Enclosure 3

THE SHREWSBURY AND TELFORD HOSPITAL NHS TRUST

Trust Board – February 2011

Serious Incidents (SI) Policy

EXECUTIVE RESPONSIBLE	Vicky Morris, Director of Quality and Safety
AUTHOR	Clare Jowett, Chief Compliance Officer
CORPORATE OBJECTIVE NO(S)	Enhancing patient experience, safety and effectiveness
BUSINESS PLAN OBJECTIVE NO(S)	Deliver agreed patient safety programmes, including implementation of the NPSA alerts
EXECUTIVE SUMMARY	The Serious Incident (SI) Policy was originally approved in 2004 and has been updated regularly since then. It was last updated in March 2010 to taken account of the responsibility of monitoring SUIs by PCTs and the statutory duty to notify the Care Quality Commission about notifiable events. The SI policy has been recently updated to take account of changes relating to the national framework for incident reporting; the revised SHA policy and operational changes in SI management within the Trust. The policy has been revised to take account of changes to the Executive Directors portfolios.
KEY FACTS	The main changes are: o Lead Nurses / Midwives will take a co-ordinating role for investigating most incidents in conjunction with clinicians o SIs will be graded as 0, 1 or 2. This grading will be agreed with the SHA and PCTs. • For incidents graded as 0 or 1, a Lead Nurse or other nominated individual will be the investigating officer. • For Grade 2 incident investigation, or inquestable deaths, a Safety Advisor will take the co-ordinating role – usually a member of the patient safety team in conjunction with nominated clinical staff. o A number of revised appendices outlining current reporting requirements and timescales. These include guidance on the types of incidents which must be reported in the following categories: • Healthcare Associated Infection • Never Events • Maternity / Newborn / Children and Young People • Data loss o There are also checklists to be used following extremely serious incidents and incidents affecting multiple patients
RECOMMENDATION	The Trust Board is asked to **APPROVE** the revised policy

Contribution to Inspection, Registration, Performance and Delivery

Risks and Assurance	Links to following risks: CRR 1 – sustainability of achieving reduction in infection rates CRR 9 – risk harm to patient following fall CRR 258 - Inconsistent focus on clinical outcomes at service level to drive quality improvements Understanding the root causes of incidents and learning lessons supports the Trust ‘s Assurance processes against the Essential Standards of Quality and Safety
Contribution to Key Performance Indicators	Links to SI slide in Integrated Performance Report
Compliance with Clinical and other Governance Requirements	Requirement to report incidents as part of Care Quality Commission regulations

Impact Assessment

Quality	Implementing lessons learnt should prevent recurrence of these types of incident and improve quality, this will however require consistent and focused leadership at all levels to ensure adequate support and embed the changes required.
Financial	Implementing lessons learnt should prevent recurrence of these types of incident and reduce cost
Workforce	Supporting staff to implement the lessons learnt should prevent recurrence of these types of incident and improve staff morale
Legislation and Policy	Providers have a statutory duty to notify CQC and HSE about certain categories of incidents
Equality and Diversity	Not applicable
Communication and Marketing	Not applicable

Engagement and Decision-Making Process

Not applicable