NHS
Herts Valleys
Clinical Commissioning Group

Serious Incident: Reporting and Management Policy

October 2017

V.11

Herts Valleys Clinical Commissioning Group

Checklist for the Review and Approval of Procedural Documents

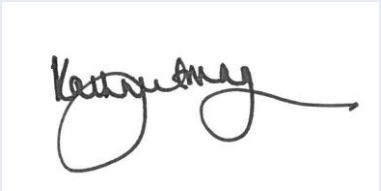
To be completed and attached to any document which guides practices when submitted to the appropriate committee for consideration and approval.

	Yes/No/ Unsure	Comments
Title of Document		**Serious Incident Management Policy and Procedure**
Could this policy be incorporated within an existing policy?	NO	
Does this policy follow the style and format of the agreed template?	YES	
Has the front sheet been completed?	YES	
Is there an appropriate review date?	YES	
Does the contents page reflect the body of the document?	YES	
Are there measurable standards or KPIs to support the monitoring of compliance with and effectiveness of the document?	YES	
Are all appendices appropriate and/or applicable?	YES	
Have all appropriate stakeholders been consulted?	YES	
Has an Equality Impact Assessment been undertaken?	YES	
Is there a clear plan for implementation?	YES	

Has the document control sheet been completed?	YES	
Are key references cited and supporting documents referenced?	YES	
Does the document identify which Committee/Group will approve it?	YES	
Plans for communicating policy to – staff;	YES	

Individual Approval			
If you are happy to approve this document, please sign and date it and forward to the chair of the committee/group where it will receive final approval.			
Name	Clare Saunders, Deputy Director of Nursing and Quality	Date	16.10.2017
Signature		16/10/17	

Committee Approval

If the committee is happy to approve this document, please sign and date it and forward copies to the person with responsibility for disseminating and implementing the document and the person who is responsible for maintaining the organisation's database of approved documents.			
Name	Kathryn Magson	Date	31 Oct 2017
Signature			

DOCUMENT CONTROL SHEET

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KEY CONTACTS

	In-Hours	Out of Hours
CCG	E-mail: hvccgsi@nhs.net Telephone: 01442 284051	SENIOR MANAGER 07881 940243 DIRECTOR 07919 014264
Central Midlands Area Team	E-mail: england.lat-si-alerts@nhs.net Telephone: 0113 824 9601/ 07918 368587	07623 508846

ACRONYMNS

ABO	ABO Blood Groups
AHP	Allied Health Professional
ASMS	Area Security Management Specialist
CCG	Clinical Commissioning Group
CEMACE	Confidential Enquiry into Maternity and Child Health
CQC	Care Quality Commission
DEQ	Directors of Education and Quality
DH	Department of Health
DHR	Domestic Homicide Review
DOLS	Deprivation of Liberty Safeguards
EIA	Equality Impact Assessment
EU	European Union
GP	General Practitioner
HEE	Health Education England
HR	Human Resources
HSAB	Hertfordshire Safeguarding Adults Board
HSCA	Health and Social Care Act
HSCB	Hertfordshire Safeguarding Children's Board
HSCIC	Health and Social Care Information Centre
HSE	Health and Safety Executive
HSIB	Healthcare Safety Investigation Branch
HSWA	Health and Safety at Work Act
HVCCG	Herts Valleys Clinical Commissioning Group
IG	Information Governance
IIRG	Independent Investigations Review Group
LSAMO	Local Supervisory Authority Midwifery Officer
LSMS	Local Security Management Specialist
MCA	Mental Capacity Act
MHRA	Medicines and Healthcare Regulatory Agency
NHS	National Health Service
NRLS	National Reporting Learning Service
PHE	Public Health England
PIA	Privacy Impact Assessment
QRM	Quality Review Meeting
RCA	Root Cause Analysis
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations
SABRE	Serious Adverse Blood Reactions and Incidents
SAR	Safeguarding Adult Review
SCR	Serious Case Review
SHOT	Serious Hazards of Transfusion
SI	Serious Incident

SIRS	Serious Incident Reporting System
SMART	Specific, Measureable, Assignable, Realistic, Time-Related
STEIS	Strategic Executive Information System
TB	Tuberculosis
TDA	Trust Development Authority

1.0 INTRODUCTION

This policy supersedes the CCG's Serious Incident Management Policy and Procedure (2015).

1.1 NHS Herts Valleys Clinical Commissioning Group (HVCCG/the CCG) is committed to ensuring that we commission services that provide high quality care with patient safety as one of its fundamental principles. It is therefore essential that the CCG and our providers have effective processes in place to allow staff to report incidents when patients have, or could be harmed.

Through investigation of incidents and analysing the root cause, there is an opportunity to learn lessons and implement actions to reduce the risk of the incident recurring and ultimately improving patient outcomes. The reporting of incidents, and the subsequent learning, should be regarded as positive by all and NHS England has provided a clear framework about the declaration and management of Serious Incidents (SI). This policy stands alongside NHS England's Serious Incident Framework 2015 and the Revised Never Event Framework 2015. (Appendix 1 – NHS England Serious Incident Framework: 2015 and Revised Never Event Framework 2015).

2.0 PURPOSE

This policy sets out the CCG's process for the reporting and management of SIs and relates to all services commissioned by the CCG and staff employed directly, and working on behalf of the CCG.

The CCG expects all commissioned organisations that provide NHS funded healthcare to incorporate the requirements of this policy into their own organisational policies, as per the requirement within the NHS Standard Contract.

This policy must not interfere with existing lines of accountability and does not replace the duty to inform the police and or other organisations or agencies where appropriate. Furthermore NHS organisations are encouraged to co-operate as fully as possible in investigations by other agencies.

3.0 DEFINITIONS

3.1 Serious Incidents

In accordance with the NHS England SI Framework (2015), SIs are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.

There is no definitive list of events/incidents that constitute a SI. Every incident must be considered on a case-by-case basis using the definitions below which set out the circumstances in which a SI must be declared.

- Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:
    - Unexpected or avoidable death of one or more people. This includes;
        - suicide/self-inflicted death; and
        - homicide by a person in receipt of mental health care within the recent past
    - Unexpected or avoidable injury to one or more people that has resulted in serious harm
    - Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent;
        - the death of the service user; or
        - serious harm
    - Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where;
        - healthcare did not take appropriate action/intervention to safeguarding against such abuse occurring or
        - where abuse occurred during the provision of NHS-funded care
- 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, including cyber security (See Section 5.1.8)
    - Property damage
    - Serious 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 of relevant agency)
- Major loss in confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation.

It may be appropriate for a 'near miss' to be classed as a SI because the outcome of an incident does not always reflect the potential severity of harm that could be caused should the incident (or a similar incident) occur again. This does not mean that every 'near miss' should be reported as a SI but any decision should be based on an assessment of risk that considers:

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

If there is uncertainty about whether an incident meets the SI definition then these should be reported as SIs and an investigation undertaken. Advice can be sought from the CCG's Quality Team on 01442 284051.

3.2 Never Events

Never Events are particular types of SI that meet all of the following criteria;

- They are wholly preventable, where guidance or safety recommendations that provide strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers.
- Each Never Event type has the potential to cause serious patient harm of death. However serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event.
- There is evidence that the category of Never Event has occurred in the past, for example through reports to the NRLS and a risk of recurrence remains.
- Occurrence of the Never Event is easily recognised and clearly defined – this requirement helps minimised disputes around classification and ensures focus on learning and improving patient safety.

The current never event list includes the following;

- Wrong Site Surgery
- Wrong implant/prosthesis
- Retained foreign object post-procedure
- Mis-selection of a strong potassium containing solution
- Wrong route administration of medication
- Overdose of Insulin due to abbreviations or incorrect device
- Overdose of methotrexate for non-cancer treatment
- Mis-selection of high strength midazolam during conscious sedation
- Failure to install functional collapsible shower or curtain rails (mental health)
- Falls from poorly restricted windows
- Chest or neck entrapment in bedrails
- Transfusion or transplantation of ABO-incompatible blood components or organs
- Scalding of patients

For further information regarding the Never Event Policy and Framework 2015, please use the following link (or refer to Appendix 1):
http://www.england.nhs.uk/ourwork/patientsafety/never-events/

4.0 ROLES AND RESPONSIBILIES

4.1 CCG Governing Body

The role of the Governing Body is to ensure it is assured around the quality of commissioned services and holds providers to account in relation to the management of SIs and all associated actions and learning. The CCG's Governing Body will receive a monthly update on SIs as part of the SI report to the Quality Committee. Update relating to the numbers, themes and trends are also included in the monthly SI report.

4.2 CCG Quality Committee

The role of the committee is to be assured that commissioned services are being delivered in a high quality and safe manner; ensuring quality sits at the heart of everything the CCG does.

The committee takes an active role in reviewing and advising on all patient safety issues, and reviewing themes, trends and learning from SIs. The Quality Committee regularly reviews reports that triangulate information from SIs with other intelligence, such as complaints and Quality Alerts. This informs the wider quality agenda and helps to build a picture of the quality of care being provided within the CCG's commissioned services.

4.3 Director of Nursing & Quality

The CCG's Director of Nursing and Quality has overall responsibility for the management of SIs and will:

- Delegate responsibility to (or undertake in the absence of) their deputies and/or relevant specialist leads, the review of all SI investigation reports and action plans, ensuring that they are sufficient
- Liaise with NHS England or any external body as required in relation to the immediate response to the declaration of a SI
- Share intelligence and escalate as determined necessary to NHS England, regulatory bodies and partner organisations

4.4 Quality Team

The CCG's Quality Team has responsibility for the management of SIs and for reporting the collective position of such to the CCG Quality Committee. The Quality Team will:

- On receipt of notification of a SI, notify the relevant personnel as advised by a locally specified internal distribution list
- Ensure that where a provider does not have access to STEIS the incident is recorded on the providers' behalf
- Maintain a robust electronic audit trail for every SI investigation
- Be responsible for liaising with the provider organisation to co-ordinate and monitor the progress of the SI; ensuring that all investigation and reporting is undertaken within the agreed timescale
- Ensure that, if appropriate, the incident is added to the CCG Risk Register
- Co-ordinate the review of all received reports, including those submitted to the CCG's SI Panel, for review and ultimate closure of the SI investigation
- Monitor compliance with Duty of Candour
- Ensure robust investigations are undertaken and appropriate actions identified.
- Report and oversee investigations for SIs occurring within the CCG
- Be the central point of contact for all provider organisations with regards to Patient Safety
- Review provider thematic reviews of SIs. following an identification of a theme or trend by the provider or CCG
- Facilitate learning across the health, and where possible, the social care system
- To alert the CCG Communications Team to any SIs which potentially will attract media attention

4.5 SI Panel

The CCG operates a regular SI Panel that will;

- Review and discuss provider SI investigations; providing appropriate challenge, ensuring the RCA is robust and meets the terms of reference set
- Provide feedback via the CCG's Credibility Checklist Tool (Appendix 2). Make recommendation where appropriate for further elements of investigation to be undertaken prior to submission for closure
- Determine whether sufficient assurance has been provided, including confirmation of completed actions, to agree closure of the SI

For SI Panel Terms of Reference please refer to Appendix 3.

4.6 All Staff

All CCG members of staff have a responsibility to familiarise themselves with the content of the Serious Incident policy and share and act on any provider learning that would impact on the commissioning process. All relevant staff are required to provide specialist knowledge and expertise to the SI panel as required.
This process is separate to the CCGs incident reporting policy which should be read in conjunction with this policy.
Additional policies which should be read in conjunction with this policy are can be found in section 7, associated documentation.

4.7 NHS England

NHS England has a responsibility to ensure that CCGs have appropriate systems in place to manage SIs in commissioned services. As part of this role, NHS has oversight of SI management and is responsible for reviewing trends and identifying areas of concern across the wider healthcare system. NHS England has a duty to provide the healthcare system with intelligence gained through this oversight role and to maintain mechanisms to support this function including local Quality Surveillance Groups.

4.8 Provider organisations

The CCG expects provider organisations to have a robust process and clear governance in place for the reporting and management of SIs which is in line with this policy and the NHS England SI Framework. As part of this the CCG expects all providers to;

- Have a clear process for the identification and reporting of SIs which should include open communication with the CCG if there is indecision about whether an incident meets the SI criteria
- Report all SIs to the CCG within 2 working days of the incident occurring, or being confirmed
- Ensure all SIs meet the full requirements of Duty of Candour which involves early and open engagement with affected patients and/or their families.
- Ensure a 72 hour report is submitted to the CCG within 3 days of the incident being declared
- Ensure investigations are robust and identify the root cause, as well as the contributory factors, human factors and meet the terms of reference set
- Ensure investigations are undertaken by appropriately trained staff that are sufficiently removed from the incident to be able to provide an objective view. A multi-disciplinary approach should occur as appropriate
- Have clear processes in place to ensure reports are submitted to the CCG within 60 days, following appropriate sign off at Director level

- Mechanisms to ensure that appropriate SMART actions are identified; implemented and embedded within the organisation and learning is shared within their organisation and more widely as required

5.0 PROCESS AND MANAGEMENT (see appendix 5)

5.1 SI Process

5.1.1 Reporting of Serious Incidents

SIs must be reported to the CCG's Quality Team and onto STEIS without delay and within two working days of the incident occurring or being confirmed. If there is a delay in reporting the incident, the provider must provide a rationale for the delay. For those organisations without access to STEIS a copy of the STEIS incident form should be completed and forwarded to the CCG's Quality Team who will record on STEIS. If all of this information is not available at the time of reporting it should be updated as soon as possible thereafter.

All SIs involving patient safety incidents must be reported to the National Reporting and Learning Service (NRLS) for the purpose of national learning and to comply with CQC registration requirements regarding the reporting of incidents leading to severe harm or death. This should be done without delay.

If an organisation becomes aware of a SI which occurred at another provider it is expected they will send all relevant information to hvccgsi@nhs.net. The CCG's Quality Team will subsequently contact the relevant provider who will be expected to complete the STEIS form.

If a SI requiring immediate escalation and reporting to the CCG occurs out of hours, the CCG on call management procedures (refer to Overtime, On-Call and Working Time Policy) must be followed. The SI should then be reported on STEIS within 2 working days by the provider.

In addition to reporting the SI on STEIS providers should ensure they have reported the incident to any external organisation where relevant

- Hertfordshire Safeguarding Children's Board: if the serious incident involves a child
- Hertfordshire Safeguarding Adult's Board: if the serious incident involves allegations of abuse or mistreatment of a vulnerable adult
- Health and Safety Executive (HSE): If the incident is reportable under RIDDOR
- Medicines and Healthcare Products Regulatory Agency: If the incident involves a medical device or adverse drug reaction is suspected
- Coroner: If a death has occurred within 24 hours of patient admission or any sudden unexplained death
- Counter Fraud and Security Management Service: If the incident involves physical violence against a member of staff
- Public Health England: If the incident raises severe widespread threats to public health. The local Public Health Team within Hertfordshire are based within Hertfordshire County Council
- Report to the police if criminal activity is suspected

If an external inquiry is required, this will need to be agreed in line with relevant national guidance. The responsibility for commissioning an external inquiry depends on the nature of the incident. See appendix 8 for further details on interested bodies.

5.1.2 COMPLIANCE WITH DATA PROTECTION ACT

The CCG, and its provider organisations, must comply with the Data Protection Act. When reporting a SI, investigation reports must not contain names or patient identifiable information and any such reports will be returned to the provider to anonymise before the CCG will accept the document.

It is the responsibility of the investigating organisation to securely retain the investigation for 30 years. Any information shared between provider and commissioner needs to be sent securely.

5.1.3 CCG SERIOUS INCIDENT PROCESS – 72 hour report

- *CCG Process*

Following the declaration of the SI, the provider should undertake an initial review of the incident and provide the CCG with a report within 72 hours of the incident being reported. This report as a minimum should:

- Identify and provide assurance that any necessary immediate action to ensure the safety of staff, patients and the public is in place
- Assess the incident in more detail (and to confirm if the incident does still meet the criteria for a serious incident and therefore does require full investigation)

The CCG will review the 72 hour report and provide feedback to the provider if immediate assurance is required.
The level of RCA investigation will be determined by the nature of the incident and should be adapted accordingly.

1. **Concise Internal Investigation**: Less complex incidents should be managed by individuals or a small group at a local level. The investigation outcome should be submitted in a concise report to the CCG within 60 working days of the incident being reported.
2. **Comprehensive Internal Investigation**: Complex incidents should be conducted by an investigation team or multi-disciplinary team with the potential to include specialist investigators. The investigation outcome should be submitted in a comprehensive report to the CCG within 60 working days of the incident being reported.
3. **Independent Investigation**: Such an investigation may be commissioned if the potential causes of the incident warrant independent scrutiny in order to ensure the root cause is identified and appropriate action taken. If an independent investigation has been commissioned then the case deadline is 6 months from the date the investigation commenced.

All provider RCA reports should include confirmation of the Director who authorised the report.

The investigation report will be reviewed by the CCG's Quality Team and feedback provided within 20 working days.

Once an investigation has been agreed for closure, the CCG will update the root causes and lessons learnt section of STEIS. This information should include key details of the investigation including root causes and recommendations and actions.
Please refer to Appendix 4 for investigation templates.

Special dispensation may be given enabling NHS providers to undertake more detailed RCA or Panel Review investigative processes. Deadlines for these investigations will be agreed at the start of each process and must be adhered to. For any overdue provider reports and action plans, the CCG will implement the internal escalation process. Please see Appendix 6 for further details. Failure to meet CCG agreed timeframes may result in a performance related penalty being applied in line with the NHS Standard Contract.

- *Clock Stop*

For cases which are subject to an external investigation a clock stop must be requested by the provider. This would include investigations such as:

- Independent homicide investigations
- Domestic Homicide Reviews
- Coroner's investigation
- Safeguarding investigation
- Child death review
- Police investigation
- Prison Ombudsman
- HSE investigation

- *Action Plans*

Actions plans must be SMART: specific, measurable, attainable, relevant and time-bound and should be relevant to the investigation report and target identified areas in order to significantly reduce the risk of incident recurrence. A responsible person must assigned responsibility for the implementation of each action with a clear deadline for completion.

- *Review of RCA Reports/ SI Panel*

Submitted investigation reports will be reviewed by the CCG's Quality Team, and appropriate individuals as required. SI investigation reports will be discussed and reviewed by the CCG's SI and closure panel. Both processes of review will determine whether further investigation is required or the case can be closed. Please see Appendix 3 for more information regarding the CCG's SI Panel.

Where concerns are identified regarding the quality of RCAs, these will be fed back to the provider and escalated to the relevant Director where required.

- *Closure*

Once a completed action plan is received with any relevant evidence of implementation, and no further investigation is required, the CCG will complete a closure form which will be signed by the CCG's Deputy Director of Nursing and Quality or designated Lead. Confirmation will be sent to the provider once the case has been closed on STEIS.

- *Multiple agency SIs*

If there are multiple organisations involved in a SI it is expected that the organisation who first became aware of the SI will report on STEIS. Where required the CCG will assist with

ensuring all relevant organisations are involved and agree who will lead the SI, and who will be responsible for ensuring Duty of Candour requirements have been adhered to.

For incidents involving multiple agencies, the CCG may decide to facilitate and co-ordinate a joint investigation and if required, Chair a SI co-ordination meeting at the beginning of the process to agree Terms of Reference. All organisations will be expected to contribute to the process and subsequent investigation. The CCG will be responsible for monitoring the completion of the action plan.

If the incident is less complex and input is required from an additional provider, the CCG expects for the investigating provider to lead the investigation with support from the CCG.

In situations related GP contact, GP reports may be requested by the CCG and shared with provider organisations involved.

Where a SI crosses the boundary of two or more CCGs, the CCGs concerned will liaise to ensure all are notified; a lead CCG is identified and a timescale is locally agreed. The lead CCG will be identified based on the main geographical location and service area where the SI occurred or in certain circumstances the residential original of the person(s) involved.

- *Associate Commissioner SIs*

Where an SI relates to non-HVCCG patient, details of the SI will be forwarded to the relevant commissioner.

5.1.4 **Extensions**

Timescales for report submission and review will be in accordance with the NHS England Serious Incident Framework 2015 and will be monitored by the CCG. Extension requests should be submitted in a timely manner as soon as the requirement is known and agreed on a case-by-case basis.

Unless there are very exceptional circumstances, extensions will not be granted where;

- There is a failure by the provider to co-ordinate internal discussions
- There is an inability to obtain an executive sign off
- The request is submitted 72 hours prior to the submission deadline

Extension requests must be completed using the extension request form (Appendix 7) and must be made by the provider organisation's Patient Safety Team no less than three working days before the deadline. The request will be reviewed by a senior member of staff from the CCG's Quality Team to make review the request and make a decision.

5.1.5 **Assurance regarding completion of actions and embedded learning**

The CCG will monitor performance in relation to the SI process and seek assurance through the following means:

- Provider Quality Review Meetings: The CCG will monitor progress made, implementation of action plans and review outcomes with the provider. Themes and trends of SIs will also be discussed at this forum for commissioner assurance and any further action required.
- Quality Assurance Visits: The CCG will use intelligence from SI investigations to inform provider Quality Assurance Visits and use this opportunity to seek assurance that specific actions have been implemented and embedded within the organisation.

The Clinical Quality Lead meets informally with provider Patient Safety Teams to review processes and seek assurance in relation to actions and learning. Occasional attendance at provider SI panel also occurs.

5.1.6 Duty of Candour

Any SI investigation should adhere to the Being Open principles and the NHS contractual Duty of Candour requirements in line with CQC Regulation 20, whereby affected patients and/or their families and carers should expect openness and honesty from the investigating organisation. Effective communication with those affected should commence as soon as the incident is identified. The NHS Standard Contract requires that the notification must be within 10 working days of the incident being reported to local systems and sooner where possible. The CCG expects all communication to be open, honest, compassionate and prompt.

The needs and expectations of the person(s) affected should be the fundamental basis of the investigation Terms of Reference and the investigation should seek to address all areas of concern. Patients and/or their families should be provided with a single point of contact and be kept updated throughout the investigation process.

The investigation report should fully detail the efforts the organisation has taken to ensure Duty of Candour has been adhered to.

5.1.7 Independent Sector

Any SI involving a patient in receipt of NHS-funded care provided by an independent sector healthcare provider must be reported by that provider to the commissioning organisation with responsibility for the contract. The CCG will then report the SI on the STEIS system on behalf of that organisation and monitor the investigation as per the normal process.

Independent sector healthcare providers should report the incident to the NRLS and are also responsible for reporting the incident directly to the CQC.

5.1.8 Special Circumstances

The following more specific incident types should generally be regarded as SIs and be rapidly escalated under the SI process. In addition the incidents may require further attention in respect of other processes applied. These incidents are likely to be closely scrutinised by CCGs and Area Teams due to the nature of their severity and sensitivity.

- *LSAMO*

The NMC state in Rule 7 of the Midwives rules and standards that “the local supervising Authority midwifery officer plays a pivotal role in clinical governance by ensuring the standards of supervision of midwives (SOM) and midwifery practice meet those required by the NMC”.
Serious incidents in relation to the role of the SOM and which should be reported to the LSA is defined as an accident or incident when a woman/ and or baby, member of staff or members of the public suffers:

- Serious injury
- Major permanent harm
- Unexpected death or the risk of death or injury
- Where actions or omissions of midwives are likely to cause significant public concern

In addition to the above, the LSAMO requires notification of the following:

- All maternal deaths as defined by the Confidential Enquiry into Maternal Health (CEMH)
- All investigations of midwifery practice being undertaken by a SOM, irrespective of the outcome
- Significant changes in service configuration that may have the potential for an adverse impact on women and babies
- Sustained deficits in midwifery staffing Midwives reported to the NMC by the Health Board or others stillbirths, neonatal deaths and late fetal death
- Unexpected significant morbidity of a mother or baby
    - Major obstetric haemorrhage
    - Eclampsia
    - Renal or liver dysfunction
    - Unexplained/ unexpected cardiac arrest

This is not an exhaustive list and where there are uncertainties the LSAMO should be contacted for advice.

- *Information Governance Incidents*

Where incidents relate to information governance (IG) issues they should be reported in the first instance to the IG Manager. The IG manager will assess the incident using the IG toolkit, in line with the Health and Social Care Information Centre guidance HSCIC Checklist Guidance for Reporting, Managing and Investigating Information Governance Serious Incidents Requiring Investigation and subsequent guidance. The severity of the incident must be assessed using the scale and severity factors outlined within the HSCIC guidance. All incidents which reach the threshold for a level 2 IG related serious incidents are reported publicly via the IG toolkit and should be reported and investigated as serious incidents. Level 2 incidents will be assessed by the SIRO and Caldicott Guardian prior to determining their reporting level.

- *Mental Health Services Incidents Including Homicides Involving Service Users*

An independent investigation may also be commissioned in the event of a homicide by a patient in receipt of mental health care. The reporting/investigation process for these incidents is defined in 3 stages:

1. Providers report an incident onto STEIS and conduct an initial review and produce a 72 hour report
2. Provider conducts an internal investigation and produce an investigation report within 60 days
3. The NHS England Regional Investigation Teams, in conjunction with the Independent Investigations Review Group (IIRG) review these reports and consider commissioning an independent investigation.

Further guidance regarding independent investigations can be found in Appendix 1 of the NHS England Framework 2015.

- *Domestic Homicide Reviews*

When there is a domestic homicide which involves Hertfordshire residents a multi-agency DHR will be undertaken. Providers will be expected by law to contribute to this review where required.

- *Suicides*

Suspected or actual suicide of any person currently in receipt of NHS services on or off NHS premises must be reported as a SI. This includes patients who are currently in receipt of mental health services or who have been discharged within the last 12 months.

- *Safeguarding Adult Reviews*

The Care Act sets out the requirement for Hertfordshire Safeguarding Adult Board (HSAB) to commission a Safeguarding Adult Review in to the involvement of agencies and professionals associated with the adult at risk when an adult with care and support needs dies and it is known or suspected that the death resulted from abuse or neglect, including suicide and there is concern that partner agencies could have worked together more effectively. Also if an adult who has care and support needs has not died but it is known or suspected that the adult has experienced serious abuse or neglect a Safeguarding Adult Review could be commissioned
HSAB will consider commissioning a Multi-agency Serious Incident Review when the above criteria are not met but when a review into the circumstances of a death or serious abuse or neglect can provide useful insights into the way organisations are working together to prevent and reduce abuse or neglect.

Although the HSAB will commission and oversee a SAR, healthcare organisations must be able to gain assurance that an appropriate internal investigation has been undertaken and learning has been identified in the form of a RCA report.

Healthcare providers are required by the HSAB to contribute towards safeguarding reviews. Where it is indicated that a SI within healthcare has occurred, the Clinical Quality Lead will liaise with the Adult Safeguarding Lead to ensure that local safeguarding adult procedures are followed in line with the Serious Incident Review Process, and if necessary, will determine whether the safeguarding incident meets the criteria of a serious incident.

The interface between the SI process and safeguarding procedures must be articulated in the local multi-agency safeguarding policies and protocols.

- *Serious Case reviews*

The Local Authority, via the Hertfordshire Safeguarding Children has a statutory duty to investigate certain types of safeguarding incidents/concerns. In circumstances set out in Working Together to Safeguard Children (2013) the HSCB will commission Serious Case Reviews.
Healthcare providers must contribute towards safeguarding reviews and are required to do so by the HSCB. Where it is indicated that a SI within healthcare has occurred, the necessary declaration must be made.
Whilst the Local Authority will lead SCR's, healthcare must be able to gain assurance that, if a problem is identified, appropriate measures will be undertaken to protect individuals that remain at risk and ultimately to identify the contributory factors and the fundamental issues to minimise the risk of further harm and/or recurrence. The interface between the SI process and safeguarding procedures must therefore be articulated in the local multi-agency safeguarding policies and protocols.

- *Death In Custody*

People in custody, including either those detained under the Mental Health Act (1983) or those detained within the police and justice system, are owed a particular duty of care by relevant authorities.

In NHS mental health services providers must ensure that any death of a patient detained under the Mental Health Act (1983) is reported to the CQC without delay. Providers are responsible for ensuring there is an appropriate investigation into the death of a patient detained under the Mental Health Act (1983) or where Mental Capacity Act (2005) applies. In circumstances where the cause of death is unknown and/or where there is reason to believe the death may have been avoidable or unexpected, i.e. not caused by the natural course of the patient's illness or underlying medical condition when managed in accordance with best practice, including suicide and self inflicted death, then the death must be reported to the CCG as a SI and investigated appropriately. Consideration should be given to commissioning an independent investigation. While the CCG will offer support, the provider organisation, is ultimately responsible for undertaking and managing the investigations and incur the cost for this process. This includes paying for independent investigations of the care the provider delivered and for undertaking its own internal investigations.

- *SIs related to National Screening Programmes*

SIs in the NHS National Screening Programmes must be managed in line with the guidance; Managing Safety Incidents in National Screening Programmes, which is aligned with the principles and processes set out in the Framework. The guidance provides further clarity with regards to the accountabilities, roles and processes for managing screening safety incidents and SIs in National Screening programmes. These are often very complex, multi-faceted incidents that require robust coordination and oversight by Screening and Immunisation Teams working within Sub-regions and specialist input from Public Health England's Screening Quality Assurance Service

5.1.9 Downgrading of Serious Incidents

At any stage during the investigation process evidence may come to light that proves an incident no longer meets the criteria of a serious incident. In this instance the provider must provide the CCG's Quality Team with a clear rationale as to why the incident no longer requires a SI investigation. The rationale will be reviewed by the CCG and if agreed, a request will be made to remove the incident from STEIS.

6. REPORTING/GOVERNANCE

6.1 Governance in Provider Organisations

SIs will form an integral part of clinical governance, contract monitoring and performance management processes. This will be achieved through the CCG Quality Team's regular review of SI's logged with the CCG by providers.

Providers are expected to maintain robust governance arrangements for the management of SIs within their organisations in accordance with Part 2; 3.1 of NHS England Serious Incident Framework (2015).

6.2 RECORDS MANAGEMENT

6.2.1 Retention of Records

Files relating to the investigation of SIs received by the CCG will be retained in an electronic format in a secure location for a minimum of 30 years, as per Records Management NHS Code of Practice Part 2 (2nd Edition) policy Department of Health/Digital Information Policy (2009).

6.3 EQUALITY AND DIVERSITY

The CCG is committed to being an organisation within which diversity, equality and human rights are valued. We will not discriminate either directly or indirectly and will not tolerate harassment or victimisation in relation to gender, marital status, gender reassignment, disability, race, age, sexual orientation, religion or belief, trade union membership, carers status as a fixed-term or part-time worker, socio-economic status and pregnancy or maternity.

6.4 INFORMATION GOVERNANCE

HVCCG works to a framework for handling personal information in a confidential and secure manner to meet ethical and quality standards. This enables NHS organisations in England and individuals working within them to ensure personal information is dealt with legally, securely, effectively and efficiently to deliver the best possible care to patients and clients.

6.5 TRAINING

Managers and staff referred to within the Policy are responsible for ensuring them and their staff, are adequately training to carry out the roles and responsibilities described. The Quality Team will provide training within the CCG as required and provide advice to providers as required.

6.6 POLICY PROCESS

6.6.1 Approval

The policy and subsequent amendments will be approved and ratified by the CCG's Executive Committee as the designated body of the CCG Board. The Policy will be refreshed in September 2018, once the new national SI framework is published. (Expected date for publication is April 2018).

6.6.2 Dissemination and Implementation

The CCG's policy will be communicated via the CCG website and CCG staff will be made aware of the revised Policy via a staff learning session.

6.6.3 Monitoring of Compliance

The Policy Owner is responsible for monitoring compliance with the process and the effectiveness of actions taken, overseen by the CCG Quality Committee.

7. Healthcare Safety Investigation Branch

HSIB became operational on 1st April 2017. Their purpose is to improve safety through effective and independent investigations that don't apportion blame or liability.

The function of HSIB is to:

- Conduct thorough, independent, impartial and timely investigations into clinical incidents
- Engage patients and relatives, NHS staff, and medical organisations throughout the investigation process

- Help the patients and relatives understand 'what happened?' and what's being done to prevent similar events in the future
- Produce clearly written, thorough and concise reports with well-founded analysis and conclusions that explain the circumstances and causes of clinical incidents without attributing blame
- Make safety recommendations to improve patient safety
- Improve patient safety by sharing the lessons learned from investigations as widely as possible
- Raise the standard of local investigations of healthcare safety incidents by establishing common standards and skills development

8. Associated documentation

- Chief Coroner guidance 16A, March 2017
- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20 (Duty of Candour)Hertfordshire Multi-agency Safeguarding Adults from Abuse Policy Hertfordshire
- HVCCG Equality and Inclusion Strategy
- HVCCG Information Governance Policy
- HVCCG Management of Freedom of Information Act Request Policy
- HVCCG Risk Management Strategy
- Safeguarding Children through the Commissioning of Services Policy

Appendix 1: NHS England Serious Incident Framework 2015

NHSE Serious Incident Framework 2

Never Events Policy and Framework FINA

APPENDIX 2: HVCCG Credibility Checklist Tool

Credibility and Thoroughness Checkl

APPENDIX 3: HVCCG CCG SI Panel – Terms of Reference

SI Panel Terms of Reference FINAL_.dc

APPENDIX 4: Investigation templates: 72 Hour Report Template & RCA template

72 hour report template.docx

RCA report template CURRENTdoc.doc

APPENDIX 5: RCA Report Requirements

A Serious Incident Investigation report should address the following areas:

1. **Executive Summary**
   - Brief Incident Description
   - Recommendations

2. **Terms of Reference**
   - Purpose
   - Objectives
   - Key Issues and Scope
   - Key Deliverables

3. **Background**
   - Description of Patient
   - Description of Service
   - Clinical Services Provided to Patient
   - Additional Information such as:
     - Did the patient die as a result of the incident?
     - Were Safeguarding procedures considered/required?
     - Was a Mental Capacity Act assessment considered?
     - Is the incident being reported or investigated externally?

4. **Duty of Candour**
   - Description of Support for Patient
   - Description of Support for Family/Carers/Guardians
   - Description of Support for Staff

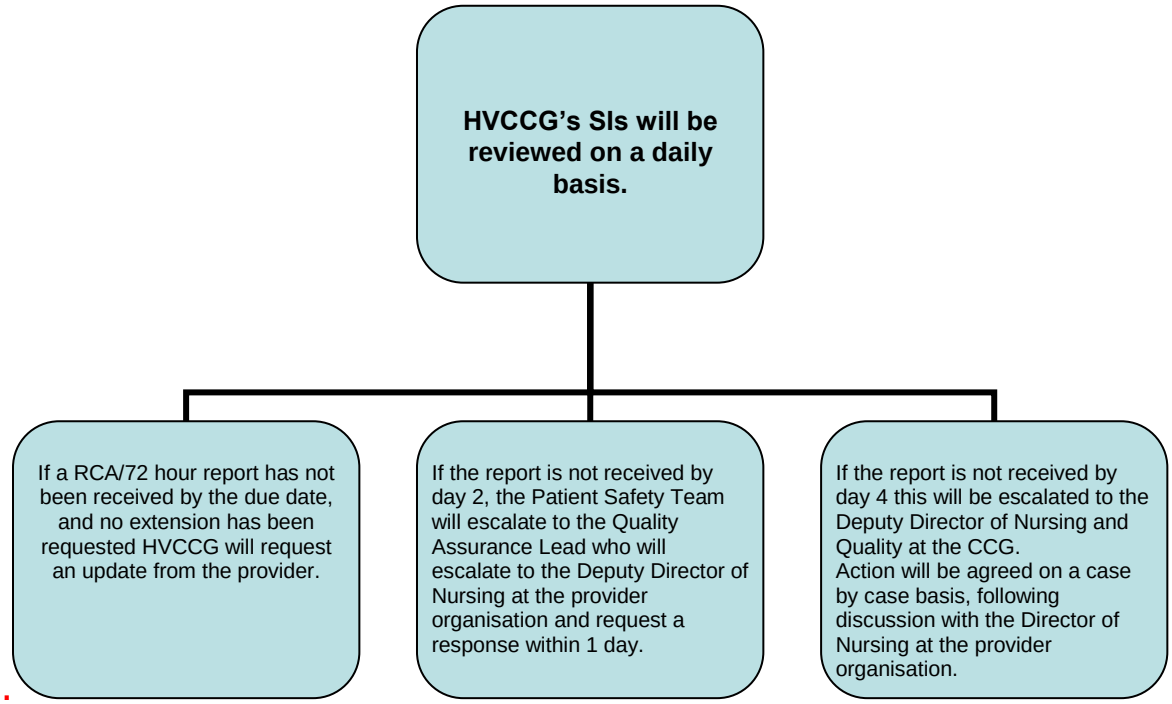
5. **Investigation Report**
   - Investigation Team
   - List of Data Sources
   - Timeline/Chronology
   - RCA Fishbone detailing Contributory Factors, including:
     - Patient Factors
     - Individual Staff Factors
     - Task Factors
     - Communication Factors
     - Team and Social Factors
     - Education and Training Factors
     - Equipment and Resource Factors
     - Working Condition Factors
     - Organisational and Strategic Factors
     - Root Cause

6. **Conclusion**

7. **Recommendations**

8. **Action Plan**

APPENDIX 6: HVCCG Escalation Process



APPENDIX 7: CCG Extension Request Form

Extension request template.doc

APPENDIX 8: Interested Bodies

Serious Incidents must be notified without delay to all relevant bodies via the appropriate routes. Guidance produced by specific bodies should be referred to in order to ensure compliance with their requirements. The CCG should be notified of a SI no later than 2 working days after the incident is identified.

CQC

In accordance with the Health and Social Care Act (HSCA) notification must be made by all services registered under the HSCA. This includes all NHS Trusts, independent healthcare, adult social care, primary dental care and independent ambulance providers.

The way in which notifications are made will depend on their nature and the type of service. The process differs slightly for NHS Trusts than for other providers.

For NHS Trusts, the requirement to report incidents is typically met by reporting incidents to the National Reporting and Learning System. Please refer to the CQC's notification guidance which outlines how each type of notification needs to be made:
http://www.cqc.org.uk/content/notifications

Controlled Drugs

SIs relating to controlled drugs must be reported to the provider's Controlled Drug Accountable Officer.

Coroner

An unexpected death, where there are suspicious circumstances, and all deaths of detained patients, under the Mental Health Act and/or subject to a DOLS (only when requisite conditions are met, in accordance with Chief Coroner guidance 16A, March 2017) must be reported to the Coroner by the treating clinician. This should be done immediately. It is recognised that, following an unexpected death, a SI may not be identified until the issuing of the coroner's report.

Coroners make two sorts of referral to the police:

- For an investigation under the Coroner's Act where the Coroner expects a police offer to investigate the death and prepare a file for the inquest by obtaining witness statements and other evidence.

- For a criminal investigation where the Coroner is concerned that circumstances of the death may involve criminal liability.

Investigating police officers should be clear with the NHS and other organisations when they are acting on behalf of the Coroner to establish the cause of death, rather than investigating a crime. If the matter becomes a criminal investigation, the investigating officer should make it clear to the NHS

organisation and others that the status of the investigation and their role in it has changed.

Defects and Failures

Where incidents relate to a defect or failure involving engineering plants, infrastructure and or non-medical devices, a defect and failure report should also be submitted by the organisation to the Department of Health via the defect and failure reporting portal: http://efm.hscic.gov.uk

Health and Safety Executive (HSE)

The HSE is responsible for the enforcement of the Health and Safety Act at Work Act 1974 (HSWA) and ensuring that "risks to people's health and safety from work activities as properly controlled." SIs may need to be reported under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR). The trigger point for RIDDOR reporting is over 7 days' incapacitation (not counting the day on which the accident happened). Further information on reporting is available at http://www.hse.gov.uk/riddor/report.htm.

Incidents involving work-related deaths (or cases where the victims suffer injuries in such an incident that are so serious there is a clear indication, according to medical opinion, of a strong likelihood death) should be reported under RIDDOR and managed in accordance with the Work-Related Deaths Protocol. In the first instance the incident should be reported within the organisation in the normal way and to the commissioning organisation.

Health Education England

Directors of Education and Quality (DEQ) in Health Education England (HEE) and its Local Education and Training Boards are responsible for the quality of the education and training provided to medical, nursing, dental and Allied Health Professionals (AHP) students and others, and training grade doctors. These students may be involved in SIs and HEE have a duty of care to them. Also they are an excellent source of feedback on the standard of patient care experienced in their placement.

HEE DEQs should therefore be informed about SIs where trainees are involved. The provider should ensure that the responsible DEQ is made aware of the incident as soon as possible. This does not however alter the SI management process which should be undertaken in line with the National Serious Incident Framework.

Care must be taken to ensure all parties understand that notification of SIs involving trainees is focused on supporting those trainees and ensuring the standards of training are appropriate. It is very rare that SIs are the result of individual failings and notifications sent to DEQs are not intended as a comment or judgement on the capability of trainees.

Information Governance SIs, Caldicott and Data Protection

When reporting SIs, providers must comply with Caldicott, data protection and information governance requirements. Where incidents relate to information governance (IG) issues, including cyber incidents, they should be reported within the IG toolkit, in line with the Health and Social Care Information Centre guidance HSCIC Checklist Guidance for Reporting, Managing and Investigation Information Governance Serious Incidents Requiring Investigation (May 2015) and subsequent

guidance.

The severity of the incident must be assessed using the scales and severity factors outlined within the HSCIC guidance. All incidents which reach the threshold for a level 2 IG related SIs are reported publicly via the IG toolkit and should be reported and investigated as SIs under this Framework. SIs relating to IG have to be reported on the NHS SI management system; STEIS, as well as the IG toolkit.

Organisations must be registered to access the HSCIC IG toolkit. Login details will be provided when the organisation undertakes the initial IG assessment which is a dual functionality of the toolkit and providers NHS organisations with a means of self-assessing performance against key aspects of IG. For further information relating to the assessment and reporting process, please refer to the HSCIC guidance or contact your regional IG Lead.

Organisations must be aware that the information reported to the IG toolkit will be published within the public domain. Consequently the transfer to STEIS reports to the IG toolkit is not recommended unless the content has been approved for publication and a separate report is typically required. It is acknowledged that reporting to both the IG toolkit and STEIS represents duplication of reporting however the IG toolkit does not currently provide a mechanism for informing relevant commissioners of IG SIs and so STEIS reporting is required to ensure that information is shared.

Local Authorities

Local authorities are responsible for commissioning specific public health services including health protection, health improvements and population healthcare. Responsibility for the quality of care being provided is recognised by the governance arrangements within the local authority. Local Authority commissioners must use their interactions with health care providers and commissioners to identify any actual or potential quality problems.

As part of the local Quality Surveillance Groups, Local Authorities will share information and a link to the Local Authorities' quality agenda where intelligence should be shared to inform local leadership for quality improvement.

Local Authorities also have a particular role to play in safeguarding adults and children and young people in vulnerable circumstances. Providers and commissioners must ensure that information about abuse or potential abuse is shared with Local Authority safeguarding teams.

The interface between the SI process and local safeguarding procedures must therefore be articulated in the local multi-agency safeguarding protocol and policies. Providers and commissioners must liaise regularly with the local authority safeguarding lead to ensure that there is a coherent multi-agency approach to investigating safeguarding concerns, which is agreed by relevant partners.

Medicines and Healthcare products Regulatory Agency (MHRA)

Organisations should report suspected problems ('adverse incidents') with a medicine or medical device to the MHRA using the Yellow Card Scheme as soon as possible if:

- A medicine causes side effects.
- Someone's injured by a medical device, either because its labelling or instructions aren't clear, it's broken or has been misused.
- A patient's treatment is interrupted because of a faulty device.
- Someone receives the wrong diagnosis because of a medical device.
- A medicine doesn't work properly.
- A medicine is of a poor quality.
- You think a medicine or medical device is fake or counterfeit.

Further details are available at:
http://www.mhra.gov.uk/Safetyinformation/Reportingsafetyproblems/index.htm

Monitor

NHS Foundation Trusts are required to inform Monitor about relevant SIs (i.e. any incidents which may reasonably be regarded as raising potential concerns over compliance with their licence) requiring investigation.

NHS Protect

NHS Protect, through their contractual standards, stipulate that appropriate security management arrangements must be in place. This includes the provider employing or contracting a qualified person to undertake and/or oversee the delivery of the full range of security management work. The qualified person (the Local Security Management Specialist (LSMS)) works with the Area Security Management Specialist (ASMS) to ensure robust arrangements are in place.

The Security Incident Reporting System (SIRS) is an electronic tool which allows NHS health bodies to report security incidents occurring on their premises to NHS Protect, enabling the creation of a national picture of such incidents across the NHS in England, for use in detecting and prevention crime in a national, regional and sector specific context.

Where a SI occurs to a member of staff resulting from a physical or non-physical assault, there is a requirement to report this to NHS Protect via the Security Incident Reporting System (SIRS). The same reporting requirement relates to incidents involving loss or damage to property and assets of NHS organisations, staff and patients.

Users can access an online web portal for incidents to be added or edited, and SIRS can also integrate with local NHS risk management systems to allow a single or bulk upload of records. More information can be found here http://www.nhsbsa.nhs.uk/4247.aspx

NHS Improvement (NHSI)

NHS Trusts should directly inform NHSI of all SIs. NHSI is the operational name for the organisation that brings together Monitor, NHS Trust Development Authority (NHS TDA), Patient Safety including the National Reporting and Learning System, the Advancing Change team and the Intensive Support Teams.

Police

The Police are likely to investigate incidents where there is:

- Evidence or suspicion that the actions leading to harm (including acts of omission) were reckless, grossly negligent or wilfully neglectful.
- Evidence or suspicion that harm/adverse consequences were intended.

In the first instance the incidents should be reported within the organisation in the normal way and to the commissioning body. Referral to the police should be undertaken by a senior member of staff in the reporting organisation.

Professional Regulators and Professional Misconduct

The vast majority of SIs are caused by the failure of systems and not the actions of individuals and this must be recognised by the team handling the investigation. SI management process should be followed and progressed in line with the national Serious Incident Framework even if grounds arise to suggest that a SI may have occurred as a result of 'professional misconduct'. If grounds for professional misconduct are suggested it is important that the appropriate lead (e.g. Responsible Officer/Medical or Nursing Director) within the provider organisation is alerted (within 2 days) to ensure that appropriate action is taken as and when required. Appropriate action includes the investigation and/or HR team taking time to carefully assess or refer on to experts the actions or omissions in question, within the context of the incident, to identify whether these are considered reckless or malicious, as opposed to slips, lapses, or a situation where there are others routinely taking the same route or in need of similar levels of support, supervision or training. System failures are most likely to be at the core of the problem and, the most effective place to target improvements/solution to prevent recurrence.

Information relating to all Statutory Regulators and the process for managing professional misconduct can be found in the statutory regulators directory:
http://www.professionalstandards.org.uk/regulators/statutory-regulators-directory

Public Health England

Managing Safety Incidents in NHS Screening Programmes 2017.
Public Health England (PHE) is responsible for the NHS Screening Programmes and the Screening Quality Assurance Service (SQAS). PHE is an executive agency of the Department of Health and works to protect and improve the nation's health and wellbeing, and reduce health inequalities.The CCG will liaise directly with PHE.

PHE also has a broader role in supporting the management of SIs that occur within other NHS services where there is a potential for the incident to have adversely affected the health of a wider population. Such incidents may include decontamination failures; inadvertent contact on NHS premises of patients and staff with someone with a transmissible infectious disease such as measles or TB; outbreaks of health care associated infections; the finding of a Health Care Worker infected with a blood borne virus; failure of microbiological laboratory practice; release/widespread exposure to harmful chemicals or a source of radiation.

Where the potential exists for the health of a wider group of people to be adversely affected by an incident in the NHS, the responsible NHS provider must contact the relevant Public Health England Centre through their Health Protection Team and involve PHE as part of the local incident control team. Commissioners must work with the providers of services which they directly commission to ensure this is the case. Public Health England will provide expert input to the assessment of population risk and advice on the management of public health aspects of the incident. The local team will draw on regional and national expertise within PHE as necessary.

Serious Adverse Blood Reactions and Incidents (SABRE)

The UK Blood Safety and Quality Regulations 2005 and the EU Blood Safety Directive require that serious adverse incidents and serious adverse reactions related to blood and blood components are reported to the MHRA, the UK Competent Authority for blood safety. This information is vital to the work that the Serious Hazards of Transfusion (SHOT) uses to compile its reports. Further details on reporting can be found at:
http://www.mhra.gov.uk/Safetyinformation/Reportingsafetyproblems/Blood/index.htm

Appendix 9
Equality Analysis – Full Equality Impact Assessment

Title of policy, service, proposal etc being assessed:
Serious Incident Policy

What are the intended outcomes of this work? This policy sets out the process by which HVCCG handles Serious Incidents in line with the underpinning national and legislative context and guiding principles.
How will these outcomes be achieved? By following the process.
Who will be affected by this work? Anyone involved in a Serious Incident

Evidence
What evidence have you considered? Against each of the protected characteristics categories below list the main sources of data, research and other sources of evidence (including full references) reviewed to determine impact on each equality group (protected characteristic). Positive impact on any of the groups below has been identified.
Age Where SI investigation occurs, the impact of age may be considered as part of the overall analysis.
Disability Where SI investigation occurs, the impact of disability may be considered as part of the overall analysis.
Gender reassignment (including transgender) Where SI investigation occurs, the impact of gender reassignment may be considered as part of the overall analysis.
Marriage and civil partnership Where SI investigation occurs, the impact of being married or in a civil partnership may be considered as part of the overall analysis.
Pregnancy and maternity Where SI investigation occurs, the impact of having just had a baby or being pregnant may be considered as part of the overall analysis.
Race Where SI investigation occurs, the impact of race may be considered as part of the overall analysis.
Religion or belief Where SI investigation occurs, the impact of religion or belief may be considered as part of the overall analysis.

Sex Where SI investigation occurs, the impact of sex may be considered as part of the overall analysis.
Sexual orientation Where SI investigation occurs, the impact of sexual orientation may be considered as part of the overall analysis.
Carers Where SI investigation occurs, the impact of carers may be considered as part of the overall analysis.
Other identified groups Where SI investigation occurs, the impact of other identified groups may be considered as part of the overall analysis.

Engagement and involvement
How have you engaged stakeholders with an interest in protected characteristics in gathering evidence or testing the evidence available? This policy follows NHS England guidance.
How have you engaged stakeholders in testing the policy or programme proposals? This policy follows NHS England guidance.
For each engagement activity, please state who was involved, how and when they were engaged, and the key outputs: n/a

Summary of Analysis
There are positive equality impacts identified for any protected characteristic group that may need additional support as a result of their protected characteristic. We will include equalities within our reporting requirements.

Eliminate discrimination, harassment and victimisation
The SI procedure supports the elimination of discrimination, harassment and victimisation. The monitoring of SIs by equality group will support us to identify particular areas of concern or good practice.

Advance equality of opportunity
The SI process supports patients without any impact as a result of a protected characteristic.
Promote good relations between groups n/a

Next Steps
We have identified there are positive equality impact for any protected characteristic group above. Where SI investigation occurs, the impact of the characteristic groups may be considered as part of the overall analysis. This will be evidenced through the Duty of Candour process.