CCG CO18: Serious Incident Policy

Ratified	Approved
Final	Draft
Issued	November 2017
Approved By	Governance and Risk Committee
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Author	NECS Senior Clinical Quality Team
Reference	CO18

Policy Validity Statement
This policy is due for review on the dates shown above. The policy will remain valid, but must be reviewed within each three year period.

Policy users should ensure that they are consulting the currently valid version of the documentation.

Version Control

Version	Release Date	Author	Update comments
1	28/02/2013	Commissioning Support Unit (CSU)	Policy provided to Clinical Commissioning Group (CCG) as part of policy suite.
2	May 2016	NECS Clinical Quality Team	Revised SI Framework & Never Events April 2015
2.1	August 2016	NECS Clinical Quality Team	Updated to include Domestic Homicide Information and updated IG references.
2.2	November 2016	NECS Clinical Quality Team	Updated national references and appendix 2 title amendment.
2.3	November 2017	NECS Clinical Quality Team	Updated screening incident links. Additional (unrelated to screening services) paragraph inserted in the policy at the end of section 3, which outlines the CCG responsibilities for closing SIs through the panel process. Updates to the IG sections and reference to GDPR. Renumbering of appendices

Approval

Role	Name	Date
Approval	Governing Body	March 2013 (1)
Approval	Governance & Risk Committee	May 2016 (2)
Approval	Governance & Risk Committee	August 2016 (2.1)
Approval	Governance & Risk Committee	November 2016 (2.2)
Approval	Governance & Risk Committee	November 2017 (2.3)

Review

The policy will remain valid, including during its period of review. However, the policy must be reviewed at least once in every three year period.

Contents

1. Introduction

The Clinical Commissioning Group (CCG) 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, the CCG 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.

The CCG as a Commissioner seeks to assure that all services which may be commissioned 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.

The role of the CCG as a Commissioner 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.

The revised 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 Serious Incident Framework 2015/16 and Never Event Framework 2015/16. This revised Framework replaces the Serious Incident Framework and Never Event Framework published in 2013.

1.1 Status

This policy is a corporate policy and outlines the Serious Incident (SI) Policy for South Tees 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 role of the CCG when a SI or NE occurs across a number of organisations.

This policy aims to ensure that the CCG complies 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 and investigating SIs and NEs.

1.2.2 This policy applies to all employees of the CCG 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, where NHS services are commissioned, need to comply with the CCG's reporting requirements within this policy, which reflects the Serious Incident Framework 2015/16 & Never Events Framework 2015/16

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. The CCG as a commissioner of services is 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. Definitions and Terms

The following definitions and terms are used in this policy document:

2.1 Definition of a Serious Incident & Never Event

2.1.1 An incident is a single distinct event or circumstance that occurs within the organisation which leads to an outcome that was unintended, unplanned or unexpected.

2.1.2 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).

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

1. 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

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

3. 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.

4. Never Events - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death. Further information can be found at: http://www.england.nhs.uk/wp-content/uploads/2015/03/never-evnts-list-15-16.pdf

5. 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

   - 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)

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

2.2 Working with other Organisations/Sectors

2.2.1 *Deaths in Custody where health provision is delivered by the NHS*

- 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 in custody is particularly stringent when that individual dies.

- In prison or police custody any death 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 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.

2.2.2 *Serious Case Reviews and Safeguarding Adult Reviews*

- The Local Authority via the Local Safeguarding Children Board or Local Safeguarding Adult Board (LSCB, LSAB as applicable) has a statutory duty to investigate certain types of safeguarding incidents/concerns.

- Healthcare providers must contribute towards safeguarding reviews as required to do so by the Local Safeguarding Board, where it is indicated that a serious incident within healthcare has occurred.

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

  See Appendix 2 for reporting and management of Safeguarding Children/Adults incidents

2.2.3 *Domestic Homicide Reviews*

- Where a Domestic Homicide is identified by the police, the Community Safety Partnership (CSP) will consider whether the case meets criteria for Domestic Homicide Review (DHR)

2.2.4 *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.

2.2.5 *Serious Incidents in National Screening Programmes*

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

2.2.5.2 The 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 nationally.

2.2.5.3 Screening SIs are often very complex, multi-faceted incidents that require robust coordination and oversight by Screening and Immunisation Teams working within Sub-regions and specialist input from Public Health England's Screening Quality Assurance Service.

2.2.5.4 Further details on the management of incidents within the screening programme are available in "Managing Safety Incidents in NHS Screening Programme" Managing Safety Incidents in NHS Screening Programmes

2.2.5.5 For SIs linked to 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.

2.2.5.6 Flow chart and accompanying notes for managing screening incidents can be found in Appendix 3.

2.3 Additional guidance for personal data related (Information Governance) SIs

2.3.1 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.

2.3.2 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.

2.3.3 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.

2.3.4 Where an IG incident impacts upon an 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)

2.3.5 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.

2.3.6 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.

2.3.7 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.

2.4 Additional Guidance for SIs involving controlled drugs.

2.4.1 SIs that involve controlled drugs must also be notified to the Commissioning Support Unit's Medicines Optimisation Team.

3. Reporting and Management of Serious Incidents

3.1 Independent Healthcare sector

3.1.1 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 (Appendix 4).

3.1.2 The CCG should ensure that IHS SIs are reported via STEIS and investigated appropriately.

3.2 Guidance for Commissioned Services/Providers

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

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

3.2.3 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.

3.2.4 If appropriate, the SI lead officer must liaise with the organisation's communications team who will liaise directly with NHS England Communications team.

3.2.5 The organisation must then provide a 72 hour report, which should be sent to the relevant commissioner the as the responsible delegate for CCGs. The report should include more information regarding the event, immediate learning and how the Root Cause Analysis will be conducted.

3.2.6 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 outcomes of investigations. The appointment of a Family Liaison Officer may be appropriate.

3.2.7 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 Commissioning Support Unit's Clinical Quality Team.

3.2.8 If an incident involves more than one NHS organisation a decision will be made (mutually agreed) as to which is 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 model should be completed in order to assign accountability (see Serious Incident framework Appendix 1).

3.2.9 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.

3.2.10 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 lead and in accordance with related guidance.

3.2.11 Where an incident is subject to the involvement of a Coroner, an independent inquiry, serious case review or any safeguarding issues, this should be highlighted clearly within the STEIS report as this may affect closure date.

3.2.12 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 5. To ensure confidentiality all reports submitted to the CCG or the Commissioning Support Unit (CSU) Clinical Quality Team should be anonymous and sent via the agreed STEIS NHS-net account. The CSU will conduct a quality assurance check on all RCAs on behalf of the CCG in order to ensure the 20 day deadline is met.

3.3 Independent Contractors

3.3.1 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 4.

3.3.2 Where an SI raises professional concerns about a GP, CCG local arrangements for assuring high standards of professional performance should be invoked, where this is applicable or NHS England notified.

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

3.4 NHS Providers

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

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

3.5 Independent Healthcare Sector Providers

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

3.6 Staff Involved in Serious Incidents

3.6.1 Serious incidents can be distressing for those involved.

3.6.2 The appropriate Manager should ensure that staff are supported at all stages of a SI with reference to CCG HR policies.

3.6.3 The appropriate Manager is responsible for ensuring that a de-briefing session occurs at an appropriate stage following a SI.

3.6.4 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.

3.7 Information for Education and Training Organisations

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

3.7.2 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 NHSE.

3.8 CCG Management & Closure of Serious Incidents

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

3.8.2 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.

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

3.9 Information Governance Serious Incidents

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.

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.

Any IG incident which involves a high risk to the rights and freedoms of individuals is likely to be a Serious Incident Requiring Investigation (SIRI) and must be reported as per 2.3.5.

4. Duties and Responsibilities

Council of Members	Has delegated responsibility to the governing body (GB) for setting 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 Nurse.
Chief Finance Officer	The Chief Finance Officer has overall responsibility for ensuring: • The incident management process is robust and adhered to. • Incidents are maintained and managed in timely manner. • Staff have the necessary training required to implement the policy. • Mechanisms are in place within the organisation for regular reporting and monitoring of incident themes and lesson learned. • Confirm to the CSU Senior Governance Officer that incidents can be marked as fully completed.
CCG Director of Nursing and Quality	The CCG Director of Nursing and Quality has overall 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 CSU Clinical Quality Team.
Line Managers	The service leads have the responsibility: • To support their senior managers and staff to maintain the incident policy and to manage individual incidents in accordance with policy. • To work closely with the Governing Body lead to ensure a transparent and consistent approach to incident management across the CCG in partnership with key stakeholders. All line managers and supervisory staff are responsible for the adherence and monitoring compliance within this policy. Managers have responsibility for promoting the policy directly with their staff and, where appropriate, taking responsibility for the co-ordination of investigations in support of the Executive Lead for Patient Safety and Safeguarding.

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 as part of their normal duties and responsibilities. • Identify the need for a change in policy or procedure as a result of becoming aware of changes to statutory requirements, revised professional or clinical standards and local/national directives, and advising there line manager. • Attending training/awareness sessions when provided.
CSU Clinical Quality Manager	The CSU Clinical Quality Manager will • Consider if a serious incident falls into the category of a STEIS reportable SI and report accordingly. • Review clinical quality incidents reported by the CCG. • Provide clinical quality incident reports as requested.
CSU Senior Medicines Optimisation Pharmacist	The CSU Senior Medicines Optimisation Pharmacist has Responsibility for ensuring that all SIs in relation to controlled drugs are investigated appropriately and liaison with the Controlled Drugs Local Intelligence Network (LIN) on behalf of NHSE.
CSU Senior Governance Officer	CSU Senior Governance Officer will: • Provide incident management support and advice. • Produce CCG reported incident reports as requested. • Identify trends, lessons learned and themes in incident reporting in order to identify any issues of concern for the CCG. • Provide training and assistance to the CCG in incident reporting and management in the SIRMS system. • Manage the administration of the SIRMS database. • Undertake an incident investigation in conjunction with CCG managers if required e.g. health and safety and IG incidents.

Data Protection Officer	To take the lead in providing expert advice and the promotion of data protection compliance and best practice in setting and maintaining standards and procedures across the CCG.
CSU Information Governance Lead	CSU 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 IG Toolkit.
CSU Staff	Whilst working on behalf of the CCG, CSU staff will be expected to comply with all policies, procedures and expected standards of behaviour within the CCG, however they will continue to be governed by all policies and procedures.
All Independent Contractors (e.g. GPs, Dental Practitioners, Optometrists and Pharmacists)	This policy is recommended to all independent contractors, where NHS services are commissioned by the CCG, 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 (IHS) providers	All NHS provider organisations and Independent Healthcare Sector providers providing NHS commissioned services 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.

5. Implementation

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

5.2 CCG 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.

5.3 The implementation of the detail of this policy is aligned into the full roll-out, development and implementation of the incident module of the SIRMS across the CCG, CSU and their Council Members.

5.4 This policy is reviewed at regular intervals to ensure that the implementation of the processes contained in the policy are in line with the practical experience of users of the Safeguard Incident & Risk Management System (SIRMS).

6. Training Implications

6.1 The CCG 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.

8 Documentation

8.1 Other related policy documents

8.1.1 *Legislation and statutory requirements:*

- Serious Incident Framework (March 2015) & Revised Never Events Policy & Framework (27 March 2015)

8.1.2 *South Tees Clinical Commissioning Group*

- Incident Reporting and Management Policy

8.2 Best practice recommendations

- Managing Safety Incidents in National Screening Programmes (Public Health England 2017)
- Health and Social Care Information Centre: Checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation.

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.

The Chief Finance Manager with support from the Governance Manager will ensure that each 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 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 the Department of Health's Records management code of practice for health and social care 2016.

10. Equality Impact Assessment

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An Equality Impact Assessment (EIA) is a process of analysing a new or existing service, policy or process. The aim is to identify what is the (likely) effect of implementation for different groups within the community (including patients, public and staff).

We need to:

- Eliminate unlawful discrimination, harassment and victimisation and other conduct prohibited by the Equality Act 2010
- Advance equality of opportunity between people who share a protected characteristic and those who do not
- Foster good relations between people who share a protected characteristic and those who do not

This is the law. In simple terms it means thinking about how some people might be excluded from what we are offering.

The way in which we organise things, or the assumptions we make, may mean that they cannot join in or if they do, it will not really work for them.

It's good practice to think of all reasons why people may be excluded, not just the ones covered by the law. Think about people who may be suffering from socio-economic deprivation or the challenges facing carers for example.

This will not only ensure legal compliance, but also help to ensure that services best support the healthcare needs of the local population.

Think of it as simply providing great customer service to everyone.

As a manager or someone who is involved in a service, policy, or process development, you are required to complete an Equality Impact Assessment using this toolkit.

Policy	A written statement of intent describing the broad approach or course of action the Trust is taking with a particular service or issue.
Service	A system or organisation that provides for a public need.
Process	Any of a group of related actions contributing to a larger action.

STEP 1 - EVIDENCE GATHERING

Name of person completing EIA:	**Sandra Ross**
Title of service/policy/process:	**CCG Serious Incident policy**
Existing: ☐ **New/proposed:** ☐ **Changed:** x	
What are the intended outcomes of this policy/service/process? Include outline of objectives and aims	
Who will be affected by this policy/service /process? (please tick)	
X Staff members ☐ **Other**	
If other please state:	

What is your source of feedback/existing evidence? (please tick)

☐ **National Reports** ☐ **Staff Profiles**
☐ **Staff Surveys** ☐ **Complaints/Incidents**
☐ **Focus Groups x Previous EIAs**
☐ **Other**

If other please state: No other

Evidence	What does it tell me? (about the existing policy/process? Is there anything suggest there may be challenges when designing something new?)
National Reports	**National Serious incident framework 2015**
Staff Profiles	**N/A**
Staff Surveys	**N/A**
Complaints and Incidents	**N/A**
Staff focus groups	**N/A**
Previous EIA's	**This version contains updates to some sections of the existing policy. Previous EIA's have not identified any issues and there are none identified at this update.**
Other evidence (please describe)	**None**

STEP 2 - IMPACT ASSESSMENT

What impact will the new policy/system/process have on the following staff characteristics: (Please refer to the 'EIA Impact Questions to Ask' document for reference)
Age A person belonging to a particular age
None
Disability A person who has a physical or mental impairment, which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities
None
Gender reassignment (including transgender) Medical term for what transgender people often call gender-confirmation surgery; surgery to bring the primary and secondary sex characteristics of a transgender person's body into alignment with his or her internal self perception.
None
Marriage and civil partnership Marriage is defined as a union of a man and a woman (or, in some jurisdictions, two people of the same sex) as partners in a relationship. Same-sex couples can also have their relationships legally recognised as 'civil partnerships'. Civil partners must be treated the same as married couples on a wide range of legal matters
None
Pregnancy and maternity Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the employment context.
None
Race It refers to a group of people defined by their race, colour, and nationality, ethnic or national origins, including travelling communities.
None

Religion or belief Religion is defined as a particular system of faith and worship but belief includes religious and philosophical beliefs including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition.
None
Sex/Gender A man or a woman.
None
Sexual orientation Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes
Carers A family member or paid helper who regularly looks after a child or a sick, elderly, or disabled person
None

STEP 3 - ENGAGEMENT AND INVOLVEMENT

How have you engaged with staff in testing the policy or process proposals including the impact on protected characteristics?
Policy was previously in place and approved via CCG committee on behalf of staff. The initial policy was also assessed as part of a CCG audit.
Please state how staff engagement will take place:
Same process will take place in respect of the updates based on national guidance.

STEP 4 - METHODS OF COMMUNICATION

What methods of communication do you plan to use to inform staff of the policy?
x Verbal – through focus groups and/or meetings ☐ **Verbal - Telephone** ☐ **Written – Letter** ☐ **Written – Leaflets/guidance booklets** **x Email x Internet** ☐ **Other**
If other please state:

STEP 5 - SUMMARY OF POTENTIAL CHALLENGES

Having considered the potential impact on the people accessing the service, policy or process please summarise the areas have been identified as needing action to avoid discrimination.

Potential Challenge	What problems/issues may this cause?
1 No areas for action	

 **STEP 6- ACTION PLAN**

Ref no.	Potential Challenge/ Negative Impact	Protected Group Impacted (Age, Race etc)	Action(s) required	Expected Outcome	Owner	Timescale/ Completion date
Not applicable						

Ref no.	Who have you consulted with for a solution? (users, other services, etc)	Person/ People to inform	How will you monitor and review whether the action is effective?
Not applicable			

 **SIGN OFF**

Completed by:	**Sandra Ross**
Date:	**23.10.07**
Signed:	
Presented to: (appropriate committee)	**Governance & Risk Committee**
Publication date:	**November 2017**

Appendix 1

SERIOUS INCIDENT FRAMEWORK 2015/16 AND FREQUENTLY ASKED QUESTIONS

http://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

http://www.england.nhs.uk/wp-content/uploads/2015/03/serious-incident-framwrk-15-16-faqs-fin.pdf

https://www.england.nhs.uk/wp-content/uploads/2015/03/nepf-faqs.pdf

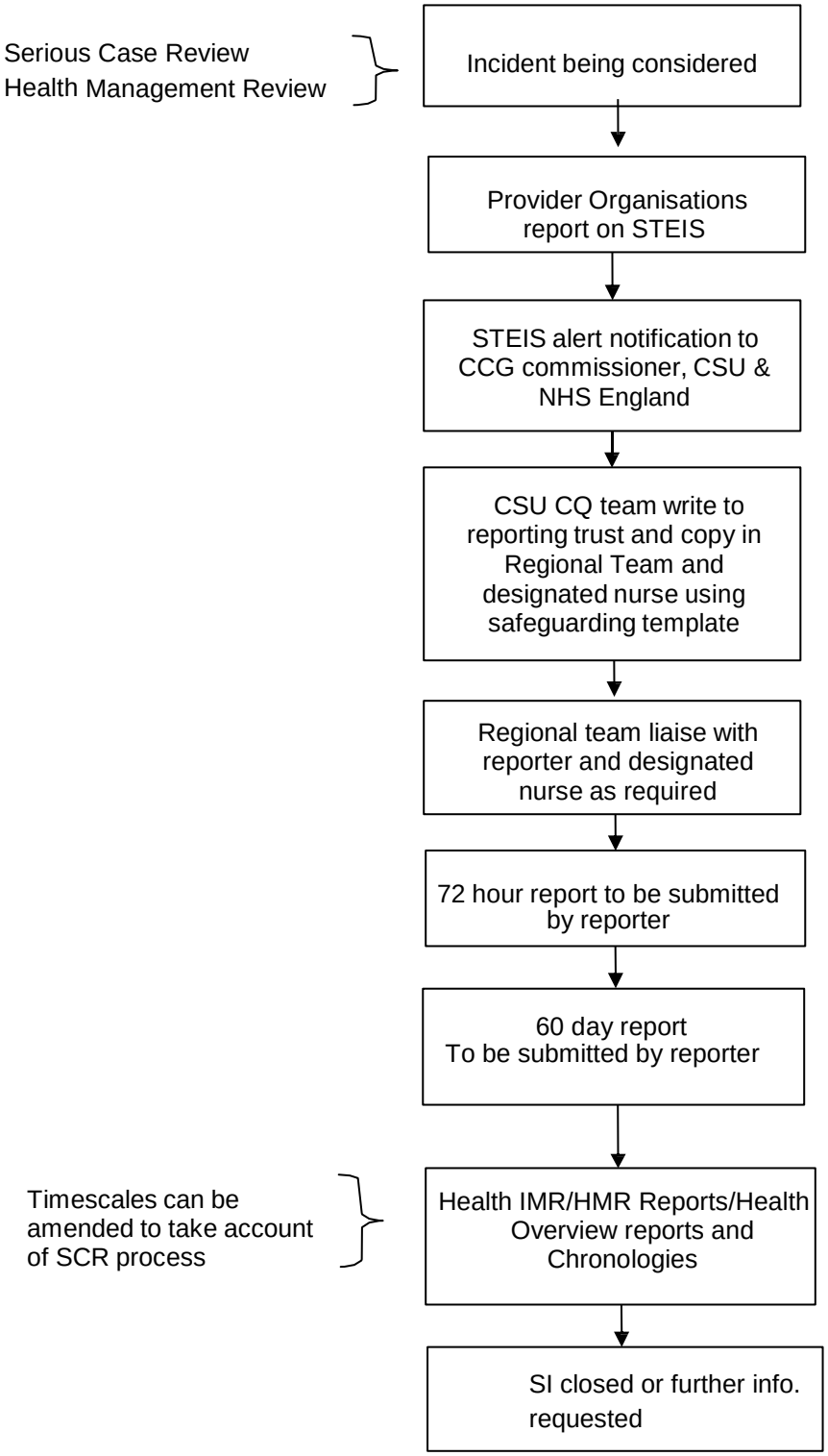
http://www.england.nhs.uk/wp-content/uploads/2015/04/never-evnts-pol-framwrk-apr.pdf

http://www.england.nhs.uk/wp-content/uploads/2015/03/never-evnts-list-15-16.pdf

http://www.england.nhs.uk/wp-content/uploads/2015/03/nepf-faqs.pdf

Appendix 2

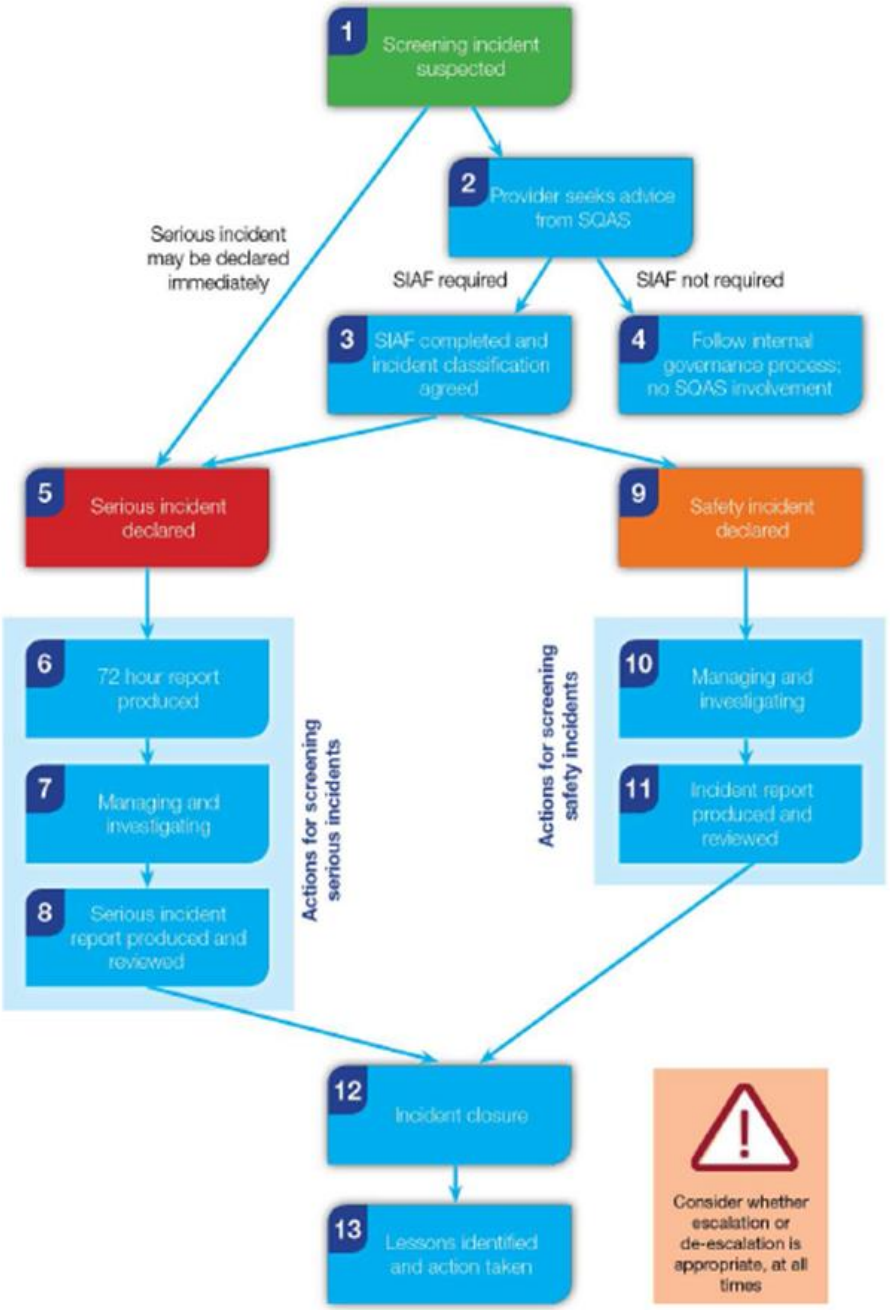
PROCEDURE FOR THE REPORTING AND MANAGEMENT OF SAFEGUARDING CHILDREN/ADULTS INCIDENTS



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]

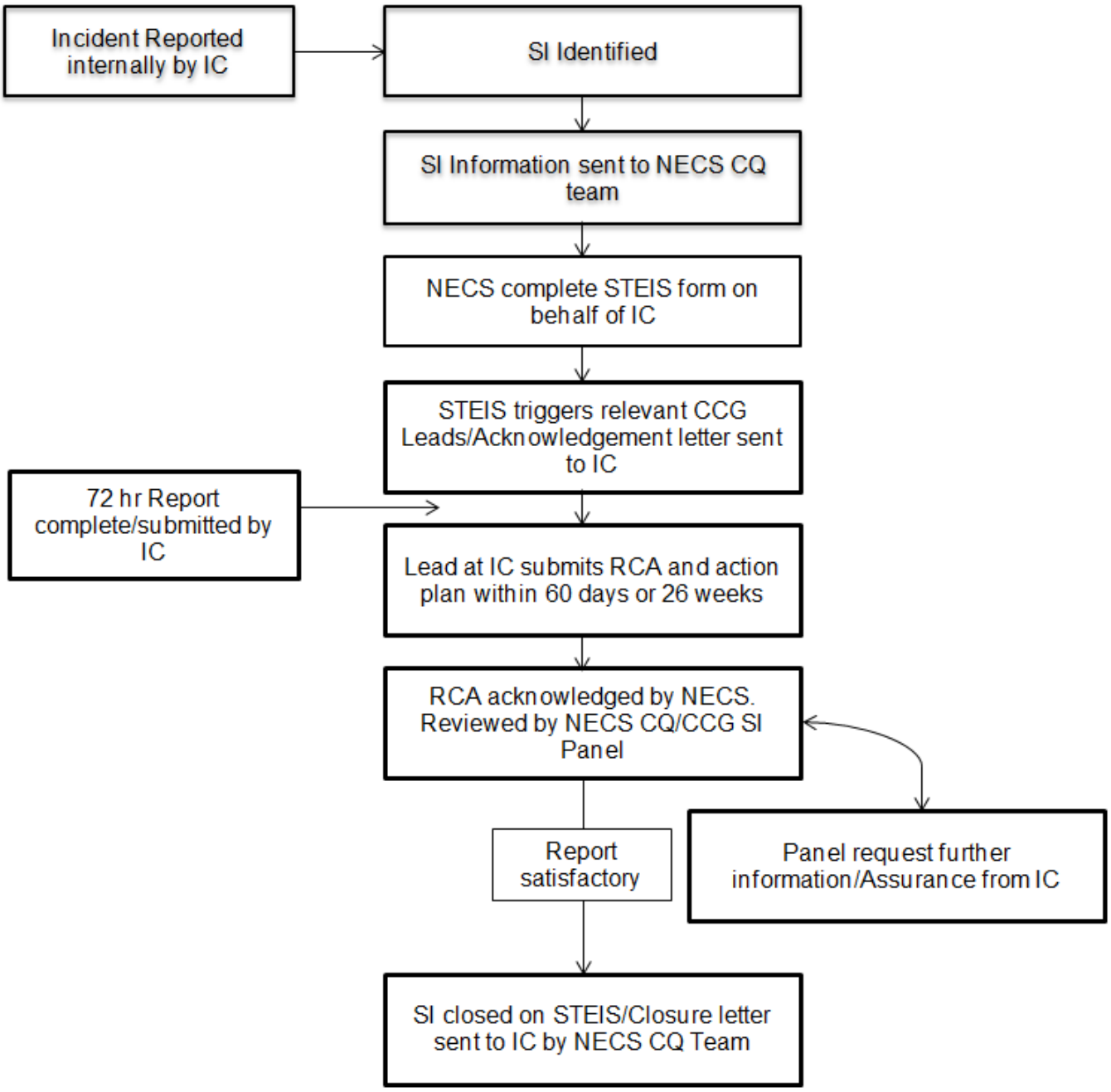


Notes to accompany reporting and screening incidents flowchart

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

PROCEDURE FOR THE REPORTING AND MANAGEMENT OF INDEPENDENT CONTACTOR/COMMISSIONED SERVICE SIs ONLY



Appendix 5

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
- Contributory Factors
- Root cause(s)
- Lessons learnt
- Recommendations

Action Plan

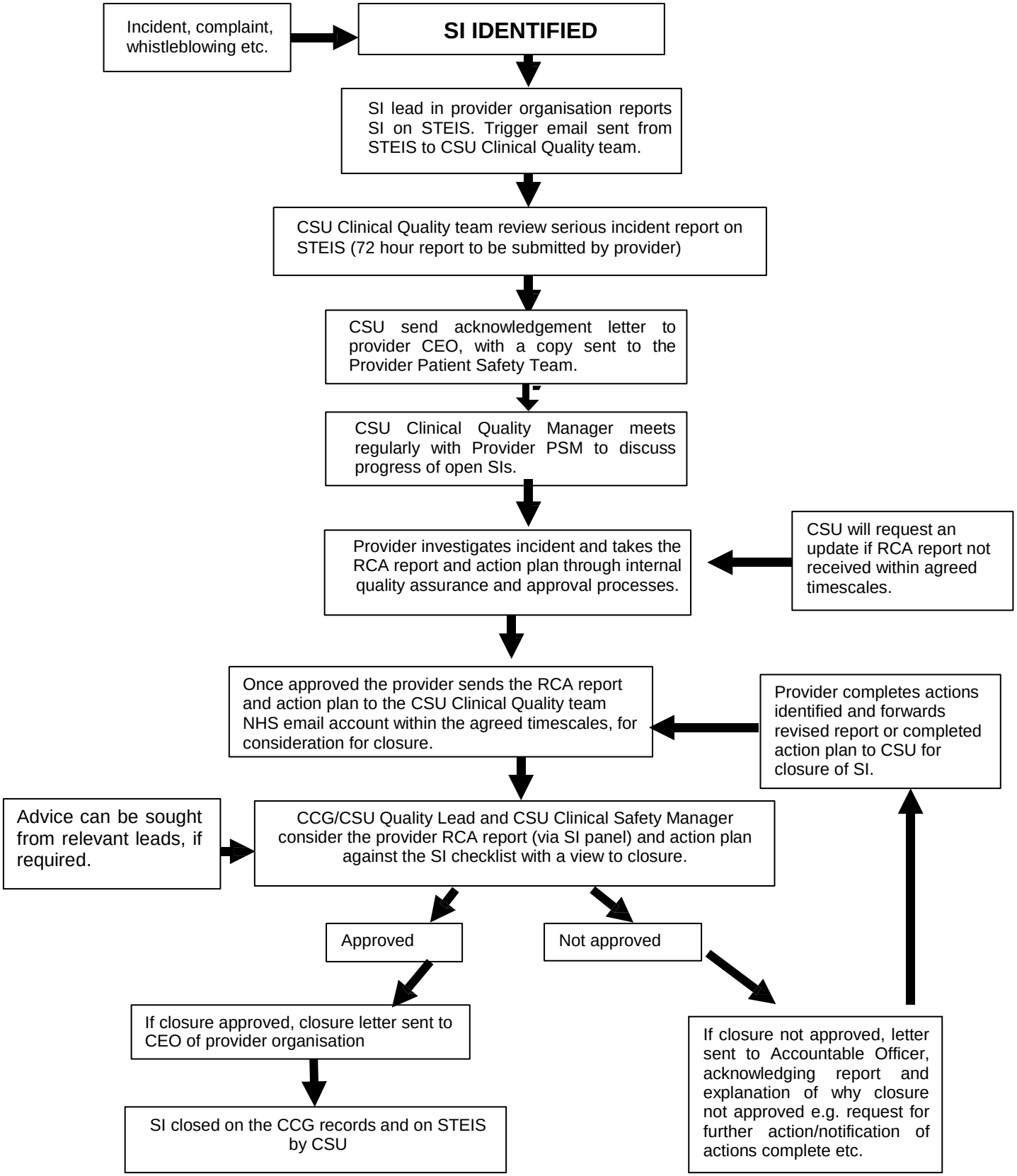
- Clearly set out actions which fall from the recommendations
- What needs to happen to achieve the outcome
- Identified title of who is responsible for the action
- Specific timescales on-going except where incorporated into the Trust's everyday business for example the organisation's annual programme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

The National Patient Safety Agency (NPSA) root cause analysis tools can assist organisations in their investigation:

http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/

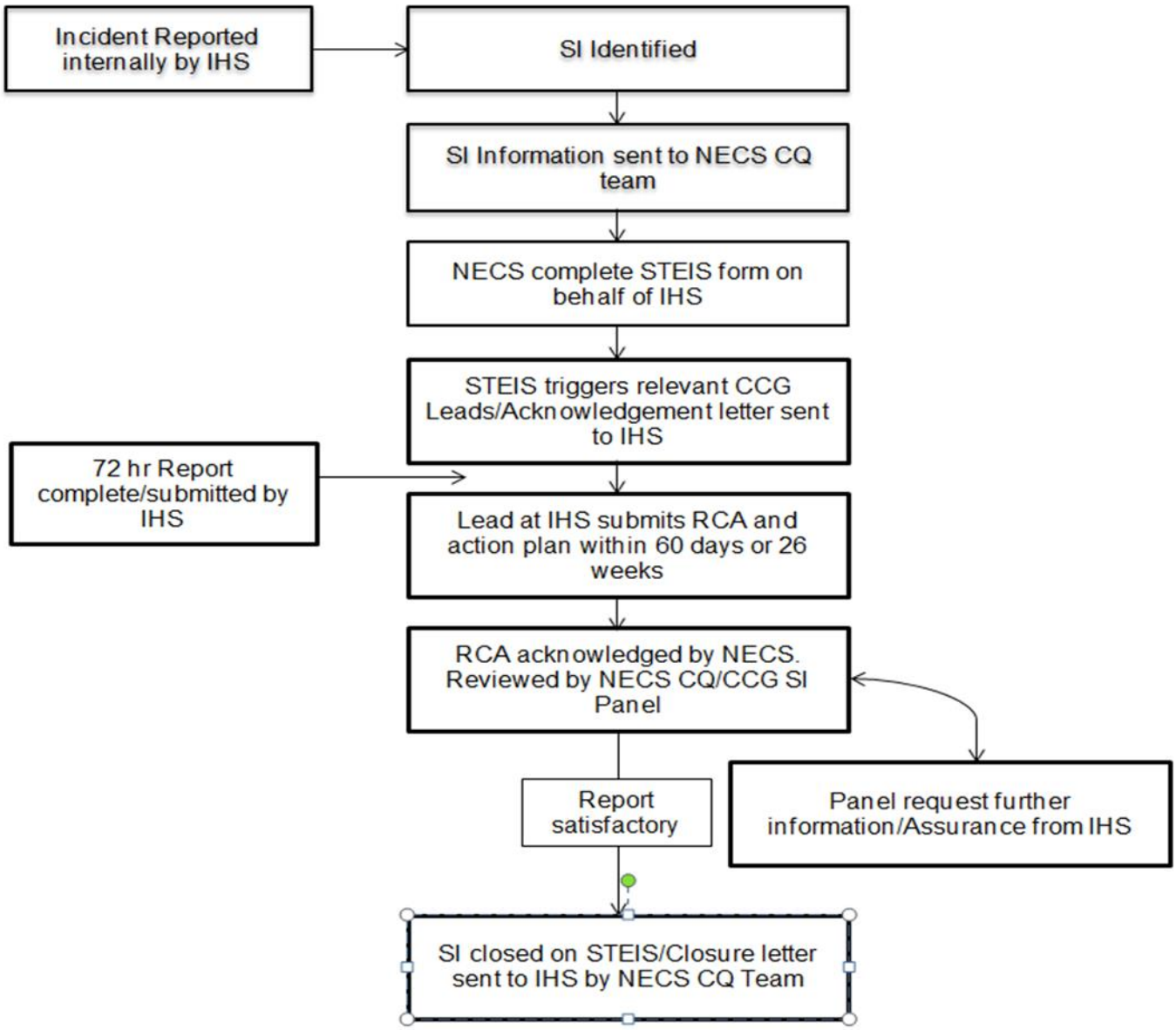
Appendix 6

PROCEDURE FOR THE REPORTING AND MANAGEMENT OF NHS PROVIDER SIs ONLY



Appendix 7

PROCEDURE FOR THE REPORTING AND MANAGEMENT OF SERIOUS INCIDENTS INDEPENDENT HEALTHCARE SECTOR (IHS) PROVIDERS



Appendix 8

Serious Incident Closure Panel and terms of reference

To be confirmed