

SERIOUS INCIDENT, INCIDENT & CONCERNS POLICY

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POLICY AMENDMENTS

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

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1 INTRODUCTION

Vale of York Clinical Commissioning Group (NHS VOY CCG) is committed to providing the best possible service to its patients, clients and staff. NHS VOY 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 VOY 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 VOY CCG has a duty to receive information on Serious Incidents from NHS organisations within its boundaries to both identify learning opportunities for improving patient safety and to ensure that NHS organisations have robust arrangements in place to identify and investigate SIs to prevent recurrence.

The principle definition of an SI is something out of the ordinary or unexpected, with the potential to cause serious harm, and/or likely to attract public and media interest that occurs on NHS premises or in the provision of an NHS or a commissioned service. SIs are not exclusively clinical issues, for example, an equipment failure may have consequences which could result in an SI.

NHS VOY CCG will be informed of SIs in line with the NHS Serious Incident National Framework (March 2013) that have occurred within any of its commissioned services listed below:

- York Teaching Hospitals NHS Foundation Trust
- Leeds and York Partnership NHS Foundation Trust
- Tees Esk and Wear Valleys NHS Foundation Trust
- Yorkshire Ambulance Service
- 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 VoY CCG

This policy sets out the requirements in relation 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 VOY CCG Board and NHS England, North Yorkshire & Humber, Area Team (NHS England NYH AT) as required

NHS VOY CCGs will work closely with the NHS England NYH AT, the Department of Health and other organisations to manage serious incidents, minimise risk and in so doing help prevent recurrence across the NHS. NHS North Yorkshire and Humber Commissioning Support Unit (NHS NY&H CSU) is contracted to deliver this area of work for NHS VOY CCG

The policy also outlines management of Incidents and Raising Concerns, which 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 VoY CCG, NHS HaRD CCG, NHS HRW, NHS SR CCG, Partnerships Commissioning Unit and NYHCSU. The National Framework for Serious Incidents (2013) on which this policy is based, has been tabled at contracting meetings with the 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 VOY 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 5.

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 6.



3.3 Bribery Act 2010

There are the following requirements to the provisions of the Bribery Act 2010 within this policy. See Appendix 7

“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.

4 SCOPE

This policy and associated tools for investigation is for use by NHS VOY CCG employees, all commissioned services and NHS NY&H CSU 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 (2013) as “patient in receipt of NHS-funded care”.

The responsibilities of this document apply to NHS VOY CCG, all commissioned services and NHS NY&H CSU staff, 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 VOY CCG.

5 POLICY PURPOSE & AIMS

The purpose of the Policy is to provide NHS VOY CCG, all commissioned services and NHS NY&H CSU employees 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

NHS VOY CCG has a responsibility to ensure there is a robust performance management process in place that meets NHS ENGLAND NYH AT requirements as well as provides 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 VOY CCG and the commissioned service. NHS VOY CCG also has a duty to comply with NHS ENGLAND Serious Incidents Framework March 2013. It is the responsibility of the NHS NY&H CSU 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 2013.

6 POLICY STATEMENT

NHS VOY CCG recognises that in a service as large and as complex as the NHS things will sometimes go wrong. When they do, the NHS VOY 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 VOY 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 dealings with patients and the public, and organisational and personal interests must never be allowed to outweigh the duty to be honest, open and truthful. Where a Serious Incident has affected or may have affected a patient by an act or omission of the 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 and be offered an appropriate level of support, whether or not the patient or representative has asked for this information. (Francis, Feb 2013)

7 DEFINITIONS

SI – Serious Incident A serious incident may be defined as an incident where a patient, member of staff, or member of the public has suffered serious injury, major permanent harm, unexpected death, or where there is cluster/pattern of incidents or actions by NHS staff which have caused or are likely to cause significant public concern

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.

Concern – Occurrence which gives cause for concern by patient, member of public, health or other care worker, which does not constitute an incident, but where collectively, can form a body of evidence for commissioners.

8. RELEVANT LEGISLATION AND STANDARDS

Putting Patients First: The NHS England Business Plan for 2013/14 – 2015/16

Recommendations and Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Feb 2013)

NHS Commissioning Board (March 2013) Serious Incident Framework

Guidance on the reporting and monitoring arrangements and post infection review process for MRSA bloodstream infections (April 2013)

<http://www.england.nhs.uk/wp-content/uploads/2013/03/pir-guidance.pdf>

Department of Health (2013) Information: To Share or not to Share Government Response to the Caldicott Review

www.nrls.npsa.nhs.uk/resources/patient-safety-topics/

Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework (March 2013)

Department of Health (2012) Compassion in Practice

National framework for reporting and learning from serious incidents requiring investigation (2010)

<http://www.nrls.npsa.nhs.uk/resources/?entryid45=75173>

NPSA (2009) Being Open Policy

National Health Services Act 1977.

Freedom of Information Act 2000

NHS VOY CCG will inform NHS ENGLAND NYH AT of any requests for information regarding serious incidents submitted to them under the Freedom of Information Act 2000. NY&H CSU provide this service on behalf of NHS VOY CCG

9 POLICY IMPLEMENTATION

9.1 SERIOUS INCIDENTS

9.1.1 Culture

NHS VOY 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 VOY CCG are able to acknowledge mistakes, learn from them and take action to put things right with the opportunity to learn from the SI and improve patient safety.

Having a safety culture encourages a working environment where many 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. While human error might immediately precede an SI, in a technically and socially complex system like healthcare, there are usually entrenched systemic factors at work. NHS VOY CCG is committed to using root cause analysis, during the investigation of SIs and requires providers to use this technique when investigating SIs.

9.1.2 Duty of Candour – Being Open

A commitment to improving communication between NHS VOY CCG and patients who have been harmed is integral to NHS VOY CCG's strategy to improve patient safety.

NHS VOY CCG expects all providers to demonstrate a Duty of Candour, based on recommendations made by Francis (2013) and in line with principle of "Being Open" which involve acknowledging, apologising and explaining what happened to patients and/or their carers who have been involved in a patient safety incident, whether or not the patient or their representative have asked for this information.

9.1.3 What is a Serious Incident (SI)

A serious incident may be defined as an incident where a patient, member of staff, or member of the public has suffered serious injury, major permanent harm, unexpected death, or where there is cluster/pattern of incidents or actions by NHS staff which have caused or are likely to cause significant public concern.

Where a patient/member of staff raises an issue about an NHS organisation direct to the media, it will be for the provider to determine, but always in conjunction with the Commissioners whether this has substance and should therefore be reported as an SI.

'Near misses' may also constitute SIs, where the contributory causes are serious and under different circumstances they may have led to serious injury, major permanent harm, or unexpected death, but no actual harm resulted on that occasion. A possible

example is that of a system failure, the result of which is incorrect/delayed diagnosis. This may not have any serious consequences for some patients, but for others could lead to the wrong treatment/serious delay in treatment and ultimately to death.

A full list of definitions of serious incidents requiring investigation can be found at Appendix 1. It is required that all incidents which are categorised as SIs within the Serious Incidents Framework (2013) will be reported as SIs. Providers may categorise or describe incidents internally, with differing titles, but are required to report all incidents which fit the criteria of a Serious Incident.

The National Patient Safety Agency (NPSA) has implemented a core list of Never Events which are listed in Appendix 2. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. If a Never Event does occur it must be reported immediately as a serious incident.

Information Governance SIs i.e. loss of data; patient or staff personal details should be reported in line with the Department of Health (DH) 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 rated as 1-5 on the Information Governance Risk Assessment tool must be categorised as SIs and reported as per this policy.

9.1.4 Reporting a Serious Incident

Who should report SIs?

All commissioned providers are required to report SIs to NHS VOY 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 which ensures Serious Incidents are reported on STEIS within 2 working days of the SI being identified from within, or to the organisation by an external organisation.

For SI's which are declared by the NHS VOY CCG itself, these are reported directly on STEIS by NHS NY&HCSU Quality team.

NHS VOY 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.

Providers can find a full list of definitions of serious incidents requiring investigation at Appendix 1.

9.1.5 Investigation of a Serious Incident

The Lead for the area 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.

The team will be led by a nominated manager fully trained in incident investigation and analysis. All staff involved in the incident will be asked to participate in the investigation.

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 by the appropriate person within 2 working days.
- Establish a set of Terms of Reference for the investigation
- 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 45 working days for Grade 1, and within 60 working days for Grade 2, 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

NH&Y CSU Quality team 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 / clients GP details and a deadline for receipt of the investigation report and action plan

- Maintain up-to-date electronic records of all Serious Incidents pertaining to the NHS VOY 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 with 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 VOY CCG and NHS England NYH AT to SI's is appropriate

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

- 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
- 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 and action plan
- Work in conjunction with the CSU 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.

If as a result of the initial enquiry disciplinary action is considered necessary, advice will be sought from the Director of Human Resources. 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 be used in parallel with the Root Cause Analysis.

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

9.1.6 Never Events

Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Please see Appendix 2 for a full list of core never events.

Local reporting and management processes will underpin the implementation of the Never Events Policy. This will provide the impetus to increase patient safety through greater transparency and accountability when serious patient safety incidents occur and will inform new ways in which local commissioners can act as a lever for safer care.

Provider reporting of Never Events to the NHS VOY CCG form part of existing contract arrangements for reporting of SIs.

The NHS England Framework supports NHS VOY CCG in their performance management of Never Events and will provide interventions with providers

9.1.7 The role of NHS England, North Yorkshire and Humber Area Team

NHS VOY CCG and its provider organisations report the SI to NHS England NYH AT electronically on STEIS as soon as practically possible (at the latest within two working days). Reports should be anonymised of identifiable information.

- NHS England NYH AT are automatically alerted when an SI is reported via the STEIS system. In some circumstances NHS England NYH AT may require immediate assurance depending on the seriousness and complexity of the SI.
- In exceptional circumstances, NHS England NYH AT may alert other Trusts in Yorkshire and the Humber or throughout the country. NHS England NYH AT 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 NYH AT 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 a 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 VOY CCG and NY&HCSU or NHS England NYH AT for advice. A single investigation report and action plan will be submitted by the reporting organisation.
- In the interest of patient safety, NHS England NYH AT will inform the CQC of “highly significant” SIs such as those which 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 NYH AT 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 NYH AT will continue to performance manage SIs involving the safeguarding of children as outlined in Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework (March 2013) This will be done through the Safeguarding Team Designated Nurses who are employed across the NHS SR, CCG, NHS HRW CCG, NHS HaRD CCG, NHS VoY CCG and NHS England NYH AT. The employing organisation is SR CCG with responsibility to the relevant organisation SR CCG, HRW CCG, HaRD CCG, VoY CCG and NHS England NYH AT, dependent on the residency of the individual and these cases will be kept open until the action plans have been fully implemented.

NHS England NYH AT will performance manage SIs reported by commissioned services of NHS VOY CCG where there are potential issues/concerns about the commissioning of services.

NHS England NYH AT will hold NHS VOY CCG to account in respect of their performance management of SIs and requires NHS VOY CCG to prepare quarterly reports on SI management.

Learning from SIs within the region will also be shared nationally through the NPSA (or other bodies) as appropriate and the NHS England NYH AT will ensure that the learning from key inquiries at national level is implemented within the North Yorkshire and the Humber.

9.1.8 Safeguarding Adults and Children

The new Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework published on 21 March 2013 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 “No Secret’s - Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse” (DH 2000), and an alert is raised as appropriate.

Under the new statutory guidance Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children published March 2013, 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 NYH AT 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 & 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' 2013)

The policy for performance managing NHS involvement in serious safeguarding children cases (version two, March 2010) is managed by the NHS England NYH AT and is updated accordingly with any national policy amendments.

NHS England NYH AT will continue to performance manage SIs involving the safeguarding of children as outlined in Working Together to Safeguard Children, DfE, 2013. This will be processed through NHS VOY CCG SI management process and these cases will be kept open until the action plans have been fully implemented.

Safeguarding Vulnerable Adults SIs are managed by the NY&H CSU Quality team, NHS SR CCG has the responsibility for Safeguarding Vulnerable Adults and are represented at the North Yorkshire Safeguarding Adults Board by The Designated Nurse for Safeguarding Adults who is employed by NHS SR CCG and managed by the Partnerships Commissioning Unit on behalf of NHS SR CCG.

The Designated Professionals for Adults and for Children are hosted by NHS SR CCG on behalf NHS SR CCG, NHS VoY CCG, NHS HRW CCG, NHS HaRD CCG, and NHE England NYH AT. These professionals provide the CCGs and AT with professional support and advice in relation to relevant SIs.

9.1.9 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.

9.1.10 Incidents Involving National Screening Programmes

SIs linked to the breast, bowel and cervical screening programmes should be reported to the Quality Assurance Reference Centre (QARC) within two working days. For the most serious of incidents the QARC should be informed immediately and a member of the QARC team should be involved in the incident investigation. This is done via the Screening Lead at NHS England NYH AT.

Further details on the management of incidents within the breast screening programme are available at:

www.cancerscreening.nhs.uk/breastscreen/publications/pm-09.html

Further details on the management of incidents within the bowel screening programme are available at: <http://www.cancerscreening.nhs.uk/bowel/index.html>

Further details on the management of incidents within the cervical screening programme are available at:

<http://www.cancerscreening.nhs.uk/cervical/publications/pm-07.html>

9.1.11 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 in the usual way. NHS England NYH AT 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)

9.1.12 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. Where pressure damage is assessed as Grade 3, 4 or “ungradeable”, these occurrences must be reported as a Serious Incident in line with SI Framework (2013). Provider organisations who do not have STEIS log on, can report the SI to NYHCSU.SeriousIncidents@nhs.net

A report will be uploaded on behalf of the organisation, and guidance given by NYHCSU SI management team.

9.1.13 Process for Reporting SIs That Fall into Category of Health Care Associated Infections (HCAI)

Incidents where a HCAI is the primary cause of death should be reported as a SI. Other cases which should be reported as a SI include: clusters of HCAIs, outbreaks which result in ward closures, recurrent incidences within the same unit and those which result in adverse media interest. IT is required that MRSA deaths will be subject to a Post Infection Review (PIR, April 2013)

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

For incidents related to health and safety, the NHS VOY 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 which result in serious harm or death, or are considered "near misses" should be reported as SIs by the provider. The NHS VOY 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.

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.

9.1.15 Midwifery Service Incidents

Where the NHS VOY CCG is performance managing a midwifery SI, it is responsible for obtaining clinical advice either from a supervisor of midwives independent of the service in question or directly from the LSA Midwifery Officer.

9.1.16 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.

9.1.17 Accountable Officer Role (AO)

Incidents that are considered to be serious enough should be reported as an organisational Serious Incident. The AO should establish a risk assessment process for determining the seriousness of an incident or concern.

Whichever route or system is used to identify the issue or concern, the AO will need to initiate an investigation. The extent and scope of the investigation will be determined based on the initial facts presented, although there will need to be some flexibility to the scope as additional facts emerge. A risk assessed approach should be taken by the AO for the investigation of incidents reported such as accidental spills, irreconcilable CD register balances of exceptionally small quantities or one-off prescriptions for quantities in excess of prescribing recommendations.

Further details of risk assessment processes within healthcare settings can be found on the National Patient Safety Agency (NPSA) website.

www.nrls.npsa.nhs.uk/resources/patient-safetytopics/risk-assessment-management/

9.1.18 Patients in Receipt of Substance Misuse 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, unless there is evidence that Suicide was intended. It is the role of the Coroner to record a verdict of Suicide.

9.1.19 Sharing Lessons Learned

NHS VOY 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 VOY CCG will also ensure that learning from serious incidents is shared with other NHS organisations in Yorkshire and the Humber and nationally where appropriate.

9.2 INCIDENT MANAGEMENT AND RAISING CONCERNS

9.2.1 Reporting Incidents and Near Misses (non-major)

An incident occurring in NHS VoY 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 2 working days. The reporter should also notify line manager of incident at same time.

An investigation will be required by the line manager or appropriate other, 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 NYHCSU clinical quality team is responsible for validating the grade of the incident and ensuring an appropriate investigation has been undertaken, and providing quarterly reporting to NHS VoY CCG.

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

9.2.2 Concerns

In line with recommendations (Francis 2013), NHS VoY 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 be something any individual has witnessed or may be third party information, which 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 VoY CCG or a nominated delegate, to identify themes requiring further investigation.

Concerns should be raised through the incidents reporting system, or can be raised through the email service, valeofyork.contactus@nhs.net or through the patient relations service VOYCCG.PatientRelations@nhs.net or 0800 068 8000.

9.3 TRAINING & 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 Internet.

Staff involved with the monitoring, management and review of Serious Incidents, Incidents and Concerns will receive Root Cause Analysis training using nationally approved tools.

9.4 MONITORING & AUDIT

A monthly review of all Serious Incidents will be held. This review will be a collaborative approach including NHS VoY CCG, NHS HaRD CCG, NHS HRW CCG, NHS SR CCG.

9.5 POLICY REVIEW

This policy will be reviewed annually. 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.

10 REFERENCES

Putting Patients First: The NHS England Business Plan for 2013/14 – 2015/16

Recommendations and Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry (Feb 2013)

NHS Commissioning Board (March 2013) Serious Incident Framework

Guidance on the reporting and monitoring arrangements and post infection review process for MRSA bloodstream infections (April 2013)

<http://www.England.nhs.uk/wp-content/uploads/2013/03/pir-guidance.pdf>

Department of Health (2013) Information: To Share or not to Share Government Response to the Caldicott Review

www.nrls.npsa.nhs.uk/resources/patient-safety-topics/

Safeguarding Vulnerable People in the Reformed NHS: Accountability and Assurance Framework (March 2013)

Department of Health (2012) Compassion in Practice

National framework for reporting and learning from serious incidents requiring investigation (2010)

<http://www.nrls.npsa.nhs.uk/resources/?entryid45=75173>

NPSA (2009) Being Open Policy

National Health Services Act 1977.

11 ASSOCIATED DOCUMENTATION

No other associated documentation.

APPENDICES


Appendix 1 - Criteria for Reporting Serious Incidents

- the death of a person currently in receipt of NHS care where the death is suicide, as a suicide or is likely to be of public concern, e.g. of particular concern is any such death occurring on NHS premises or potentially high profile patient suicides involving bridges and railway lines .
- death or serious injury to a child which results in a Part 8 review under the Children Act 1989 in which health has a major role.
- homicide or serious injury of a member of staff (including independent contractors) in the course of their NHS duties.
- the death or serious injury of a patient which is alleged to be at the hands of another patient or a member of the public while on NHS premises.
- serious injury of a person currently in receipt of NHS care such as deliberate self harm, accidental injury or injury inflicted by another person.
- incidents which involve concerns regarding the actions of NHS staff (including independent contractors) which is likely to lead to the involvement of the criminal justice system. This may include fraudulent behaviour, actions resulting in harm to patients.
- serious fires or other serious damage which occurs on health service premises. Of particular concern would be any fire which resulted in the death or serious injury of patients or staff and/or would result in the major disruption of service provision.
- patients detained under the Mental Health Act 1983 who abscond from mental health/learning disability services who present a serious risk to themselves and/or to others. Of particular concern are those patients who abscond from medium secure or specialist forensic services, those who are likely to pose a risk to the public, attract media attention and/or who commit an offence while at large.
- any incident involving a serious outbreak of infectious diseases in hospital or the wider community (eg food poisoning, MRSA etc.), the transmission of infectious disease from an NHS staff member to a patient or any incident involving an HIV or Hepatitis B infected health care worker.

- any instance of staff or patients being poisoned in the course of receiving treatment or as a direct result of NHS employment.
- the unplanned release of substances into the environment likely to cause a substantial hazard to the public (e.g. toxic gas, infected clinical material etc).
- serious chemical or microbiological contamination incidents
- any incident which is attracting significant media attention is likely to become high profile and/or is likely to be of public concern.
- a pattern emerging that is causing local concern such as a high number of complaints regarding a member of staff, a particular service and/or hospital that may warrant further investigation and action
- theft of computers or laptops which contain patient sensitive data
- This list is not exhaustive but should help in clarifying under what circumstances an incident should be reported. Senior Managers on Call will need to exercise personal judgement when considering whether or not the incident is a Serious Incident. Senior Managers on Call and Directors with responsibility for the service will also need to make the final decision about whether or not the incident is of sufficient severity and/or focus of public concern to warrant reporting.
- If a SI escalates into a major incident the procedure detailed in the Major Incident Plan must be implemented immediately.

Appendix 2 - Core list of Never Events

1. Wrong site surgery
2. Wrong implant/prosthesis
3. Retained foreign object post-operation
4. Wrongly prepared high-risk injectable medication
5. Maladministration of potassium-containing solutions
6. Wrong route administration of chemotherapy
7. Wrong route administration of oral/enteral treatment
8. Intravenous administration of epidural medication
9. Maladministration of Insulin
10. Overdose of midazolam during conscious sedation
11. Opioid overdose of an opioid-naïve patient
12. Inappropriate administration of daily oral methotrexate
13. Suicide using non-collapsible rails
14. Escape of a transferred prisoner
15. Falls from unrestricted windows
16. Entrapment in bedrails
17. Transfusion of ABO-incompatible blood components
18. Transplantation of ABO or HLA-incompatible Organs
19. Misplaced naso- or oro-gastric tubes
20. Wrong gas administered
21. Failure to monitor and respond to oxygen saturation
22. Air embolism
23. Misidentification of patients
24. Severe scalding of patients
25. Maternal death due to post-partum haemorrhage after elective Caesarean section



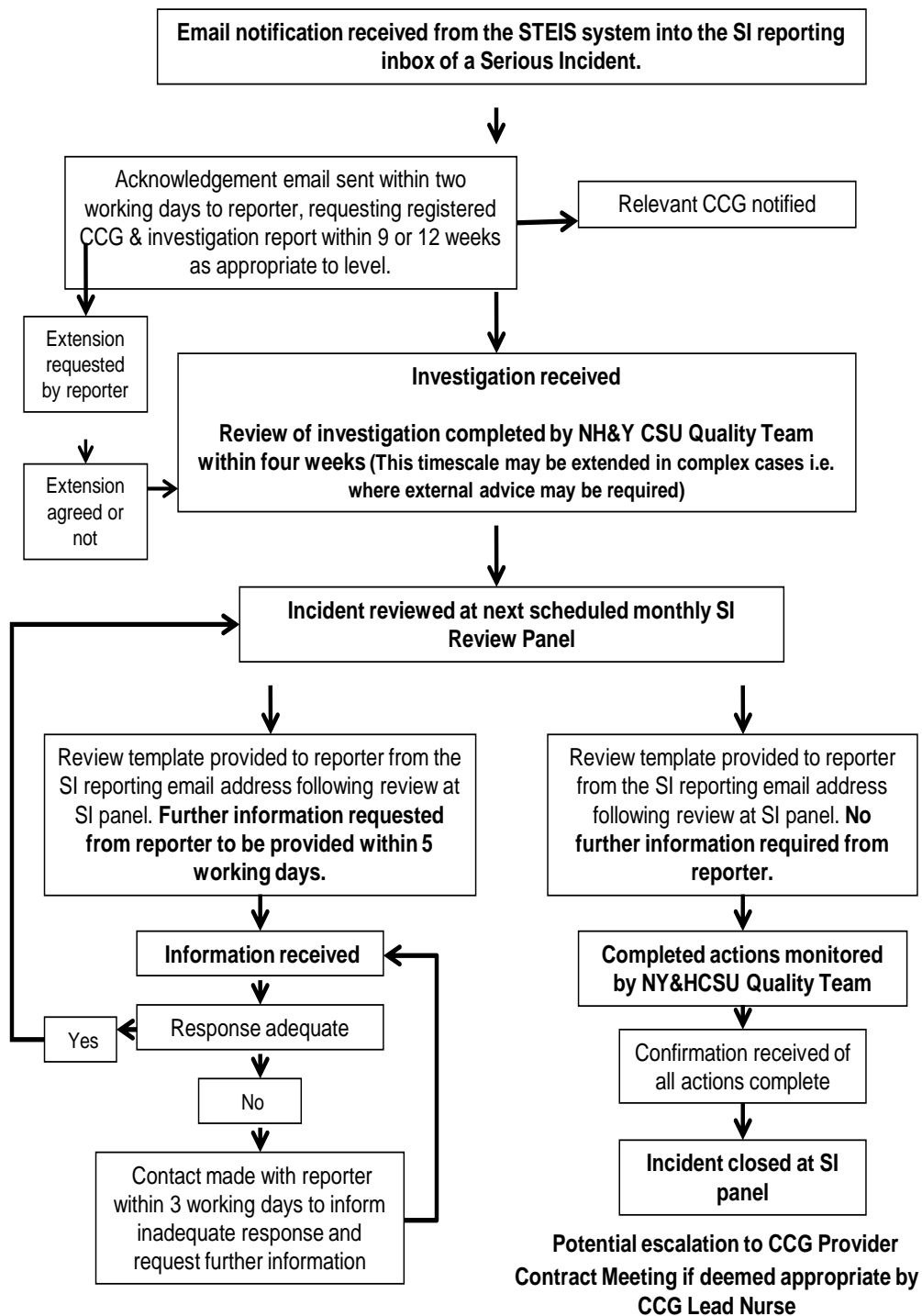
The best health and
wellbeing for everyone.

Appendix 3

Commissioned Services Reporting Process

****all communication to be sent via SI reporting e-mail address:**

NYYCSU.SeriousIncidents@nhs.net



Appendix 4

Serious Incident Report Submission – Extension Requests

Provider organisations are required to report Serious Incidents (SI) within two working days, once identified. As per Framework for SIs (March 2013) the date of SI's discovery by the organisation is the date from which 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 no later than 9 or 12 week dependent on the grade of the SI, from the date of organisations awareness of the SI.

It is expected that SI reports will be submitted within the 9 or 12 week 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 9 or 12 weeks. An interim report will always be required to be submitted at the initial 9 or 12 week 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 9 or 12 week 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
- Coroners 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 CSU Quality Manager will liaise with CCG Quality Lead.

In all these circumstances, an interim SI report will be required in the initial 9 or 12 week deadline.

In conclusion, providers are expected to complete SI investigations and submit reports to the SI Inbox within the 9 or 12 week deadline. SIs reported, reports submitted and number of extensions requested will be monitored through the contract management board.

Appendix 5

1. Equality Impact Analysis									
Policy / Project / Function:	Serious Incident Policy								
Date of Analysis:	11 February 2014								
This Equality Impact Analysis was completed by: (Name and Department)	Liz Vickerstaff RGN RMN Quality Lead Quality and Outcomes Team NYHCSU								
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 VoY 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 ✓	<table style="width: 100%; border: none;"> <tr> <td style="padding: 5px;">Employees</td> <td style="text-align: right; padding: 5px;">x<input type="checkbox"/></td> </tr> <tr> <td style="padding: 5px;">Service Users</td> <td style="text-align: right; padding: 5px;">x<input type="checkbox"/></td> </tr> <tr> <td style="padding: 5px;">Members of the Public</td> <td style="text-align: right; padding: 5px;">x<input type="checkbox"/></td> </tr> <tr> <td style="padding: 5px;">Other (List Below)</td> <td style="text-align: right; padding: 5px;"><input type="checkbox"/></td> </tr> </table>	Employees	x <input type="checkbox"/>	Service Users	x <input type="checkbox"/>	Members of the Public	x <input type="checkbox"/>	Other (List Below)	<input type="checkbox"/>
Employees	x <input type="checkbox"/>								
Service Users	x <input type="checkbox"/>								
Members of the Public	x <input type="checkbox"/>								
Other (List Below)	<input type="checkbox"/>								



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 which already exists from previous (e.g. from previous engagement) to evidence this impact
	Yes	No	Yes	No	
Race	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Age	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Sexual Orientation	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Disabled People	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Gender	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Transgender People	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Pregnancy and Maternity	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Marital Status	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	
Religion and Belief	<input type="checkbox"/>	<input checked="" type="checkbox"/>	<input type="checkbox"/>	<input checked="" type="checkbox"/>	

<p>Reasoning</p>	<p>Serious Incidents are reported in line with national framework (2013) and are managed anonymously by the commissioner. The benefits of reporting serious incidents are the learning which is shared to help prevent future occurrences and grow knowledge and understanding of patient safety, as well as the individual resolution which may be achieved for a patient or their family, and also the wider learning which can be shared across one or many organisations</p> <p>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.</p> <p>NHS VOY CCG promotes a culture of Equality and Diversity within its organisation and actively monitors themes arising from incidents for any potential discriminatory activity.</p>
<p>If there is no positive or negative impact on any of the Nine Protected Characteristics go to Section 7</p>	

3. Equality Impact Analysis: Local Profile Data

Local Profile/Demography of the Groups affected (population figures)	
General	
Age	
Race	
Sex	
Gender reassignment	
Disability	
Sexual Orientation	
Religion, faith and belief	
Marriage and civil partnership	
Pregnancy and maternity	

4. Equality Impact Analysis: Equality Data Available

<p>Is any Equality Data available relating to the use or implementation of this policy, project or function?</p> <p>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 <i>Protected Characteristics</i> – referred to hereafter as '<i>Equality Groups</i>'.</p> <p>Examples of <i>Equality Data</i> include: (this list is not definitive)</p> <ol style="list-style-type: none"> 1. Application success rates <i>Equality Groups</i> 2. Complaints by <i>Equality Groups</i> 3. Service usage and withdrawal of services by <i>Equality Groups</i> 4. Grievances or decisions upheld and dismissed by <i>Equality Groups</i> 5. <i>Previous EIAs</i> 	<p>Yes <input type="checkbox"/></p> <p>No <input type="checkbox"/></p> <p>Where you have answered yes, please incorporate this data when performing the <i>Equality Impact Assessment Test</i> (the next section of this document).</p>
<p>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</p>	
<p>Promoting Inclusivity How does the project, service or function contribute towards our aims of eliminating discrimination and promoting equality and diversity within our organisation</p>	

5. 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 <i>Genuine Determining Reason</i> exists
Gender (Men and Women)				
Race (All Racial Groups)				
Disability (Mental and Physical)				
Religion or Belief				
Sexual Orientation (Heterosexual, Homosexual and Bisexual)				

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 <i>Genuine Determining Reason</i> exists
Pregnancy and Maternity				
Transgender				
Marital Status				



Age				
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6. 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:



7. Equality Impact Analysis Findings

Analysis Rating:	<input type="checkbox"/> Red	<input type="checkbox"/> Red/Amber	<input type="checkbox"/> Amber	xGreen
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		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 <i>Protected Characteristics</i> . 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 which 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 <i>Protected Characteristics</i> . 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 <ul style="list-style-type: none"> • 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 which 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 <i>Protected Characteristics</i> . However, a genuine determining reason exists which justifies the use of this policy and further professional advice. <i>[Insert what the discrimination is and the justification of the discrimination plus any actions which could help what reduce the risk]</i>



Equality Impact Findings (continued):

		Actions	Wording for Policy / Project / Function
<p>Amber</p> <p>Adjust the Policy</p>	<p>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 <i>Action Planning</i> section of this document.</p>	<p>The policy can be published with the EIA</p> <ul style="list-style-type: none"> • 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. 	<p>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 <i>Action Planning</i> section of this document.</p> <p><i>[Insert what the discrimination is and what work will be carried out to reduce/eliminate the risk]</i></p>
<p>Green</p> <p>No major change</p>	<p>As a result of performing the analysis, the policy, project or function does not appear to have any adverse effects on people who share <i>Protected Characteristics</i> and no further actions are recommended at this stage.</p>	<p>The policy can be published with the EIA</p> <p>Another EIA must be completed if the policy is changed, reviewed or if any discrimination is identified at a later date</p>	<p>As a result of performing the analysis, the policy, project or function does not appear to have any adverse effects on people who share <i>Protected Characteristics</i> and no further actions are recommended at this stage.</p>



Brief Summary/Further comments	
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Approved By		
Job Title:	Name:	Date:



Appendix 6

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 VoY 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		14 February 2014		
Completed by		Liz Vickerstaff		
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 for all groups?	1	Use of teleconference facilities for meetings	
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	0		

	<p>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</p>			
Facilities Management	<p>Will it reduce the amount of waste produced or increase the amount of waste recycled? Will it reduce water consumption?</p>	1	All documentation processed electronically, and meetings conducted using “e” technology.	
Workforce	<p>Will it provide employment opportunities for local people? Will it promote or support equal employment 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?</p>	0		
Community Engagement	<p>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?</p>	0		
Buildings	<p>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</p>	0		



	<p>transport (choice of mode of transport, reducing need to travel)?</p> <p>Will it provide sympathetic and appropriate landscaping around new development?</p> <p>Will it improve access to the built environment?</p>			
Adaptation to Climate Change	<p>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 weather extremes)?</p>	0		
Models of Care	<p>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?</p> <p>Will it promote prevention and self-management?</p> <p>Will it provide evidence-based, personalised care that achieves the best possible outcomes with the resources available?</p> <p>Will it deliver integrated care, that co-ordinate different elements of care more effectively and remove duplication and redundancy from care pathways?</p>	0		



Appendix 7
Bribery Act 2010 Guidance and Bribery Prevention Checklist

Areas for action	Expected Action	Evidence of Compliance/Assurance
1. Governance and Top Level Commitment	<p>The Chief Executive should make a statement in support of the anti-bribery initiative and this should be published on the organisation’s website.</p> <p>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.</p>	
2. Due Diligence	<p>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.</p>	



Areas for action	Expected Action	Evidence of Compliance/Assurance
3. Code of conduct	<p>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.</p> <p>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.</p>	
4. Declaration of Interests/Hospitality	<p>The organisation should have in place a declaration of business interests/gifts and hospitality policy which clearly sets out acceptable limits and also a mechanism to monitor implementation.</p>	
5. Employee employment procedures	<p>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.</p>	
6. Detection procedures	<p>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.</p>	
7. Internal reporting procedures	<p>The organisation should have internal procedures for staff to report suspicious activities including bribery.</p>	



Areas for action	Expected Action	Evidence of Compliance/Assurance
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.	
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.	<p>"Never Event" Serious Incidents</p> <p>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.</p> <p>Never Events are clearly described in National Framework for SIs, and trusts required to declare these on STEIS.</p> <p>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.</p> <p>Organisational Integrity</p> <p>Organisations are required to declare Serious Incidents and Incidents. Organisations also investigate Serious Incidents and Incidents using internal investigators.</p> <p>These requirements present a very low level of risk to the CCG.</p>
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.	



Areas for action	Expected Action	Evidence of Compliance/Assurance
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.	
13. Internal and External communications	<p>The organisation should publicise the NHS Fraud and Corruption Reporting Line (FCRL) and on-line fraud reporting facility.</p> <p>The organisation should publicise the Security Management role (theft and general security issues) and reporting arrangements.</p> <p>The organisation should work with its stakeholders in the public and private sector to help reduce bribery and corruption in the health industry.</p>	
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.	



Areas for action	Expected Action	Evidence of Compliance/Assurance
15. Monitoring: <ul style="list-style-type: none"> • Overall Responsibility • Financial/Commercial Controls 	<ul style="list-style-type: none"> • 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. 	

