# Surrey Heartlands CCGs' Joint Serious Incident Management Policy

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| Approving Committee | Quality Committee |
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**Working together as the Surrey Heartlands Clinical Commissioning Groups**

Guildford and Waverley CCG | North West Surrey CCG | Surrey Downs CCG

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| **Owner** | Executive Director of Quality, Surrey Heartlands CCGs | | | |
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## Purpose

To set out how Surrey Heartlands CCGs (NHS Guildford and Waverley, NHS North West Surrey and NHS Surrey Downs Clinical Commissioning Groups) will establish and maintain robust arrangements for monitoring and performance managing Serious Incidents (SIs) reported by services they commission. For the purposes of this document any references to the "Surrey Heartlands CCGs" should be taken as meaning the above three statutory organisations as constituted under the 2012 NHS Act.

## Distribution and Accessibility

This document will be made available to all staff via the Intranet and Internet following approval by the Quality Committees in Common.

The policy will also be shared through individual contractual routes with all Surrey Heartlands providers.

## Significant changes since last version

| Version | Status | Who | Changes |
|---|---|---|---|
| 1.0 | Final | Georgette Ahearne, Senior Quality and Safety Manager | *This policy has superseded NW Surrey, Guildford and Waverley and Surrey Downs CCGs Serious Incident policies.*<br><br>Joint Policy written following feedback from the 3 CCGs.<br><br>Approved by the Surrey Heartlands CCGs' Quality Committees in Common. |

## Equality statement

Surrey Heartlands Clinical Commissioning Groups aim to design and implement services, policies and measures that meet the diverse needs of our service, population and workforce, ensuring that none are placed at a disadvantage over others. It takes into account the Human Rights Act 1998 and promotes equal opportunities for all. This document has been assessed to ensure that no-one receives less favourable treatment on grounds of their gender, sexual orientation, marital status, race, religion, age, ethnic origin, nationality, or disability. Members of staff, volunteers or members of the public may request assistance with this policy if they have particular needs. If the person requesting has language difficulties and difficulty in understanding this policy, the use of an interpreter will be considered.

Surrey Heartlands CCGs' embrace the six staff pledges in the NHS Constitution. This policy is consistent with these pledges.

## Equality analysis

This policy has been subject to an Equality Analysis, the outcome of which is recorded below.

| | | Yes, No or N/A | Comments |
|---|---|---|---|
| 1. | Does the document/ guidance affect one group less or more favourably than another on the basis of: | No | This policy encourages the equitable management of Serious Incidents regardless of protected characteristics |
| | **Age**<br>Where this is referred to, it refers to a person belonging to a particular age<br>(e.g. 32 year olds) or range of ages<br>(e.g. 18 - 30 year olds). | No | |
| | **Disability**<br>A person has a disability if s/he has a physical or mental impairment which has a substantial and long-term adverse effect on that person's ability to carry out normal day-to-day activities. | No | |
| | **Gender reassignment**<br>The process of transitioning from one gender to another. | No | |
| | **Marriage and civil partnership**<br>In England and Wales marriage is no longer restricted to a union between a man and a woman but now includes a marriage between a same-sex couple.<br><br>Same-sex couples can also have their relationships legally recognised as 'civil partnerships'. Civil partners must not be treated less favourably than married couples (except where permitted by the Equality Act). | No | |
| | **Pregnancy and maternity**<br>Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth, and is linked to maternity leave in the | No | |

| | | Yes, No or N/A | Comments |
|---|---|---|---|
| | employment context. In the non- work context, protection against maternity discrimination is for 26 weeks after giving birth, and this includes treating a woman unfavourably because she is breastfeeding. | | |
| | **Race**<br>Refers to the protected characteristic of Race. It refers to a group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins | No | |
| | **Religion and belief**<br>Religion has the meaning usually given to it but belief includes religious and philosophical beliefs including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition. | No | |
| | **Sexual orientation**<br>Whether a person's sexual attraction is towards their own sex, the opposite sex or to both sexes | No | |
| 2. | Is there any evidence that some groups are affected differently? | No | |
| 3. | If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable? | No | |
| 4. | Is the impact of the document/guidance likely to be negative? | No | |
| 5. | If so, can the impact be avoided? | N/A | |
| 6. | What alternative is there to achieving the document/guidance without the impact? | N/A | |
| 7. | Can we reduce the impact by taking different action? | N/A | |

| Names and Organisation of Individuals who carried out the Assessment | Date of the Assessment |
|---|---|
| Head of Quality – Safety, Surrey Heartlands CCGs | July 2018 |
| | |

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- Surrey Heartlands CCGs' SI Closure Panel Terms of Reference (G&W)

- Surrey Heartlands and Blackwater Alliance CCGs' Surrey and Borders Partnership NHS Foundation Trust Serious Incident Scrutiny Panel terms of reference

**Appendix 6** - NHS England's Specialist Commissioning Standard Operating Procedure for Serious Incidents

# 1 Introduction

1.1 This policy outlines the systems and processes within which serious incidents (SIs) will be reported and managed. It applies to serious incidents reported by the Surrey Heartlands CCGs and organisations for which the Surrey Heartlands CCGs are lead commissioners.

1.2 Serious incidents requiring investigation in healthcare are rare, but when they do occur, everyone must ensure there are systematic measures in place to respond to them. These measures must protect patients, their families and carers and staff, and ensure that robust investigations are conducted, which result in organisations learning from serious incidents to minimise the risk of the incident happening again. When an incident occurs, it must be reported to all relevant bodies.

1.3 Surrey Heartlands CCGs' have a duty to obtain information on serious incidents from NHS providers where they have commissioned services and within its boundaries, to both identify learning opportunities for improving safety and to ensure that these NHS organisations have robust arrangements in place.

1.4 Surrey Heartlands CCGs will ensure that appropriate management systems are in place across their commissioned providers to:

- Comply with the requirements of the NHS England Serious Incident Framework 2015/16 (including the revised 2018 Never Events Policy);
- Report all SIs in a timely fashion and without prejudice;
- Embed systematic measures to robustly and effectively manage SIs;
- Ensure actions are taken to improve quality and safety and to minimise the risk of future reoccurrences;
- Share the learning.

1.5 Intelligence gained from SIs will be used to influence contract monitoring, quality and safety standards for care pathway development and service specifications.

1.6 Reporting SIs is a legal requirement under CQC regulations. Therefore all SIs, including Never Events must be reported to the CQC. This requirement continues regardless of the organisational changes within the NHS.

## 2 Purpose and Scope

2.1 The purpose of this policy is to describe the Surrey Heartlands CCGs' framework for reporting and managing SIs reported by their commissioned organisations. The Surrey Heartlands CCGs' Serious Incident Management Policy is aligned to the NHS England Revised Serious Incident Framework published in March 2015.

2.2 This policy applies to all substantive and temporary staff employed by Surrey Heartlands CCGs. It should also be complied with by all organisations whose services are commissioned by the Surrey Heartlands CCGs and to all third parties and others authorised to undertake work on behalf of the CCGs. It applies to all Serious Incidents involving members of staff, patients, relatives, visitors, contractors, provider organisations and the general public.

2.3 This policy should be read in conjunction with the following guidance:

- Serious Incident Framework - NHS England (March 2015):
- CQC Regulation 20: Duty of Candour. Guidance for NHS bodies (November 2014)
- National Patient Safety Agency - National Framework for Reporting and Learning from Serious Incidents Requiring Investigation
- Checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation - HSCIC May 2015
- Working Together to Safeguard Children 2018
- Safeguarding Vulnerable People in the NHS - Accountability and Assurance Framework NHSE July 2015
- The Care Act 2014
- Mental Capacity Act 2005
- Never Events Policy and Framework (January 2018)
- Never Events List 2018

## 3 Definition of a Serious Incident (SI)

3.1 In broad terms, serious incidents are events 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.

3.2 The occurrence of a serious incident demonstrates weaknesses in a system or process that need to be addressed to prevent future incidents leading to avoidable death or serious harm to patients or staff, future incidents of abuse to patients or staff, or future significant reputational damage to the organisations involved. Serious incidents therefore require investigation in order to identify the factors that contributed towards the incident occurring and the fundamental issues (or root causes) that underpinned these. Serious incidents can be isolated, single events or multiple linked or unlinked events signaling systemic failures within a commissioning or health system.

3.3 There is no definitive list of events/incidents that constitute a serious incident and lists should not be created locally as this can lead to inconsistent or inappropriate management of incidents. Where lists are created there is a tendency to not appropriately investigate things that are not on the list even when they should be investigated, and equally a tendency to undertake full investigations of incidents

where that may not be warranted simply because they seem to fit a description of an incident on a list.

3.4 The definition below sets out circumstances in which a serious incident must be declared. Every incident must be considered on a case-by-case basis using the description below. Inevitably, there will be borderline cases that rely on the judgement of the people involved.

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 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.

      This includes 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 Never Event - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death. See Never Events Policy and Framework for the national definition and further information. (Link in appendix1).

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

- Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues.
- Property damage.
- Security breach/concern.
- Incidents in population-wide healthcare activities 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 series of incidents, which necessitate ward/ unit closure or suspension of services or activation of the 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.

### 3.5 Assessing whether an incident is serious or not

3.5.1 In many cases it will be immediately clear that a serious incident has occurred and further investigation will be required to discover what exactly went wrong, how it went wrong (from a human factors and systems-based approach) and what may be done to address the weakness to prevent the incident from happening again.

3.5.2 Whilst a serious outcome (such as the death of a patient who was not expected to die or where someone requires on going/long term treatment due to unforeseen and unexpected consequences of health intervention) can provide a trigger for identifying serious incidents, outcome alone is not always enough to delineate what counts as a serious incident. The NHS strives to achieve the very best outcomes but this may not always be achievable. Upsetting outcomes are not always the result of error/acts, and/or omissions in care. Equally some incidents, such as those which require activation of a major incident plan for example, may not reveal omissions in care or service delivery and may not have been preventable in the given circumstances. However, this should be established through thorough investigation and action to mitigate future risks should be determined.

3.5.3 Where it is not clear whether or not an incident fulfils the definition of a serious incident, providers and commissioners must engage in open and honest discussions to agree the appropriate and proportionate response. It may be unclear initially whether any weaknesses in a system or process (including acts or omissions in care) caused or contributed towards a serious outcome, but the simplest and most defensible position is to discuss openly, to investigate proportionately and to let the investigation decide. If a serious incident is declared but further investigation reveals that the definition of a serious incident is not fulfilled- for example there were no acts or omissions in care which caused or contributed towards the outcome- the incident can be downgraded. This can be agreed at any stage of the investigation and the purpose of any downgrading is to ensure efforts are focused on the incidents where problems are identified and learning and action are required.

### 3.6 Never Events

3.6.1 Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

3.6.2 Deciding whether or not a Never Event should be classified as a Serious Incident should be based on 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

3.6.3 This does not mean that every 'Never Event' should be reported as 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.

3.6.4 The most updated list can be found at Appendix 1.

## 4 Roles and Responsibilities

### 4.1 The Joint Accountable Officer

4.1.1 Has the overall responsibility for ensuring all incidents are appropriately managed as stipulated in this policy and ensure that the Surrey Heartlands CCGs have the processes in place to support the successful implementation of the management of serious incidents.

### 4.2 Surrey Heartland Executive Director of Quality

4.2.1 Has responsibility for monitoring the effective management of SIs across all Surrey Heartlands CCGs.

### 4.3 Surrey Heartland Head of Quality - Safety

4.3.1 Has responsibility for the effective management of SIs by ensuring:

- Commissioned organisations have robust systems and processes for prompt reporting and management systems for SIs,
- Performance monitoring of commissioned organisations' reported SIs is robust
- Surrey Heartlands CCGs' Governing Bodies and the Quality Committees in Common are assured on the performance management of SIs within commissioned organisations and the CCGs overall serious incident management process,
- NHS England, other stakeholder CCGs and/or relevant professional bodies are informed of the relevant SIs,
- Informing the NHS England (South East) Regional Team when an SI originates in or involves the actions of the Surrey Heartlands CCGs and ensuring a robust investigation is undertaken.

### 4.4 Surrey Heartlands CCGs' Quality - Patient Safety Team

4.4.1 Has delegated responsibility for:

- Monitoring and maintaining an overview of all serious incidents logged onto STEIS by providers of the Surrey Heartlands CCGs' commissioned services, ensuring they are recorded appropriately and identifying any trends and patterns;
- Ensuring relevant respective CCGs are notified of SIs promptly, highlighting those that may be of higher risk and/or media interest;
- Reporting incidents on STEIS for all commissioned providers who do not have access to the system;
- Providing a consistent approach for the sign-off and closure of commissioned provider SIs by the Surrey Heartlands CCGs;
- Monitoring provider timeframes for reporting and submission of SI reports to ensure compliance with all relevant national guidance;
- Developing close working relationship with commissioned providers' identified Quality and Safety Leads;
- Supporting & offering guidance to all commissioned providers to ensure they are able to comply with policy requirements;
- Providing regular reports on commissioned provider SIs to the Surrey Heartlands CCGs;
- Preparation and administration of the Serious Incident Scrutiny Panel meetings.

### 4.5 Clinical Leads

4.5.1 Engagement with specialist clinical leads including representation at Serious Incident Scrutiny Panel Meeting will be undertaken in line with the Serious Incident Scrutiny Panel Terms of Reference.

### 4.6 Surrey Heartlands CCGs' Serious Incident Scrutiny Panels

4.6.1 Have delegated responsibility from Quality Committees for the review and closure of commissioned services serious incidents. This group is also responsible for reviewing investigation reports prior to their submission to NHS England (South East) for review before closure. The terms of reference for the SI Scrutiny Panels are outlined in Appendix 2

### 4.7 Quality Committees

4.7.1 Provide assurance to the Surrey Heartlands CCGs' Governing Bodies that robust serious incident performance management processes are in place.

### 4.8 Commissioned Providers

4.8.1 Providers must be compliant with the requirements identified within the NHS England SI Framework document, published in March 2015 and have a responsibility to ensure that their first priority when an SI occurs is to ensure the needs of individuals affected by the SI are attended to, including any urgent clinical care and management action that may reduce harmful impact. The commissioned provider should give early consideration to the provision of information and support to patients, relatives and carers and staff involved in the SI, including information regarding support systems which are available. The commissioned provider must comply with the duty of candour requirements and the principles of being open and have an approved 'Being

Open Policy'.

4.8.2 Commissioned providers also have the following responsibilities:

- Ensuring there are structured risk management systems and processes for collecting, collating and analysis of data on all SIs and lessons identified, including reporting SIs via STEIS. Those commissioned providers without access to STEIS should contact the Surrey Heartlands CCGs' Quality – Safety Team directly and report SIs using the reporting form in Appendix 3.
- Reporting and ensuring all SIs defined by the National SI Framework, are investigated as per national guidance, using root cause analysis (RCA) methodologies.
- Re-establishing a safe environment where all equipment or medication involved in the SI are retained and isolated, relevant documentation copied and secured to preserve evidence and facilitate investigation and learning,
- Contacting the police if there is a suggestion that a criminal offence has been committed,
- Manage the reporting to HSE, as appropriate of Health and Safety Incidents, CQC and to NHS Improvement through the National Reporting and Learning System (NRLS) for Patient Safety Incidents,
- Informing Surrey Heartlands CCGs if they are considering commissioning services (or parts of) through other commissioned providers and assuring Surrey Heartlands CCGs that any commissioned services are compliant with this policy.
- Ensuring appropriate representatives attend the Surrey Heartlands SI Scrutiny Panels as outlined in the relevant panel's terms of reference.

### 4.9 Involvement of more than one Commissioned Provider:

4.9.1 Often more than one organisation is involved in the care and service delivery in which a serious incident has occurred. The organisation that identifies the serious incident is responsible for recognising the need to alert other providers, commissioners and partner organisations as required in order to initiate discussions about subsequent action.

4.9.2 All organisations and agencies involved should work together to undertake one single investigation wherever this is possible and appropriate.

4.9.3 Surrey Heartlands CCGs' Quality Team may be contacted to help facilitate discussions relating to who is the most appropriate organisation to take responsibility for co-ordinating the investigation process if this is unclear or is disputed. The team can provide support in complex circumstances and where no one provider organisation is best placed to assume responsibility for co-ordinating an investigation, Surrey Heartlands CCGs may lead this process.

### 4.10 Quality Surveillance Groups

4.10.1 The NHS England has developed Quality Surveillance Groups where data, incident reports and the quality of responses to SIs that give cause for concern will be shared. This will assist in the triangulation of other quality-related information and the formulation appropriate responses, such as

triggering a Risk Summit or keeping the provider under regular review. The NCB, CCGs, and NHS Improvement should fully exploit the opportunities for sharing information about SIs in relevant providers with partner organisations who make up the relevant local and regional Quality Surveillance Groups.

### 4.11 NHS England

4.11.1 Has responsibility for:

- Commissioning independent investigations/inquiries into serious incident cases which meet nationally agreed criteria. Working with NHS and Regional Teams to identify relevant intelligence and learning to be shared at national level and to facilitate such learning and sharing at a national level.
- High level oversight of SI reporting and responses, including reviewing trends, quality analysis and early warnings via Quality Surveillance Groups will be proportionate to requirements.
- Providing support to contract management for primary and specialised care providers' responses to SIs and, where appropriate, commissioning and co-ordinating primary and specialised care SI investigations.
- Having oversight of SI investigations undertaken in acute, community, mental health and ambulance care including reviewing trends, quality analysis and early warnings via Quality Surveillance Groups.
- Management of SIs in services directly commissioned by NHS England will be the responsibility of NHS England to comply with National Standards & SI investigation.

## 5 Process for reporting and managing SIs

5.1 All providers commissioned by Surrey Heartlands CCGs' are required to report SIs using the STEIS system. Providers are required to put in place an internal governance process which ensures all serious incidents are reported on STEIS within 2 working days of the SI being identified.

5.2 Incidents falling into any of the serious incident categories below should be reported immediately to Surrey Heartlands CCGs' via telephone and electronically. This should be via the on-call procedure if out of hours:-

- Incidents which activate the NHS Trust or Commissioner Major Incident Plan;
- Incidents which will be of significant public concern;
- Incidents which will give rise to significant media interest or will be of significance to other agencies such as the police or other external agencies.

5.3 Serious Incidents declared by providers that do not have access to STEIS must be reported to Surrey Heartlands CCGs using the dedicated email address nwsccg.sisurreyheartlands@nhs.net within two working days of identification of the incident, using the form found at Appendix 3.

5.4 Providers should undertake an initial review within 72 hours and upload this onto STEIS.

5.5 Surrey Heartlands CCGs will review all SIs reported and initial questions/comments

to support the investigation will be sent to the provider.

5.6 Providers then have 60 working days from declaration of the incident to complete a Root Cause Analysis investigation which must be sent to the Surrey Heartlands CCGs for review.

5.7 On receipt of the investigation, Surrey Heartlands CCGs will undertake a review of the final report and action plan and ensures it meets requirements for a robust investigation using the checklist found at Appendix 4.

5.8 The SI will then be reviewed at the relevant Serious Incident Scrutiny Panel and Surrey Heartlands CCGs will make the decision to close the SI based on the evidence submitted by the provider. This will include ensuring that the action-plan contains action points to address all root causes identified and that they include a named lead for each action and a timescale for completion.

## 6 Dissemination of Learning

6.1 One of the key aims of the serious incident reporting and learning process is to reduce the risk of recurrence, both where the original incident occurred and elsewhere in the NHS. The timely and appropriate dissemination of learning following a serious incident is core to achieving this and to ensure that these lessons identified are embedded in practice.

6.2 Learning can be demonstrated at organisational level by sustainable changes and improvements in process, policy, systems and procedures relating to patient safety within healthcare organisations. Key learning points that may be shared more widely may fall into the following areas:

- understanding and identification of the influence of Human Factors;
- solutions to address incident root causes that may be relevant to other teams, services and provider organisations;
- Identification of the components of good practice that reduced the potential impact of the incident and how they were developed and supported;
- Systems and processes that allow early detection or intervention that will reduce the potential impact of the incident;
- Lessons identified from conducting the investigation that may improve the management of investigations in future;
- Documentation of identification of the risks, the extent to which they have been reduced and how this is measured and monitored.

6.3 Reporting organisations and Surrey Heartlands CCGs will work together to share the learning from serious incidents both within the Surrey Heartlands CCGs healthcare system and also through Serious Incident Learning Events both at Surrey, Regional and National levels.

## 7 Training and Competencies

7.1 In order to comply with the requirements of the NHS England national guidance, the Surrey Heartlands CCGs will ensure the following training and competencies for staff involved in;

7.1.1 Leading a Root Cause Analysis, Patient Safety Investigation

Staff should attend a 2-day training course which offers a practical element to the training, in particular the analysis section and should;

- cover effective solution generation and implementation
- follow and promote the Serious Incident framework
- follow and endorse the National Patient Safety Agency (NPSA) guidance and toolkit (for further information visit: https://www.england.nhs.uk/patientsafety/root-cause/)
- specifically promote the use of the NPSA final report templates.

The individual should undertake a full RCA patient safety investigation within 12 months of the training.

Individuals continuing to conduct investigations should complete advanced training within 2- 3 years of their initial 2-day course. (Having attended a two day course investigators should be aiming to advance analytical and improvement skills; and the subsequent quality of investigations and reports).

The individual should have updates to the training every three years.

7.1.2 Assisting or quality assuring the investigation

Staff assisting or quality assuring the investigation should attend a 1-day training course which offers a practical element to the training, in particular the analysis section and should;

- follow and promote the Serious Incident framework
- follow and endorse the NPSA guidance and toolkit
- specifically promote the use of the NPSA final report templates.

The individual should assist with an RCA patient safety investigation within 12 months of the training

The individual should have updates to the training every 3 years.

7.1.3 Quality assuring Root Cause Analysis, Patient Safety Investigation

Staff quality assuring root cause analysis patient safety investigation should attend a 1 or 2-day training course which offers a practical element to the training, in particular the analysis section and focuses on the key elements of how to critique an RCA investigation report, and should;

- follow and promote the Serious Incident framework
- follow and endorse the NPSA guidance and toolkit
- specifically promote the use of the NPSA final report templates.

The individual should undertake or shadow an RCA patient safety investigation to consolidate their training

The individual should have updates to the training every 3 years.

7.2 The NPSA guidance on: human error, fair blame, human factors, cognitive interviewing, being open and effective solution generation and implementation should all be part of the courses for all of the above.

## 8 Monitoring Compliance with this policy

8.1 In order to comply with the requirements of the National Framework for the reporting and learning from serious incidents, Surrey Heartlands CCGs will monitor trends in serious incidents. Surrey Heartlands CCGs will use both quantitative and qualitative data analysis of incidents where root causes and lessons have been identified.

8.2 On-going compliance with the requirements of the National Reporting and Learning Framework for Reporting and Learning from serious incidents will be carried out by using the following measures:

| Standard | Detail | Data Source |
|---|---|---|
| Incidents will be reported within two working days of identification of the incident | Time from date of knowledge to incident reported on STEIS | STEIS |
| A 72 hour update report will be uploaded onto STEIS | Time from date of incident coming to light and completion of 72 hour update must be no more than 72 hours | STEIS |
| Incident investigations will follow the structure and process of Root Cause Analysis methodology. Understanding and analysis within the investigation should include a thorough analysis of key contributory factors to include description against these and identification and understanding of any Human Factors that may lead to wider learning. | Investigation structure to follow the National Patient Safety Agency Root Cause Analysis Guidance and Template or similar robust framework determined at local level | Investigation reports |
| STEIS must be kept up to date and incidents closed according to national timescales. | STEIS will reflect the current status of the investigation. | STEIS |
| Serious Incident Scrutiny Panels to receive assurance on the implementation of action plans | Serious Incident Scrutiny Panel to receive assurance on SIs so that robustness of actions resulting from SIs can be assured | Serious Incident Scrutiny Panels' papers, action plans and investigation reports |

8.3 Key performance indicators to be used to review the effectiveness of the incident reporting process are;

- Monitoring of the level of incident reporting via provider organisation's quarterly incident and serious incident reports
- Monitoring the numbers of incidents reported within 2 working days of the incident occurring
- Monitor completion of 72 hour updates provided on STEIS
- Monitoring the number of incident investigation and SI investigations completed within 60 days
- Monitoring the incidents formally closed within 6 months of date of reporting.

8.4 Ongoing review of the policy will take place in line with the Surrey Heartlands Policy review requirements or when there are national changes to Serious Incident Management guidance.

# Appendix 1

**NHS Improvement Revised Serious Incident Framework 2015**
**Never Events Guidance 2018**

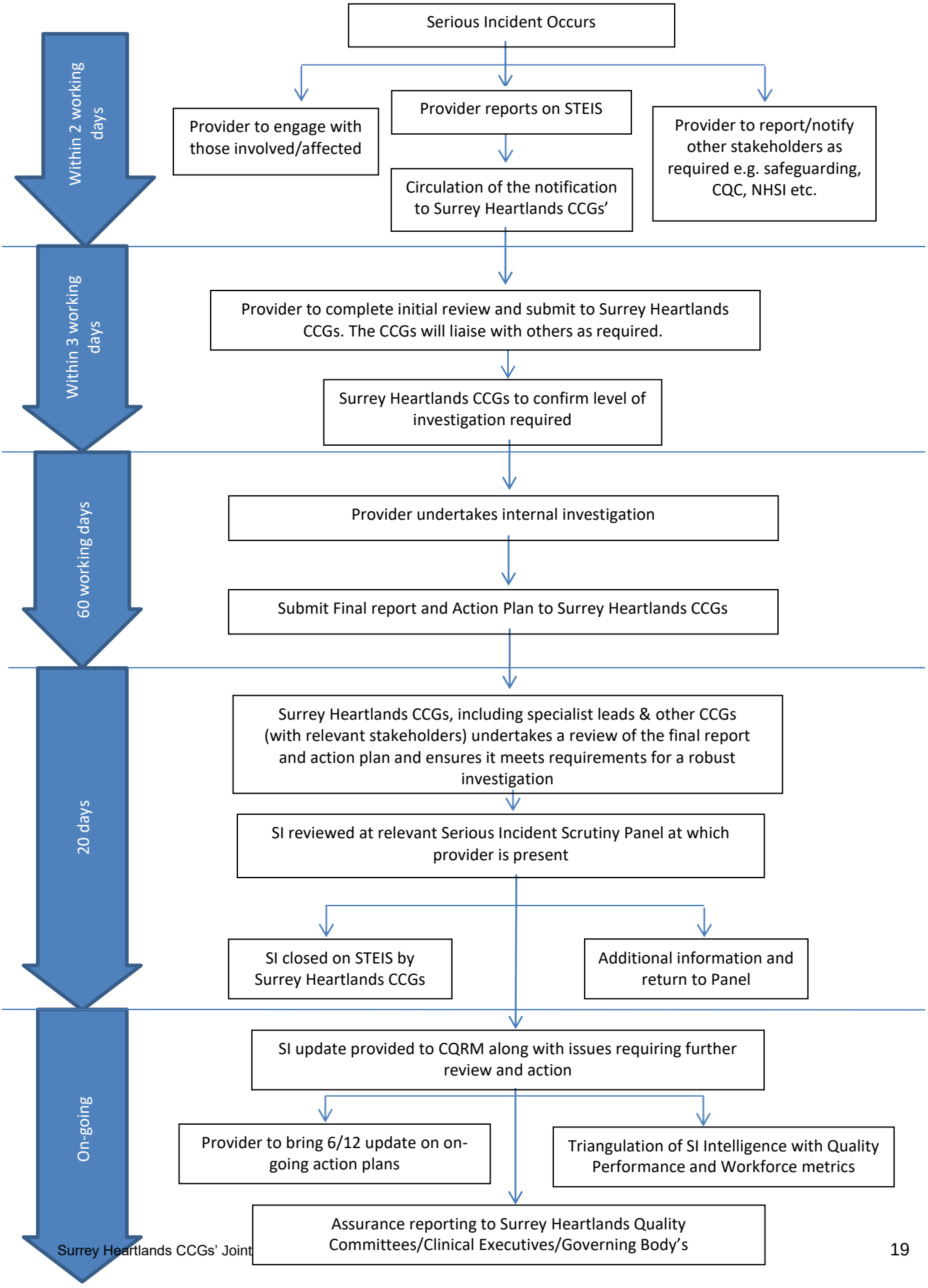
NHS England Serious Incident Framework March 2015

NHS England Never Events Policy & Framework Jan 2018

NHS England Never Events List 2018

## Appendix 2

### Surrey Heartlands CCGs'
### Provider Serious Incident Management Process



Guildford and Waverley Clinical Commissioning Group

North West Surrey Clinical Commissioning Group

Surrey Downs Clinical Commissioning Group

## Appendix 3

### Surrey Heartlands CCGs'
### Serious Incident 48 Hour Notification Form

| **Type of Incident** | **Reason for Reporting** |
|---|---|
| Select one | Select one |
| **Location of Incident** | **Date of Incident** |
| Click here to enter text. | Click here to enter text |
| **Time of Incident** | **Date Incident Identified** |
| Click here to enter text. | Click here to enter text. |
| **Never Event** | **Reporting Organisation** |
| Select one | Click here to enter text. |
| **Reporter Name** | **Reporter Job Title/Role** |
| Click here to enter text. | Click here to enter text. |
| **Reporter Tel** | **Reporter Email** |
| Click here to enter text. | Click here to enter text. |

| **Name of Other Organisations Involved** (where relevant): eg hospital, ambulance service, OoH, Care Home, Mental Health Services, Police, NRLS etc | |
|---|---|
| Click here to enter text. | |
| **Have you Reported to NRLS? (if not why not)** | |
| Select one | Click here to enter text. |
| **Care Sector:** eg General Practice, Pharmacy, Optometrists, Mental Health, Other (if other please specify) | |
| Click here to enter text. | |

**PATIENT DETAILS**

This information should only be submitted if this form is transmitted via a secure transmission ie. NHS.net email account. **Please do not include patient name or other patient identifier.**

| | |
|---|---|
| **Patient Date of Birth** | Click here to enter text. |
| **Patient Gender** | Select One |
| **Patient Ethnic Group** | Click here to enter text. |
| **Patient Registered GP Practice** | Click here to enter text. |
| **Legal Status of Patient** | Select One |
| **Type of Patient** | Select One |

**WHAT HAPPENED?**

| | |
|---|---|
| **Description of What Happened** | Click here to enter text. |
| **Immediate Action Taken** | Click here to enter text. |
| **Any Further Information** | Click here to enter text. |
| **Where is Patient at Time of Reporting?** | Click here to enter text. |
| **Details of any Police/Media Involvement/Interest** | Click here to enter text. |
| **Any other Organisations Notified** (eg MHRA, CQC, CCG etc) | Click here to enter text. |
| **Details of Contact with or Planned Contact with Patient / Family or Carers** | Click here to enter text. |

NHS Guildford and Waverley Clinical Commissioning Group

NHS North West Surrey Clinical Commissioning Group

NHS Surrey Downs Clinical Commissioning Group

**Appendix 4**

## Closure Checklist

This checklist provides a tool which can be used by providers and commissioners in their assessment of systems investigation into serious incidents. The STEIS report must be fully completed including date investigation is completed, lesson learned and actions taken

| Phase of investigation | Element | Answer (yes/no) | If no, was there a robust rationale and that prevents this affecting the quality of the investigation? |
|---|---|---|---|
| Set up/ preparation | Is the Lead Investigator appropriately trained? | | |
| | Was there a pre-incident risk assessment? | | |
| | Did the core investigation team consist of more than one person? | | |
| | Were national, standard NHS investigation guidance and process used? | | |
| Gathering and mapping | Was the appropriate evidence used (where it was available) i.e. patients notes/records, written account? | | |
| | Were interviews conducted? | | |
| | Is there evidence that those with an interest were involved (*making use of briefings, de-briefings, draft reports etc*.)? | | |
| | Is there evidence that those affected (*including patients/staff/ victims/ perpetrators and their families*) were involved and supported appropriately? | | |
| | Is a timeline of events produced? | | |
| | Are good practice guidance and protocols referenced to determine what should have happened? | | |
| | Are care and service delivery problems identified? (This includes what happened that shouldn't have, and what didn't happen that should have. There should be a mix of care (human error) and service (organisational) delivery problems) | | |
| | Is it clear that the individuals have not been unfairly blamed? (Disciplinary action is only appropriate for acts of wilful harm or wilful neglect) | | |
| Analysing information | Is there evidence that the contributory factors for each problem have been explored? | | |
| | Is there evidence that the most fundamental issues/ or root causes have been considered? | | |
| Generating solutions | Have strong (effective) and targeted recommendations and solutions (targeted towards root causes) been developed? Are actions assigned appropriately? Are the appropriate members i.e. those with budgetary responsibility involved in action plan development? Has an options appraisal been undertaken before final recommendation made? | | |
| Throughout | Is there evidence that those affected have been appropriately involved and supported? | | |
| Next steps | Is there a clear plan to support implementation of change and improvement and method for monitoring? | | |
| Overall assessment and feedback | | | |

## Appendix 5

NHS Guildford and Waverley Clinical Commissioning Group

NHS North West Surrey Clinical Commissioning Group

NHS Surrey Downs Clinical Commissioning Group

# Surrey Heartlands CCGs' Serious Incident Scrutiny Panel (NWS Panel)
## Terms of Reference

### 1. CONSTITUTION

**1.1** The Governing Bodies of the Surrey Heartlands Clinical Commissioning Groups (The CCGs) are responsible for performance management and closure on the national reporting system (STEIS) of each investigation report into Serious Incidents (SIs) that occur within organisations to which they are the host commissioner or where they have commissioned the services of independent providers.

**1.2** The process for closure must be robust and auditable so that assurance around closure decisions is evident. This responsibility is under the auspices of the CCG Quality Committee, which hereby resolves to establish a sub Committee to be known as the Serious Incident Scrutiny Panel

**1.3** The purpose of the Serious Incident Scrutiny Panel is to provide assurance to Quality Committee, Clinical Executive and Governing Bodies on the robustness of investigation and action-planning as a result of serious incidents, and that learning from serious incidents has been identified and shared.

**1.4** The Serious Incident Scrutiny Panel will work closely with the Clinical Quality Review Meetings (CQRM), which monitor the quality of service provision within the commissioned services, to ensure an integrated, coordinated approach to the management of Serious Incidents and strengthen the assurance provided to the Quality Committee, Clinical Executive and Governing Bodies.

**1.5** The Serious Incident Scrutiny Panel has no executive powers, other than those specifically delegated in these terms of reference.

**1.6** All procedural matters in respect of conduct of meetings shall follow the Governing Bodies Standing Orders.

### 2. SCOPE

**2.1** To consider for closure all serious incidents declared and investigated by provider organisations (including Independent Providers) for which Surrey Heartland CCGs are the host provider.

**2.2** To receive the investigation reports for any Serious Incidents reported by Surrey Heartlands CCGs and recommend a decision on closure to the Quality Committee

and Governing Bodies before submission to NHS England South, South East Region for closure.

**2.3** The Serious Incident Scrutiny Panel advocates the principle of system wide learning by reviewing all serious incidents as a whole system Commissioner and Provider forum including engagement with Social Care as required.

## 3. ACCOUNTABILITY

**3.1** The Serious Incident Scrutiny Panel is accountable to the CCG Governing Bodies via the Quality Committee.

**3.2** Any risks associated with the incidence of serious incidents and/or identified during the investigation will be shared, immediately where prompt action is required, and via the Clinical Quality Review Meeting/Quality Performance Review Meeting, the relevant provider Contract Management Board, Quality Committee and by disclosure to other relevant bodies and necessary.

**3.3** The Serious Incident Scrutiny Panel is responsible for sharing information with other CCGs as appropriate for providers/services where they are the lead commissioner.

## 4. MEMBERSHIP

**4.1** The Serious Incident scrutiny panel will be appointed by the Quality Committee

**4.2** The members shall be:

| **SURREY HEARTLAND CCG MEMBERS** |
|---|
| Head of Quality – Safety (Chair) |
| Clinical Lead for Quality and Medicines Management |
| Quality & Safety Manager (also provides admin support to the meeting) |
| Head of Quality – Head of 999 Quality and Governance |
| **PROVIDER REPRESENTATION** |
| CSH Surrey - Head of Patient Safety |
| Ashford and St Peters Hospital Risk & Incidents Co-ordinator |
| Ashford & St Peters Hospital - Assistant Director of Patient Safety |
| Ashford and St Peter's Senior clinical/ medical representatives from Divisions presenting serious incidents for closure |
| South East Coast Ambulance - Serious Incident Lead |
| **SOCIAL CARE** |
| Surrey County Council - Safeguarding Advisor (Adult Social Care) |
| **Other Providers** - will attend as required |
| **Subject Matter Experts** - Depending on the incident, this might include leads for information governance, infection prevention and control, safeguarding children and adults, or other senior managers or specialist staff as deemed appropriate and able |

| |
|---|
| to provide an independent perspective. This can be done prior to the meeting and the outcome fed back at the meeting itself. |
| **Quality Leads from Other CCGs** - Where an SI involves a patient residing in their locality or involves a service of whom they are Host Commissioners. This can be done prior to the meeting and the outcome fed back at the meeting itself. |

## 5. QUORACY

The quorum shall be the following:

- At least two CCG members of which one must be a clinician and one must be a member of the Quality Committee in common.
- Representation of at least two members from different commissioned services to attend the full meeting.
- Representation of at least one person from any other provider presenting a serious incident for closure.

## 6. ATTENDANCE AND FREQUENCY OF MEETINGS

**6.1** All members (or agreed nominated representatives) are expected to attend each meeting.

**6.2** Monthly meetings shall be held at both CCG and Provider sites on a rotational basis.

**6.3** The CCG will provide the secretariat for the meetings with;

- The agenda being circulated 5 days before the meeting
- Notes of meetings will be circulated within two weeks of the meeting held.
- The Strategic Executive Information System (STEIS) updated with the outcome of panel within 3 days for those report agreed a closed/de- escalated and pending no further action by the commissioned service.

**6.4** Ongoing monitoring of actions, issues and audits resulting from Serious Incident investigations will be undertaken through the Provider Clinical Quality Review Meetings with reporting to Contract Management Board and the Quality Committee as required.

## 7. AUTHORITY

**7.1** The Serious Incident Scrutiny Panel is authorised by the CCG Governing Bodies via the Quality Committee to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any requests made by or on behalf of the chair.

## 8. DUTIES

**8.1** To review all serious incident investigation reports from commissioned services, including independent providers to assess the quality of the investigation, report and action plan, in line with national best practice guidelines and local Serious Incident policies, and to identify opportunities for wider learning.

**8.2** To agree that recommendations arising from investigations are robust, feasible and meet the patient safety and quality requirements of the commissioning CCG.

**8.3** To assess the processes in place to implement the action plan, follow up on any outstanding matters and disseminate of organisational learning (internally and in the wider health economy).

**8.4** To provide challenge where appropriate and request re-submission of reports deemed unsatisfactory within an agreed timescale.

**8.5** Provide a forum for reviewing and scrutinising any joint investigations for which the organisation/Trust may not be the lead organisation/Trust.

**8.6** To receive copies of serious incident reports pertaining to Surrey Heartlands CCGs residents, reviewed for closure through other CCG closure panels, so that learning can be shared within the local healthcare system.

**8.7** The Serious Incident Review Panel will work closely with the CCG contracts team to monitor contractual quality standard compliance of commissioned services, to ensure correct contractual sanctions are applied and assurances are sought where required.

## 9. REPORTING

**9.1** The Serious Incident Scrutiny Panel will report a summary of the outcomes from the meeting and monitor action plans through provider Clinical Quality Review Meetings/ Quality Performance Review Meetings in order to highlight any significant areas or issues for concern.

**9.2** The Serious Incident Scrutiny Panel will circulate monthly position statements of provider open, closed and overdue SIs to Provider Clinical Quality Review Meetings/ Quality Performance Review Meetings to ensure timely sharing of learning and themes and to the Quality Committee through the Serious Incident Paper.

**9.3** The Serious Incident Scrutiny Panel is responsible for immediate sharing of risk issues or learning that require prompt action or awareness

**9.4** The Serious Incident Scrutiny Panel will report to the Quality Committee as

part of the Serious Incident Report received at each meeting. The report will include a summary of the reports reviewed in the period, opportunities for wider learning that require further discussion and action, as well as progress on implementation of action plans. The action notes from the Serious Incident Scrutiny Panel will also be received by Clinical Executive as part of the Quality Surveillance Report.

**9.5** The Chair of the Serious Incident Scrutiny Panel shall draw to the attention of the Providers Clinical Quality Review Meetings, Quality Committee in common and Governing Bodies, any issue that require immediate disclosure.

**9.6** An Annual Serious Incident Report shall be produced and presented to Clinical Executive, Quality Committee and Governing Bodies.

**Date of Review: July 2018**
**Next Review Due: July 2019**

## Surrey Heartlands CCGs' Serious Incident Scrutiny Panel (G&W Panel)
**Terms of Reference**

### 1. CONSTITUTION

**1.1** The Governing Bodies of the Surrey Heartlands Clinical Commissioning Groups (The CCGs) are responsible for performance management and closure on the national reporting system (STEIS) of each investigation report into Serious Incidents (SIs) that occur within organisations to which they are the host commissioner or where they have commissioned the services of independent providers.

**1.2** The process for closure must be robust and auditable so that assurance around closure decisions is evident. This responsibility is under the auspices of the CCG Quality Committee, which hereby resolves to establish a sub Committee to be known as the Serious Incident Scrutiny Panel

**1.3** The purpose of the Serious Incident Scrutiny Panel is to provide assurance to Quality Committee, Clinical Executive and Governing Bodies on the robustness of investigation and action-planning as a result of serious incidents, and that learning from serious incidents has been identified and shared.

**1.4** The Serious Incident Scrutiny Panel will work closely with the Clinical Quality Review Meetings (CQRM), which monitor the quality of service provision within the commissioned services, to ensure an integrated, coordinated approach to the management of Serious Incidents and strengthen the assurance provided to the Quality Committee, Clinical Executive and Governing Bodies.

**1.5** The Serious Incident Scrutiny Panel has no executive powers, other than those specifically delegated in these terms of reference.

**1.6** All procedural matters in respect of conduct of meetings shall follow the Governing Bodies Standing Orders.

### 2. SCOPE

**2.1** To consider for closure all serious incidents declared and investigated by provider organisations (including Independent Providers) for which Surrey Heartland CCGs are the host provider.

**2.2** To receive the investigation reports for any Serious Incidents reported by Surrey Heartlands CCGs and recommend a decision on closure to the Quality Committee and Governing Bodies before submission to NHS England South, South East Region for closure.

**2.3** The Serious Incident Scrutiny Panel advocates the principle of system wide learning by reviewing all serious incidents as a whole system Commissioner and Provider forum including engagement with Social Care as required.

## 3. ACCOUNTABILITY

**3.1** The Serious Incident Scrutiny Panel is accountable to the CCG Governing Bodies via the Quality Committee.

**3.2** Any risks associated with the incidence of serious incidents and/or identified during the investigation will be shared, immediately where prompt action is required, and via the Clinical Quality Review Meeting/Quality Performance Review Meeting, the relevant provider Contract Management Board, Quality Committee and by disclosure to other relevant bodies and necessary.

**3.3** The Serious Incident Scrutiny Panel is responsible for sharing information with other CCGs as appropriate for providers/services where they are the lead commissioner.

## 4. MEMBERSHIP

**4.1** The Serious Incident scrutiny panel will be appointed by the Quality Committee

**4.2** The members shall be:

| **SURREY HEARTLAND CCG MEMBERS** |
|---|
| Head of Quality – Patient Safety (Chair) |
| Clinical Lead for Quality and Medicines Management |
| Quality & Safety Manager (also provides admin support to the meeting) |
| Secondary Care Lead, GW CCG |
| Patient Representative |
| Designated Nurse for Safeguarding Adults, Surrey |
| **PROVIDER REPRESENTATION** |
| Consultant Clinical Oncologist & Medical Director, RSCH |
| Director of Nursing and Chief Operating Officer, RSCH |
| Associate Director – Quality Governance & Risk, RSCH |
| Head of Patient Safety & Quality, RSCH |
| **Other Providers** - will attend as required |
| **Subject Matter Experts** - Depending on the incident, this might include leads for information governance, infection prevention and control, safeguarding children and adults, or other senior managers or specialist staff as deemed appropriate and able to provide an independent perspective. This can be done prior to the meeting and the outcome fed back at the meeting itself. |
| **Quality Leads from Other CCGs** - Where an SI involves a patient residing in their locality or involves a service of whom they are Host Commissioners. This can be done prior to the meeting and the outcome fed back at the meeting itself. |

## 5. QUORACY

The quorum shall be the following:

- At least two CCG members of which one must be a clinician and one must be a member of the Quality Committee in common.
- Representation of at least two members from different commissioned services to attend the full meeting.
- Representation of at least one person from any other provider presenting a serious incident for closure.

## 6. ATTENDANCE AND FREQUENCY OF MEETINGS

**6.1** All members (or agreed nominated representatives) are expected to attend each meeting.

**6.2** Monthly meetings shall be held at both CCG and Provider sites on a rotational basis.

**6.3** The CCG will provide the secretariat for the meetings with;

- The agenda being circulated 5 days before the meeting
- Notes of meetings will be circulated within two weeks of the meeting held.
- The Strategic Executive Information System (STEIS) updated with the outcome of panel within 3 days for those reports agreed or closed/de-escalated and pending no further action by the commissioned service.

**6.4** Ongoing monitoring of actions, issues and audits resulting from Serious Incident investigations will be undertaken through the Provider Clinical Quality Review Meetings with reporting to Contract Management Board and the Quality Committee as required.

## 7. AUTHORITY

**7.1** The Serious Incident Scrutiny Panel is authorised by the CCG Governing Bodies via the Quality Committee to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any requests made by or on behalf of the chair.

## 8. DUTIES

**8.1** To review all serious incident investigation reports from commissioned services, including independent providers to assess the quality of the investigation, report and action plan, in line with national best practice guidelines and local Serious Incident policies, and to identify opportunities for wider learning.

**8.2** To agree that recommendations arising from investigations are robust,

feasible and meet the patient safety and quality requirements of the commissioning CCG.

**8.3** To assess the processes in place to implement the action plan, follow up on any outstanding matters and disseminate of organisational learning (internally and in the wider health economy).

**8.4** To provide challenge where appropriate and request re-submission of reports deemed unsatisfactory within an agreed timescale.

**8.5** Provide a forum for reviewing and scrutinising any joint investigations for which the organisation/Trust may not be the lead organisation/Trust.

**8.6** To receive copies of serious incident reports pertaining to Surrey Heartlands CCGs residents, reviewed for closure through other CCG closure panels, so that learning can be shared within the local healthcare system.

**8.7** The Serious Incident Review Panel will work closely with the CCG contracts team to monitor contractual quality standard compliance of commissioned services, to ensure correct contractual sanctions are applied and assurances are sought where required.

## 9. REPORTING

**9.1** The Serious Incident Scrutiny Panel will report a summary of the outcomes from the meeting and monitor action plans through provider Clinical Quality Review Meetings/ Quality Performance Review Meetings in order to highlight any significant areas or issues for concern.

**9.2** The Serious Incident Scrutiny Panel will circulate monthly position statements of provider open, closed and overdue SIs to Provider Clinical Quality Review Meetings/ Quality Performance Review Meetings to ensure timely sharing of learning and themes and to the Quality Committee through the Serious Incident Paper.

**9.3** The Serious Incident Scrutiny Panel is responsible for immediate sharing of risk issues or learning that require prompt action or awareness

**9.4** The Serious Incident Scrutiny Panel will report to the Quality Committee as part of the Serious Incident Report received at each meeting. The report will include a summary of the reports reviewed in the period, opportunities for wider learning that require further discussion and action, as well as progress on implementation of action plans. The action notes from the Serious Incident Scrutiny Panel will also be received by Clinical Executive as part of the Quality Surveillance Report.

**9.5** The Chair of the Serious Incident Scrutiny Panel shall draw to the attention of the Providers Clinical Quality Review Meetings, Quality Committee i n co m m o n and Governing Bodies, any issue that require immediate disclosure.

**9.6** An Annual Serious Incident Report shall be produced and presented to Clinical Executive, Quality Committee and Governing Bodies.

**Date of Review:** **July 2018**
**Next Review Due:** **July 2019**

Guildford and Waverley Clinical Commissioning Group

North West Surrey Clinical Commissioning Group

Surrey Downs Clinical Commissioning Group

**Surrey Heartlands and Blackwater Alliance CCG's**
**Surrey & Borders Partnership NHS Foundation Trust Serious Incident Scrutiny Panel**
**Terms of Reference**

## 1. CONSTITUTION

**1.1** The Governing Bodies of the Surrey Heartlands and Blackwater Alliance Clinical Commissioning Groups (The CCGs) are responsible for performance management and closure on the national reporting system (STEIS) of each investigation report into Serious Incidents (SIs) that occur within Surrey and Borders Partnership NHS Foundation Trust (SABP), across the commissioned Adults, Children's and Learning Disability Services

**1.2** The process for closure must be robust and auditable so that assurance around closure decisions is evident. This responsibility is under the auspices of the CCG Quality Committee, which hereby resolves to establish a sub Committee to be known as the SABP Serious Incident Scrutiny Panel.

**1.3** The purpose of the SABP Serious Incident Scrutiny Panel is to provide assurance to Quality Committee, Clinical Executive and Governing Bodies on the robustness of investigation and action-planning as a result of serious incidents, and that learning from serious incidents has been identified and shared.

**1.4** The SABP Serious Incident Scrutiny Panel will work closely with the Clinical Quality Review Meetings (CQRM), which monitors the quality of service provision within the commissioned services, to ensure an integrated, coordinated approach to the management of Serious Incidents and strengthen the assurance provided to the Quality Committee in common, Clinical Executive and Governing Bodies.

**1.5** The SABP Serious Incident Scrutiny Panel has no executive powers, other than those specifically delegated in these terms of reference.

**1.6** All procedural matters in respect of conduct of meetings shall follow the Governing Bodies Standing Orders.

## 2. SCOPE

**2.1** To consider for closure all serious incidents declared and investigated by SABP, for which Surrey Heartland and Blackwater Alliance CCGs is the host provider.

## 3. ACCOUNTABILITY

**3.1** The SABP Serious Incident Scrutiny Panel is accountable to the CCG Governing Bodies via the Quality Committee.

**3.2** Any risks associated with the incidence of serious incidents and/or identified during the investigation will be shared, immediately where prompt action is required, and via the Clinical Quality Review Meeting, SABP's Contract Management Board, Quality Committee and by disclosure to other relevant bodies and necessary.

**3.3** The SABP Serious Incident Scrutiny Panel is responsible for sharing information with other CCGs as appropriate for providers/services where they are the lead commissioner.

## 4. MEMBERSHIP

**4.1** The scrutiny panel will be appointed by the Quality Committee.

**4.2** The members shall be:

| **CCG MEMBERS** |
|---|
| Head of Quality - Patient Safety, Surrey Heartlands CCGs (Chair) |
| Deputy Director of Quality and Nursing, Surrey Heartlands CCGs |
| Clinical Advisor to Quality Committees, Surrey Heartlands CCGs |
| Clinical Lead for Mental Health, Surrey Heartlands Mental Health Collaborative CCGs |
| Quality And Safety Manager, Surrey Heartlands CCGs ( also admin support) |
| Quality Manager, North Hampshire CCG (Representing Blackwater Alliance) |
| Surrey wide Designated Nurse for Adult Safeguarding |
| Senior Public Health Lead \| Substance Misuse Commissioning |
| Mental Health Commissioning and Quality Manager, Surrey Heartlands Mental Health Collaborative CCGs |
| Quality Leads from other Surrey CCGs |
| Quality Leads from other CCGs: Can attend where an SI involves a patient residing in their locality or involves a service of whom they are Host Commissioners. CCG Quality Leads can also review and feedback on an SI outside the meeting and the outcome fed back at the meeting itself. |
| **PROVIDER REPRESENTATION** |
| Director of Nursing or nominated Deputy |
| Director of Risk & Safety |
| Head of Clinical Risk & Safety |
| Other leads involved in SI investigations such as Risk/Patient Safety Manager |
| **Subject Matter Experts** - Depending on the incident, this might include leads for information governance, infection prevention and control, safeguarding children and adults, or other senior managers or specialist staff as deemed appropriate and able to provide an independent perspective. This can be done prior to the meeting and the outcome fed back at the meeting itself. |

## 5. QUORACY

The quorum shall be the following:

- At least two CCG members of which one must be a Clinical lead and one must be a member of the Surrey Heartlands CCGs Quality Committees.
- Representation of at least two members from SABP one of which must the Director of Nursing or their deputy and one a member of the risk and safety team.

## 6. ATTENDANCE AND FREQUENCY OF MEETINGS

**6.1** All members (or agreed nominated representatives) are expected to attend each meeting.

**6.2** Monthly meetings shall be held at both CCG and Provider sites on a rotational basis.

**6.3** The CCG will provide the secretariat for the meetings with;

- Agendas and papers being produced and circulated at least 5 days before the meeting.
- Notes of meetings will be circulated within two weeks of the meeting been held.
- Decisions made at the meetings updated onto the Strategic Executive Information System (STEIS) within three working days of the meeting for those serious incidents where revised reports are not required.

**6.4** Ongoing monitoring of actions, issues and audits resulting from Serious Incident investigations will be undertaken through the Provider Clinical Quality Review Meetings with reporting to Contract Management Board and the Quality Committees as required.

## 7. AUTHORITY

**7.1** The SABP Serious Incident Scrutiny Panel is authorised by the CCG Governing Bodies via the Quality Committees to investigate any activity within its terms of reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any requests made by or on behalf of the chair.

## 8. DUTIES

**8.1** To review all serious incident investigation reports from SABP to assess the quality of the investigation, report and action plan, in line with national best practice guidelines and local Serious Incident policies, and to identify opportunities for wider learning.

**8.2** To agree that recommendations arising from investigations are robust,

feasible and meet the patient safety and quality requirements of the commissioning CCG.

**8.3** To assess the processes in place to implement the action plan, follow up on any outstanding matters and dissemination of organisational learning (internally and in the wider health economy).

**8.4** To provide challenge where appropriate and request re-submission of reports deemed unsatisfactory within an agreed timescale.

**8.5** Provide a forum for reviewing and scrutinising any joint investigations for which the organisation/Trust may not be the lead organisation/Trust.

**8.6** To receive copies of SI reports pertaining to Surrey Heartlands and Blackwater Alliance CCGs residents, reviewed for closure through other CCG closure panels, so that learning can be shared within the local healthcare system.

**8.7** The SABP Serious Incident Review Panel will work closely with the Surrey Heartlands Mental Health and Blackwater Alliance Contract teams to monitor contractual quality standard compliance of commissioned services, to ensure correct contractual sanctions are applied and assurances are sought where required.

## 9. REPORTING

**9.1** The SABP Serious Incident Scrutiny Panel will report a summary of the outcomes from the meeting and monitor action plans through provider Clinical Quality Review Meeting in order to highlight any significant areas or issues for concern.

**9.2** The SABP Serious Incident Scrutiny Panel will circulate monthly position statements of provider open, closed and overdue SIs to Provider Clinical Quality Review Meeting to ensure timely sharing of learning and themes and to the Quality Committee.

**9.3** The SABP Serious Incident Scrutiny Panel is responsible for immediate sharing of risk issues or learning that require prompt action or awareness

**9.4** The SABP Serious Incident Scrutiny Panel will report to the Quality Committee as part of provider reporting and patient safety reporting. The report will include a summary of the reports reviewed in the period, opportunities for wider learning that require further discussion and action, as well as progress on implementation of action plans. The action notes from the Serious Incident Scrutiny Panels will also be received by Quality Committee and Clinical Executive as part of the Quality Surveillance Report.

**9.5** The Chair of the SABP Serious Incident Scrutiny Panel shall draw to the attention of the Providers Clinical Quality Review Meeting, Quality Committee and Governing Bodies, any issues that require immediate disclosure.

**9.6** An Annual Serious Incident Report shall be produced and presented to Clinical Executive, Quality Committee and Governing Bodies.

**9.7** The Surrey Heartlands and Blackwater Alliance CCGs require the provider to ensure their local processes comply with the requirements of the NHS England Reporting Framework.

**9.8** Evidence on the completion of actions and assurance on the effectiveness of these will be received quarterly by the panel and any issues or concerns relating to the process escalated to the Clinical Quality review Meeting.

**Date of Review:** **July 2018**
**Next Review Due:** **July 2019**

**Appendix 6 – Specialist Commissioning Standard Operating Procedure for Serious Incidents**

# Standard Operating Procedure for the Management of Serious Incidents within Specialised Commissioning for NHS England: South East and South West.

| | |
|---|---|
| **Title** | Standard Operating Procedure (SOP) for the management of Serious Incidents across NHS England South East and South West |
| **Authors** | Wendy Cotterell<br>Director of Nursing and Quality for Specialised Commissioning |
| **Version** | 3.0 |
| **Review Date** | December 2018 |

Standard Operating Procedures are designed to promote consistency in delivery, to the required quality standards, across the NHS England. They should be regarded as a key element of the training provision for staff to help them to deliver their roles and responsibilities.

## Document Management:

### Revision History

| Revision History | Date | Summary of Changes |
|---|---|---|
| | | |
| | | |
| | | |

### Reviewers

This document must be reviewed by the following people

| Reviewer Name | Title/Responsibility | Date | Version |
|---|---|---|---|
| Luke Culverwell | Chief Operating Officer: South West | | |
| Sue Whiting | Chief Operating Officer: South East | | |

### Approved By

This document must be approved by the following people

| Name | Signature | Title | Date | Version |
|---|---|---|---|---|
| Janet Meek | | Regional Director of Specialised Commissioning South | | |
| Vaughn Lewis | | Medical Director of Specialised Commissioning South | | |
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## 1. Purpose

The purpose of the NHS England South East and South West Specialised Commissioning Serious Incident Reporting and Management standard operating procedure (SOP) is to define the process for the reporting and management procedure for Serious Incidents (SI) and Never Events.
This SOP relates to specialised commissioned services across the South East and South West regions of England and is applicable to services commissioned across the six programmes of care: Women and Children; Cancer; Internal medicine; Trauma; Mental Health and Blood and Infection.

## 2. Background

Two key operational changes were made to the 2015 SIRI guidance published by NHS England to improve the management of SI's. The grading of incidents was removed as SI's were often graded without clear rationale and a single timeframe of 60 working days was agreed for the completion of investigation reports.
The primary guidance document we refer to in managing incidents is the same as all
NHS commissioners and providers, which is the Serious Incident Framework. (NHS England Patient Safety Domain, March 2015: Serious Incident Framework)
There are slightly differing processes for acute and mental health providers but all follow the same general principle.
There are three specialised commissioning hubs responsible for the commissioning of specialised services across the South East and South West Regions of England. Two of these hubs; Wessex and the South East Hub are located within the South East Region with the South West Hub located within the South West of England Region.
The flow chart in appendix 1 illustrates the process for the management of SI relating to Specilaised Commissioning across the South East and South West Regions.

## 3. Acute Trusts Serious Incidents

All providers of NHS commissioned care are required to report Serious Incidents (SI's) on the national database known as the Strategic Executive Information System (STEIS) following the rules set out in the guidance.

The decision on whether an incident is serious in nature is not prescriptive but any unexpected death, never event or disruption to service must be reported by trusts on STEIS within 24 hours of becoming aware of the incident.

In the rare event of a provider not having access to STEIS, they are required to complete a STEIS form and email it to NHS England in order that it can be entered onto STEIS by NHS England. All NHS trusts are required to install and use STEIS.

There is a secure 'membership' of those entitled to access the STEIS system and it is very limited in nature. The DCO teams within NHS England regional offices has oversight locally of all SI reported on STEIS.

An automated notice is sent by STEIS to all the distribution list of colleagues entitled to see it when an incident is reported by a provider. The distribution is based on the CCG geography where the incident occurred.

The information uploaded by the Provider will afford enough information to justify the rationale for raising the incident and the immediate actions taken. This initial information does not get updated by the Provider however should provide the site and location details.

From the initial information provided it is often difficult to identify incidents that involve patients in receipt of specialised commissioned care and at the point of uploading the incident onto STEIS the

Provider does not differentiate between commissioners of the service.

The service specialists in the three hubs receive the SI database created by the DCO teams in which SI's reported by acute providers of care within their geographical patches are shared.

The service specialists interrogate each notification and make a judgement on whether or not an incident relates to a specialised commissioned service, which is not always obvious given the complexity of some commissioned clinical pathways. If not obvious, more information is sought from the relevant CCG or provider as appropriate.

Relevant SIs are noted in a separate spreadsheet kept by each of the three hubs service specialists.

The lead CCG for that provider is contacted and specialised commissioning's interest in the investigation is noted. Specialised Commissioning will review the root cause analysis and liaise with the lead CCG.

Once specialised commissioning is assured the report is comprehensive with the root causes being identified and organizational learning will be embedded the incident is closed on STEIS by the lead CCG and the database updated by the service specialist.

This information is then included in each hub's quarterly quality report which is received regionally and nationally.

## 4. Mental Health Serious Incidents

It is a contractual requirement that mental health incidents are reported within 24 hours with an update at 72 hours to a secure email address.

These incidents are then investigated with the contract managers and case managers involved at all stages. There are proscribed incidents that must be reported in the mental health specialised commissioning service.

Independent Providers of care do not all have access to STEIS.
Those providers with access are required to report on STEIS as above but it is not the primary mechanism used to manage incidents. In the case of NHS trusts, the CCGs have the same responsibilities as above.

For providers without access to STEIS the incident would be uploaded by one of the commissioning organisations on their behalf.

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 depending on the circumstances of the case.

## 5. Review of Root cause Analysis

The provider is required to submit the root cause analysis to commissioners within sixty (60) days of declaration of the incident.

Commissioners are required to review the submitted RCA and complete NHS England closure check list.

There is agreement with CCG's that SI's declared by acute providers of care will be reviewed within the CCG SI closure panels, however, these cases cannot be closed without the review and subsequent agreement of the Specialised Commissioning team for that local DCO office.

This process enables the lead CCG to maintain an oversight of all SI's within individual providers whilst ensuring specialised commissioning teams receive assurances in relation to SI's and Never Events involving NHS E commissioned pathways.

For those providers for whom there is not a lead CCG, for example Independent providers of care NHS E Specilaised Commissioning will convene a bespoke SI review panel ensuring the relevant discipline specific practitioner has reviewed the RCA prior to the panel decision being taken.

The case will be updated and closed on STEIS by the lead CCG or NHS England in the absence of a lead CCG.

## 6. Reporting Mechanism

The Service Specialists for each hub will report the number of SI's involving patients in receipt of specialized services by organisation within the following reports:

- Monthly contract assurance report
- Monthly quality report
- Quarterly regional report

In addition, an annual report that identifies the trends and learning from SI's and Never Events across the South Region relating to specialised services will be presented to the Quality Committee at the end of quarter 4.

## 7. Conclusion

This standard operating procedure describes the process for the management of Serious Incidents across the South East and South West Regions

## Appendix 1

## Process for management of Serious Incidents