NHS
Liverpool
Clinical Commissioning Group

Serious Incident Reporting and Management Policy

Version	1.0
Ratified by	The Quality Safety and Assurance Committee
Date ratified	02 October 2018
Name of originator/author	Jan Lloyd Senior Clinical Quality and Safety Manager
Executive Lead	Jane Lunt Chief Nurse
Date issued	12 October 2018
Review date	October 2021
Target audience	Organisation Wide Policy

Any changes to this policy should be outlined and recorded in the version control table below. In the event of any changes to relevant legislation or statutory procedures or duty this policy will be updated to ensure compliance without approvals being necessary.

Version no.	Type of change	Date	Description of change

To be read in conjunction with the following documents/references:

Document
NHS England Never Events Policy 2018
NHS England Serious Incident Framework, 2015
Learning from deaths: Guidance for NHS trusts on working with bereaved families and carers
National Guidance on Learning from Deaths: A Framework for NHS Trusts and NHS Foundation Trusts on Identifying, Reporting, Investigating and Learning from Deaths in Care
Health and Social Care Act 2008
Liverpool CCG Incident Reporting Policy (v2; February 2018)

Equality Impact Assessment

This policy has been screened to ensure that there is no discrimination on the basis of race, colour, nationality, ethnic or national origins, religious beliefs gender, marital status, age, sexual orientation or disability.

NHS
Liverpool
Clinical Commissioning Group

Contents

1.0 Executive Summary

1.1 Serious incidents (SI) requiring investigation in healthcare are rare, but when they do occur, everyone must make sure that there are systematic measures in place to respond to them. These measures must protect patients and ensure that robust investigations are carried out. When an incident occurs it must be reported to all relevant bodies.

1.2 The 7 key principles in managing Serious Incidents are as follows:

- Open & Transparent
- Preventative
- Objective
- Timely & Responsive
- Systems based
- Proportionate
- Collaborative

1.3 The fundamental purpose and principles of Serious Incident management is to learn from incidents to prevent the likelihood of recurrence of harm by:

- Having a process, procedures and ethos that facilitate organisations in achieving this fundamental purpose;
- Clarity on key accountabilities of those involved in Serious Incident management, which is to support those affected including patients, victims, their families and staff and to engage with them in an open, honest and transparent way;
- Recognition of key organisational accountabilities where the provider is responsible for their response to Serious Incidents and where commissioners are responsible for assuring this response is appropriate.

1.4 This policy establishes a clear approach to the handling of an incident defined as a serious incident (SI). It contains the minimum reporting requirements expected by NHS Liverpool Clinical Commissioning Group (LCCG) in line with the principles laid out in the NHS England Serious Incident Reporting and Never Event Frameworks (2015 and 2018).

1.5 Underpinning this process is a system of good governance that promotes a culture of openness and an attitude that facilitates learning from all incidents. This should include prompt reporting, appropriate and

robust investigation, action planning, learning and follow-up, and where necessary, communications management.

2.0 Introduction

2.1 This policy is based on the NHS England Serious Incident Framework published in March 2015. Organisations providing NHS funded care in England are required to demonstrate accountability for effective governance and learning following a Serious Incident or Never Event. Serious incidents in healthcare are relatively uncommon, but when they occur the National Health Service (NHS) has a responsibility to ensure there are systematic measures in place for safeguarding people, property, NHS resource and reputation. This includes the responsibility to learn from these incidents to minimise the risk of reoccurrence (NPSA, 2010).

2.2 NHS England has provided a clear framework to ensure consistency across the reporting and the management of SIs. The purpose of this policy is to outline the overarching governance arrangements for the management of Serious Incidents and/or Never Events occurring within LCCG providers.

2.3 NHS Liverpool CCG is committed to the commissioning of high quality care and services and the achievement of a high standard of health, safety and welfare at work for all its employees and others visiting, engaged in or affected by its activities and services.

2.4 This policy supports openness, trust, continuous learning and service improvement from SI reporting, monitoring and learning from incidents.

2.5 NHS Liverpool CCG makes explicit in its contracts with all providers its expectations regarding serious incident reporting and management, the indicators and the process for performance management.

2.6 The role of NHS Liverpool CCG in dealing with Serious Incidents is to ensure that:

- Serious incidents are thoroughly investigated
- Duty of Candour is applied appropriately
- Providers take appropriate action to ensure they effectively support, communicate and engage with families following a death of someone in their care.

- Action is taken where necessary, to improve clinical quality and patient safety
- Lessons are learned in order to minimise the risk of similar incidents occurring in the future and that learning is shared across the wider health community
- Independent investigations are commissioned where appropriate

3.0 The Scope of this Policy

3.1 This policy relates to Liverpool CCG and all LCCG commissioned services (including primary care)

3.2 This policy is designed to help providers take appropriate steps in the best interests of their service users, staff and the NHS as a whole. It contains the minimum reporting requirements expected by NHS Liverpool CCG.

3.3 This policy does not replace the provider duty to have a serious incident policy and reporting system in place or the requirement to inform other relevant authorities of serious incidents as required. Where regulated activities take place, registration with the Care Quality Commission and compliance with Essential Standards of Quality and Safety are required.

4.0 Roles and Responsibilities

4.1 Providers of LCCG Commissioned Services

Are responsible for ensuring they have appropriate governance arrangements in place to support the effective and timely reporting, investigation and management of serious incidents as per the NHS England Serious Incident Framework (2015)

4.2 The Chief Officer of LCCG

The Chief Officer for Liverpool CCG has overarching accountability and responsibility for ensuring that the organisation has the necessary management systems and processes in place to enable the effective performance management of Serious Incidents

4.3 The Chief Nurse of LCCG

The Chief Nurse has delegated responsibility from the Chief Officer for the performance management of SIs and the implementation of/compliance with this policy. The Chief Nurse has lead responsibility for ensuring and monitoring effective management of SIs and for assuring the Governing Body in relation to risk mitigation strategies and

the effective governance of learning following individual and aggregated SIs.

The Chief Nurse also has responsibility for any required engagement/liaison with NHS England (or other external body such as the Care Quality Commission, Monitor and media) as required in relation to the notification of SIs or providing assurances that the requirements of the policy are being met.

4.4 The LCCG Quality Team

The CCG Quality Team assumes responsibility for the overall management of SIs and for reporting position statements and aggregated risks to the CCG Quality Committee and/or Governing Body as appropriate. The Quality Team will ensure that all reporting is undertaken within agreed timescales. Although the Quality Team can assist in and advise on individual SI investigations, the primary responsibility for completion of RCA reports within the agreed timescale rests with the reporting provider organisation.

4.5 Liverpool CCG Clinical Safety and Serious Incident Group

The CCG's Serious Incident Panel acts under delegated authority of the Quality, Safety & Outcomes Committee as a line of assurance and specialist advice in supporting the CCG in the discharge of its responsibilities for the performance management of SIs. The Clinical Safety and Serious Incident Group will make recommendations for the closure of SIs/Never Events once it is satisfied that the SI has been investigated thoroughly and that there are no further risks posed to patient/staff safety or that any risks have been mitigated.

Additional expertise, knowledge and experience will be utilised depending upon the type of service reporting the incident/event and the type of event reported. The CCG will ensure that the Group has sufficient knowledge and experience of the subject matter to enable an objective assessment of the adequacy of the scope of the review and subsequent review report, together with any recommendations made.

Should any aspect of service quality/safety raise concerns as a result of the review of a RCA investigation report, the Group will be responsible for agreeing the actions required to rectify the issue (i.e. referral to the Quality Safety and Outcomes Committee if there are wider performance concerns).

4.6 Quality, Safety and Outcomes Committee (QSOC)
Whilst the Governing Body retains overall responsibility for oversight and assurance of the SI management process, the CCG Quality, Safety and Outcomes Committee will act as the responsible committee for monitoring the effective application and compliance of this policy and associated processes.

4.7 Quality Surveillance Group (QSG)
The Quality Surveillance Group is hosted/chaired by NHS England and can support the triangulation of data, quality related information and incident report responses where SIs (or trends) give cause for concern. The QSG will be attended by the CCG's Chief Nurse and any information shared will be for the purpose of formulating an appropriate response (e.g. triggering a Risk Summit or maintaining a regular review of providers).

5.0 Definitions
5.1 There is no definitive list of incidents that constitute an SI, although StEIS (Strategic Executive Information System) does include a list of types of incident for ease of categorisation. The following is the criteria stated in the framework:

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
    - 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
    - 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

  - 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.
- 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
  - Activation of Major Incident Plan (by provider, commissioner or relevant agency)
- Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation

5.2 As a minimum, patient safety incidents leading to unexpected death or severe harm should be investigated to identify root causes and enable improvement action to be taken to prevent recurrence. The definition of SIs requiring investigation extends beyond those which affect patients directly, and includes incidents which may indirectly impact patient safety or an organisation's ability to deliver on-going healthcare. All serious patient safety incidents should be reported to the NRLS and to notifiable partner organisations.

5.3 Definitions of key types and levels of harm

- NHS-funded healthcare: all services providing NHS funded care including independent providers where NHS funded services are delivered.
- Serious Harm: Severe harm (patient safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care):
    - Chronic pain (continuous, long-term pain of more than 12 weeks or after the time that healing would have been thought to have occurred in pain after trauma or surgery); or
    - Psychological harm, impairment to sensory, motor or intellectual function or impairment to normal working or personal life which is not likely to be temporary (i.e. has lasted, or is likely to last for a continuous period of at least 28 days).
- Unexpected/avoidable death: caused or contributed to by weaknesses in care/service delivery (including lapses/acts and/or omission) as opposed to a death which occurs as a direct result of the natural course of the patient's illness or underlying condition where this was managed in accordance with best practice.
- Homicide by a person in receipt of mental health care includes those in receipt of care within the last 6 months but this is a guide and each case should be considered individually; it may be appropriate to declare a serious incident for a homicide by a person discharged from mental health care more than 6 months previously.
- Security breach/concern: includes absence without authorised leave for patients who present a significant risk to themselves or the public.
- Patient Safety Incident: any unintended or unexpected incident that could have led or did lead to harm for one or more patients receiving NHS-funded healthcare.
- 'Never Event': Never Events are "serious, largely preventable, patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers (DOH, 2012). Never events are patient safety incidents that are preventable because:
    - there is guidance that explains what the care or treatment should be;
    - there is guidance to explain how risks and harm can be prevented;

- there has been adequate notice and support to put systems in place to prevent them from happening."

6.0 A Just Culture

6.1 A just culture is one in which people are not punished for actions omissions/decisions which are commensurate with their experience and training but where wilful and intentional actions are not tolerated.

6.2 NHS Liverpool CCG recognises that most incidents occur because of problems with systems as opposed to individuals and is committed to a just culture. To foster a just culture, LCCG expects all providers to adopt the principles of just culture. It expects all providers will ensure that no disciplinary action results from the reporting of any adverse event, mistake, serious incident or near miss, except where there has been criminal or malicious activity, professional malpractice, acts of gross misconduct, repeated mistakes or where errors or violations have not been reported. Lessons need to be learned from these events in order that every effort is made to prevent a recurrence.

6.3 As a healthcare system we should try to distinguish between different behaviours and respond appropriately and proportionately to these behaviours. To try to help us understand the differences between errors, risky behaviours and reckless or negligence or criminal intent three definitions are:

- Human error: inadvertent action; inadvertently doing other that what should have been done; slip, lapse, mistake
- Risky behaviour: choices that increase risk, where risk is not recognised or is mistakenly believed to be justified; includes violations and negligence
- Reckless behaviour: behavioural choice, intentional acts, conscious disregard to a substantial and unjustifiable risk

7.0 Duty of Candour

7.1 NHS Liverpool CCG is committed to a culture of openness and accountability and encourages openness and honesty.

7.2 The requirement to comply with the statutory Duty of Candour is explicitly required and is reflected within contracts with providers.

7.3 Duty of Candour is detailed in the Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20. The intention of this regulation is to ensure that providers are open and transparent with people who use services and other 'relevant persons' (people acting

lawfully on their behalf) in general in relation to care and treatment. It also sets out some specific requirements that providers must follow when things go wrong with care and treatment, including informing people about the incident, providing reasonable support, providing truthful information and an apology when things go wrong.

7.4 The regulation applies to registered persons when they are carrying on a regulated activity.

7.5 CQC can prosecute for a breach of parts 20(2) (a) and 20(3) of this regulation and can move directly to prosecution without first serving a Warning Notice. Additionally, CQC may also take other regulatory action.

7.6 Compliance with the requirements of Duty of Candour is monitored by LCCG in several ways as follows:

- By reviewing the initial reports on StEIS
- By reviewing the 72 hour reports
- By reviewing the final report and actions taken
- By reviewing the quality schedule submissions relating to Duty of Candour

7.7 LCCG requires all providers to ensure that they are following the *National Quality Board Learning from deaths: Guidance for NHS trusts on working with bereaved families and carers*. LCCG will monitor compliance via the serious incident reports submitted and the regular reports to the Clinical Quality and Performance Groups (CQPGs) which details how providers support, communicate and engage with families following a death of someone in their care.

8.0 Accountability for Reporting

8.1 Provider Serious Incidents

Providers of LCCG commissioned services are responsible for logging incidents on the Strategic Executive Information System (StEIS) as per the NHS England Serious Incident Framework. Some providers do not have access to StEIS (i.e. Spire Liverpool, care homes, primary care, some independent providers) and therefore any serious incidents in these services, once reported, are logged on StEIS by the LCCG Quality Team on their behalf (as per appendix A).

8.2 Where LCCG is the lead commissioner for the provider they take the lead on SI management. For cases where the patient involved is from another CCG the LCCG Quality Team will notify the patients CCG

Quality Team and will share the report with them for review and comment. For clarity LCCG utilises the RASCI model as defined in the Serious Incident Framework.

8.3 Any incident in another CCG involving a Liverpool patient will be notified to the LCCG Quality Team via the email sui.management@nhs.net. The LCCG Quality Team will also review and provide feedback on the report.

8.4 LCCG Serious Incidents
Any internal incident meeting the SI criteria must be escalated to the LCCG Quality Team for logging on StEIS. The investigation and subsequent production of a Root Cause Analysis (RCA) report is the responsibility of the CCG, sign off and closure of the SI must be carried out by NHS England Sub Region office, however, LCCG will update StEIS prior to any request for closure

9.0 Serious Incident Reporting and Management
9.1 All providers of LCCG Commissioned services are expected to have their own internal policies and procedures that detail how they report and manage serious incidents that occur.

9.2 All serious incidents must be reported on StEIS within 48 hours of identification (this may be after the incident actually occurred or if it is not clear from the outset that the incident meets the criteria for serious incident reporting).

9.3 For never events and potentially high profile incidents LCCG requires providers to contact the Quality Team to inform them of the incident at the earliest opportunity (preferably before reporting on StEIS although this must not be delayed). The contact number to call is: **0151 296 7611**

9.4 The flow chart at appendix A details the process followed by LCCG when an incident is reported on StEIS.

9.5 If more than one organisation is involved in an SI, the organisation that is responsible for the care of the patient at the time of the incident will report the SI on StEIS.

9.6 For a multi organisational RCA providers are expected to work together to investigate and develop a report. Providers should decide between themselves who is best placed to lead the investigation and if

an agreement cannot be reached they should contact the LCCG Quality Team for support and arbitration.

9.7 Where potential media interest exists, NHS Liverpool CCG will develop a media response, with the appropriate stakeholders, based on the available information, this will be shared with NHS England Sub Region to ensure any necessary media management is proportionate and well managed.

9.8 Following notification of a SI, LCCG will liaise with the provider organisation as required to request any additional information/clarify details, confirm the appropriate level of investigation, terms of reference and reports required. An entry will be made onto StEIS to this effect.

9.9 In addition to ensuring entry onto StEIS conforms to the minimum dataset, LCCG Quality Team will ensure that Datix is updated to enable the production of reports and monitoring on behalf of NHS Liverpool CCG as per the Datix SOP.

9.10 All providers will undertake a 72 hour review following the reporting of a serious incident on StEIS. The aim is for an initial incident review to be undertaken by a clinician/manager with relevant expertise which will:

- Identify and provide assurance that any immediate action has been taken to ensure safety of patients/staff/public and identify immediate learning that should be implemented
- Assess the incident in more detail to clarify whether it does meet the reporting requirements of an SI
- Propose a proportionate level of investigation (this must be agreed with the commissioner)

9.11 This report should be sent to the LCCG Quality Team via email to: sui.management@nhs.net

9.12 All actions and correspondence taken by NHS Liverpool CCG will be recorded on StEIS within the Trust/Commissioner section on StEIS under the “Correspondence” or “Comments field”. The initials of the person adding the detail should be recorded against the comments.

10.0 Serious Incident Investigation

10.1 The reporting organisation is responsible for ensuring that all SI are investigated fully and documented. The principles of RCA will be applied to all investigations, but the scale, scope and timescales of investigation will be appropriate to the incident.

10.2 There are three levels of investigation:-

- Level 1 concise: internal investigation for less complex incidents manageable by individuals or a small group at local level
- Level 2 comprehensive: internal investigation for complex issues manageable by a multi-disciplinary team. It can involve experts/specialists and the provider can involve external members to add a level of scrutiny/objectivity
- Level 3 independent: there are two types available: the first is a provider focussed investigation where the provider has been unable to carry out an effective/objective and timely investigation due to the complexity or involvement of other agencies and where significant systemic failures appear to have occurred. There may also be conflicts of interest identified. This investigation will normally be commissioned by the commissioner of the care and undertaken by individuals independent of the provider. The second type is SIs that involves the examination of the roles of wider commissioning systems or configuration of services including multi agency and multiple SIs. Any investigation will be independent of the directly involved commissioners and will usually be led by a regional or centrally led team identified by NHS England

10.3 The levels should be agreed between provider and commissioner within the first 72 hours following the reporting on StEIS. Commissioners may decide to undertake an independent investigation at any stage including following the outcome of a providers own internal investigation.

10.4 The level of investigation may need to be reviewed and can be changed as new information emerges, with the agreement of the commissioner/provider.

10.5 The timescale of the investigation, including notification to NHS Liverpool CCG, in normal circumstances will not exceed the 60 working day deadline (for Level 1 and 2 incidents. Level 3 external investigation may take up to 6 months), and should be completed within the terms of the agreed contract.

10.6 It is not expected that extensions will routinely be required by providers. However, if the reporting organisation faces unavoidable delays in its investigation of a SI then NHS Liverpool CCG should be notified of the reason for the delay, the anticipated delay period and a new reporting timescale will be negotiated on a case by case basis. Agreement of the commissioner must be obtained before the expiry of

the original deadline and any extension will be effective from the date on which the SI Report was originally due.

10.7 If, at any stage during a SI investigation, it becomes apparent that the incident does not constitute a SI it can be downgraded by formal notification, including reasons for downgrading, and agreement with NHS Liverpool CCG. At this point the SI will be removed from StEIS and the LCCG Datix system updated accordingly.

10.8 It is acknowledged that whilst every effort should be made to ensure that all SI investigations are completed in a timely manner, in accordance with the National Framework, there are instances when this is impossible due to circumstances which are beyond the immediate control of the reporting organisation due to issues of primacy. Where unavoidable delays are due to an external party, e.g. where the Police, HM Coroner or Judge has requested that any internal investigation is placed on hold as it may potentially prejudice any criminal investigation and subsequent proceedings. In such cases discussion between the organisation undertaking the investigation and NHS Liverpool CCG are required with the rationale for the request to stop the clock. It is the decision of NHS Liverpool CCG whether or not a SI meets the criteria for a 'stop the clock'. This rationale will be reported on StEIS

10.9 Process for restarting the clock: in order to ensure that RCA investigations progress in a timely manner, once the outcome of the recorded delay is known e.g. outcome of court proceedings, post mortem findings, the provider and NHS Liverpool CCG will discuss the removal of the clock-stop and agree a timeframe for completion of the RCA investigation. This date will then become the timeframe for closure of that incident and an entry made on StEIS. This timeframe whilst negotiated with the provider will be required to be realistic yet prompt in order to ensure timely feedback to the patient/family and closure of the incident.

10.10 For cases of mental health homicide LCCG will follow the guidance in the NHS England Serious Incident Framework 'Regional Investigation Teams: Investigation of homicide by those in receipt of mental health care'

10.11 With regards to Serious Case Reviews and Safeguarding Adult Reviews LCCG will follow the guidance detailed in the NHSE Serious

Incident Framework as well as the guidance from the LSCB and the LSAB.

11.0 Process for Closure and Sign-Off

11.1 Where a SI investigation has been completed and a full investigation report received from the provider including an agreed action plan, NHS Liverpool CCG will list the report for review at the next available Clinical Safety and Serious Incident Group.

11.2 The Clinical Safety and Serious Incident Group process including terms of reference are detailed in appendix B. Two panels operate: one for fall fractures and pressure ulcers (led by the nursing and safeguarding team) and one for all other SI reports.

11.3 The Clinical Safety and Serious Incident Group is a multidisciplinary meeting between LCCG and the provider organisation(s) who undertook the review/report. The pressure ulcer and fall fracture review panel is a nurse led panel with provider representation to present their reports.

11.4 The Groups aim to provide a robust process for the oversight and performance management of serious incidents and never events reported by providers of NHS services commissioned by LCCG. It looks to implement a quality assurance process on behalf of LCCG to ensure policy requirements and responsibilities for patient safety are met by all providers under individual contracting arrangements and to ensure a consistent quality approach that supports and challenges providers' skills in investigating and reporting Serious Incidents

11.5 Providers are invited to present their reports to the Group and answer any queries the Group may have. This process aims to reduce the administrative burden on both the CCG and the providers by seeking assurance at the time of the review. There may be circumstances where the report is deemed unsatisfactory and extra assurance or information is required. This will be sought from the reporting organisation at the Group or they will be asked to provide further assurance post meeting.

11.6 Templates are used for the assessment of SI reports. Two templates are available: one for fall fracture and pressure ulcer reports and one for all other SI reports. A template is completed for each SI report reviewed at the Group and is scanned into the SI meeting folders for reference, assurance and audit purposes. The templates can be found at Appendix C

11.7 Where the SI investigation report is deemed by NHS Liverpool CCG to be complete, the incident will be authorised for closure. The incident will be closed on StEIS by the LCCG Quality Manager. The incident can be closed on StEIS but will only be closed on Datix when LCCG have received a copy of the final completed action plan.

11.8 Providers are required to update StEIS with the RCA outcome including recommendations; actions; lessons learnt; how learning is shared across the organisation and any notable practice. Where there has been a death of the patient, the actual cause of death should be recorded on StEIS.

11.9 Where the SI is subject to a Level 3 (external investigation), closure cannot be effected until evidence is supplied by the provider that all actions have been implemented.

11.10 Assurance will be sought by NHS Liverpool CCG that action plans resulting from a SI investigation are completed within appropriate timescales. The LCCG Datix system will be used to track action plans and the action dates identified in the reports will be used for tracking purposes. An alert will be set on the LCCG Datix system to request a copy of the completed action plan one month after the data the last action was due.

12.0 Governance and Oversight

12.1 NHS Liverpool CCG makes explicit reference within its contracts to its expectation regarding incident reporting and management. To ensure continuous improvement in serious incident management NHS Liverpool CCG has a range of key performance indicators built into provider contracts which it uses for monitoring purposes.

12.2 The Clinical Quality and Performance Group (CQPG) meetings held with providers monitors the provider's SI performance and highlight any concerns in relation to trends, robustness of actions and lack of assurance with regard to quality and safety.

12.3 The Quality, Safety and Outcomes Committee is a sub-committee of the CCG Governing Body and receives information and assurance regarding serious incident management via a quarterly report and ad hoc escalations between these reports as required depending upon the nature of the incidents reported

12.4 LCCG is developing the Datix system in use to capture themes and trends from incidents and has developed a performance report for presentation to each SI panel.

13.0 Dissemination of Shared Learning

13.1 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 NHS funded care. The timely and appropriate dissemination of learning following a serious incident is core to achieving this and to ensure that lessons are embedded in practice.

13.2 Reports are assessed to identify how learning is shared in the organisation where it occurred and also wider. The panel may request wider sharing if deemed appropriate

13.3 The NHS England Cheshire and Merseyside Quality and Safety Forum is a regional meeting where learning can be shared and disseminated across a wide range of providers.

14.0 Monitoring and Review

14.1 This policy will be reviewed by the Quality Team every three years or sooner as required if there is a change to policy or guideline.

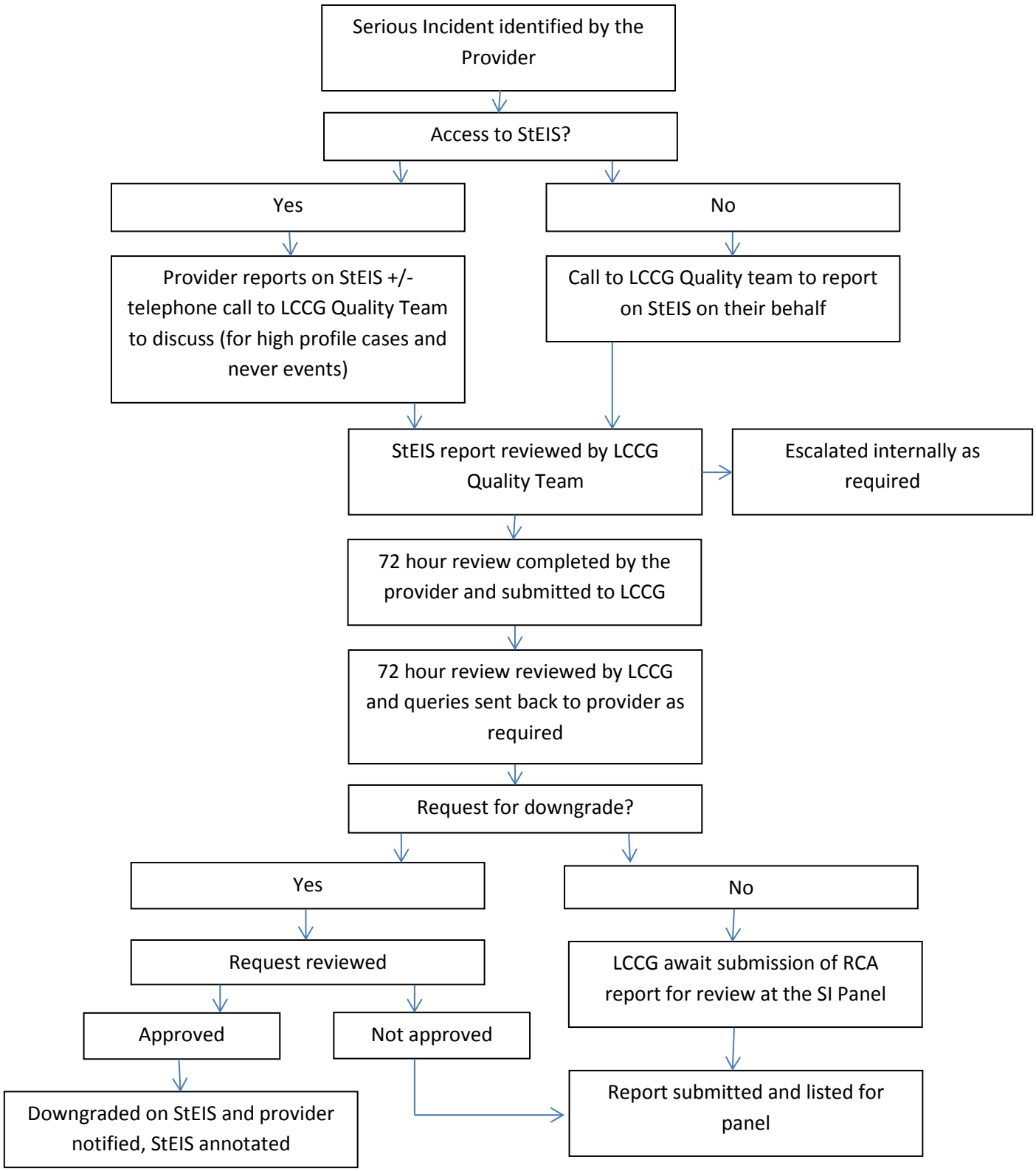
14.2 Compliance with this policy will be demonstrated via the following processes:

- Quarterly reports to the serious incident panel relating to themes and trends identified in the pressure ulcer and fall fracture panels
- The quarterly QSOC reports
- Ad hoc escalations to QSOC detailed in the minutes
- The dashboards presented to the SI panels
- The closure templates completed for each RCA report reviewed at panel
- The performance reports presented to the CQPG meetings detailing individual provider performance

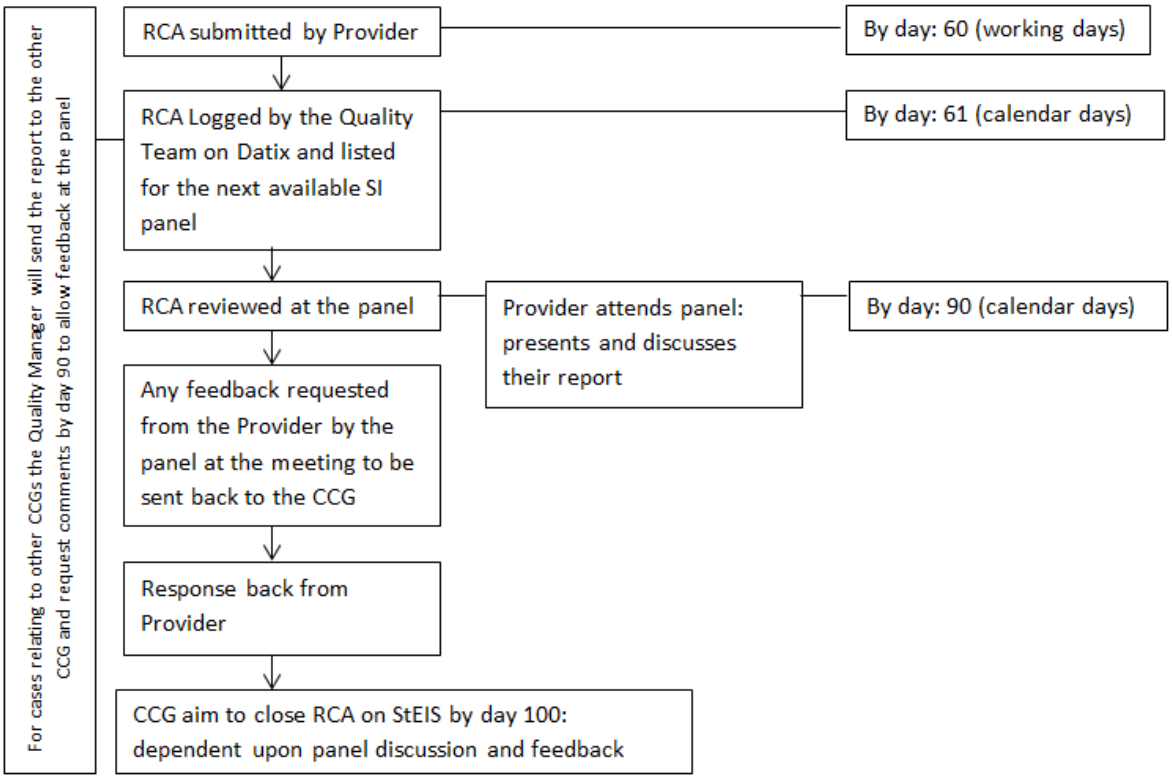
15.0 References and relevant documents

NHS England Serious Incident Framework
http://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf
Revised Never Events policy and framework
https://improvement.nhs.uk/resources/never-events-policy-and-framework/

Appendix A: Serious Incident Process



Appendix B: The SI Panel process including terms of reference



(i) Terms of Reference – LCCG Serious Incident Panel

Terms of Reference
Serious Incident Panel

Purpose

To provide a robust process for the oversight and performance management of serious incidents (SI) and never events (NE) reported by providers of NHS services commissioned by NHS Liverpool Clinical Commissioning Group (LCCG).

To implement a quality assurance process on behalf of LCCG to ensure policy requirements and responsibilities for patient safety are met by all providers under individual contracting arrangements.

To ensure a consistent quality approach that supports and challenges providers' skills in investigating and reporting Serious Incidents.

Responsibilities:

- To review, discuss and approve serious incident reports submitted by providers.
- To ensure lessons are learnt and actions taken to reduce risk from SI and NE
- To ensure recommendations and learning are identified and the recommendations and actions recorded are sufficient to reduce risk and are embedded in the systems of care
- To report, where appropriate, to the Coroner or other professional body or organisation or regulatory authority
- To receive information on lessons learned and identification of trends.
- To identify areas of potential risk to inform future commissioning decisions.
- To identify specialist expertise/advice to reviews as required.
- To provide assurance information to LCCG Governing Body regarding SI and NE via the Quality, Safety and Outcomes Committee (QSOC)
- To escalate unresolved/urgent issues to QSOC and/or Clinical Quality and Performance Groups as appropriate
- To provide assurance to NHSE when requested to demonstrate appropriate, robust performance management processes
- To receive escalations regarding the non-submission of completed action plans.

Scope

The panel will review all SI reports submitted for LCCG commissioned services. Reports submitted for Liverpool patients in services where LCCG is not the lead commissioner will be reviewed outside the SI meeting.

A separate panel for the review of incidents relating to pressure ulcers and fall fractures has been developed by LCCG. These reports are reviewed outside of the main multidisciplinary SI meeting by the clinical nursing team with provider representation at the panel meetings. These reports can be escalated to the main SI panel should the nursing team feel it appropriate.

Membership

The SI panel will be multidisciplinary with membership from the following:

- Chief Nurse or Deputy Chief Nurse (chair)
- Governing Body GP (deputy chair)
- Senior Clinical Quality and Safety Manager
- Clinical Quality and Safety Managers
- Quality Manager
- Safeguarding Representatives
- GP with special interest in serious incidents
- Representatives from other CCGs or Specialised Commissioning where the incident has occurred in a LCCG commissioned service but involving a patient from another CCG locality

The chair of the meeting will be the Chief Nurse, Deputy Chief Nurse or the Governing Body GP.

Representatives from provider organisations will be invited to attend the SI meetings to present their reports. It is the responsibility of the provider organisation to ensure that the staff attending the SI meeting know and understand the reports; the services the reports relate to and are of a senior enough level to be able to provide the CCG with assurance. Other members will be co-opted onto the group as required.

Quoracy

The panel will be quorate with the following present:

- The chair or deputy chair
- 2 members of the quality team

- One representative from safeguarding or one representative of Primary Care

Operational Arrangements

Frequency: the panel will meet on a three weekly basis for 3.5 hours or as required by the numbers and complexity of the reports submitted.

Dates/times: The dates and times of the meetings will be circulated in advance to all providers, members and other CCG colleagues. The agenda will be circulated one week in advance of the meeting. Providers will be given a presentation 'slot' on the meeting agenda. The first 30 minutes of the meeting will be a pre meet for panel members to discuss the reports, previous action notes and performance data which will be provided by the Quality Manager. The remaining 3 hours will be with providers.

Administration: the Quality Manager or representative will take an attendance log and action notes of the meeting, a SI panel closure document will be completed for each SI reviewed at the panel. The Quality Manager will scan each template into the appropriate meeting folder for assurance and audit purposes

Review by other CCG colleagues: when a serious incident report relating to a patient from another CCG locality is received by LCCG it will be sent to the appropriate CCG for review and comment. The email will indicate which panel the report will be reviewed at (the date of the panel) and other CCG colleagues are requested to either submit their comments/feedback to LCCG the day before the appropriate panel or attend the meeting to discuss the report directly with the provider.

Reporting Arrangements

The Serious Incident Panel reports into QSOC. Incidents are escalated as required on an ad hoc basis (depending upon the nature of the incident) and a serious incident report is submitted to QSOC on a quarterly basis.

The Quality Manager presents reports to each multidisciplinary panel outlining current provider performance in relation to Serious Incident Management including themes identified and actions planned.

Review Arrangements:

The TOR will be reviewed annually

Date Approved:

Review date:

NHS
Liverpool
Clinical Commissioning Group

Appendix C: LCCG closure templates

(i) Liverpool CCG Checklist for the review of Pressure Ulcer and Fall Fracture RCAs

Date of Review		Reviewed by		StEIS Number	

	Yes/No	Comments to be sent back to the Trust
Does the report provide a description of the incident and details of the admission history/current period of care		
Does the report detail if the patient was fully assessed on admission to the team/caseload or within 6 hours of admission to a ward		
Does the report detail the ongoing assessments undertaken for the patient whilst admitted/on the caseload		
If yes: do the assessments appear to have been completed as per policy i.e. at least weekly or when the patient's condition changes		
For fall fractures does the report evidence the use of a multifactorial risk assessment taking account of the following: • Walking aids • Call bell (for in patients) • Delirium assessment • Continence care plan • Vision assessment • Medicines review • Lying and standing blood pressure		
If the report indicates that the patient should have been referred onto other members of the MDT i.e. TVNS, SALT, continence etc. were they?		
Does the report detail the information and evidence gathered sources		
Do they include all you would expect them to i.e. Trust policy, patient records, patient assessments, statements, off duty, pictures, training records etc.		
Does the report detail the Trust response under duty of candour		
Is this response appropriate?		
Does the report detail the involvement and support provided for staff involved		

NHS
Liverpool
Clinical Commissioning Group

	Yes/No	Comments to be sent back to the Trust
Is this response appropriate?		
Does the report contain terms of reference		
Do the terms of reference appear appropriate to the incident and include input from family members		
Does the risk scoring (pre and post) appear reasonable and relate to the actual level of harm		
From the list of staff involved in the investigation and development of the report were the most appropriate people involved i.e. for a pressure ulcer: tissue viability and safeguarding or for a fall fracture the falls specialist and possibly safeguarding		
Was the capacity of the patient referenced in the report		
If not should it have been/do you have any concerns over cognition or capacity of the patient involved		
Does the report detail any carers assessments required or carried out		
Should carers assessments have been carried out based on the contents of the report		
Does the report detail what information was supplied to patients and carers		
For reports where the Trust indicates non-compliance/concordance by the patient: does the report detail the actions taken by staff, including the frequency to encourage the patient to comply with the management plan		
Based on the report do you feel a safeguarding referral should have been made		
Was the referral made?		
If the report details notable practice: is the practice notable or just what would be expected for good quality health care		
Where deficiencies in staffing or skill mix are identified in the report: does the report detail the escalation undertaken at the time by staff to ensure safe staffing		
Does the report detail and analyse effectively the care and service delivery problems		
Does the report detail and analyse effectively the associated contributory factors		

NHS
Liverpool
Clinical Commissioning Group

	Yes/No	Comments to be sent back to the Trust
Does the root cause seem appropriate based on the investigation carried out		
Does the report detail the lessons learnt		
Do they appear complete based on the report		
Does the report list the recommendations applicable to the lessons identified		
Do you feel the recommendations identified would reduce the likelihood of recurrence		
Does the report detail how the learning will be shared		
Does the sharing appear to be appropriate i.e. is it being shared too narrowly, should it be shared wider than identified		
Is there an action plan with the report		
Does the action plan detail all of the recommendations previously listed and the actions to mitigate risk		
Which ward/team is this ulcer/fracture linked to		
Have there been previous reports relating to this ward/team with the same type of incident		
If yes please detail the information from the past 12 months		

CCG reviewer comments		
Outcome of review	Approved to be removed from StEIS	
	Approved with no comments back to the Trust; LCCG happy to close on StEIS	
	Not approved: comments to be sent back to the Trust and reviewed before closure agreed	
	Not approved: comments to be sent back to the Trust and report to be resubmitted	

NHS
Liverpool
Clinical Commissioning Group

(ii) SI Panel Incident Review Template

StEIS Number		**Date of Panel**	
Provider			

Criteria For Review			
Does the panel feel the following has been adequately undertaken	**Yes**	**No**	**Comments**
The incident been adequately investigated utilising appropriate sources of information and accessing appropriate people to support the review (including external partners as required)			
Duty of candour has been completed appropriately and within the required timescales			
Staff involved with or affected by the incident have been treated fairly and adequately supported			
Does the report detail any safeguarding concerns and have they been addressed			
Does the listed expertise of the investigation panel reach the breadth of knowledge required for the investigation			
Is the risk score pre and post appropriate to the level of concern detailed in the incident report			
All learning has been captured			
An appropriate root cause been identified			
Other contributory factors been identified and considered			
The report contains details of all of the learning including incidental findings from the review			
The action plan included address all of the recommendations with SMART actions			
The method of sharing the learning across the Trust or wider has been identified			
CCG Feedback			
Feedback/actions required by the provider (will be sent as an email following the panel)			
Has feedback been provided by other CCGs as appropriate	Yes	No	Not applicable

Criteria For Review			
Does the panel feel the following has been adequately undertaken	**Yes**	**No**	**Comments**
If no which CCG is feedback awaited from			
Closure on StEIS agreed by the panel (report will remain open on Datix until the completed action plan is submitted – actions tracked by LCCG to follow up 1 month after the last action due date)	Yes		No