Harrogate and Rural District
Clinical Commissioning Group

SERIOUS INCIDENT, INCIDENT AND CONCERNS POLICY

March 2017

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The on-line version is the only version that is maintained. Any printed copies should, therefore, be viewed as 'uncontrolled' and as such may not necessarily contain the latest updates and amendments.

POLICY AMENDMENTS

Amendments to the policy will be issued from time to time. A new amendment history will be issued with each change.

New Version Number	Issued by	Nature of Amendment	Approved by and Date	Date on Intranet
1.0	NHS HaRD CCG			
2.0	NHS HaRD CCG	Updates from new NHS England national Serious Incident framework and including minor amendments following committee review 08 September 2015	Quality and Clinical Governance Committee - 08 September 2015	12 October 2015
2.1	NHS HaRD CCG	Reformatted as part of 2 year review	Quality and Clinical Governance Committee - 14 March 2017 subject to minor amendments to be signed off by Dr Sarah Hay, Chair post meeting	
3.0	NHS HaRD CCG	Minor amendments have been made and approved	Dr Sarah Hay, Chair Quality and Clinical Governance Committee - 21 March 2017	

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Appendices

1 INTRODUCTION

NHS Harrogate and Rural District Clinical Commissioning Group (NHS HaRD CCG) is committed to providing the best possible service to its patients, clients and staff. NHS HaRD CCG recognises that, on occasions, serious incidents (SIs) or near misses will occur and that it is important to identify causes and to ensure that lessons are learnt to prevent recurrence.

Learning from Serious Incidents is an important function of NHS HaRD CCGs commitment to the safety of its patients, staff and the general public. Modern healthcare is a complex and at times high risk activity where serious incidents or near misses may occur. Promoting patient safety by reducing error is a key priority for the NHS, supported by the establishment of the National Patient Safety Agency (NPSA).

NHS HaRD CCG has a duty to receive information on Serious Incidents from NHS organisations within its boundaries as well as affecting its patients treated out of area. This is in order to assure themselves of the quality of services they have commissioned, and support holding providers to account for their responses and actions relating to serious incidents. NHS HaRD CCG quality assures the robustness of providers' serious incident investigations and action plan implementation. This approach both identifies learning opportunities for improving patient safety and ensures that NHS organisations have robust arrangements in place to identify and investigate SIs to prevent recurrence.

NHS HaRD CCG also has a responsibility to report and investigate incidents which occur within its own organisation. It also needs to ensure Governing Body is aware of Serious Incidents which occur within the CCG and that all action plans are monitored by the Quality and Clinical Governance Committee. Learning will be disseminated through the CCG. NHS HaRD CCG is supported in its responsibility by the Serious Incident Team – this team is shared between a number of CCGs and is currently hosted by NHS Hull CCG.

NHS HaRD CCG will be informed of SIs in line with the NHS Serious Incident National Framework (March 2015) that have occurred within any of its commissioned services listed below:

- Harrogate and District NHS Foundation Trust (Acute and Community Contract)
- Tees Esk and Wear Valleys NHS Foundation Trust
- Yorkshire Ambulance Service
- Primary Care Services
- Independent and Private Providers, commissioned to provide NHS services for the CCGs population, including NHS commissioned placements and service provision in care homes.
- Any other provider of NHS commissioned services affecting the patient population of NHS HaRD CCG.
- SI in services that fall under NHS HaRD CCG's responsibility under the co-commissioning agenda.

This policy sets out the requirements of how to respond to a Serious Incident and provides the tool for investigation. This policy sets out the arrangements to be followed by commissioned services and the CCG, to :

- Promptly and fully report serious incidents
- Effectively manage serious incidents so as to minimise harm and damage
- Thoroughly and systematically investigate and analyse serious incidents
- Identify learning from serious incidents and share that learning as appropriate
- Take actions and put in place measure to minimise the risk of recurrence
- Report to the NHS HaRD CCG Board and NHS England as required

NHS HaRD CCG will work closely with NHS England, the Department of Health and other organisations to manage serious incidents, minimise risk and in so doing help prevent recurrence across the NHS. External organisations contracted to support delivery of this area of work for NHS HaRD CCG will be referred to as associated team with lead for Serious Incident service.

The policy also outlines management of Incidents and Raising Concerns, that are of a less serious nature, but require monitoring and management to promote a culture of safety in NHS commissioned services.

2 ENGAGEMENT

This policy has been developed by Lead Nurses, GPs and clinical and managerial staff in NHS HaRD CCG, NHS Scarborough & Ryedale (CCG NHS S&R CCG) , NHS Hambleton, Richmondshire and Whitby CCG (NHS HRW CCG), NHS Vale of York CCG (NHS VoY CCG) and the Yorkshire and Humber Commissioning Support (YHCS). The National Framework for Serious Incidents (2015) on which this policy is based, has been circulated to all hospital, ambulance and community providers.

3 IMPACT ANALYSES

3.1 Equality

In developing this policy, an analysis of the impact on Equality has been undertaken. As a result of performing the analysis, the policy, project or function does not appear to have any adverse effects on people who share Protected Characteristics and no further actions are recommended at this stage.

NHS HaRD CCG promotes a culture of Equality and Diversity within its organisation and actively monitors themes arising from incidents for any potential discriminatory activity. See Appendix 6.

3.2 Sustainability

The Sustainability Impact Assessment identifies two positive impacts in relation to this policy or the CCG's sustainability themes. These relate to teleconferencing and electronic documentation and meeting management. See Appendix 7.

3.3 Bribery Act 2010

There are requirements to the provisions of the Bribery Act 2010 within this policy. See Appendix 8 These requirements present a very low level of risk to the CCG in relation to potential bribery.

4 SCOPE

This policy and associated tools for investigation is for use by NHS HaRD CCG employees, all commissioned services and the associated team with lead for Serious Incident service staff.

For the purpose of this policy an NHS patient is defined as a person receiving care or treatment under the NHS Act 1977, and described in Serious Incident Framework (2015) as “patient in receipt of NHS-funded care”.

The responsibilities of this document apply to NHS HaRD CCG, all commissioned services and associated team with lead for Serious Incident service who should make themselves aware of their responsibilities in this document as part of their duties to report incidents. An SI can be declared in relation to any member of staff, patient or member of the public who comes into contact with any service commissioned or provided by the NHS HaRD CCG.

5 POLICY PURPOSE AND AIMS

The purpose of the Policy is to provide NHS HaRD CCG, all commissioned services and associated team with lead for Serious Incident service with a working procedure for managing SIs to improve patient and staff safety.

The objective of this policy is to provide :

- A written description of the procedure
- Areas of responsibility
- Accountability
- Internal and external communication guidance
- Serious Incident classification
- Methods for investigation processes
- Learning from incidents
- Role, responsibility and accountability

6 DEFINITIONS

Incident – An incident is any event or circumstance that could or did lead to unintended or unexpected harm, loss or damage to one or more patients, members of staff, visitors, other persons or property, but does not constitute a Serious Incident.

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 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 like screening and 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 a series of incidents, which necessitate ward/unit closure or suspension of services)
- Activation of Major Incident Plan (by provider, commissioner or relevant agency)
- Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation

Concern – Occurrence that gives cause for concern by patient, staff, member of public, health or other care worker, that does not constitute an incident, but where collectively, can contribute to or form a body of evidence for commissioners to require actions and promote learning to encourage a safety culture.

Near miss – a near miss may be classified as a serious incident based on an assessment of risk that considers:

- The likelihood of the incident occurring again if current systems/process remain unchanged, and
- The potential for harm to staff, patients and the organisation should the incident occur again

This does not mean that every near miss should be reported as a serious incident but, where there is a significant existing risk of system failure and serious harm, the serious incident process should be used to understand and mitigate that risk.

Serious Incidents (SI) – include acts or omissions in care that result in; unexpected or avoidable death, unexpected or avoidable injury resulting in serious harm – including those where the injury required treatment to prevent death or serious harm.

Serious incidents in the NHS include:

- Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:
- Unexpected or avoidable death of one or more people.

This includes:

- Suicide/self-inflicted death; and
- 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 health care 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

- Abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS-funded care caused/contributed towards the incident
- A near miss may also constitute an SI where the contributory causes are serious, which under different circumstances may have led to serious injury, major permanent harm, or unexpected death, but no actual harm resulted on this occasion
- Never events are serious incidents that are wholly preventable as guidance or safety recommendations that provide strong systemic protective barriers are available at a national level and should have been implemented by providers. Each never event type has the potential to cause serious patient harm or death. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a never event. See Appendix 1 for core list of never events

7 ROLES, RESPONSIBILITIES AND ACCOUNTABILITY

NHS HaRD CCG has a responsibility to ensure there is robust performance management process in place that meets NHS England requirements as well as providing clear guidance on the identification, investigation and feedback of an SI. Part of this responsibility is to ensure commissioned services report Sis electronically on the Strategic Executive Information System (STEIS) and for this requirement to form part of the contract between NHS HaRD CCG and the commissioned service.

NHS HaRD CCG also has a duty to comply with NHS England Serious Incidents Framework March 2015. It is the responsibility of the Serious Incident Team on behalf of the CCG, to ensure this process is executed. The CCG will remain accountable for ensuring there is a robust process and the commissioned service are accountable for delivering in line with the Serious Incidents Framework 2015.

The responsibilities of this document apply to NHS HaRD CCG, all commissioned services and associated team with lead for Serious Incident service. Individuals should make themselves aware of their responsibilities within this document as part of their duties to report incidents. A Serious Incident can be declared in relation to any member of staff, patient or member of the public who comes into contact with any service commissioned or provided by NHS HaRD CCG.

8 POLICY STATEMENT

NHS HaRD CCG recognises that in a service as large and as complex as the NHS things will sometimes go wrong. When they do, NHS HaRD CCG supports the view that the response should not focus on blame and retribution, but of organisational learning with the aim of encouraging participation in the overall process and supporting staff, rather than exposing them to recrimination. NHS HaRD CCG will advocate justifiable accountability and a zero tolerance for inappropriate blame,

The Incident Decision Tree (NPSA 2006) should be used to promote fair and consistent staff treatment within and between healthcare organisations. Appendix 4 provides more information about using the Incident Decision Tree, and Appendix 5 provides an example in practice to provide more clarity.

Where there are concerns about individuals practice frameworks and policies are in place to maintain public safety and to ensure the public are protected and support staff.

Duty of Candour

NHS HaRD CCG is committed to promoting an open and fair culture, with a clear Duty of Candour. Every commissioned healthcare provider or organisation and everyone working for them must be honest, open and truthful in all their communication with patients and the public. Organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful (CQC 2015). Where a Serious Incident has affected or may have affected a patient by an act or omission of an organisation or its staff, the patient (or any lawfully entitled personal representative or other authorised person) should be informed of the incident, given full disclosure of the surrounding circumstances, be given a full apology followed by a written apology and be offered an appropriate level of support, whether or not the patient or representative has asked for this information. (Francis 2013, CQC 2015)

9 RELEVANT LEGISLATION AND STANDARDS

- Putting Patients First: The NHS England Business Plan for 2013/14-2015/16 https://www.england.nhs.uk/wp-content/uploads/2013/04/ppf-1314-1516.pdf
- Recommendations and Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry (Feb 2013) https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry
- NHS England (March 2015) Serious Incident Framework https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/04/serious-incidnt-framwrk-upd2.pdf
- Guidance on the reporting and monitoring arrangements and post infection review process for MRSA bloodstream infections (April 2014) https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2014/02/post-inf-guidance2.pdf
- Department of Health (2013) Information: To Share or not to Share Government response to the Caldicott Review https://www.gov.uk/government/publications/the-information-governance-review
- http://www.nrls.npsa.nhs.uk/resources/patient-safety-topics/
- Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework (March 2013) https://www.england.nhs.uk/wp-content/uploads/2013/03/safeguarding-vulnerable-people.pdf
- Department of Health (2012) Compassion in Practice https://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf
- National framework for reporting and learning from serious incidents requiring investigation http://www.nrls.npsa.nhs.uk/resources/?entryid45=75173
- NPSA (2009) Being Open Policy http://www.nrls.npsa.nhs.uk/beingopen/
- Freedom of Information Act (2000) http://www.legislation.gov.uk/ukpga/2000/36/contents
- CQC (2015) Duty of Candour Regulation 20 http://www.cqc.org.uk/content/regulation-20-duty-candour
- Managing Safety Incidents in NHS Screening Programmes (2015) Public Health England

https://www.gov.uk/government/publications/managing-safety-incidents-in-nhs-screening-programmes

- NHS HaRD CCG will inform NHS England of any requests for information regarding serious incidents submitted to them under the Freedom of Information Act 2000. The commissioned service will deliver this on behalf of NHS HaRD CCG.
- Policy Implementation
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10 POLICY IMPLEMENTATION

Serious Incidents

Culture

NHS HaRD CCG is actively engaged in promoting and developing a safety culture where staff have a constant and active awareness of the potential for things to go wrong both internally and with commissioned providers. Through the development of this culture, NHS HaRD CCG is able to acknowledge mistakes, learn from them and take action to put things right with the opportunity to learn and share the learning from the SI and improve patient safety.

Having a safety culture encourages a working environment where many complicated components are taken into account and recognised as contributing to an SI or to the events leading up to it. It is recognised that the causes of any SI frequently extend far beyond the actions of the individual staff involved, and are often out of their control. Consideration and discussion of both situational and human factors is required to ensure all potential contributing factors have been considered. While human error may be a part of an SI, in a technically and socially complex system like healthcare, there are usually entrenched systemic factors at work. NHS HaRD CCG is committed to using a detailed, structured, investigative methodology such as using root cause analysis during the investigation of Sis and requires providers to use this technique when investigating Sis.

Duty of Candour – Being Open

A commitment to improving communication between NHS HaRD CCG and patients who have been harmed is integral to NHS HaRD CCG's strategy to be open and transparent. This demonstrates the value of NHS HaRD CCG places on honesty combined with a recognition of user contribution and involvement in the investigation process to improve patient safety. This is a national contractual requirement for all providers of NHS services under the NHS standard contract as well as one of the fundamental standards applied by the Care Quality Commission (2015).

NHS HaRD CCG requires all providers to demonstrate a Duty of Candour, based on recommendations made by Francis (2013) and in line with principle of "Being Open" that involves acknowledging, *apologising*, and explaining what happened in a patient safety incident to the patient and/or their carers who have been involved, whether or not the patient or their representative have asked for this information. Following a verbal apology a written apology should be sent with clear arrangements for ongoing involvement and communication.

11 Reporting a Serious Incident

Who should report SIs?

All incidents which are categorised as Sis within the Serious Incident Framework (2015) will be reported. Commissioned providers are required to report Sis to NHS HaRD CCG using the STEIS system. The reporting process for commissioned providers can be found at Appendix 3.

Providers are required to demonstrate an internal governance process that ensures Serious Incidents are reported on STEIS within 2 working days of the SI being *identified* from within the organisation, or to the organisation by an external organisation.

For SIs that are declared by NHS HaRD CCG itself, these are reported directly on STEIS by the associated team with lead for Serious Incident service.

NHS HaRD CCG is automatically informed via e-mail of an SI when a STEIS record is completed by a provider organisation. This e-mail contains a link to securely log into STEIS to view the incident details. The CCG can request a 72 hour report if additional information or assurance is required prior to completion of the SI report.

12 Investigation of a Serious Incident

Responsibilities

The Lead with responsibility for serious incidents in the relevant commissioned provider services or in the CCG will:

- ensure the establishment and co-ordination of an investigation team to thoroughly investigate the SI and to ensure objectivity using Root Cause Analysis (RCA) tools.
- Ensure Being Open and Duty of Candour requirements have been adhered to

The investigation team will:

- be led by a nominated manager fully trained in incident investigation and analysis and sufficiently removed from the incident itself so as to be able to conduct an objective investigation. All staff involved in the incident will be asked to participate in the investigation and be asked to give their version of events, either in a statement and/or an interview. Best practice is to record this. Ensure all staff have access to identified support and appropriate information with statement writing and interview.

The Investigation team will support organisational learning through root cause analysis and will:

- Ensure the incident is logged on the national reporting system (STEIS)
- The SI must be logged on STEIS within 2 working days
- Establish a set of Terms of Reference for the investigation which is shared with the family if appropriate
- Ensure that all proper records are obtained and kept secure, including the copying of Medical Records prior to their leaving the site of the incident
- Ensure there is adequate support to staff affected by the SI
- Ensure that there is a thorough investigation of serious or repeated incidents so that causation factors (root causes) can be identified

- Complete investigations and the investigation report so that it can be reviewed by the SI panel **within 60 working days** of the incident date
- Report the SI summary, investigation report including root causes and lessons learnt to the relevant committees in line with the investigation terms of reference
- Identify which committee or team is responsible for providing an update on actions taken following the SI investigation
- Update the STEIS system as appropriate
- Identify how lessons will be shared within the team / directorate / service

The associated team with lead for Serious Incident service will :

- Monitor that SIs are logged onto the STEIS system appropriately
- Acknowledge receipt of SIs received via the STEIS system to providers within two working days, conformation of the patient's / client's GP details and a deadline for receipt of the investigation report and action plan
- Request 72 hour additional reports from providers if requested
- Maintain up-to-date electronic records of all Serious Incidents pertaining to the NHS HaRD CCG and commissioned services
- Provide specialist advice to support the SI process
- Ensure or advise that SIs are reported to the relevant professional bodies
- Negotiate requests for extensions of investigation reports from providers
- Forward SI reports to appropriately trained clinical and managerial reviewers
- Organise the SI panel meetings
- Ensure feedback is provided following review of investigation reports
- Produce quarterly SI data for both NHS HaRD CCG and NHS England as appropriate.

All SI investigation reports are reviewed and discussed at the SI panel. The SI panel is a collaborative group drawn from HaRD, VoY, S&R & HRW CCGs. The SI panel will:

- Receive, critique and provide feedback on the SI report
- Maintain a transparent and open system to assure quality of Root Cause Analysis, and to receive assurance that action plans resulting from SI reports have been followed up and adequately completed within the timescales indicated in the SI report
- Review implementation of action plans and assurance on SI reports received
- Identify learning points and be assured of sharing of learning
- Monitor the implementation of this policy, including reporting timescales, quality of reporting, feedback to providers, performance management responsibilities, dissemination of lessons learned and assurance on actions taken
- Ensure SIs are closed on STEIS when it is satisfied the investigation is completed and evidence of implementation has been provided for assurance
- Work in conjunction with the CCG Communications service where a media response is required
- Ensure actions are adequate or when it has sufficient assurance that actions have been completed

The sharing of lessons learnt post-investigation is a critical part of serious incident management. Following a review of the SI, the Lead will ensure that procedures are adopted or altered to reflect the lessons learnt from Serious Incidents. The Lead Director and Investigation Officer will ensure that such procedures are disseminated to all departments through the appropriate means e.g. local networks, through team meetings, inclusion in appropriate newsletters, all in anonymised form. Lessons will be shared across organisational boundaries through local networks, NHS England and Public Health England.

If as a result of the initial enquiry disciplinary action is considered necessary, advice will be sought from the Director of Human Resources or equivalent. The NPSA has a simple-to-use on-line Incident Decision Tree, which, depending on the nature of the incident and the amount of information gathered, usually takes 30 to 60 minutes to work through and provides information on whether to suspend/remove a member of staff whose conduct is under suspicion as part of an SI and can be used in parallel with the Root Cause Analysis and in order to make decisions on reporting to professional bodies as necessary.

Investigation of Serious Incidents reported within NHS HaRD CCG will be reviewed by the Executive Nurse, Clinical Quality Manager and any other officer with an associated interest in the SI. Reports will be discussed at Quality and Clinical Governance Committee and action plans will be monitored through the Quality and Performance Committee.

The Executive Lead for Serious Incidents with NHS HaRD CCG will have a duty to report regularly to the HaRD CCG Quality and Clinical Governance committee and will escalate matters to the wider membership and Governing Body as appropriate.

The Role of NHS England

NHS England has a direct commissioning role as well as a role in leading and enabling the commissioning system. As part of the latter role, NHS England maintains oversight and surveillance of serious incident management within NHS-funded care and assures that CCGs have systems in place to appropriately manage serious incidents in the care they commission. They are responsible for reviewing trends, analysing quality and identifying issues of concern. They have a responsibility for providing the wider system with intelligence gained through their role as direct commissioners and leaders of the commissioning system. NHS England must maintain mechanisms to support this function, including exploiting opportunities provided by their involvement and participation in local and regional Quality Surveillance Groups.

In certain circumstances (for example with many incidents relating to mental health homicide) NHS England may be required to lead a local, regional or national response (including the commissioning of an independent incident investigation) depending on the circumstances of the case.

Provider reporting of Never Events to NHS HaRD CCG forms part of the contract arrangements for reporting Sis. The NHS England Framework supports NHS HaRD CCG in their performance management of never events and will ensure interventions are enacted with providers where appropriate.

- NHS England are automatically alerted when an SI is reported via the STEIS system. In some circumstances NHS England may require immediate assurance depending on the seriousness and complexity of the SI.
- In exceptional circumstances, NHS England may alert other Trusts in Yorkshire and the Humber or throughout the country. NHS England will also lead on informing relevant networks if there are serious concerns about the actions of an individual health professional and s/he is considered likely to be seeking work with other employers who would be unaware of the concerns.

- Out of hours, the provider should contact NHS England on-call manager if the SI is of an exceptional nature, for example, requiring immediate investigation by the Police/HSE and/or likely to attract media attention, e.g. a fire on NHS premises causing major service disruption. The SI should be formally reported on STEIS the next working day.
- Where an SI involves more than one NHS organisation (e.g. a patient affected by system failures both in an acute hospital and in primary care), a decision should be made jointly by the organisations concerned about where the frequency/severity of the problem(s) appears to have been greatest, if necessary referring to NHS HaRD CCG and associated team with lead for Serious Incident service or NHS England for advice. A single investigation report and action plan will be submitted by the reporting organisation.
- In the interest of patient safety, NHS England and NHS HaRD CCG will inform the CQC of "highly significant" SIs such as those that are likely to generate significant interest and possibly require consideration by the Care Quality Commission Investigations Department as indicative of system failure and are subject to national or a high level of local media interest. Where NHS England decides to notify the CQC of such an incident the relevant organisation will be informed of this first and this action does not negate the organisation from reporting to the CQC where appropriate.

NHS England will continue to performance manage SIs involving the safeguarding of children as outlined in Safeguarding Vulnerable People in the NHS: Accountability and Assurance Framework (March 2015). This will be done through the Safeguarding Team Designated Nurses who are employed across the NHS HaRD CCG, NHS S&R CCG, NHS HRW CCG, NHS VoY CCG and NHS England. The employing organisation is S&R CCG with responsibility to the relevant organisation HaRD CCG, S&R CCG, HRW CCG, VoY CCG and NHS England dependent on the residency of the individual and these cases will be kept open until the action plans have been fully implemented.

NHS England will performance manage Sis reported by commissioned services of NHS HaRD CCG where there are potential issues/concerns about the commissioning of services.

NHS England will hold NHS HaRD CCG to account in respect of their performance management of Sis and requires NHS HaRD CCG to prepare quarterly reports on SI management.

Learning from SIs within the region will also be shared nationally by NHS England as appropriate and NHS England will ensure that the learning from key inquiries at national level is implemented within North Yorkshire and the Humber.

13 Safeguarding Adults and Children

Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework published on 21 March 2015 makes clear that regardless of the individual circumstances, both commissioner and provider organisations should :

- Ensure that the Local Safeguarding Adult boards (LSABs) and Local Safeguarding Children Boards (LSCBs) have been notified of relevant incidents and agree arrangements for the management of Serious Case Reviews / Lessons Learnt Reviews, Domestic Homicide Reviews and other non-statutory reviews, depending on circumstances; including action planning and learning

from incidents. All actions should be consistent with the local multi-agency safeguarding protocol and policies

- Ensure robust communication between safeguarding boards, commissioners, regulators and providers. There should not be duplication of investigations and action planning within the health care provider organisations where external bodies, such as safeguarding boards, are carrying out these activities and health care organisations are assured that actions are satisfactorily in hand and that there are robust process for ensuring any outcomes from the external investigation will be communicated and acted upon; SIs must be reported on STEIS to ensure health element of SI is reported and evidence of action implementation is submitted to commissioner.
- Ensure understanding of, and apply, reporting and liaison requirements with regard to agencies such as the Police, Public Health England, Health and Safety Executive (HSE), Coroner, Education Partners, Local Authority partners, Local Midwifery Supervising Authority or Medicines and Healthcare products Regulatory Agency (MHRA);
- Ensure incidents are reported to the appropriate regulatory and healthcare bodies, including the CQC and, for patient safety incidents, the National Reporting and Learning System
- Ensure that all SIs are considered by the provider in relation to whether there has been a possible incident of abuse as defined by the Care Act,2014, and an alert is raised as appropriate.

Children

Under the statutory guidance Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children published March 2015, NHS England has a statutory duty to safeguard and promote the welfare of children. It will also be accountable for the services it directly commissions. NHS England will also lead and define improvements in safeguarding practice and impact / outcomes, and should also ensure that there are effective mechanisms for LSCBs and Health and Wellbeing Boards to raise concerns about the engagement and leadership of the local NHS in relation to safeguarding children and adults.

For clarity, incidents relating to safeguarding children should be reported if they fall within the criteria set below:

(a) abuse or neglect of a child is known or suspected; and

(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child. ('Working Together' 2015)

Adults

The Care Act defines adult safeguarding as protecting a person's right to live in safety, free from abuse and neglect. The Care Act requires that each local authority must: make enquiries, or ensure others do so (e.g. health providers or police) if it believes an adult (with care and support needs, regardless of whether those needs are being met) is, or is at risk of, abuse or neglect. An alert should be raised and an enquiry undertaken to establish whether any action needs to be taken to stop or prevent abuse and neglect and if so by whom.

NHS England is responsible for ensuring that the health commissioning system as a whole is working effectively to safeguard and promote the welfare of children. It is also accountable for the services it directly commissions, including health care services in the under-18 secure estate and in police custody.

NHS England also leads and defines improvement in safeguarding practice and outcomes and should also ensure that there are effective mechanisms for LSCBs and health and wellbeing boards to raise concerns about the engagement and leadership of the local NHS.

NHS HaRD CCG as the commissioner of local health services is responsible for safeguarding quality assurance through contractual arrangements with all provider organisations. NHS HaRD CCG has the responsibility for Safeguarding Vulnerable Adults and is represented at the North Yorkshire Safeguarding Adults Board by The Designated Nurse for Safeguarding Adults.

The Designated Professionals for Adults and for Children for NHS HaRD CCG are hosted by NHS S&R CCG. These professionals provide the CCGs and NHS England with professional support and advice in relation to relevant SIs.

The administrative records of Sis linked with safeguarding investigations will be processed through the NHS HaRD CCG SI management process via the associated team with lead for Serious Incident service and these cases will be kept open until the action plans have been fully implemented.

Criteria for Safeguarding Children Serious Incident Review Statutory Guidance (HM Government, 2015) identified the criteria for the LSCB to commission a Serious Case Review (SCR) are where:

a) abuse or neglect of a child is known or suspected; and

(b) either — (i) the child has died; or (ii) the child has been seriously harmed and there is cause for concern as to the way in which the authority, their Board partners or other relevant persons have worked together to safeguard the child. ('Working Together' 2015)

- Chapter 4 of the Guidance (HM Government, 2015) also directs that reviews should also be considered where the threshold for a SCR is not reached but where there may be valuable lessons in terms of interagency or single agency working. In this case a Learning Lesson Reviews or Single Agency Review may be commissioned. Should these reviews identify any significant learning for Health organisations consideration should be given as to if the criteria for a SI reporting is reached. If not already involved, the Designated Professionals must be consulted in order to provide expertise into the decision making process
- Should CCG staff identify any other case where there may be an associated safeguarding children issue they should consult with the Designated Professionals for expert advice regarding if this fits the criteria for a Safeguarding Children SI

Criteria for Safeguarding Adult Reviews (Care Act 2014)

1. A SAB must arrange for there to be a review of a case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs) if:

- There is reasonable cause for concern about how the SAB, members of it or other persons with relevant functions worked together to safeguard the adult and
- Condition 1 or 2 is met

2. Condition 1 is met if:
   - The adult has died and
   - The SAB knows or suspects that the death resulted from abuse or neglect (whether or not it knew about or suspected the abuse or neglect before the adult died)
3. Condition 2 is met if:
   - The adult is still alive and
   - The SAB knows or suspects that the adult has experienced serious abuse or neglect
4. A SAB may arrange for there to be a review of any other case involving an adult in its area with needs for care and support (whether or not the local authority has been meeting any of those needs)
5. Each member of the SAB must co-operate in and contribute to the carrying out of a review under this section with a view to:
   - Identifying the lessons to be learnt from the adult's case and
   - Applying those lessons to future cases

The application for consideration of a Safeguarding Adult Board review will be made to the Independent Chair of the relevant Safeguarding Adult Board.

14 Use of Adult Psychiatric Wards for Children Under 16

Any incident involving children under 16 who are admitted to adult mental health beds requires reporting on STEIS by the commissioning organisation. A category called 'Admission of under 16s to Acute Mental Health Ward' has been added to STEIS and requires details of how the child will be moved to appropriate accommodation within 48 hours. The definitive date is the child's date of birth.

15 Incidents Involving National Screening Programmes

SIs linked to screening programmes should also be reported to NHS England within two working days. For the most serious of incidents NHS England should be informed immediately and a member of the Public Health team should be involved in the incident investigation. This is done via the screening lead at Public Health England who is embedded within NHS England.

Further information on Population Screening Programmes can be found at:
https://www.gov.uk/topic/population-screening-programmes

16 Breaches of Confidentiality Involving Person Identifiable Data (PID), Including Data Loss

Any incident involving the actual or potential loss of personal information that could lead to identity fraud or have other significant impact on individuals should be considered as serious and be reported as a SI. NHS England has a role in notifying the Department of Health (DH) of certain data loss incidents, depending on the severity and in line with recommendations of Caldicott Review (2013)

Information Governance Sis should be reported in line with the Department of Health Digital Information Policy January 2009: Checklist for reporting, managing and investigating Information Governance Serious Untoward Incidents. The DH

Information Governance Risk Assessment Tool should be used for categorising the incident. All incidents raised as 1-5 on the Information Governance Risk Assessment Tool must be categorised as Sis and reported as per this policy.

17 Process for Reporting SIs that Fall into Category of Pressure Damage

Patients who are in receipt of NHS commissioned care, in hospital and community settings who experience pressure damage, should be assessed appropriately using nationally recognised assessment and care management tools. Patients should be initially and appropriately assessed within six hours of admission or at their first planned visit within the community setting (EPUAP 2015 NICE Quality Standard Q589). Where pressure damage occurs and the assessment identifies that there have been any acts or omissions in care contributing to the development of the pressure damage, any neglect of the patient or any safeguarding alerts the incident must be reported as a Serious Incident in line with SI Framework (2015). It may therefore also be raised as a safeguarding concern.

Provider organisations who do not have STEIS log on, can report the SI to nyyccgs.seriousincidents@nhs.net

A report will be uploaded on behalf of the organisation, and guidance given by associated team with lead for Serious Incident service.

18 Process for Reporting SIs that Fall into Category of Health Care Associated Infections (HCAI)

It is required that MRSA and C Difficile deaths will be subject to a Post Infection Review (PIR, April 2013). These cases will be managed elsewhere and do not require to be reported as Sis unless a HCAI is on Part 1 of death certificate.

Other HCAI that should be considered for reporting as a SI include :

- Clusters or recurrences of HCAIs that are not being managed via PIR or other HCAI process
- Unusual outbreaks in care settings
- Incidents that result in adverse media interest

Services will ensure engagement with NHS England Public Health teams where appropriate and for all outbreaks in non-NHS care settings.

19 Incidents Relating to Health and Safety, Medicines Management and Drug Errors, Equipment Failure and Waste

For incidents related to health and safety, the NHS HaRD CCG approved Health and Safety Specialists will advise whether it is necessary to inform the Health and Safety Executive (HSE) and whether the area involved needs to be isolated until an HSE Inspector has visited.

Any SI involving a drug error must include the name of the drug and the details of the error when reported on STEIS.

For SIs involving defective 'products' (i.e. drugs, equipment, etc.), the item(s) must be isolated and retained (where this has not already occurred for the purposes of a police investigation) and the relevant staff should be contacted, Medication and

Drug related errors that result in serious harm or death, or are considered “near misses” should be reported as SIs by the provider. The NHS HaRD CCG has a duty to report defects in medicinal products, buildings and plant, and other medical and non-medical equipment and supplies to the relevant external authorities, currently the Medicines and Healthcare Products Regulatory Agency (MHRA) and/or the Health and Safety Executive (HSE).

For SIs relating to waste the appointed team for waste at the Local Authority should be involved in all investigations following accident or incident that requires reference to waste legislation. Contact with the relevant team at the Local Authority must be made through the Facilities department.

20 Midwifery Service Incidents

Where NHS HaRD CCG is performance managing a midwifery SI, it is responsible for obtaining clinical advice if required either from a supervisor of midwives independent of the service in question or directly from the Local Supervising Authority Midwifery Officer.

21 Patients in Receipt of Mental Health Services

For SIs reported involving patient/s in receipt of mental health services the details of the section of the Mental Health Act the patient is under (if applicable) should be included on STEIS along with confirmation if the patient is a formal or informal patient.

22 Patients in Receipt of Substance Misuse Services

In NHS commissioned services, where the cause of death of a substance misuse service user is a direct result of their substance misuse, the reporting organisation should report this as an unexpected death on STEIS.

Where patients are in receipt of care commissioning by non-NHS commissioners, such as Local Authority commissioned Drug and Alcohol Services, these are not required to be reported on STEIS, but managed through that commissioning organisations processes.

23 12 Hour Breech

Where a 12 Hour breech occurs the provider is to submit to both NHS HaRD CCG and NHS I a detailed timeline of events, completed by a clinician (as per the agreed template – see Appendix 9) within 48 hours (2 working days). NHS HaRD CCG will alert the local NHS England Team through the agreed escalation process and will consider any contractual implications.

NHS HaRD CCG will review the timeline of events. If no harm is determined the SI is de-logged following agreement with NHS HaRD CCG. If harm is determined the provider must complete a SI investigation as per national framework.

24 Sharing Lessons Learned

NHS HaRD CCG will work in partnership with, and support provider and co-commissioning organisations to share transferable lessons learnt from serious incidents. This will enable a wider impact when implementing actions to improve the quality and safety of services provided both locally and nationally. Provider organisations will be expected to lead and implement changes to improve patient safety in line with recommendations of Francis (2013) and NHS CB (2012) Compassion in Practice (2012), provide evidence of impact on lessons learnt and quality improvement with staff. NHS HaRD CCG will work with NHS England in order that learning from serious incidents is shared with other NHS organisations in Yorkshire and the Humber and nationally where appropriate.

25 INCIDENT MANAGEMENT AND RAISING CONCERNS

Reporting Incidents and Near Misses within NHS HaRD CCG

An incident occurring in NHS HaRD CCG is any event or circumstance that could or did lead to unintended or unexpected harm, loss or damage to one or more patients, members of staff, visitors, other persons or property.

Incidents should be reported using the Incident Reporting system as soon as possible following the incident and within two working days. The reporter should also notify their line manager of incident at same time.

An investigation will be required by the line manager or appropriate other. The level of the investigation will depend upon the grade of the incident. The investigation into the incident must be completed within an agreed timescale.

The associated team with lead for Serious Incident service is responsible for validating the grade of the incident and ensuring an appropriate investigation has been undertaken, and providing quarterly reporting to NHS HaRD CCG.

The Communications service will initiate a communication media handling strategy for responding incidents that have the potential to attract multiple enquires from the public.

Reporting and Managing Concerns

In line with recommendations (Francis 2013), NHS HaRD CCG recognises the value of concerns being reported. An individual concern in itself may not constitute an incident for investigation, but collectively, can contribute towards a body of evidence to enable the CCG to investigate where a number of similar concerns are reported. Concerns can relate to local NHS services or care homes. Concerns raised may emerge from a variety of sources, such as something any individual has witnessed or may be third party information that is regarded as needing to be noted.

No patient or person identifiable information should be reported in a concern report.

Concerns reported will be reviewed by an appropriate officer in NHS HaRD CCG or a nominated delegate, to identify themes requiring further investigation.

Concerns should be raised through the incidents reporting system or through the patient relations service HARDCCG.PatientRelations@nhs.net or phone 0800 068 8000.

26 TRAINING AND AWARENESS

Staff will be made aware of the policy through the staff induction process, when directed to review policies and procedures of the organisation. The policy will be held on the intranet.

Line managers have a responsibility to ensure staff undertake the correct level of training in relation to conducting investigations as appropriate.

27 POLICY REVIEW

This policy will be reviewed every two years. Earlier review may be required in response to exceptional circumstances, organisational change or relevant changes in legislation/guidance, and as instructed by the senior manager responsible for this policy.

28 REFERENCES

- Care Act 2014 http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted
- CQC Regulation 20 Duty of Candour March 2015 http://www.cqc.org.uk/sites/default/files/20150327_duty_of_candour_guidance_final.pdf
- Department of Health (2013) Information: To Share or not to Share Government response to the Caldicott Review https://www.gov.uk/government/publications/the-information-governance-review
- Department of Health (2012) Compassion in Practice DOH https://www.england.nhs.uk/wp-content/uploads/2012/12/compassion-in-practice.pdf
- Guidance on the reporting and monitoring arrangements and post-infection review process for MRSA bloodstream infections (April 2013) https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2014/02/post-inf-guidance2.pdf
- National framework for reporting and learning from serious incidents requiring investigation http://www.nrls.npsa.nhs.uk/resources/?entryid45=75173
- NPSA (2009) Being Open Policy http://www.nrls.npsa.nhs.uk/beingopen/
- National Health Service Act 1977
- Health and Social Care Information Centre (HSCIC) (February 2015) Checklist Guidance for the Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation https://www.igt.hscic.gov.uk/resources/HSCIC%20SIRI%20Reporting%20and%20Checklist%20Guidance.pdf
- NHS England (2013/14 update) The Never Events List https://www.england.nhs.uk/wp-content/uploads/2013/12/nev-ev-list-1314-clar.pdf
- NHS England (September 2014) Twelve Hour Breach AE Standard Guide
- NHS England (November 2014) Safer Staffing Guide Care Contact Time https://www.england.nhs.uk/wp-content/uploads/2014/11/safer-staffing-guide-care-contact-time.pdf

- NHS England (March 2015) Serious Incident Framework https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf
- NICE Quality Guideline Q589 (June 2015)
- Putting Patients First: The NHS England Business Plan for 2013/14-2015/16 https://www.england.nhs.uk/wp-content/uploads/2013/04/ppf-1314-1516.pdf
- Recommendations and Report of the Mid Staffordshire NHS Foundation Trust Public Enquiry (Feb 2013) https://www.gov.uk/government/publications/report-of-the-mid-staffordshire-nhs-foundation-trust-public-inquiry
- Safeguarding Vulnerable People in the NHS: Accountability and Assurance Framework (March 2015) https://www.england.nhs.uk/wp-content/uploads/2015/07/safeguarding-accountability-assurance-framework.pdf
- Working Together to Safeguard Children https://www.gov.uk/government/publications/working-together-to-safeguard-children--2
- Freedom of Information Act (2000) http://www.legislation.gov.uk/ukpga/2000/36/contents
- Managing Safety Incidents in NHS Screening Programmes (2015) Public Health England https://www.gov.uk/government/publications/managing-safety-incidents-in-nhs-screening-programmes
- Department of Health Digital Information Policy January 2009: Checklist for reporting, managing and investigating Information Governance Serious Untoward Incidents https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/200507/Checklist_for_Reporting__Managing_and_Investigating.pdf

29 ASSOCIATED DOCUMENTATION

Information Governance Reporting Procedure

30 LIST OF APPENDICES

Appendix 1

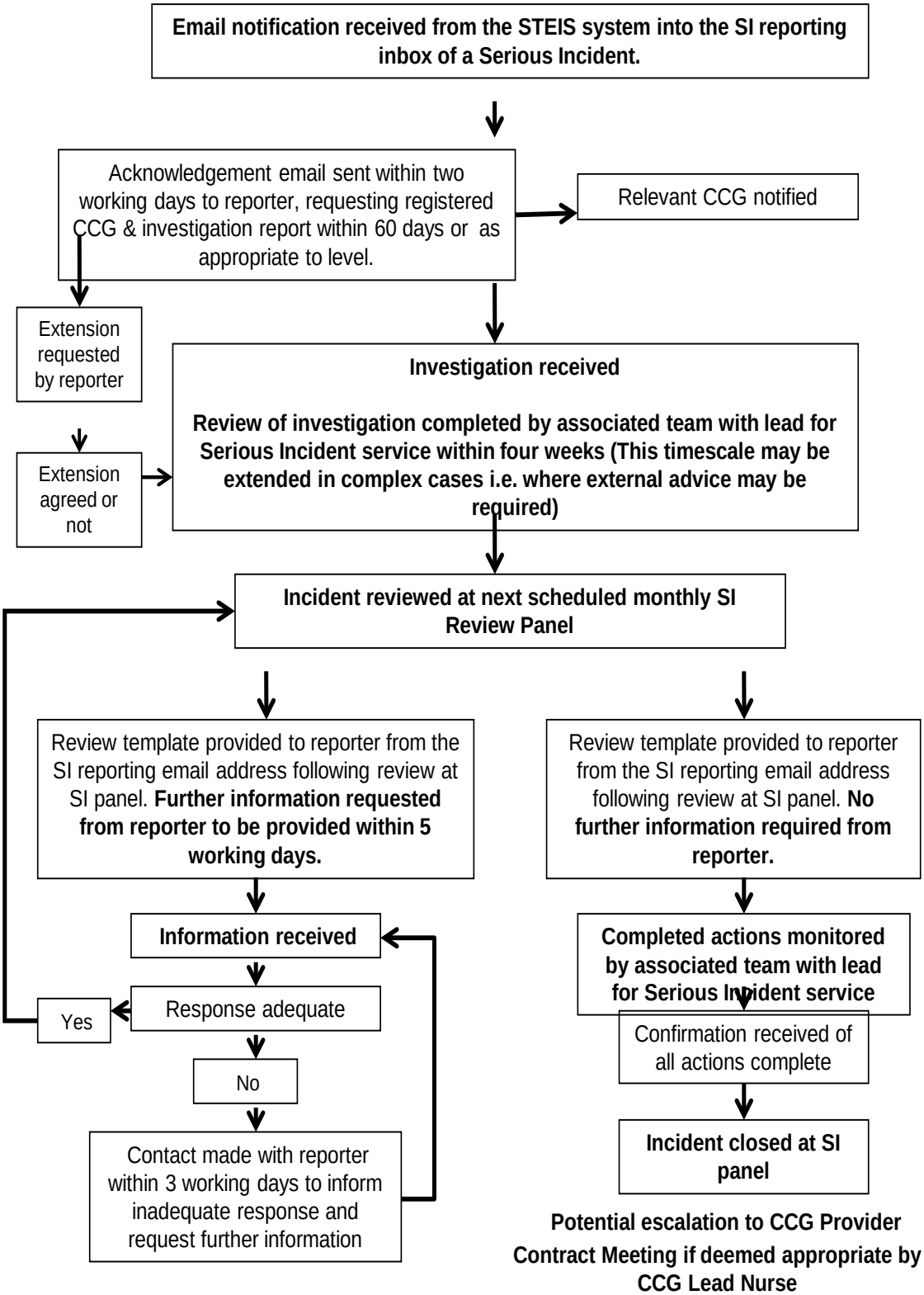
Core List of Never Events

1. Wrong site surgery
2. Wrong implant / prosthesis
3. Retained foreign object post-procedure
4. Mis-selection of a strong potassium containing solution
5. Wrong route administration of medication
6. Overdose of Insulin due to abbreviations or incorrect device
7. Overdose of methotrexate for non-cancer treatment
8. Mis-selection of high strength midazolam during conscious sedation
9. Failure to install functional collapsible shower or curtain rails
10. Falls from poorly restricted windows
11. Chest or neck entrapment in bedrails
12. Transfusion or transplantation of ABO-incompatible blood components or organs
13. Misplaced naso- or oro-gastric tubes
14. Scalding of patients

Appendix 2

Commissioned Services Reporting Process

****all communication to be sent via SI reporting e-mail address:**
nyyccgs.seriousincidents@nhs.net



Appendix 3

Serious Incident Report Submission – Timescales and Extension Requests

Provider organisations are required to report Serious Incidents (SI) within two working days, once identified. As per Framework for SIs (March 2015) the date of SI's discovery by the organisation is the date from that the deadline is taken for a report into SI to be completed and submitted. Organisations are requested to use "Strategic Executive Information System (STEIS) to log SIs, and are required to keep commissioners informed as per contractual arrangements.

SIs should be fully investigated by the provider using nationally recognised tools and a report with action plan signed off by a director, submitted to the commissioner within12 weeks, from the date of organisation's awareness of the SI.

It is expected that SI reports will be submitted within the 60 day timeframe. When the provider recognises they may need to ask for an extension to a known deadline date, requests MUST BE formally requested via the SI Inbox. It is expected the provider will make request for extension deadline well ahead of the due date. Repeated extension requests made within last 4 weeks of the due date for the report will be challenged by the commissioner.

It is acknowledged that on occasion, some SIs investigations cannot be completed within 60 days. An interim report will always be required to be submitted at the initial 60 day deadline. The provider must request an extension for the final report submission.

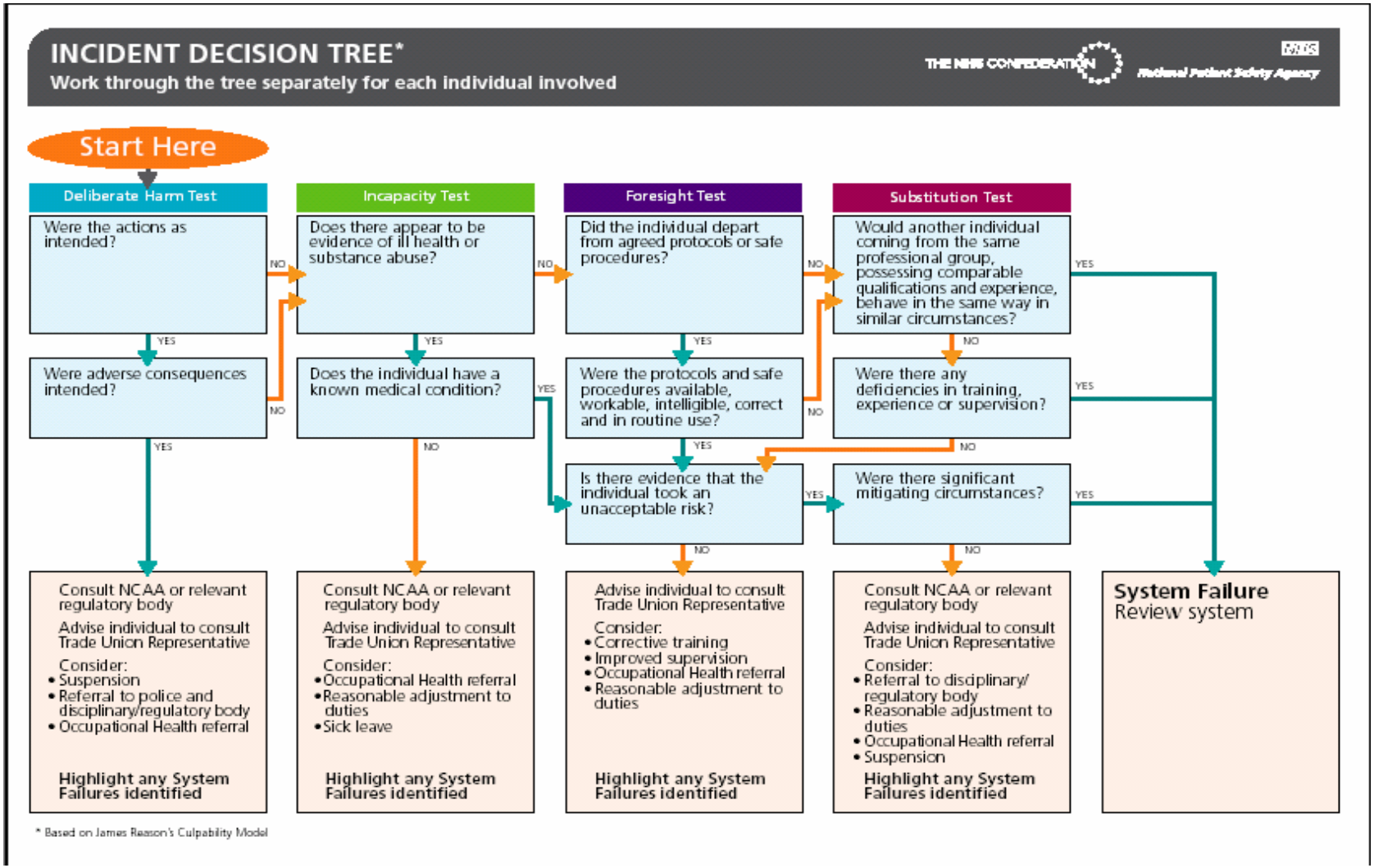
Coroner/inquest investigations often benefit from completed SI Investigations and Coroners will often await SI investigation reports. On occasion the SI investigation completion may be held up by the Coroner / inquest investigation. In these circumstances, an interim SI report will be required in the initial 60 day deadline.

All extension requests MUST BE formally requested via the SI Inbox. The extension requested should be a realistic timeframe, to avoid the potential for repeated requests for extensions. Extensions will be agreed on a case by case basis, and may include:

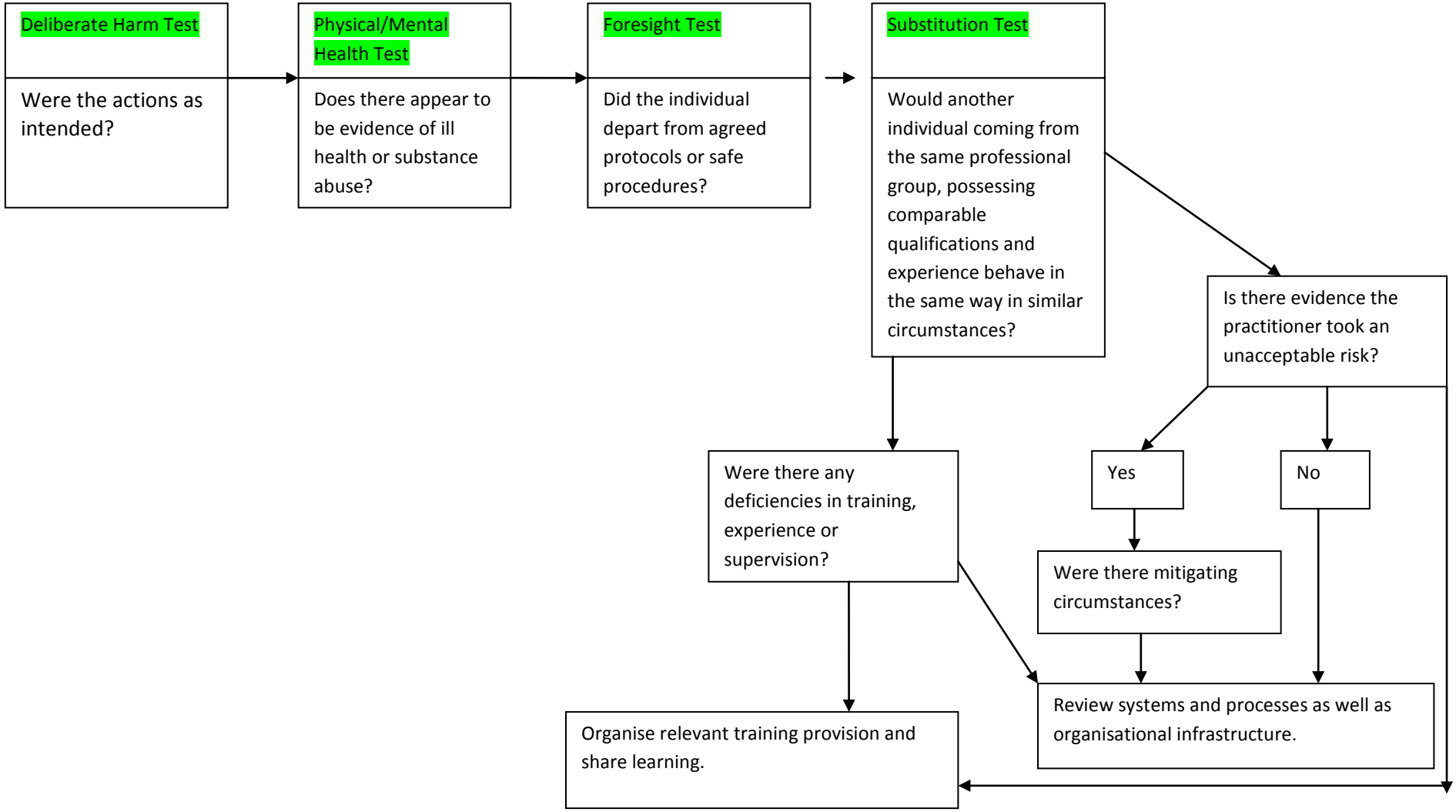
- Police investigation
- Coroner's investigation requiring completion prior to SI report completion
- Where one or more members of staff are unavailable for a prolonged period whose information is important to the SI investigation.
- Other situations on case by case basis, where the associated team with lead for Serious Incident service will liaise with relevant CCG Lead.

In all these circumstances, an interim SI report will be required in the initial 60 day deadline.

In conclusion, providers are expected to complete SI investigations and submit reports to the SI Inbox within the 60 day deadline. SIs reported, reports submitted and number of extensions requested will be monitored through the SI Panel and the contract management board.


INCIDENT DECISION TREE*
Work through the tree separately for each individual involved
THE NHS CONFEDERATION
NPSA
National Patient Safety Agency
Start Here
Deliberate Harm Test
Were the actions as intended?
NO
YES
Were adverse consequences intended?
NO
YES
Consult NCAA or relevant regulatory body
Advise individual to consult Trade Union Representative
Consider:
• Suspension
• Referral to police and disciplinary/regulatory body
• Occupational Health referral
Highlight any System Failures identified
Incapacity Test
Does there appear to be evidence of ill health or substance abuse?
NO
YES
Does the individual have a known medical condition?
YES
NO
Consult NCAA or relevant regulatory body
Advise individual to consult Trade Union Representative
Consider:
• Occupational Health referral
• Reasonable adjustment to duties
• Sick leave
Highlight any System Failures identified
Foresight Test
Did the individual depart from agreed protocols or safe procedures?
NO
YES
Were the protocols and safe procedures available, workable, intelligible, correct and in routine use?
NO
YES
Is there evidence that the individual took an unacceptable risk?
YES
NO
Advise individual to consult Trade Union Representative
Consider:
• Corrective training
• Improved supervision
• Occupational Health referral
• Reasonable adjustment to duties
Highlight any System Failures identified
Substitution Test
Would another individual coming from the same professional group, possessing comparable qualifications and experience, behave in the same way in similar circumstances?
YES
NO
Were there any deficiencies in training, experience or supervision?
YES
NO
Were there significant mitigating circumstances?
YES
NO
Consult NCAA or relevant regulatory body
Advise individual to consult Trade Union Representative
Consider:
• Referral to disciplinary/ regulatory body
• Reasonable adjustment to duties
• Occupational Health referral
• Suspension
Highlight any System Failures identified
System Failure
Review system
* Based on James Reason's Culpability Model

Example of using the Decision Tree (Post Incident)



1. Equality Impact Analysis	
Policy / Project / Function:	Serious Incident Policy
Date of Analysis:	09 January 2017
This Equality Impact Analysis was completed by: (Name and Department)	Liz Hodgkinson Deputy Executive Nurse NHS HaRD CCG
What are the aims and intended effects of this policy, project or function ?	Reporting and Management of Serious Incidents in NHS commissioned services for the population of NHS HaRD CCG
Please list any other policies that are related to or referred to as part of this analysis?	
Who does the policy, project or function affect ? Please Tick ✔	Employees ✓ Service Users ✓ Members of the Public ✓ Other (List Below) ☐

2. **Equality Impact Analysis: Screening**					
	Could this policy have a positive impact on…		Could this policy have a negative impact on…		Is there any evidence that already exists from previous (e.g. from previous engagement) to evidence this impact
	Yes	No	Yes	No	
Race	☐	✓	☐	✓	
Age	☐	✓	☐	✓	
Sexual Orientation	☐	✓	☐	✓	
Disabled People	☐	✓	☐	✓	
Gender	☐	✓	☐	✓	
Transgender People	☐	✓	☐	✓	
Pregnancy and Maternity	☐	✓	☐	✓	
Marital Status	☐	✓	☐	✓	
Religion and Belief	☐	✓	☐	✓	
Reasoning	Serious Incidents are reported in line with national framework (2015) and are managed anonymously by the commissioner. The benefits of reporting serious incidents are the learning that is shared to help prevent future occurrences and grow knowledge and understanding of patient safety, as well as the individual resolution that may be achieved for a patient or their family, and also the wider learning that can be shared across one or many organisations As a result of performing this analysis, the policy, project or function does not appear to have any adverse effects on people who share Protected Characteristics and no further actions are recommended at this stage. NHS HaRD CCG promotes a culture of Equality and Diversity within its organisation and actively monitors themes arising from incidents for any potential discriminatory activity.				
If there is no positive or negative impact on any of the Nine Protected Characteristics go to Section 7					

3. **Equality Impact Analysis: Equality Data Available**	
Is any Equality Data available relating to the use or implementation of this policy, project or function? Equality data is internal or external information that may indicate how the activity being analysed can affect different groups of people who share the nine *Protected Characteristics* – referred to hereafter as *'Equality Groups'.* Examples of *Equality Data* include: (this list is not definitive) 1. Application success rates *Equality Groups* 2. Complaints by *Equality Groups* 3. Service usage and withdrawal of services by *Equality Groups* *4.* Grievances or decisions upheld and dismissed by *Equality Groups* 5. *Previous EIAs*	Yes ☐ No X☐ Where you have answered yes, please incorporate this data when performing the *Equality Impact Assessment Test* (the next section of this document).
List any Consultation e.g. with employees, service users, Unions or members of the public that has taken place in the development or implementation of this policy, project or function	
Promoting Inclusivity **How does the project, service or function contribute towards our aims of eliminating discrimination and promoting equality and diversity within our organisation**	

4. Equality Impact Analysis: Assessment Test				
What impact will the implementation of this policy, project or function have on employees, service users or other people who share characteristics protected by *The Equality Act 2010* ?				
Protected Characteristic:	**No Impact:**	**Positive Impact:**	**Negative Impact:**	**Evidence of impact and if applicable, justification where a *Genuine Determining Reason* exists**
Gender (Men and Women)	X			
Race (All Racial Groups)	X			
Disability (Mental and Physical)	X			
Religion or Belief	X			
Sexual Orientation (Heterosexual, Homosexual and Bisexual)	X			
Pregnancy and Maternity	X			
Transgender	X			
Marital Status	X			
Age	x			

5. Action Planning				
As a result of performing this analysis, what actions are proposed to remove or reduce any risks of adverse outcomes identified on employees, service users or other people who share characteristics protected by *The Equality Act 2010* ?				
Identified Risk:	**Recommended Actions:**	**Responsible Lead:**	**Completion Date:**	**Review Date:**

6. Equality Impact Analysis Findings				
Analysis Rating:	□ Red	□ Red/Amber	□ Amber	xGreen

		Actions	Wording for Policy / Project / Function
Red **Stop and remove the policy**	**Red:** As a result of performing the analysis, it is evident that a risk of discrimination exists (direct, indirect, unintentional or otherwise) to one or more of the nine groups of people who share *Protected Characteristics.* It is recommended that the use of the policy be suspended until further work or analysis is performed.	**Remove the policy** Complete the action plan above to identify the areas of discrimination and the work or actions that needs to be carried out to minimise the risk of discrimination.	No wording needed as policy is being removed
Red Amber **Continue the policy**	As a result of performing the analysis, it is evident that a risk of discrimination exists (direct, indirect, unintentional or otherwise) to one or more of the nine groups of people who share *Protected Characteristics.* However, a genuine determining reason may exist that could legitimise or justify the use of this policy and further professional advice should be taken.	**The policy can be published with the EIA** • List the justification of the discrimination and source the evidence (i.e. clinical need as advised by NICE). • Consider if there are any potential actions that would reduce the risk of discrimination. • Another EIA must be completed if the policy is changed, reviewed or if further discrimination is identified at a later date.	As a result of performing the analysis, it is evident that a risk of discrimination exists (direct, indirect, unintentional or otherwise) to one or more of the nine groups of people who share *Protected Characteristics.* However, a genuine determining reason exists that justifies the use of this policy and further professional advice. ***[Insert what the discrimination is and the justification of the discrimination plus any actions that could help what reduce the risk]***

Equality Impact Findings (continued):			
		Actions	Wording for Policy / Project / Function
Amber **Adjust the Policy**	As a result of performing the analysis, it is evident that a risk of discrimination (as described above) exists and this risk may be removed or reduced by implementing the actions detailed within the *Action Planning* section of this document.	**The policy can be published with the EIA** • The policy can still be published but the Action Plan must be monitored to ensure that work is being carried out to remove or reduce the discrimination. • Any changes identified and made to the service/policy/ strategy etc. should be included in the policy. • Another EIA must be completed if the policy is changed, reviewed or if further discrimination is identified at a later date.	As a result of performing the analysis, it is evident that a risk of discrimination (as described above) exists and this risk may be removed or reduced by implementing the actions detailed within the *Action Planning* section of this document. ***[Insert what the discrimination is and what work will be carried out to reduce/eliminate the risk]***
Green **No major change**	As a result of performing the analysis, the policy, project or function does not appear to have any adverse effects on people who share *Protected Characteristics* and no further actions are recommended at this stage.	**The policy can be published with the EIA** Another EIA must be completed if the policy is changed, reviewed or if any discrimination is identified at a later date	As a result of performing the analysis, the policy, project or function does not appear to have any adverse effects on people who share *Protected Characteristics* and no further actions are recommended at this stage.

Brief Summary / Further comments	

Approved By		
Job Title:	Name:	Date:
Director of Quality and Governance/Executive Nurse	Joanne Crewe	February 2017

Appendix 7

Sustainability Impact Assessment

Staff preparing a policy, Governing Body (or Sub-Committee) report, service development plan or project are required to complete a Sustainability Impact Assessment (SIA). The purpose of this SIA is to record any positive or negative impacts that this is likely to have on sustainability.

Title of the Document	**NHS HaRD CCG Serious Incident, Incident and Concerns Policy**
What is the main purpose of the Document	**Management of Serious Incidents, Incidents and Raised Concerns**
Date completed	**09 January 2017**
Completed by	**Liz Hodgkinson**

Domain	**Objectives**	**Impact of activity** Negative = -1 Neutral = 0 Positive = 1 Unknown = ? Not applicable = n/a	**Brief description of impact**	**If negative, how can it be mitigated?** **If positive, how can it be enhanced?**
Travel	Will it provide / improve / promote alternatives to car based transport? Will it support more efficient use of cars (car sharing, low emission vehicles, environmentally friendly fuels and technologies)? Will it reduce 'care miles' (telecare, care closer) to home? Will it promote active travel (cycling, walking)? Will it improve access to opportunities and facilities	1	Use of teleconference facilities for meetings	

	for all groups?			
Procurement	Will it specify social, economic and environmental outcomes to be accounted for in procurement and delivery? Will it stimulate innovation among providers of services related to the delivery of the organisations' social, economic and environmental objectives? Will it promote ethical purchasing of goods or services? Will it promote greater efficiency of resource use? Will it obtain maximum value from pharmaceuticals and technologies (medicines management, prescribing, and supply chain)? Will it support local or regional supply chains? Will it promote access to local services (care closer to home)? Will it make current activities more efficient or alter service delivery models	0		
Facilities Management	Will it reduce the amount of waste produced or increase the amount of waste recycled? Will it reduce water consumption?	1	All documentation processed electronically, and meetings conducted using "e" technology.	
Workforce	Will it provide employment opportunities for local people? Will it promote or support equal employment	0		

	opportunities? Will it promote healthy working lives (including health and safety at work, work-life/home-life balance and family friendly policies)? Will it offer employment opportunities to disadvantaged groups?			
Community Engagement	Will it promote health and sustainable development? Have you sought the views of our communities in relation to the impact on sustainable development for this activity?	0		
Buildings	Will it improve the resource efficiency of new or refurbished buildings (water, energy, density, use of existing buildings, designing for a longer lifespan)? Will it increase safety and security in new buildings and developments? Will it reduce greenhouse gas emissions from transport (choice of mode of transport, reducing need to travel)? Will it provide sympathetic and appropriate landscaping around new development? Will it improve access to the built environment?	0		
Adaptation to Climate Change	Will it support the plan for the likely effects of climate change (e.g. identifying vulnerable groups; contingency planning for flood, heat wave and other	0		

	weather extremes)?			
Models of Care	Will it minimise 'care miles' making better use of new technologies such as telecare and telehealth, delivering care in settings closer to people's homes? Will it promote prevention and self-management? Will it provide evidence-based, personalised care that achieves the best possible outcomes with the resources available? Will it deliver integrated care, that co-ordinate different elements of care more effectively and remove duplication and redundancy from care pathways?	0		

Appendix 8

Bribery Act 2010 Guidance and Bribery Prevention Checklist

Areas for Action	Expected Action	Evidence of Compliance / Assurance
1. Governance and Top Level Commitment	The Chief Executive should make a statement in support of the anti-bribery initiative and this should be published on the organisation's website. The board of directors should take overall responsibility for the effective design, implementation and operation of the anti-bribery initiatives. The Board should ensure that senior management is aware of and accepts the initiatives and that it is embedded in the corporate culture.	
2. Due Diligence	This is a key element of good corporate governance and involves making an assessment of new business partners prior to engaging them in business. Due diligence procedures are in themselves a form of bribery risk assessment and also a means of mitigating that risk. It is recommended that at the outset of any business dealings, all new business partners should be made aware in writing of the organisation's anti-corruption and bribery policies and code of conduct.	
3. Code of conduct	The organisation should either have an anti-bribery code of conduct or a general code of conduct for staff with an anti-bribery and corruption element. The organisation should revise the Standards of Business Conduct Policy (or equivalent) and Declaration of Interests guidance (see point 4 below) to reflect the introduction of the Bribery Act.	

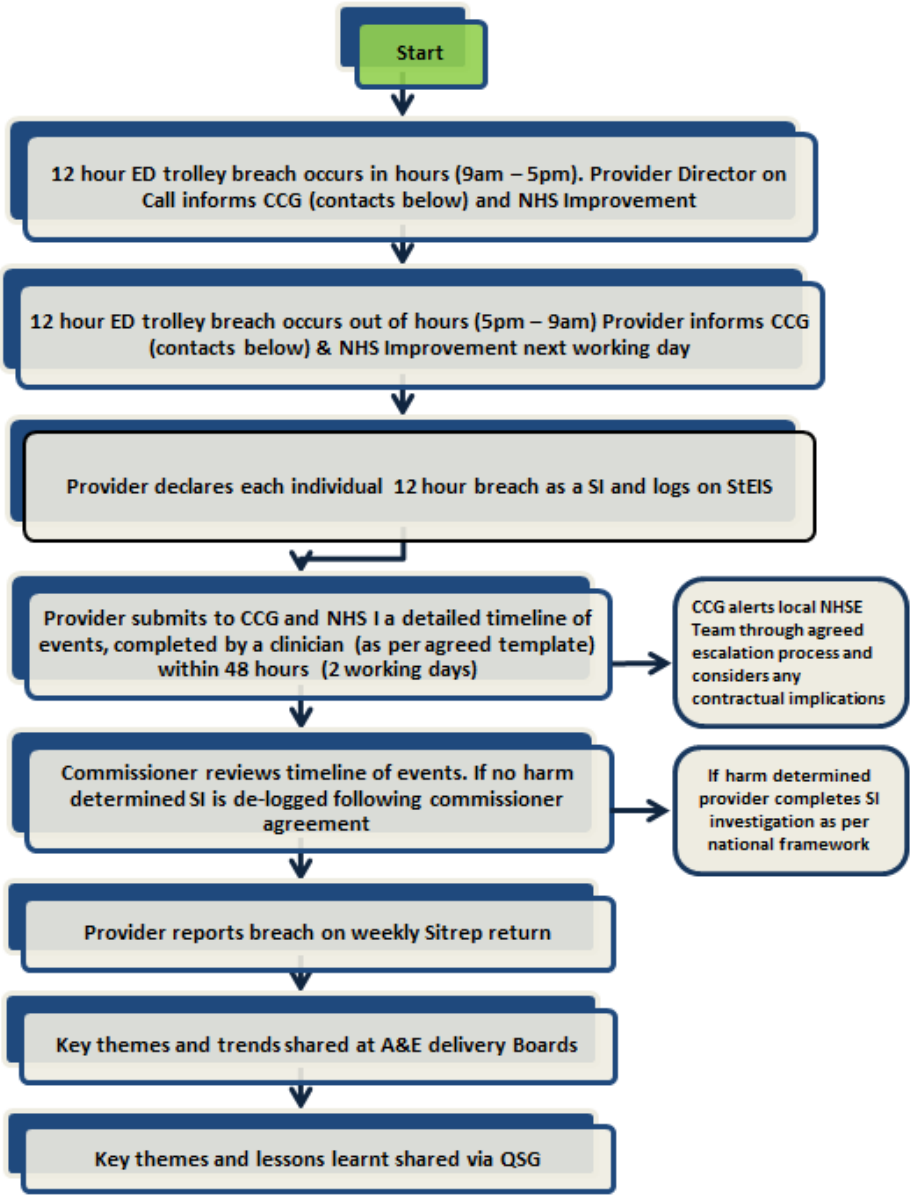
Areas for Action	Expected Action	Evidence of Compliance / Assurance
4. Declaration of Interests/Hospitality	The organisation should have in place a declaration of business interests/gifts and hospitality policy that clearly sets out acceptable limits and also a mechanism to monitor implementation.	
5. Employee employment procedures	Employees should go through the appropriate propriety checks e.g. CRB (Criminal Records Bureau) and/or a combination of other checks before they are employed to ascertain, as far as is reasonable, that they are likely to comply with the organisation's anti-bribery policies.	
6. Detection procedures	The organisation should ensure Internal Audit/Counter Fraud check projects, contracts, procurement processes and any other appropriate systems where there is a risk that acts of bribery could potentially occur.	
7. Internal reporting procedures	The organisation should have internal procedures for staff to report suspicious activities including bribery.	
8. Investigation of Bribery allegations	The organisation should have procedures for staff to report suspicions of bribery to NHS Protect (previously NHS Counter Fraud and Security Management Service) and the organisation's Local Counter Fraud Specialist for investigation/referral to the appropriate authorities.	

Areas for Action	Expected Action	Evidence of Compliance / Assurance
9. Risk assessment	MoJ (Ministry of Justice) guidance states"…organisations should adopt a risk-based approach to managing bribery risks…[and] an initial assessment of risk across the organisation is therefore a necessary first step". The organisation should, on a regular basis, assess the risk of bribery and corruption in its business and assess whether its procedures and controls are adequate to minimise those risks.	"Never Event" Serious Incidents Where a patient pathway error has been identified as a Never Event, the commissioner is not required to pay for the care delivered for the episode of the patients care in relation to the Never Event. Never Events are clearly described in National Framework for SIs, and trusts required to declare these on STEIS. All Serious Incidents, including Never Events are reported to the Contract Management Group on a monthly basis and where necessary, funds recouped for Never Event occurrence. Organisational Integrity Organisations are required to declare Serious Incidents and Incidents. Organisations also investigate Serious Incidents and Incidents using internal investigators. These requirements present a very low level of risk to the CCG.
10. Record keeping	The organisation should keep reasonably detailed records of its anti-fraud and corruption initiatives, including training given, hospitality given and received and other relevant information.	
11. Internal review	The organisation should carry out an annual internal review of the anti-bribery and corruption programme.	
12. Independent assessment and certification	Proportionate to risks identified, the organisation should commission, at least every three years, an independent assessment and certification of its anti-bribery programme.	

Areas for Action	Expected Action	Evidence of Compliance / Assurance
13.Internal and External communications	The organisation should publicise the NHS Fraud and Corruption Reporting Line (FCRL) and on-line fraud reporting facility. The organisation should publicise the Security Management role (theft and general security issues) and reporting arrangements. The organisation should work with its stakeholders in the public and private sector to help reduce bribery and corruption in the health industry.	
14.Awareness and training	The organisation should provide appropriate anti-bribery and corruption awareness sessions and training on a regular basis to all relevant employees.	
15. Monitoring: • Overall Responsibility • Financial/Commercial Controls	• A senior manager should be made responsible for ensuring that the organisation has a proportionate and adequate programme of anti-fraud, corruption and bribery initiatives. • The organisation should ensure that its financial controls minimise the risk of the organisation committing a corrupt act. • The organisation should ensure that its commercial controls minimise the risk of the organisation committing a corrupt act. These controls would include appropriate procurement and supply chain management, and the monitoring of contract execution.	

Appendix 9

12 hour A&E trolley breach process



Key HaRD CCG Contacts:

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- Operational Director - Mike Forster; mike.forster@hdft.nhs.uk (01423) 553786
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Area Team Contact:

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Appendix 10

12 hour Emergency Department Trolley Breach Interim Report

(To be completed and submitted within 48 hours from time of breach - within 2 working days)

48 Hour Report – Date completed:	
Hospital Trust and site:	CCG:
SI Number:	Trust Incident Number:
DoB:	Gender
Did the provider inform the CCG immediately of the 12 hour breach if the breach occurred within hours (9am – 5pm) or the next working day if occurred out of hours (5pm – 9am)and provide notification in line with the A&E Delivery Board?	Time/date CCG informed
Was an apology made to the patient/family by an Executive/Operational Director or OOH by the Site Management Team	Yes/No By whom:
What arrangements have been made to provide updates/further communications with the patient and/or the family?	
What was the total length of time the patient was in ED? What time did they arrive/present?	
What was the time of the decision to admit? What time did they leave the department?	
Please provide a detailed clinical timeline/chronology of events including, date and time of attendance, patient condition/diagnosis, interventions undertaken whilst patient in ED and time patient obtained a bed. To be completed by clinician	
What was the impact (if any) on the clinical condition of the patient, as a consequence of the delay?	
Was the patient's skin integrity assessed on admission and thereafter based on the patient's	

clinical risk? Was the SSKIN bundle implemented? What actions were undertaken to ensure adequate pressure area management e.g. regular risk assessment, pressure relieving equipment, regular monitoring of skin integrity.		
How was the patient's nutrition and hydration adequately maintained? If the patient was nil by mouth, were IV fluids initiated?		
How was the patient's privacy and dignity maintained in terms of toileting or bathing?		
Was the patients' emotional and psychological care considered, for example by making sure that the carer/family could remain with patient Was the patient/carer regularly updated on the situation		
Did the patient receive routine medications in addition to any newly commenced treatments?		
Was the patient admitted to a ward that was clinically appropriate for their condition? If not, state the type of ward were they admitted to and the reasons why		
Please state what immediate actions were implemented to ensure similar situations do not reoccur including the root cause of the incident		
Was the Chief Executive fully briefed on the breach?		
Please confirm that Monitor/TDA have been informed of the breach Date of notification & By whom		
Has the interim investigation concluded that the patient has come to any harm?	Yes	No
	Full SI investigation to be submitted within 60 days	SI to be de-logged following commissioner approval

Please complete and submit to:

NYYCCGS.SERIOUSINCIDENTS@NHS.NET