NHS
Sunderland
Clinical Commissioning Group

Serious Incident (SI) Management Policy

CO18

Better health for Sunderland

Contents

Version Control

Version	Date Approved	Committee	Date of next review	CCG Lead
V2	10/08/14	Quality Safety and Risk Committee (QSRC)	10/08/15	Sue Goulding, Head of Quality and Patient Safety
V3	30/10/15	Quality Safety and Risk Committee (QSRC)	30/10/17	Sue Goulding, Head of Quality and Patient Safety
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V5.1	January 2021	Extension for 12 months in light of COVID19	December 2022	Kirstie Hesketh, Head of Quality and Patient Safety
V5.2	10/08/2021	Joint Quality and Safety Committee	10/08/23	Kirstie Hesketh, Head of Quality and Patient Safety

1. Introduction

Sunderland Clinical Commissioning Group (SCCG) aspires to the highest standards of corporate behaviour and clinical competence, to ensure that safe, fair and equitable procedures are applied to all organisational transactions, including relationships with patients, their carers, public, staff, stakeholders and the use of public resources. In order to provide clear and consistent guidance, SCCG will develop documents to fulfil all statutory, organisational and best practice requirements and support the principles of equal opportunity for all.

The NHS treats over one million patients every single day. The vast majority of patients receive high standards of care however, incidents do occur and it is important they are reported and managed effectively.

SCCG as commissioners, seek to assure that all services which may be commissioned or directly provided meet nationally identified standards and this is managed through the local contracting process. Compliance with Serious Incident (SI) and Never Event (NE) reporting is a standard clause in all contracts and service level agreements as part of a quality schedule.

One of the roles of SCCG as Commissioners is to gain assurance that incidents are properly investigated, that action is taken to improve clinical quality, and that lessons are learnt in order to minimise the risk of similar incidents occurring in the future. It is intended that intelligence gained from SIs will be used to influence quality and patient safety standards for care pathway development, service specifications and contract monitoring.

In accordance with the SCCG Quality Strategy and underpinning Quality Assurance Framework, the Serious Incident Management Policy is intended to reflect the responsibilities and actions for dealing with SIs and NEs and the tools available.

It outlines the process and procedures to ensure that SIs and NEs are identified, investigated and learned from as set out in the revised Serious Incident Framework published in March 2015 and the revised Never Event Policy and Framework published in January 2018. . These updated frameworks replace those published in 2015. The Serious Incident Framework is expected to be replaced by the Patient Safety Incident Response Framework (PSIRF) in 2022.

1.1 Status

This policy is a corporate policy and outlines the Serious Incident (SI) Policy for Sunderland CCG.

1.2 Purpose and scope

1.2.1 The purpose of this policy is to identify what is meant by a SI or NE and to describe the processes for the reporting and management of such an incident within SCCG's NHS commissioned services and jointly commissioned services between SCCG and Local Authorities. This policy will also describe the role of SCCG when a SI or NE occurs across a number of organisations. This policy aims to ensure that SCCG as commissioners comply with current legislation as well as current

national guidance, NHS England and requirements with regard to accident/incident reporting generally, but in particular reporting, notifying, managing, investigating and learning from SIs and NEs.

1.2.2 This policy applies to all employees of SCCG and is recommended to independent contractors e.g. GPs, Dental Practitioners, Optometrists and Pharmacists.

1.2.3 All NHS providers including Independent Healthcare Sector providers need to comply with SCCG's reporting requirements within this policy, which reflects the revised Serious Incident Framework 2015 and the updated Never Events Policy and Framework 2018.

1.2.4 This policy does not include the management of incidents which do not meet the 'serious incident' definition. Incidents (including serious incidents) which occur within the CCG should be dealt with in accordance with SCCG's Incident Reporting and Management Policy (CO08)

1.3 Policy Statement

It is the duty of each NHS body to establish and keep in place arrangements for the purpose of monitoring and improving the quality of healthcare provided by and for that body. SCCG as commissioners of services are committed to this policy and the implementation of a consistent approach to the implementation of robust arrangements for the management of SIs and NEs

2. Duties and Responsibilities

SCCG Governing Body	The governing body (GB) sets the strategic context in which organisational process documents are developed, and for establishing a scheme of governance for the formal review and approval of such documents.
Chief Officer	The Chief Officer has overall responsibility for the strategic direction and operational management, including ensuring that CCG process documents comply with all legal, statutory and good practice guidance requirements. The Chief Officer has responsibility for ensuring that the CCG has the necessary management systems in place to enable the effective management and implementation of all risk management and governance policies and delegates the responsibility for the management of SIs to the Executive Lead for Nursing, Quality and Safety.
Director of Nursing, Quality and Safety	The Director of Nursing, Quality and Safety has responsibility for ensuring the necessary management systems are in place for the effective implementation of serious incident reporting for the CCG and delegates management of SIs and reporting to the Head of Quality and Patient Safety.

Directors	Directors are designated leads for supporting and implementing this policy within their individual Directorates and implementing appropriate action plans and both organisational and function specific learning.
CCG Controlled Drugs Accountable Officer / Head of Medicines Optimisation	The CCG Controlled Drugs Accountable Officer and Head of Medicines Optimisation have the responsibility for ensuring that all SIs relating to controlled drugs are investigated appropriately and for liaison with the Controlled Drugs Local Intelligence Network (LIN).
Head of Quality and Patient Safety	The Head of Quality and Patient Safety (HQPS) has delegated responsibility for ensuring SIs are reported, recorded and managed effectively across the CCG. NECS Clinical Quality team are commissioned to provide this service. The HQPS is responsible for notifying CCG Directors and the Chair of the Joint Quality and Safety Committee that a Never Event has occurred within our locally commissioned services.
Head of Safeguarding	The Head of Safeguarding will be asked to contribute or oversee the safeguarding component of any serious incidents.
Managers	Managers have responsibility for promoting the policy directly with their staff and, where appropriate, taking Directorate responsibility for the co-ordination of investigations in support of the Director for Nursing, Quality and Safety.
All Staff	All staff, including temporary and agency staff, are responsible for: • Compliance with relevant process documents. Failure to comply may result in disciplinary action being taken. • Co-operating with the development and implementation of policies and procedures and as part of their normal duties and responsibilities. • Identifying the need for a change in policy or procedure as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and advising their line manager accordingly. • Identifying training needs in respect of policies and procedures and bringing them to the attention of their line manager. • Attending training / awareness sessions when provided.
All Independent Contractors	This policy is recommended to all independent contractors for implementation appropriately and working across the health economy in learning and improving care for our patients and services.

All NHS provider organisations and Independent Healthcare Sector (HIS) providers	All NHS provider organisations and independent healthcare sector providers are responsible for ensuring that their own SI policy reflects the reporting arrangements for NHS provider organisations and Independent Healthcare Sector organisations within this policy.
North of England Commissioning Support (NECS) Clinical Quality Teamr	The NECS Clinical Quality representative will • Consider if a serious incident falls into the category of a STEIS reportable SI to the national system and report accordingly where the provider organisation does not have access to StEIS • Review clinical quality incidents reported by the CCG. Provide clinical quality incident reports as requested. • Facilitate the Serious Incident Panel process
North of England Commissioning Support (NECS) Information Governance Lead	NECS Information Governance Lead has the responsibility to: • Provide information governance support to staff in the organisation. • Co-ordinate different areas of information governance and to ensure progress against key standards and requirements. • In collaboration with IT, develop, implement and monitor information security across the organisation. • Support the CCG in evidence collation, upload and publicise the Data Security and Protection Toolkit.

2.1 Lead committee duties and accountabilities:

2.1.1 The Joint Quality and Safety Committee has responsibility for overseeing the trends and themes from serious incidents and receives regular updates within the Quality Reports. The Committee reports to the Governing Bodies.

2.1.2 Serious Incident Panel has been established jointly with South Tyneside CCG (STCCG). The panel has responsibility to review and monitor all relevant serious incidents until closure can be recommended to ensure the completion of all required actions and identification of appropriate lessons learnt. The Panel is co-chaired by the Executive Directors for Nursing, Quality and Safety for both CCGs or the Chair of STCCG. The panel is organised by North of England Commissioning Support service (NECS) Clinical Quality Team.

2.1.3 Quality Review Group meetings take place routinely with providers to discuss quality issues. Serious incidents are a standing item on the agendas and issues discussed directly with the provider concerned.

3. Definitions

The following terms are used in this document:

3.1 Definition of a Serious Incident & Never Event

3.1.1 Serious incidents are events in health care where the potential for learning is so great, or the consequences to patient, families and carers, staff or organisations are so significant that they warrant our particular attention to ensure these incidents are identified correctly, investigated thoroughly and most importantly, learned from to prevent the likelihood of similar incidents happening again. Serious incidents can extend beyond incidents that affect patients directly and include incidents that may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare. Serious incidents can be isolated, single events or multiple linked or unlinked events signalling systemic failures within a commissioning or health system. NHS England has produced an information resource to support the reporting and management of serious incidents which can be found in The SI Framework and supporting appendices (Appendix 1).

3.1.2 Whilst the definition of a SI is quite broad, the following criteria outline the type of incidents which should be included:

a) Unexpected or avoidable death of one or more people. This includes:
- Suicide/self-inflicted death
- Homicide by a person in receipt of mental health care within the recent past

b) Unexpected or avoidable injury to one or more people that has resulted in serious harm.

c) Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent:

- The death of the service user
- Serious harm
- Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment or acts of omissions which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery.

d) Never Events - All Never Events are defined as serious incidents, although not all Never Events necessarily result in serious harm or death. The Never Events Policy and Framework and List can be found in Appendix 1.

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

Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues (see Appendix 4 for further information);

- Property damage
- Security breach/concern
- Incidents in population-wide healthcare activities such as screening or immunisation programmes where the potential for harm may extend to a large population;
- Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS);
- Systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/ unit closure or suspension of services); or
- Activation of Major Incident Plan (by provider, commissioner or relevant agency)

f) Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation.

3.2 Working with other Organisations/Sectors

3.2.1 Deaths in Custody

- People in custody, including those detained under the Mental Health Act (1983) or those detained under the police and justice system, are owed a duty of care by relevant authorities. The obligation on the authorities to account for the treatment of an individual is particularly stringent when that individual dies.
- Any death in prison or police custody will be referred to the Prison and Probation Ombudsman (PPO) or the Independent Police Complaints Commission (IPCC) who are responsible for carrying out the relevant investigations. Healthcare providers must fully support these investigations where required to do so.

- In NHS Mental Health services, providers must ensure that any death of a patient detained under the Mental Health Act (1983) is reported to the Care Quality Commission (CQC) without delay. However providers are responsible for ensuring that there is an appropriate investigation into the death of a patient detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies. In circumstances where the cause of the death is unknown and/or where there is reason to believe the death may have been avoidable or unexpected then the death must be reported to the provider's commissioner(s) as an SI and investigated appropriately.

- Where the deceased is subject to a Deprivation of Liberty Safeguards (DoLS) authorisation, the coroner must always be informed, whether the death was expected or not, a coroner's officer will attend.

3.2.2 Child Safeguarding Practice Reviews and Safeguarding Adult Reviews

- The Local Safeguarding Children Partnerships have the statutory responsibility to commission a Child Safeguarding Practice Review when specific criteria are met. The Local Safeguarding Adult Board now has a statutory responsibility to commission a Safeguarding Adult Review in certain circumstances.

- Healthcare providers must contribute towards safeguarding reviews as

requested to do so by the Local Safeguarding Partnership/Board where it is indicated that a serious incident has occurred. CCG Safeguarding Designated Professionals will provide health leadership to review processes.

- The interface between the serious incident process and local safeguarding policies must therefore be articulated in the local multi-agency safeguarding policy and protocol.

3.2.3 Domestic Homicide Reviews

- Where a Domestic Homicide is identified by the police, the Community Safety Partnership (CSP) will consider whether the case meets the criteria for a Domestic Homicide Review (DHR). Healthcare providers must co- operate in this process. CCG Safeguarding Designated Professionals will provide health leadership to review processes.

3.2.4 Homicide by patients in receipt of mental health care

- Where patients in receipt of mental health services commit a homicide, NHS England will consider and, if appropriate, commission an investigation. This process is overseen by NHS England's Regional investigation teams.

3.2.5 Serious Incidents in National Screening Programmes

- There are a number of immunisation or screening programmes which require a broader approach to handling incidents.

- Public Health England's Screening Quality Assurance Service is responsible for surveillance and trend analysis of all screening incidents. It will ensure that the lessons learned from incidents are collated and disseminated across screening services and geographical areas.

- Screening SIs are often complex, multi-faceted incidents which require robust coordination and oversight by Screening and Immunisation Teams embedded within NHS England at sub-regional level, and specialist input from Public Health England's Screening Quality Assurance Service.

- Further details on the management of incidents within the screening programme are available in "Managing Safety Incidents in NHS Screening Programme" (Appendix 3)

- For SIs linked to other national screening programmes (e.g. ante natal and child health screening, retinal screening etc.) the Regional Screening Lead will provide advice to local organisations and will inform the national coordinating bodies as appropriate.

Flow chart for managing screening incidents can be found in Appendix 3

3.3 Information Governance and Cyber Security Serious Incidents requiring Investigation

3.3.1 The General Data Protection Regulation (GDPR)/UK Data Protection Bill imposes legal obligations on controllers to comply with the requirement to report specific breaches to the Information Commissioner's Office (ICO) without undue delay and no later than 72 hours of becoming aware of such a breach, where the breach is likely to result in a risk to the rights and freedoms of individuals.

3.3.2 GDPR/UK Data Protection Bill requires that a controller informs individuals affected by a breach of their personal data of the breach without undue delay, where the breach is likely to result in a risk to the rights and freedoms of individuals.

3.3.3 Any incident involving the actual or potential loss of personal information that involves a high risk to the rights and freedoms of individuals should be considered as potentially serious and advice should be sought from the IG service.

3.3.4 Where an IG incident impacts upon a patient's rights and freedoms it must be reported to the Clinical Quality team so they can report it through the STEIS system as soon as possible (and no later than 24 hrs. after the incident during the working week). These must be categorised in STEIS using the "Confidential Information Leak/IG Breach" category. NHS England is responsible for notifying the Department of Health of any category 3-5 incident and will do this as soon as possible after they have been made aware of such an incident (either through STEIS or other means).

3.3.5 Individual organisations are responsible for following the Health and Social Care Information Centre's (NHS Digital) Checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation. Incidents which score Level 2 or above must be reported centrally via the Information Governance Toolkit. If a CCG is unsure of the level of the incident, further guidance can be sought from the Commissioning Support Unit's Information Governance Team.

3.3.6 Consideration should always be given to informing patients/service users when person identifiable information about them has been lost or inappropriately placed in the public domain.

3.3.7 Loss of encrypted media should not be reported as a SI unless the data controller has reason to believe that the encryption did not meet the Department of Health Standards that the protections had been broken, or were improperly applied.

3.3.8 There is no simple definition of an information governance serious incident. The scope of an Information Governance Serious Incident may include:

- A breach of one of the principles of the Data Protection Act and/or the Common Law Duty of Confidentiality.
- Unlawful disclosure or misuse of confidential data, recording or sharing of inaccurate data, information security breaches and inappropriate invasion of people's privacy.
- Personal data breaches which could lead to identity fraud or have other significant impact on individuals.

3.3.9 There are many possible definitions of what a Cyber incident is, for the purposes of reporting the definition is anything that could (or has) compromised information assets within Cyberspace. “Cyberspace is an interactive domain made up of digital networks that is used to store, modify and communicate information. It includes the internet, but also the other information systems that support a businesses, infrastructure and services.”

These types of incidents could include:

- Denial of Service attacks
- Phishing emails
- Social Media Disclosures
- Web site defacement
- Malicious Internal damage
- Spoof website
- Cyber Bullying

3.3.10 NHS Digital has provided guidance for how SIs relating to information governance and cyber security should be dealt with and should be embedded within local process and procedures. The full guidance is accessible at https://www.dsptoolkit.nhs.uk/Help/29

3.4 Serious Incidents involving controlled drugs.

SIs that involve controlled drugs must also be notified to the North of England Commissioning Support Medicines Optimisation Pharmacy Team.

4. Reporting and Management of Serious Incidents

4.1 Independent Healthcare sector

4.1.1 The Independent Healthcare Sector (IHS) should be subject to contractual obligations for the reporting of SIs. The CCG should ensure that appropriate reporting arrangements are in place with the IHS in relation to SIs (Appendix5).

4.1.2 SCCG should ensure that IHS SIs are reported via NHS England’s web based serious incident management system StEIS (the Strategic Executive Information System) and investigated appropriately.

4.2 Guidance for Commissioned Services/Providers

4.2.1 Each NHS Trust/organisation must nominate a single point of contact or lead officer for managing all SIs.

4.2.2 Organisations should ensure that mechanisms are in place to report all incidents meeting the criteria.

4.2.3 The SI lead officer must report a SI through StEIS within 2 working days of Identification of the SI, completing all relevant sections. At this stage it is important that any immediate learning is included in this report.

4.2.4 If appropriate, the SI lead officer must liaise with the organisations communications team who will liaise directly NHS England Communications team.

4.2.5 The organisation must then provide a 72hr report, which should be sent to North of England Commissioning Support (NECS) necsu.durham-si@nhs.net as the responsible delegate for CCGs. The report should include further information regarding the event, immediate learning and how the RCA will be conducted.

4.2.6 Under the Data Protection Act (2018) organisations need to be open and transparent with regards to investigation processes, unless there are specific exceptions. Arrangements may need to be put in place to support patients and family members through the investigation process and sharing of the outcome of investigations. The appointment of a Family Liaison Officer may be appropriate.

4.2.7 If an incident spans organisational boundaries, **it is the responsibility of the organisation where the incident took place** to formally report it through StEIS. All other additional organisations involved must contribute and fully cooperate with the process in line with the agreed timescales. Where there is doubt about who should report the incident then clarity must be sought through the North of England Commissioning Support Clinical Quality Team.

4.2.8 If an incident involves more than one NHS organisation a decision will be mutually agreed as to which organisation will be the lead investigating organisation. Where an incident involves the independent sector or contracted services, it is the role of the commissioning CCG to lead. The RASCI (Responsible, Accountable, Supporting, Consulted, Informed) model should be completed in order to assign accountability.

4.2.9 This guidance must not interfere with existing lines of accountability and does not replace the duty to inform the police and/or other organisations or agencies where appropriate. Further guidance can be obtained from the Department of Health publication *Memorandum of Understanding: Investigating Patient Safety Incidents* June 2004 and accompanying NHS guidance of December 2006. The need to involve outside agencies should not impede the retrieval of immediate learning.

4.2.10 Certain SIs may also be subject to independent investigations conducted by the Healthcare Safety Investigation Branch (HSIB) and this includes all patient safety investigations of maternity incidents occurring in the NHS which meet criteria for the Each Baby Counts programme.

4.2.11 Serious Incidents which have impacted or have had potential to impact on children and/ or vulnerable adults must be investigated in conjunction with the identified safeguarding designated professional and in accordance with related guidance.

4.2.12 Where an incident is subject to the involvement of a coroner, an independent inquiry, or safeguarding review processes, this should be highlighted clearly within the StEIS report as this may affect closure date.

4.2.13 Organisations should undertake investigation procedures / root cause analysis (RCA) as per organisation policy and submit to the responsible body within the agreed timescales. An example for the contents of a report and action plan can be found in Appendix **.** To ensure confidentiality all reports submitted to SCCG or North of England Commissioning Support Clinical Quality Team should be anonymous and sent via the agreed StEIS NHS-net account. NECS will conduct a quality assurance check on all RCAs on behalf of the relevant CCG in order to ensure the 20 day deadline is met.

4.3 Clinical Commissioning Groups (CCGS) SIs

4.3.1 If a Serious Incident has been identified as occurring within the CCG, reporters should refer to SCCG C008 Incident Reporting and Management Policy.

4.4 Independent Contractors

4.4.1 Once an SI is identified, in a CCG commissioned service, the Independent Contractors Procedure for the Reporting and Management of Serious Incidents should be followed, or where applicable NHS England should be notified. This is explicit in Appendix 6.

4.4.2 Where an SI raises professional concerns about a GP the CCG must be informed so that local arrangements for assuring high standards of professional performance can be invoked where applicable and/or NHS England notified where necessary.

4.4.3 Independent Contractors should have systems in place to ensure that staff are supported appropriately following the identification of a SI.

4.5 NHS Providers

4.5.1 Once an SI is identified, the Providers' Procedure for the Reporting and Management of Serious Incidents should be followed (Appendix 6).

4.5.2 Providers should have systems in place to ensure that staff are supported appropriately following identification of a SI.

4.6 Independent Healthcare Sector Providers

4.6.1 Once an SI is identified, the Procedure for the Reporting and Management of Independent Healthcare Sector Serious Incidents should be followed (Appendix 7).

4.6.2 Independent providers should have systems in place to ensure that staff are supported appropriately following identification of a SI.

4.7 Staff Involved in Serious Incidents

Serious incidents can be distressing for those involved.

4.7.1 The Director, Head of Service or appropriate Manager should ensure that staff are supported at all stages of a SI with reference to HR policies.

4.7.2 The Director, Head of Service or appropriate Manager are responsible for ensuring that a de-briefing session occurs at an appropriate stage following a SI.

4.7.3 If, during the course of a SI investigation, it becomes apparent that a member of staff may be subject to a disciplinary hearing, appropriate advice and support should be taken via Human Resources and the relevant policy followed.

4.8 Information for Education and Training Organisations

4.8.1 In the event an incident involves a student or trainee, the relevant academic institution will be notified by the NHS Trust/CCG as appropriate.

4.8.2 Where a SI concerns the commissioning or provision of medical or dental education or training, or a medical or dental trainee or trainees, there will be appropriate communication between the CCG and Health Education England (North East).

4.9 CCG Management and Closure of Serious Incidents

4.9.1 The CCG is responsible for quality assuring the robustness of its providers' serious incident investigations and their action plan implementation.

4.9.2 The CCG is responsible for evaluating investigations and gaining assurance that the processes and outcomes of investigations include identification and implementation of improvements that will prevent recurrence of serious incidents.

In order to achieve this, the CCG has established the joint Serious Incident Panel and the terms of reference can be found in Appendix 8.

5 Implementation

5.1 This policy will be available to all CCG Staff for use in the circumstances described on the title page.

5.2 All managers are responsible for ensuring that relevant staff within the CCG have read and understood this document and are competent to carry out their duties in accordance with the procedures described.

6 Training Implications

6.1 The sponsoring director will ensure that the necessary training or education needs and methods required to implement the policy are identified and resourced or built into the delivery planning process. This may include identification of external training providers or development of an internal training process.

6.2 The level of training required in incident reporting and management varies depending on the level and responsibility of the individual employee.

6.3 The training required to comply with this policy is key to the successful implementation of the policy and embedding a culture of incident reporting and management in the organisation. Through a training and education programme, staff will have the opportunity to develop more detailed knowledge and appreciation of the role of incident reporting and management. Training and education will be offered through a rolling programme of incident reporting and management training.

7. Fair Blame

The CCG is committed to a policy of 'fair blame'. In particular formal disciplinary procedures will only be invoked following an incident where:

- there are repeat occurrences involving the same person where their actions are considered to contribute towards the incident
- there has been a failure to report an incident in which a member of staff was either involved or about which they were aware (failure to comply with organisation's policy and procedure)
- in line with the organisation and/or professional regulatory body, the action causing the incident is removed from acceptable practice or standards, or where
- there is proven malice or intent

Fair blame means that the organisation:

- operates its incident reporting policy in a culture of openness and transparency which fulfils the requirements for integrated governance
- adopts a systematic approach to an incident when it is reported and does not rush to judge or 'blame' without understanding the facts surrounding it
- encourages incident reporting in the spirit of wanting to learn from things that go wrong and improve services as a result

7.1 Support for staff, and others

When an incident is reported it can be a stressful time for anyone involved, whether they are members of staff, a patient directly involved or a witness to the incident. They all need to know that they are going to be treated fairly and that lessons will be learned and action taken to prevent the incident happening again.

7.2 A Just Culture Guide

In March 2018 NHS Improvement published 'A just culture guide' (Appendix 8) which replaced the NPSA incident decision tree. The fair treatment of staff supports a culture of fairness, openness and learning in the NHS by making staff feel confident to speak up when things go wrong, rather than fearing blame.

Supporting staff to be open about mistakes allows valuable lessons to be learnt so the same errors can be prevented from being repeated.

The guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely.

- It asks a series of questions that help clarify whether there truly something is specific about an individual that needs support or management versus whether the issue is wider, in which case singling out the individual is often unfair and counter-productive.
- it helps reduce the role of unconscious bias when making decisions and will help ensure all individuals are consistently treated equally and fairly no matter what their staff group, profession or background.

The guide should not be used routinely. It should only be used when there is already suspicion that a member of staff requires some support or management to

work safely, or as part of an individual practitioner performance/case investigation. Remember, you have moved into individual practitioner performance investigation when it is suggested a single individual needs support to (including training, supervision, reflective practice, or disciplinary action), as opposed to where a whole cohort of staff has been identified, which would be examined as part of a safety investigation.

The guide does not replace the need for patient safety investigation and should not be used as a routine or integral part of a patient safety investigation. This is because the aim of those investigations is system learning and improvement. As a result, decisions on avoidability, blame, or the management of individual staff are excluded from safety investigations to limit the adverse effect this can have on opportunities for system learning and improvement

8. Documentation

8.1 Other related policy documents

Legislation and statutory requirements

- Serious Incident Framework (March 2015) or replacement framework
- Revised Never Events Policy and Framework (January 2018)
- Working Together to Safeguard Children 2018
- Care Act 2014
- Domestic Homicide Reviews: statutory guidance 2016

8.2 Best practice recommendations

- Managing Safety Incidents in NHS Screening Programmes (August 2017)

- NHS Digital: Guide to the Notification of Data Security and Protection Incidents (September 2018)

9. Monitoring, Review and Archiving

9.1 Monitoring

The governing body will agree a method for monitoring the dissemination and implementation of this policy. Monitoring information will be recorded in the policy database.

9.2 Review

9.2.1 The governing body will ensure that this policy document is reviewed in accordance with the timescale specified at the time of approval. No policy or procedure will remain operational for a period exceeding three years without a review taking place.

9.2.2 Staff who become aware of any change which may affect a policy should advise their line manager as soon as possible. The governing body will then consider the need to review the policy or procedure outside of the agreed timescale for revision.

9.2.3 For ease of reference for reviewers or approval bodies, changes should be noted in the ‘document history’ table on the front page of this document.

NB: If the review consists of a change to an appendix or procedure document, approval may be given by the sponsor director and a revised document may be issued. Review to the main body of the policy must always follow the original approval process.

9.3 Archiving

The governing body will ensure that archived copies of superseded policy documents are retained in accordance with Records Management Code of Practice for Health and Social Care 2016.

10. Equality Analysis

Equality Impact Assessment
Initial Screening Assessment

STEP 1

Step 1

As a public body organisation we need to ensure that all our strategies, policies, services and functions, both current and proposed have given proper consideration to equality and diversity, do not aid barriers to access or generate discrimination against any protected groups under the Equality Act 2010 (Age, Disability, Gender Reassignment, Pregnancy and Maternity, Race, Religion/Belief, Sex, Sexual Orientation, Marriage and Civil Partnership, Carers and Health Inequalities).

A screening process can help judge relevance and provides a record of both the process and decisions made.

This screening determines relevance for all new and revised strategies, policies, projects, service reviews and functions.

Completed at the earliest opportunity it will help to determine:

- The relevance of proposals and decisions to equality, diversity, cohesion and integration.
- Whether or not equality and diversity is being/has already been considered for due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED).
- Whether or not it is necessary to carry out a full Equality Impact Assessment.

Name(s) and role(s) of person completing this assessment:

Name: Helen Osborn
Role: Senior Clinical Quality Officer, NECS

Title of the service/project or policy:

Serious Incident (SI) Management Policy – Sunderland CCG

Is this a:

[x]	Strategy / Policy	[ ]	vice Review	Proje	[ ]

If other, please specify:

What are the aim(s) and objectives of the service, project or policy:

The purpose of this policy is to identify what is meant by a Serious Incident (SI) or Never Event (NE) and to describe the role of the CCG when a SI or NE occurs across a number of organisations.

Who will the project/service /policy / decision impact?

Consider the actual and potential impacts:

- [x] Staff
- [x] service users/patients
- [x] other public sector organisations
- [ ] voluntary / community groups / trade unions
- [ ] others, please specify:

Questions	Yes	No
Could there be an existing or potential impact on any of the protected characteristic groups?		X
Has there been or likely to be any staff/patient/public concerns?		X
Could this piece of work affect how our services, commissioning or procurement activities are organised, provided, located and by whom?		X
Could this piece of work affect the workforce or employment practices?		X
Does the piece of work involve or have an impact on: • Eliminating unlawful discrimination, victimisation and harassment • Advancing equality of opportunity • Fostering good relations		X

If you have answered no to the above and conclude that there will not be a detrimental impact on any equality group caused by the proposed policy/project/service change, please state how you have reached that conclusion below:

The policy outlines the process and responsibilities of key partners in following the NHS England guidance on managing and investigating serious incidents and never events. This will apply to all incidents that take place under the remit of the commissioners regardless of the characteristics/protected groups applicable to the EIA process.

If you have answered yes to any of the above, please now complete the 'STEP 2 Equality Impact Assessment' document.

Governance, ownership and approval

Please state here who has approved the actions and outcomes of the screening		
Name	**Job title**	**Date**
Kirstie Hesketh	Head of Quality and Patient Safety	24.02.19

Publishing

This screening document will act as evidence that due regard to the Equality Act 2010 and the Public Sector Equality Duty (PSED) has been given.

If you are not completing 'STEP 2 - Equality Impact Assessment' this screening document will need to be approved and published alongside your documentation.

A copy of all screening documentation should be sent to: **NECSU.Equality@nhs.net** for audit purposes.

Appendix 1

SERIOUS INCIDENT FRAMEWORK 2015 AND FREQUENTLY ASKED QUESTIONS AND NEVER EVENT POLICY AND FRAMEWORK 2018

NHS England Serious Incident Framework 2015

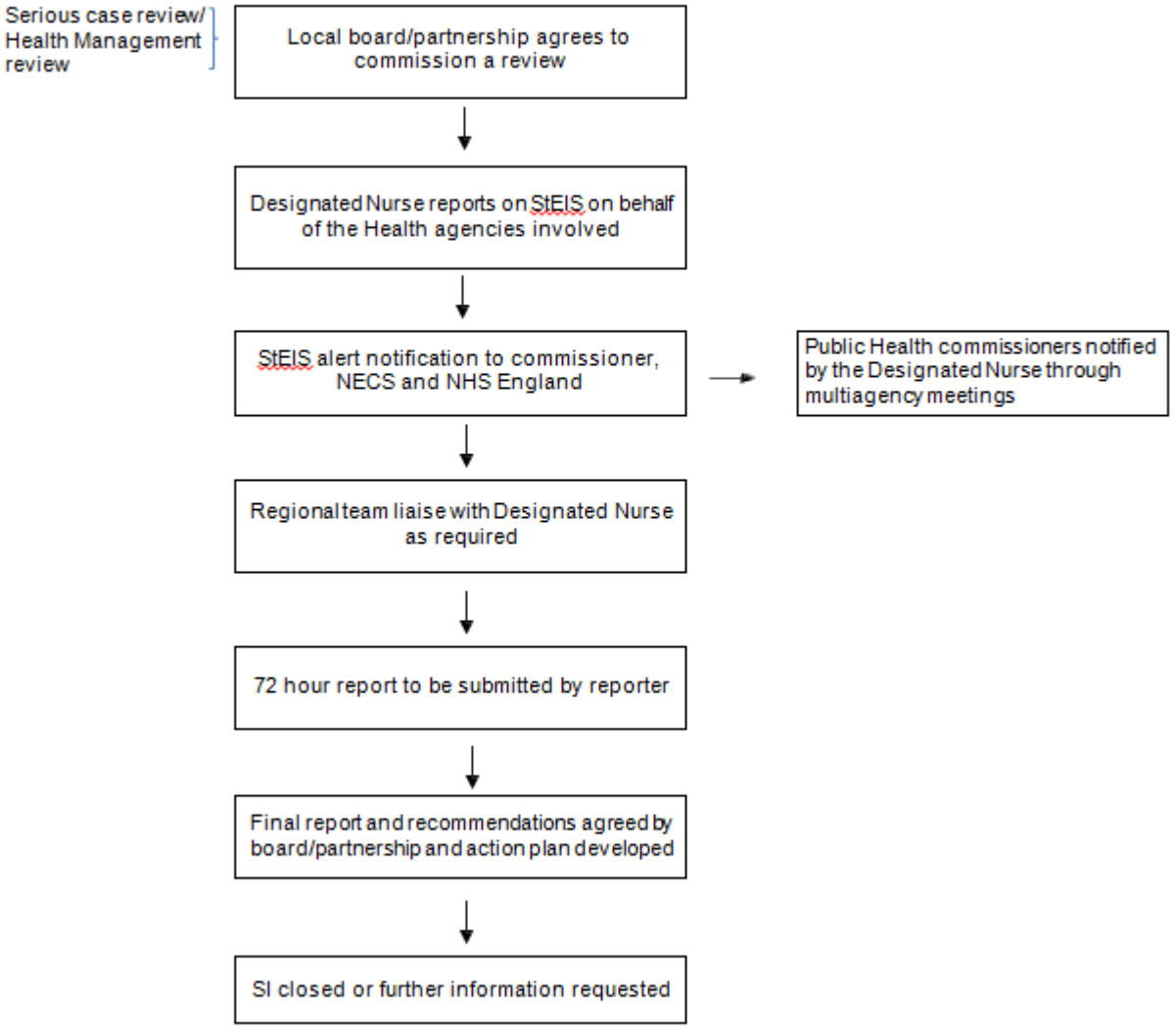
NHS England Serious Incident Framework FAQs

Never Event Policy and Framework 2018

Never Events List 2018

Appendix 2

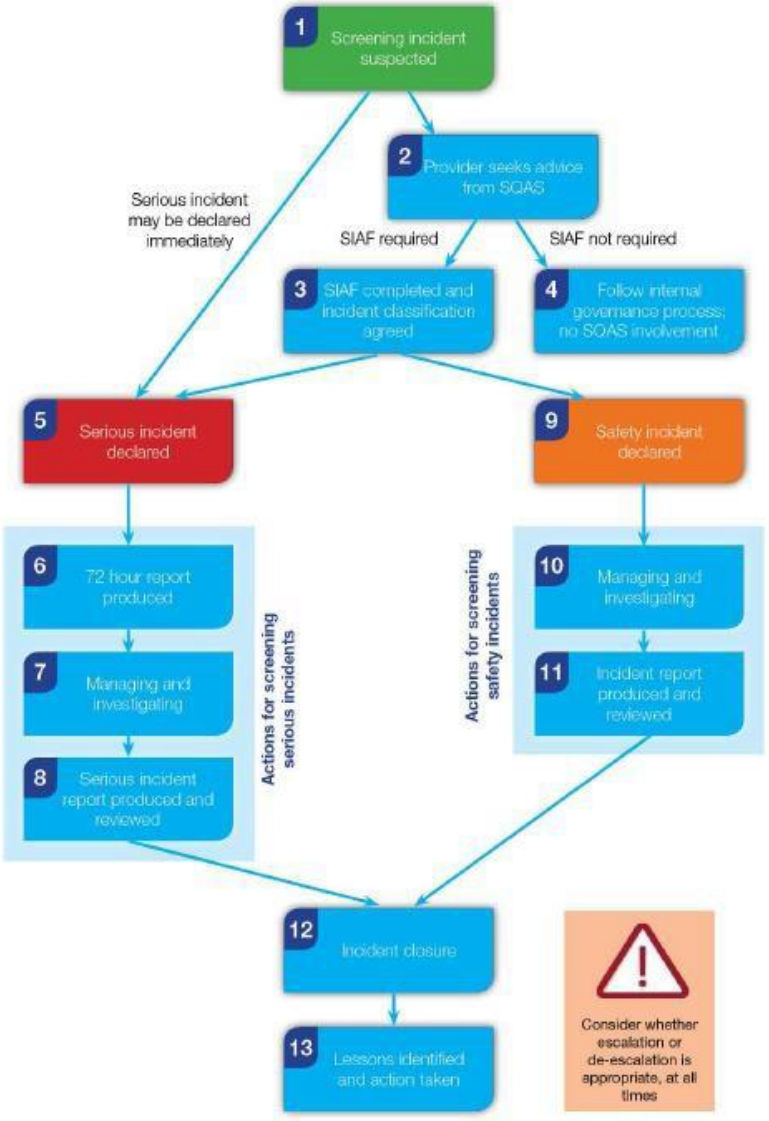
PROCEDURE FOR THE REPORTING AND MANAGEMENT OF SAFEGUARDING CHILDREN, SAFEGUARDING ADULTS AND DOMESTIC HOMICIDE REVIEW INCIDENTS



Appendix 3

REPORTING AND MANAGING SCREENING INCIDENTS

Further details on the management of incidents within the screening programme are available in [Managing Safety Incidents in NHS Screening Programmes]



Notes to accompany reporting and screening incidents flowchart

1. **Screening incident suspected**
2. **Provider seeks advice from SQAS**
   A serious incident may be suspected but if there is insufficient evidence or a risk to declare a serious incident then ensure advice is sought.
3. **SIAF completed and incident classification agreed**
   Aim to complete within 5 working days.
   i. Provider details the facts in section 1 guided by SQAS (region).
   ii. Provider registers suspected incident on national reporting and learning system (NRLS) or replacement (reference provided on SIAF).
   iii. SQAS assesses and recommends a classification and handling to provider and SIT.
   iv. SIT confirms classification and handling to provider and SQAS.
4. **Follow internal governance process; no further SQAS involvement**
   This will also apply if a SIAF is completed and the classification is 'not a screening incident'. If there is an incident but it is outside the screening pathway, the responsible commissioner is informed.
5. **Serious incident declared**
   Provider reports serious incident on StEIS within 2 working days. Provider sets up incident panel (should include SIT and SQAS).
6. **72 hour report produced**
7. **Managing and investigating**
   Serious incident managed in accordance with agreed handling plan guided by SQAS (region). Changes to the handling plan and classification may be agreed by provider/SQAS (region) and SIT as more information is known.
8. **Serious incident report produced and reviewed**
   Provider produces an incident report within 60 working days or alternative time period agreed with SQAS and SIT. SQAS and SIT comment on report. Aim is for all parties to agree the report within 20 working days.
9. **Safety incident declared**
   If a final incident report is required then ensure the following actions are taken.
10. **Managing and investigating**
    Safety incident managed in accordance with agreed handling plan guided by SQAS (region). Changes to the handling plan and classification may be agreed by provider/SQAS (region) and SIT as more information is known.
11. **Incident report produced and reviewed**
    Provider produces an incident report within 60 working days or alternative time period agreed with SQAS and SIT. SQAS and SIT comment on report. Aim is for all parties to agree the report within 20 working days.
12. **Incident closure**
    SQAS recommend incident for closure and responsible commissioner reviews and closes, governance for incomplete actions agreed, for example Programme Board monitoring.
13. **Lessons identified and action taken**
    SQAS records

Appendix 4

EXAMPLE TEMPLATE

Guidance on Serious Incident Report and Action Plan

The report into Serious Incidents and the associated action plan should cover the following minimum information. Further work is under way with local organisations to develop and agree a common template

Report

- Introduction
- Constitution and investigation procedure
- Membership of the investigation team
- Terms of reference
- Background information
- Chronology
- Findings – to be identified against each of the terms of reference
- Conclusions - Care and Service Delivery problems
- Root cause(s)
- Contributory factors
- Lessons learnt
- Recommendations

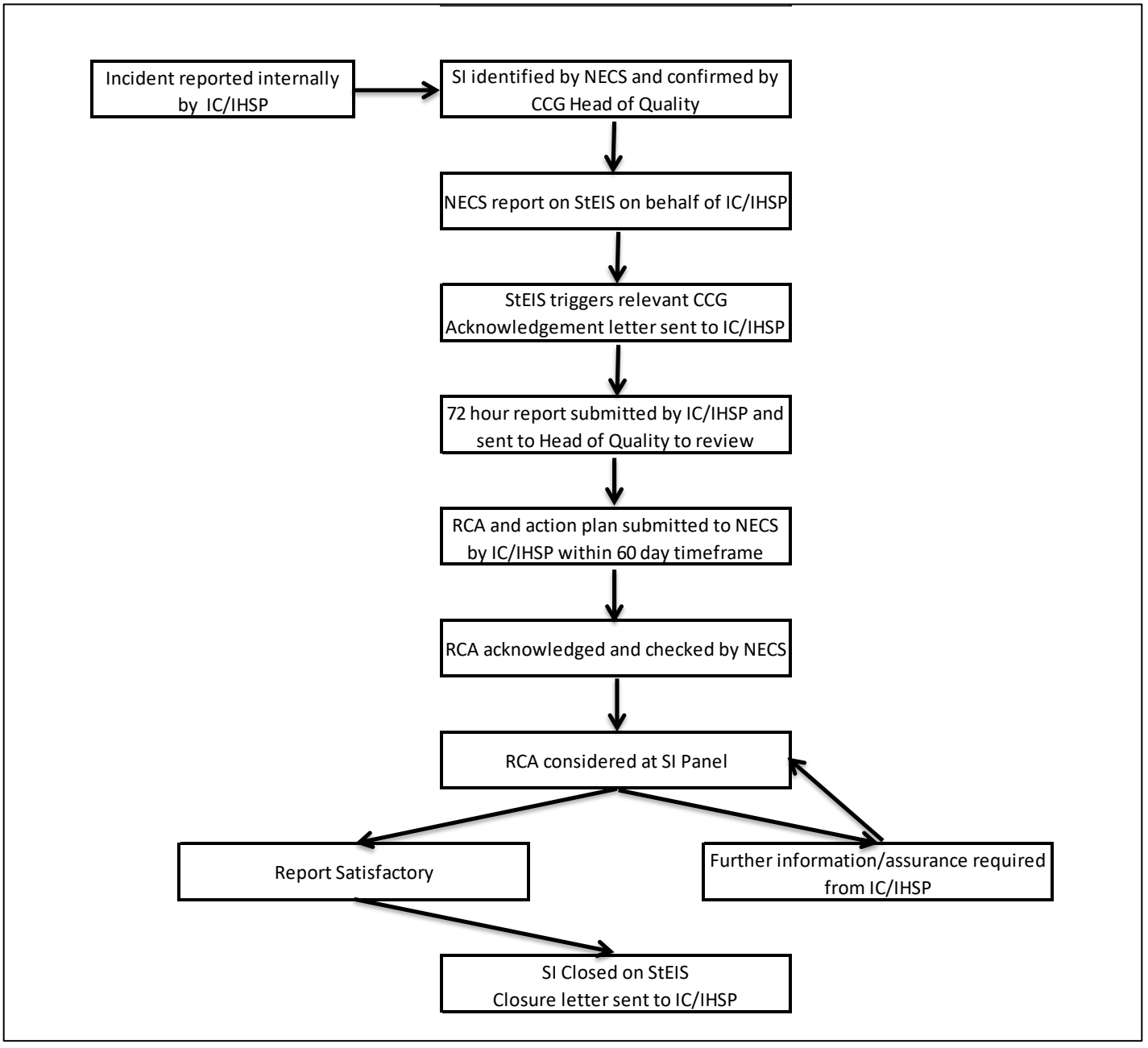
Action Plan

- Clearly set out actions which fall from the recommendations
- What needs to happen to achieve the outcome?
- Identified title of who is responsible for the action
- Specific timescales on-going except where incorporated in to the Trust's everyday business for example the organisations annual programme of audit.

Root cause analysis tools to assist organisations in their investigation can be found at NPSA resources

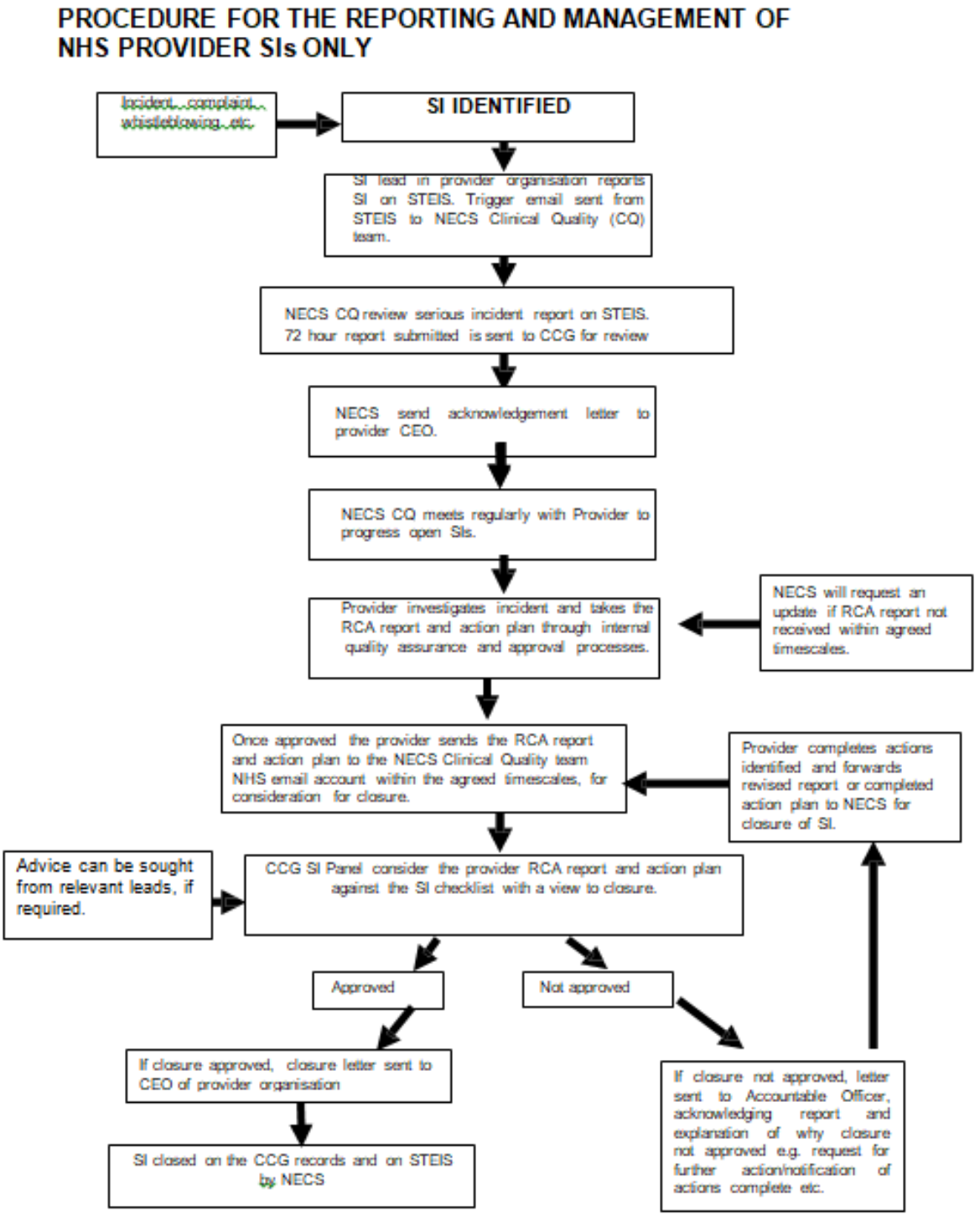
Appendix 5

PROCEDURE FOR THE REPORTING AND MANAGEMENT OF SERIOUS INCIDENTS BY GENERAL PRACTICE INDEPENDENT CONTRACTORS/INDEPENDENT PROVIDER COMMISSIONED SERVICE SIs ONLY



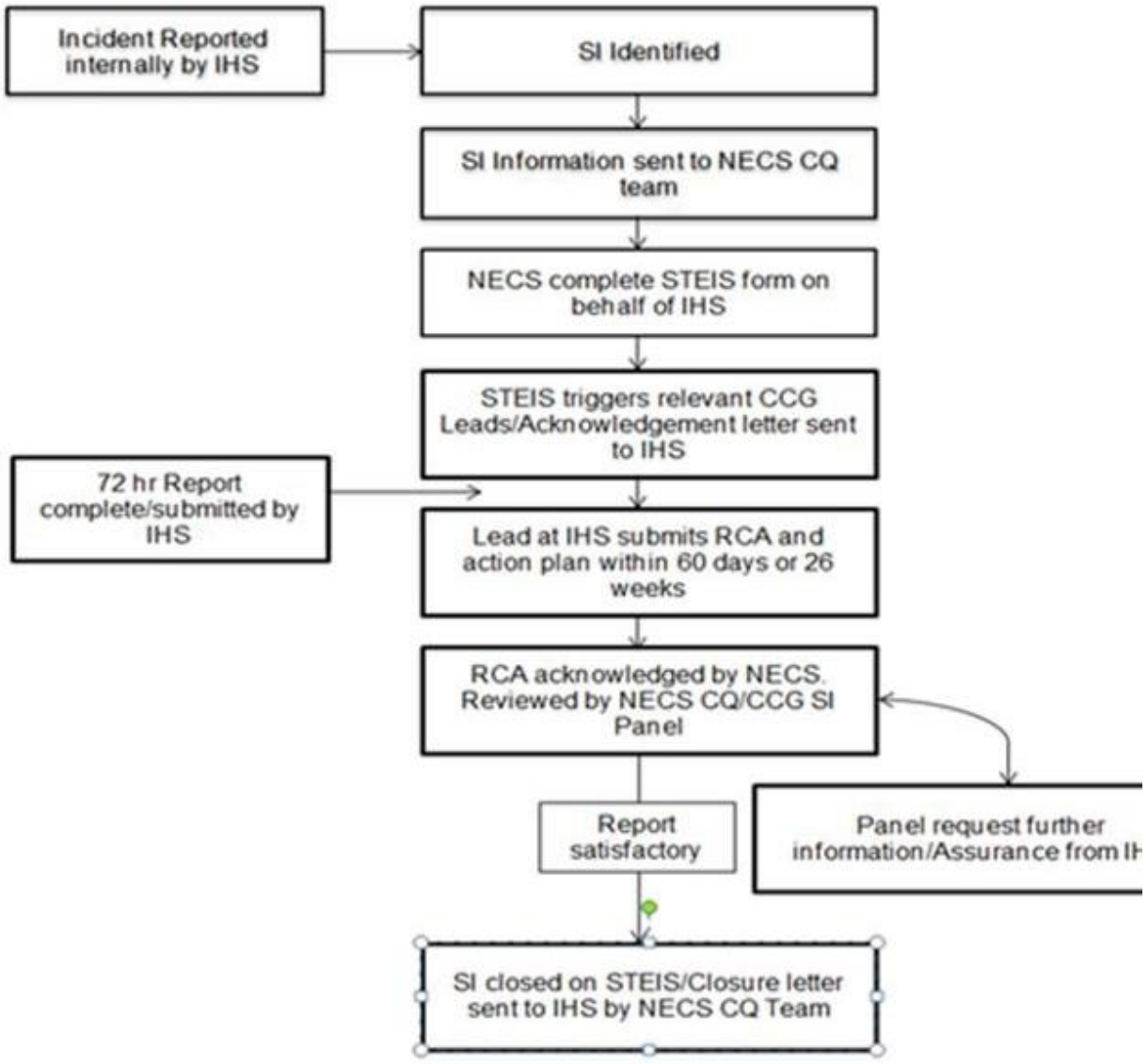
Appendix 6a

PROCEDURE FOR THE REPORTING AND MANAGEMENT OF NHS PROVIDER SERIOUS INCIDENTS



APPENDIX 6b

PROCEDURE FOR THE REPORTING AND MANAGEMENT OF SERIOUS INCIDENTS BY GENERAL PRACTICE INDEPENDENT CONTRACTORS/INDEPENDENT PROVIDER COMMISSIONED SERVICE SIs ONLY



Appendix 7

Serious Incident Panel Terms of Reference

SERIOUS INCIDENT PANEL
TERMS OF REFERENCE

1. Aim

1.1 The Serious Incident (SI) Panel is a joint panel held between NHS South Tyneside Clinical Commissioning Group (STCCG) and NHS Sunderland Clinical Commissioning Group (SCCG). The panel has responsibility for quality assuring the robustness of providers' serious incident investigations and the action plan implementation undertaken by their providers. Commissioners do this by evaluating investigations and gaining assurance that the processes and outcomes of investigations include identification and implementation of improvements that will prevent recurrence of serious incidents.
The purpose of the SI panel is to ensure that the Clinical Commissioning Groups (CCGs) fulfil their duty/responsibility for the management of serious incidents by overseeing investigations that are led and resourced by the provider(s) of care in which the serious incident occurred, involving patients of the CCGs. This will include, but is not limited to serious incidents reported by South Tyneside and Sunderland NHS Foundation Trust; Cumbria, Northumberland, Tyne & Wear NHS Foundation Trust; North East Ambulance Service NHS Foundation Trust and as CCGs themselves (covering internal reporting and external such as CCG commissioned independent providers) and General Medical Practices, including liaison with NHS England.

2. Accountability

2.1 The Serious Incident Panel is a sub group of the South Tyneside and Sunderland CCGs' Joint Quality and Safety Committee.

3. Membership

3.1 The membership of the Panel will include:

- Executive Director of Nursing, Quality and Safety from each of the CCGs
- Medical Director or equivalent Executive GP/Clinical Lead from each of the CCGs
- Head of Quality and Patient Safety (Joint)
- Safeguarding CCG representative
- NECS representative

Other representatives will be co-opted as appropriate, as well as representatives from provider organisations. CCG representation may be rotated, providing there is at least one director level clinician present as decision-maker.

4. Authority

4.1 The South Tyneside and Sunderland CCGs' Joint Quality and Safety Committee authorise the Serious Incident Panel to pursue any activity within these Terms of Reference in relation to serious incident management including:

- Seeking any information required from CCG employees and commissioned services in line with its responsibilities under these terms of reference;
- Requiring all CCG employees to co-operate with any reasonable request made by the Panel in line with its responsibilities under these terms of reference;

- Requiring all provider services to co-operate with any reasonable request made by the Panel in line with its responsibilities under these terms of reference.

4.2 The Panel is required to comply with:

- The CCGs' Information Governance Policies
- The CCGs' Standing Orders and Standing Financial Instructions
- The CCGs' Conflict Of Interest Policies
- The CCGs' Serious Incident and Management Policies
- The CCGs' Safeguarding Adult and Children Policies
- NHS England Serious Incident and Never Event Frameworks.

5. Roles and Responsibilities

5.1 To monitor levels of reporting and compliance with the agreed Serious Incident Policy as Commissioners of services.

5.2 To ensure appropriate reporting in line with the agreed Serious Incident Policy in relation to commissioned services and SCCG & STCCG as corporate bodies.

5.3 To ensure safeguarding issues are identified and relevant action taken.

5.4 To ensure robust root cause analysis is undertaken by the provider in relation to all reported serious incidents.

5.5 To monitor progress against identified actions, making recommendations for further actions as appropriate.

5.6 Request further information in relation to serious incidents to ensure robust performance management arrangements are in place with all providers.

5.7 Request attendance from lead officers/directors as appropriate to demonstrate assurance in serious incident management.

5.8 To ensure that timely learning from serious incidents is identified and shared through the appropriate mechanisms across the reporting organisation and wider where required.

5.9 To ensure appropriate links are made with other serious incident and statutory review processes, e.g. Child safeguarding practice reviews (CSPR), safeguarding adult reviews (SAR) , domestic homicide reviews (DHR), mental health homicide reviews (MHHR) and mortality reviews, including learning disability mortality reviews (LeDeR) and Child death overview panel (CDOP) where appropriate..

5.10 The panel will not dispute coronial verdicts but will seek to ensure that learning is maximised from serious incident investigations.

6. Attendance at Meetings

6.1 The members of the group are required to provide information to progress and inform the agreed agenda items.

6.2 The group members are required to attend each meeting or if apologies are made, any information they are expected to contribute must be supported either through a deputy, or in writing to the Chair.

6.3 In addition to the core membership the committee may co-opt additional members as appropriate to enable it to undertake its role.

7. Quorum

7.1 A minimum of two clinical representatives must be present at each Panel meeting, one from each CCG.

8. Frequency of Meetings

8.1 Meetings will be held monthly or at a more frequent interval as deemed necessary by the Chair.

9. Reporting

9.1 The Joint Serious Incident Panel, as a sub-group to the South Tyneside and Sunderland's CCGs' Joint Quality and Safety Committee reports by exception to the committee and at the relevant Quality Review Groups.

9.2 Significant quality/patient safety/ safeguarding issues will be identified to the Executive Team/ Governing Body on an exception basis when appropriate.

9.3 Reports identifying lessons learned from closed incidents will be included in the annual report to the Joint Quality and Safety.

10. Escalation Process

10.1 In line with the roles and responsibilities set out in section 5, the panel may seek additional assurance to ensure that robust root cause analysis of serious incidents has been undertaken and that all learning has been identified.

10.2 If additional assurance is not provided within four weeks, the chair of the Serious Incident Panel will formally write to the relevant provider organisation Lead for Quality to seek this assurance.

11. Administration

11.1 Meetings will be arranged, outcomes recorded and distributed, and all other administration needs will be undertaken by the Clinical Quality Team in NECS.

12. Approval

12.1 The CCGs' Joint Quality and Safety Committee will approve these Terms of Reference.
Date adopted: 8th June 2021

13. Date for Review

13.1 These Terms of Reference will be reviewed on an annual basis.

NHS

A just culture guide

Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents

This guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. Action singling out an individual is rarely appropriate - most patient safety issues have deeper causes and require wider action.

The actions of staff involved in an incident should **not** automatically be examined using this just culture guide, but it can be useful if the investigation of an incident begins to suggest a concern about an individual action. The guide highlights important principles that need to be considered before formal management action is directed at an individual staff member.

An important part of a just culture is being able to explain the approach that will be taken if an incident occurs. A just culture guide can be used by all parties to explain how they will respond to incidents, as a reference point for organisational HR and incident reporting policies, and as a communication tool to help staff, patients and families understand how the appropriate response to a member of staff involved in an incident can and should differ according to the circumstances in which an error was made. As well as protecting staff from unfair targeting, using the guide helps protect patients by removing the tendency to treat wider patient safety issues as individual issues.

Please note:

- **A just culture guide** is not a replacement for an investigation of a patient safety incident. Only a full investigation can identify the underlying causes that need to be acted on to reduce the risk of future incidents.
- **A just culture guide** can be used at any point of an investigation, but the guide may need to be revisited as more information becomes available.
- **A just culture guide** does not replace HR advice and should be used in conjunction with organisational policy.
- **The guide** can only be used to take one action (or failure to act) through the guide at a time. If multiple actions are involved in an incident they must be considered separately.

Start here - **Q1. deliberate harm test**

1a. Was there any intention to cause harm?

→ Yes → **Recommendation:** Follow organisational guidance for appropriate management action. This could involve: contact relevant regulatory bodies, suspension of staff, and referral to police and disciplinary processes. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual. → END HERE

No go to next question - **Q2. health test**

2a. Are there indications of substance abuse?

→ Yes → **Recommendation:** Follow organisational substance abuse at work guidance. Wider investigation is still needed to understand if substance abuse could have been recognised and addressed earlier. → END HERE

2b. Are there indications of physical ill health?

2c. Are there indications of mental ill health?

→ Yes → **Recommendation:** Follow organisational guidance for health issues affecting work, which is likely to include occupational health referral. Wider investigation is still needed to understand if health issues could have been recognised and addressed earlier. → END HERE

if **No to all** go to next question - **Q3. foresight test**

3a. Are there agreed protocols/accepted practice in place that apply to the action/omission in question?

3b. Were the protocols/accepted practice workable and in routine use?

3c. Did the individual knowingly depart from these protocols?

→ if **No** to any → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. → END HERE

if **Yes to all** go to next question - **Q4. substitution test**

4a. Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances?

4b. Was the individual missed out when relevant training was provided to their peer group?

4c. Did more senior members of the team fail to provide supervision that normally should be provided?

→ if **Yes** to any → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. → END HERE

if **No to all** go to next question - **Q5. mitigating circumstances**

5a. Were there any significant mitigating circumstances?

→ Yes → **Recommendation:** Action directed at the individual may not be appropriate; follow organisational guidance, which is likely to include senior HR advice on what degree of mitigation applies. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. → END HERE

if **No**

Recommendation: Follow organisational guidance for appropriate management action. This could involve individual training, performance management, competency assessments, changes to role or increased supervision, and may require relevant regulatory bodies to be contacted, staff suspension and disciplinary processes. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. → END HERE

improvement.nhs.uk

Based on the work of Professor James Reason and the National Patient Safety Agency's Incident Decision Tree

Supported by:

NHS England and NHS Improvement