Item Number:6

NHS VALE OF YORK CLINICAL COMMISSIONING GROUP **SHADOW GOVERNING BODY MEETING**	NHS Vale of York Clinical Commissioning Group

Meeting Date: 20 September 2012

Report's Sponsor:	**Report Author:**
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1. Title of Paper: Serious Incident reporting and management – transition from PCT to CCG

2. Strategic Objectives supported by this paper:

In exercising its functions the CCG will have a general duty to act with a view to securing continuous improvements in the quality of services for patients and in outcomes, with particular regard to clinical effectiveness, safety and patient experience. Serious incident management is an integral part of this duty.

3. Executive Summary

The purpose of this paper is to update the Shadow Governing Body on progress towards putting in place a process for the investigation and management of serious incidents as part of the transition from the PCT to the CCG, and to seek agreement from the CCG Shadow Governing Body in respect of developing the CCG process.

4. Risks relating to proposals in this paper

Risks around the transition from PCT to CCG responsibilities are mitigated through the establishment of robust handover arrangements.

5. Summary of any finance / resource implications

Not relevant to this report

6. Any statutory / regulatory / legal / NHS Constitution implications

The CCG has to put in place effective systems and processes to proactively identify early warning of ailing services, monitoring and acting on patient feedback, identify quality including safety issues and secure continuous improvements in the quality of services provided.

7. Equality Impact Assessment

Not relevant to this report however subsequent policies developed will be subject to equality impact assessment.

8. Any related work with stakeholders or communications plan

Not relevant to this report however subsequent policies developed will be subject to relevant communications.

9. Recommendations / Action Required

The Shadow Governing Body is asked to:

- receive the report
- agree on a process for the overview and management of SIs and related matters within the CCG to enable development of appropriate policies in conjunction with the Commissioning Support Unit

10. Assurance

Serious incident policies are included in all provider contracts and related matters are monitored through the monthly Contract Management Board structures.

For further information please contact:

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NHS VALE OF YORK CLINICAL COMMISSIONING GROUP

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Serious Incident reporting and management – update on the transition from PCT to CCG responsibility

1. Background

1.1 A Serious Incident (SI) is defined as an incident that occurred in relation to NHS funded services, including but not limited to incidents such as; resulting in unexpected or avoidable death or serious harm to one or more patients, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm; a scenario that prevents or threatens to prevent a provider organisation's ability to continue to deliver healthcare services; allegations of abuse; potential or actual adverse media coverage or public concern about the organisation or the wider NHS; use of adult psychiatric wards for children 16 years old and under; information security incidents; maternal mortality; safeguarding children; or one of the core set of NPSA 'Never Events'.

1.2 Currently the process for the reporting and investigation of SIs, is managed through NHS North Yorkshire and York utilising the Department of Health's central Strategic Executive Information System (StEIS) to report and manage the administration processes behind serious incident investigations. Files and documents relating to the investigation are securely stored outside of the StEIS system by the Quality team who also undertake reviews and updates to the policy framework as and when required. Incidents include both commissioner and provider events.

1.3 In order to ensure comprehensive investigations have been carried out, the quality team allocate the final investigation report submitted by the provider to two internal PCT reviewers, one of whom is a clinician. If the incident is maternity related one of the reviewers will be the Local Supervising Authority for Midwifery representative based in the SHA. The two reviewers assess the report against expected standards (using National Patient Safety Authority methodology) and return a completed template to the quality team. Further information or assurance can be sought at this stage, or an amalgamated report is presented a wider group if no further information is deemed to be required (see 1.4).

1.4 The decision making process regarding progress on a provider serious incident investigation, and the action planning and process for sharing learning from an event, including when the SI can be considered as 'closed' is currently facilitated through the quality team with a six weekly SI Review Group (including clinicians) meeting to review all cases prior to closure and taking joint decisions regarding sign off.

Where an incident is also classed as a 'never event' final sign off rests with the SHA however the process is broadly similar to an SI. Matters can be escalated at any stage in the process to the PCT Committees or Shadow Governing Body as appropriate. The group is Chaired by the Director of Nursing for NHS North Yorkshire of York or her deputy, and also receives overview reports on numbers of new events and progress updates, trend analysis and ad hoc reports. Updates from this group have been a standing item on both the PCT relevant Committee agendas and included in the monthly Board reports.

2. Proposed arrangements to manage the transition

2.1 It is proposed that the administration and facilitation of the serious incident management process is purchased from the Commissioning Support Unit (CSU). This will enable the CCG to continue to draw on the expertise of the staff who are transferring into that team and will enable the CCGs own knowledge and understanding to increase over time. This will further allow the CCG to focus on patient safety and clinical matters as opposed to the administration and facilitation of a system. This service will also be expected to include policy management, updates and training provision. Discussions with the CSU are progressing but are still at a reasonably early stage and therefore the CCG is able to influence how the process will work and is able to set out the level of support and reporting that is required.

2.2 CCGs will remain accountable for the the sign off and closure of Sis and as such need to establish internal mechanisms for carrying out this duty including sharing any learning and picking up on trends to support improved quality and patient safety. It is proposed that in order to promote shared learning and to make best use of the CSU resource that the CCG collaborates with other CCGs, either as an SRCCG/ VoYCCG collaborative, or in partnership with the four North Yorkshire CCGs, in either case through a restructured and augmented SI review group (facilitated by the CSU).

2.3 It is further proposed that the CCG receives regular reports regarding SIs and other related matters (such as Central Alerting System (CAS) alerts and National Reporting and Learning System (NRLS) trends and analysis) as a standing item at their relevant Shadow Governing Body Committee with matters being escalated from that Committee to the Shadow Governing Body as and when appropriate.

3. Recommendation

The Shadow Governing Body is asked to:

3.1 Note the content of the paper and the progress made to secure the administrative and facilitative service from the CSU in relation to SIs, and approve the continuation of discussions with the CSU to enable a bespoke service to be put in place for the CCG.

3.2 Agree the proposal to continue to work collaboratively, in the management of serious incidents, either in partnership with Scarborough and Ryedale CCG, or a group of four with Hambleton, Richmondshire and Whitby CCG, and Harrogate and Rural CCG (subject to wider agreement).

3.3 Agree that matters relating to serious incident reporting will be discussed and considered at the CCG Quality and Performance (or other relevant) Committee, and matters will be escalated to the Shadow Governing Body as necessary.

3.4 Note that the final draft CCG serious incident policy will be brought to a subsequent Shadow Governing Body meeting and that until this transition is complete the CCG will continue to work with the policies of NHS North Yorkshire and York.