NHS
St Helens
Clinical Commissioning Group

Serious Incident Management Policy

Standard Operating Procedure	St Helens CCG Serious Incident Management Policy
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REVISIONS			
Date	**Section**	**Reason for Change**	**Approved By**
16/10/2017	Policy 5.3 5.5	General review and update and update to logo Update to role and name change Clarification of reporting requirements to Quality and Performance Committee	

POLICY OBSOLETE		
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16/10/2017	**Version 1**	

Contents

1. INTRODUCTION

1.1 This policy sets out for staff of St Helens Clinical Commissioning Group (CCG) and their relevant local provider organisations how Serious Incidents should be reported, managed and investigated.

1.2 The policy has been developed by St Helens CCG to comply with the 2015 'NHS England Serious Incident Framework while setting out a locally agreed set of principles to ensure consistency in Serious Incident reporting, management and monitoring across St Helens CCG. This reflects the Revised Framework's recommendation that commissioners must work collaboratively to agree how best to manage Serious Incidents that occur in their services.

1.3 The priority of St Helens CCG is to ensure that Serious Incident investigations achieve their fundamental purpose of ensuring that lessons are learnt to prevent similar lessons from re-occurring.

1.4 The NHS England national frameworks can be found at the following links:
NHS England Serious Incident Framework: Supporting Learning to prevent recurrence
NHS England Serious Incident Framework - frequently asked questions
NHS England Revised Never Events Policy and Framework

1.5 The Revised Framework replaces the 'National Framework for Reporting and Learning from Serious Incidents Requiring Investigation' issued by the National Patient Safety Agency (NPSA, March 2010) and NHS England's 'Serious Incident Framework' (March 2013). It also replaces and the 'NPSA Independent investigation of serious patient safety incidents in mental health services, Good Practice Guide' (2008).

1.6 The framework confirms that the purpose of patient safety investigations is to learn from incidents, and not apportion blame, while endorsing the application of the recognised system-based method for conducting investigations, commonly known as Root Cause Analysis (RCA), and its potential as a powerful mechanism for driving improvement.

2. PURPOSE

2.1 The purpose of this policy is to set out a consistent and explicit agreement as to how the principles of the Revised Framework will be applied to the management of Serious Incidents that occur to population of St Helens CCG.

3. SCOPE

3.1 This policy applies to all staff employed by St Helens CCG. It should also be complied with by all organisations whose services are commissioned by the CCG. It is intended to compliment (rather than replace) the incident reporting systems already operating within organisations that provide NHS funded care.

3.2 When providers identify a serious incident, they must also consider whether the incident is

a adult at risk incident or safeguarding child incident. Where the serious incident meets the criteria for referral under the St Helens Multi Agency Adult Safeguarding Procedures or St Helens Multi Agency Child Protection procedures, a referral should be made as appropriate, by the provider in the required timescales. This brings together the two processes at an early stage to ensure an integrated approach and to minimize duplication in the investigation process.

3.3 All serious incidents involving adults at risk, reported to St Helens CCG will be reviewed by the Designated Nurse for Adult Safeguarding and all serious incidents involving children, reported to St Helens CCG will be reviewed by the Designated Nurse for Children's Safeguarding

4. DEFINITIONS

4.1 The Revised Framework defines a Serious Incident as:

A serious incident is an event in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious Incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver on going healthcare:

4.2 NHS England has produced a list that sets out the circumstances in which a Serious Incident must be declared. Providers are therefore asked to consider each incident on a case-by-case basis using the description below.

- 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
- Unexpected or avoidable injury to one or more people that has resulted in serious harm
- 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 or
  - Serious harm
- Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where:
  - Healthcare did not take appropriate action/intervention to safeguard against such abuse occurring or where abuse occurred during the provision of NHS-funded care.
- A Never Event - all Never Events are defined as Serious Incidents although not all Never Events necessarily result in serious harm or death
- 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:
  - Data loss, property damage, security breach/concern, incidents affecting

population-wide healthcare activities like screening and immunisation programmes, 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 or activation of a major incident plan.

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

5. DUTIES AND RESPONSIBILITIES

5.1 Provider

The Provider holds an organisational accountability to the commissioner of the care in which the incident took place and must have mechanisms in place to ensure commissioners are notified of serious incidents within 48 working hours following identification. Serious incident management is a critical component of corporate and clinical governance which means that providers are responsible for arranging and resourcing investigations in addition to ensuring that robust systems are in place for recognising, reporting, investigating within 60 working days and responding to serious incidents.

5.2 St Helens CCG

St Helens CCG must assure themselves of the quality of services commissioned and hold providers to account for their responses to Serious Incidents, by quality assuring the robustness of their provider's investigation and action plan implementation.

Use Serious Investigation Reports along with other information and intelligence, to inform actions that continuously improve services and share that information with relevant regulatory and partner organisations.

Work with providers and facilitate discussions about which organisation should take responsibility for co-ordinating the Serious Incidents in matters which involve multiple providers. This could include individual CCGs leading the investigation if the circumstances suggest this may be warranted.

Develop and agree procedures for managing concerns raised to them about the management of the investigation process.

5.3 Quality Project Support Officer has delegated responsibility from the Safety and Quality Lead Nurse for:

- Monitoring Serious Incident deadlines and liaising with providers to ensure a timely response, escalating any delays to the Chief Nurse for consideration.
- Acknowledging receipt of completed investigation reports and sharing any feedback from the Serious Incident Review Group to providers.

- Approving any extension requests from providers and escalating concerns to the Chief Nurse
- Ensuring that the agenda papers for the monthly Serious Incident Review group are received on time and compiling and circulating the minutes and action log following each Serious Incident Review group.
- Ensure any required actions identified at each Serious Incident Review group are escalated and completed as required.
- Generating reports from the SI Database about the Serious Incidents which will include monthly RAG rated reports to providers and the Serious Incident Review Group in addition to any ad hoc reports that may be requested by the members of the Serious Incident Review Group and/or other CCG individuals.
- Liaising with other CCGs in multi-commissioner Serious Incidents.
- Escalating Serious Incident Review Group matters to the Quality and Performance Committee when indicated.
- In accordance with section 1.1 of the NHS England National Framework, reviewing any incidents that providers are either unsure is a Serious Incident or feel no longer meet the threshold, taking advice from the appropriate Serious Incident Review Group members (whereapplicable) and recording all discussions and any decision rationale
- Attendance at relevant meetings with providers, neighboring CCGs and NHS England to review trends and best practice in Serious Incident work.
- Review and update relevant guidance to reflect changing policy and practice as and when required.

5.4 Serious Incident Review Group

Holding providers to account for the quality and timeliness of their Serious Incident investigations and accompanying action plans by:

- Reviewing and monitoring all Serious Incidents that occur within services commissioned by St Helens CCG
- Ensure that a robust and timely investigation is undertaken by providers that will include the review of systems and processes relating to the incident
- Ensuring that the Serious Incident report fulfills the required standard for a robust investigation by following a systems-based approach that identifies the correct root causes and contributory factors (where possible to do so) to produce focused recommendations that inform an action plan and accompanying learning that will prevent recurrence.
- Agree that the actions set out in the accompanying action plan will eliminate or reduce the risk of recurrence.
- Highlighting any concerns or areas that require further action in respect of the investigation or action plan that need to be fed back to the provider.
- Monitoring and regularly reviewing the provider's implementation of the action plan.
- Making recommendations to close the incident when the group are satisfied that above requirements are satisfied, referencing the appropriate closure checklist in reaching these judgments.
- Identifying themes, trends or Serious Incidents that require escalation to the Quality and Performance Committee and/or the relevant Provider Quality and Performance Meetings.

- Agreeing a mechanism for the monitoring and review of learning amongst providers that is highlighted in action plans.

5.5 Quality and Performance Committee

Receive notification of:

- Items discussed from the previous month's Serious Incident Group meeting via the provider monitoring report
- Incidents being reported via the STEIS system;
- 6 monthly report from SIRG and SI management that outlines at the very least:
  - Concerns escalated
  - Compliance with national framework KPI's
  - Themes and trends

6. LEVELS OF INVESTIGATION

6.1 The level of response required in response to a Serious Incident varies on a case-by-case basis. Providers should therefore be assessing each incident to determine whether it requires the following levels of investigation:

- **Level 1**: Concise Investigations - These are suited to less complex incidents which can be managed by individuals or a small group of individuals at a local level. These investigations should be completed in 60 working days.

- **Level 2**: Comprehensive investigations - These are suited to complex issues which should be managed by a multidisciplinary team involving experts and/or specialist investigators. These investigations should be completed in 60 working days.

- **Level 3**: Independent investigations - These are required for incidents where the integrity of the internal investigation is likely to be challenged or where it will be difficult for an organisation to conduct an objective investigation internally due to the size of organisation, or the capacity/ capability of the available individuals and/or number of organisations involved. These investigations should be completed within six months of the investigation being commissioned.

7. PROCEDURE FOLLOWING A SERIOUS INCIDENT

7.1 Review

If the provider is unclear as to whether the incident meets the definition of a Serious Incident, contact should be made with the nominated person at the CCG who will discuss and review the incident.

The CCG will receive notification of a new Serious Incident via the StEIS alert system. The information contained within the alert should be recorded on the SI database and an update added to StEIS, with an acknowledgement sent to the provider.

The provider should undertake a 72 hour review within 3 working days. The aim of the 72-hour review is to:

- Identify and provide assurance that appropriate immediate action has been taken
- Assess the incident in more detail
- Propose the appropriate level of investigation

If the commissioner feels the initial notification suggests the incident is large scale or likely to result in national media attention, they must alert NHS England, consider sharing the matter at the Quality Surveillance Group or, if very serious, request a Risk Summit.

7.2 Investigation Report

The provider should identify a lead investigator and investigation team who will draft terms of reference and a management plan to support the undertaking of the investigation in addition to considering a communication/media handling strategy. The focus of the investigation should be to:

- Gather and map the information
- Analyse the information
- Generate a solution

The provider should also consider involving and supporting affected patients, staff, victims, perpetrators, patients/victims' families and carers.

If the investigation report is not received on day 60, a reminder should be sent requesting the RCA as soon as possible. If the investigation report is still not received and an extension request has not been agreed then this will be escalated and managed via the contracts meeting which are held with the organisation.

Once received, both the SI database and StEIS must be updated to reflect receipt and confirm when it is due to be considered by the CCG group. A copy of the RCA should be saved in the appropriate Serious Incident Group Monthly meeting folder so it can be incorporated in to the agenda.

7.3 Serious Incident Review Group

The completed RCA will be presented to the relevant CCG Serious Incident Review Group which is a subcommittee of the Quality and Perform ace Committee and it is aimed that the group will review the report within 20 working days.

While the content of meetings will depend on the papers available, when reviewing and discussing the papers the Serious Incident Review group should reference their specific function which is to hold providers to account for the quality and timeliness of the Serious Incident investigation and accompanying action plan. They do this by:

- Ensuring that the Serious Incident report fulfills the required standard for a robust investigation by following a systems-based approach that identifies the correct root

causes and contributory factors (where possible to do so) to produce focused recommendations that inform an action plan and accompanying learning that will prevent recurrence.

- Highlighting any concerns or areas that require further action in respect of the investigation or action plan that need to be fed back to the provider
- Agreeing that the actions set out in the accompanying action plan will eliminate or reduce the risk of recurrence.
- Determining a schedule to monitor and review the providers implementation of the action plan
- Making recommendations to close the incident when the group are satisfied that above requirements are satisfied, referencing the appropriate closure checklist in reaching these judgments.
- Identifying themes, trends or Serious Incidents that require escalation to the Clinical, Quality and Performance Committee and/or the relevant Provider Quality and Performance Meetings.

The Serious Incident Review Group can close an incident before all preventative actions have been implemented and review; particularly where these are continuous or long term and the commissioner has received evidence that the actions have been initiated. It is good practice for commissioners to agree a mechanism for monitoring and reviewing actions undertaken by providers.

7.4 Follow Up

Following the meetings, the SI database and StEIS records should be updated to reflect any discussions or action points identified by the Serious Incident Review group for each Serious Incident. Relevant deadline and action activities should also be completed for each database record to assist with the monitoring. In the case of action plans, the next activity will be dependent on what the group identified as a suitable period for monitor and review

Providers should then be provided with a report of the review of the serious incident report with key actions or feedback highlighted with appropriate deadlines. This should be sent within five working days of the meeting to enable suitable time for the provider to prepare for the following months meetings.

Providers should share with the relevant CCGs any evidence in response to feedback or to demonstrate completed action plans. Details of responses and actions taken should also be recorded in the relevant STEIS and SI database records

7.5 Closure

If the Serious Incident Review group confirm they are happy to close the investigation the root causes and lessons learned should also be copied into StEIS before being closed and notification sent to the provider.

8.0 Equality & Diversity

The Policy should be read in conjunction with the CCG's Equality and Diversity policy.

In applying this policy, the Organisation will have due regard for the need to eliminate unlawful discrimination, promote equality of opportunity, and provide for good relations between people of diverse groups, in particular on the grounds of the following characteristics protected by the Equality Act (2010); age, disability, gender, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, and sexual orientation, in addition to offending background, trade union membership, or any other personal characteristic.

Promoting diversity embodies the principles of fair treatment for all and will, as a result, improve the retention of staff. The CCG values the diversity of its workforce and aims to ensure that all staff understand this commitment and adhere to the required standards.

Appendix A

The Serious Incident Management Process