Emergency Duty Team Children & Adults 0191 2328520

- ❑ Trust Solicitor (C/O Samuel Phillips 0191 2328451 or admin@samuelphillips.co.uk)

Appendix 3

The Newcastle Upon Tyne Hospitals NHS Foundation Trust
SUI Initial Notification Form

To be completed by Risk Manager or Patient Safety Advisor

Name of Person Reporting	
Post Held	
Date of Reporting	
Date of Incident	
Time of Incident	
Site of Incident	
Incident report number	
Ward/Department	
Name of Affected Person	
MRN	
Date of Birth	

Nature of Incident (e.g. Surgical Error, Medication Incident, Fire)
Full Details of Incident – continue on separate sheet if necessary
Affected Person and/or Relatives Informed of Incident – Yes ☐ No ☐
If No, please explain why person/relatives have not been informed

Action Taken Immediately Following Incident
Internal/External Stakeholders which have been/need to be informed
Details of any anticipated media and/or Political Interest

INCIDENT DECLARED SUI – YES ☐ NO ☐

Rationale For Decision

BOARD DIRECTORS MAKING DECISION:

______________________ _________________________

NAME OF NOMINATED RESPONSIBLE DIRECTOR:

DATE: ______________________________

FOR RISK MANAGEMENT USE:

Nominated Lead Investigator	
Date SHA Notified	
Date Final Report Due	

Appendix 4

The Newcastle Upon Tyne Hospitals NHS Foundation Trust

Template for SUI Report and Action Plan

The report should include the following:

Introduction

Brief details of the incident and the intended recipient(s) of the report.

Terms of reference

The purpose and structure of the task that has been assigned to the investigator.

Methodology

A list of persons interviewed prior to compiling the report.
A list of documents reviewed, referred to or used to support the report.

Membership of the investigation team

A list of persons involved and their role in the investigation.

Chronology

This must be factual and in strict date and time order. In a complex case it may be helpful to put it in the form of a table with columns for date, time etc.

Background information

The background to the incident, perhaps including clarification of the usual working practices in the area where the incident occurred or an explanation of clinical procedures if this is helpful to the investigation.

Evidence

This section will build on the chronology and set out the evidence gathered and any other documentation referred to e.g. local or national standards. It should be factual and any statement or opinion should be clearly identified as such, e.g. "We were told that…."

Analysis

The interpretation of the evidence collected during the investigation. Root cause analysis findings should be included in this section, along with consideration of practices and procedures to identify both good and poor practice.

Conclusions

This section should set out individual conclusions and may repeat points already made. Ideally conclusions will be ranked or organised in some way e.g. relate to sequential points in the chronology, go from most important to least important or separate points of good and bad practice. In any event, it should again be made clear which conclusions are about root causes of the event and which are not. This section should include a summary of lessons learned.

Recommendations
This should include the intended approach to dissemination of lessons learned

Action plan
To include what needs to happen to achieve the outcome, the names or titles of persons responsible for the actions and specific timescales for completion.
It is helpful to present the actions in a table.

All actions included must be carried out and confirmed as complete before the Commissioners will consider an incident for closure.

THE NEWCASTLE UPON TYNE HOSPITALS NHS FOUNDATION TRUST
IMPACT ASSESSMENT – SCREENING FORM A

This form must be completed and attached to any procedural document when submitted to the appropriate committee for consideration and approval.

Policy Title:	**Policy for the Reporting and Management Of Serious Untoward Incidents (SUIs)**	**Policy Author:**	**Director of Quality & Effectiveness**
		Yes/No?	You must provide evidence to support your response:
1.	Does the policy/guidance affect one group less or more favourably than another on the basis of:		This policy will not affect one group more or less favourably on grounds of race, ethnic origin, nationality, gender, culture, religion or belief, sexual orientation, age or disability.
	• Race	N	
	• Ethnic origins (including gypsies and travellers)	N	
	• Nationality	N	
	• Gender	N	
	• Culture	N	
	• Religion or belief	N	
	• Sexual orientation including lesbian, gay and bisexual people	N	
	• Age	N	
	• Disability – learning difficulties, physical disability, sensory impairment and mental health problems.	N	
2.	Is there any evidence that some groups are affected differently?	N	
3.	If you have identified potential discrimination, are any exceptions valid, legal and/or justifiable?	N/A	
4(a).	Is the impact of the policy/guidance likely to be negative? *(If "yes", please answer sections 4(b) to 4(d)).*	N	
4(b).	If so can the impact be avoided?		
4(c).	What alternatives are there to achieving the policy/guidance without the impact?		
4(d)	Can we reduce the impact by taking different action?		

Comments:	**Action Plan due (or Not Applicable):**

Name and Designation of Person responsible for completion of this form: Jane Skeates Date: 02/02/2010

Names & Designations of those involved in the impact assessment screening process: Jane Skeates

(If any reader of this procedural document identifies a potential discriminatory impact that has not been identified on this form, please refer to the Policy Author identified above, together with any suggestions for the actions required to avoid/reduce this impact.)