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**Policy for the Management of Serious Incidents Reported by Commissioned Service Providers or the Commissioning Function**

 **26 August 2016**

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| Version: | 1.7 |
| Date ratified: | 26 August 2016 |
| Policy Number  | CL008/08/2017 |
| Name of originator/author: | Tony Moore, Senior Quality Manager - Commissioning |
| Name of Sponsor: | Kevin Clifford, Chief Nurse |
| Name of responsible committee | Quality Assurance Committee |
| Date issued: | August 2016 |
| Review date: | August 2017 |
| Target audience: | All staff working within or on behalf of NHS Sheffield CCG |

**To ensure you have the most current version of this policy please access via the NHS Sheffield CCG Intranet Site by following the link below:**

<http://www.intranet.sheffieldccg.nhs.uk/policies-procedure-forms-templates.htm>

This policy has been reviewed in accordance with Equalities Legislation on race, disability, age, gender, sexual orientation and gender identity, faith and belief.



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| **VERSION CONTROL** |
| **Version** | **Date** | **Author** | **Status** | **Comment** |
| **1.2** | **18th May 2011** | **Head of Quality** | **FINAL** | **Supersedes 1.1** |
| **1.3** | **17 May 2012** | **Senior Quality Manager** | **FINAL** | **Supersedes 1.2** |
| **1.4** | **March 2013** | **Senior Quality Manager** | **FINAL**  | **Supersedes 1.3** |
| **1.5** | **March 2014** | **Senior Quality Manager** | **FINAL** | **Supersedes 1.4** |
| **1.6** | **August 2015** | **Senior Quality Manager** | **FINAL** | **Supersedes 1.5** |
| **1.7** | **August 2016** | **Senior Quality Manager** | **FINAL** | **Supersedes 1.6** |

**Policy Audit Tool**

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

**Please give status of Policy: Revised**

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| **1.** | **Details of Policy** |  |
| 1.1 | Policy Number | CL008/08/2016 |
| 1.2 | Title of Policy: | Policy for the Management of Serious Incidents (SIs) reported by commissioned service providers or the commissioning function |
| 1.3 | Sponsor  | Kevin Clifford |
| 1.4 | Author: | Tony Moore |
| 1.5 | Lead Committee | Quality Assurance Committee |
| 1.5 | Reason for policy: | Good Practice |
| 1.6 | Who does the policy affect? | Sheffield CCG Quality Managers / Leads, Contract and Commissioning Managers, Provider organisations |
| 1.7 | Are the National Guidelines/Codes of Practices etc. issued? | Yes |
| 1.8 | Has an Equality Impact Assessment been carried out? | Yes |
| **2.** | **Information Collation** |  |
| 2.1 | Where was Policy information obtained from? | NHS England Serious Incident framework 2015 and National best practice |
| **3.** | **Policy Management** |  |
| 3.1 | Is there a requirement for a new or revised management structure for the implementation of the Policy? | No |
| 3.2 | If YES attach a copy to this form. |  |
| 3.3 | If NO explain why. | Can be operated under existing structures |
| **4.** | Consultation Process |  |
| 4.1 | Was there external/internal consultation? | Yes |
| 4.2 | List groups/persons involved | Quality Team |
| 4.3 | Have external/internal comments been included? | Yes |
| 4.4 | If external/internal comments have not been included, state why. | N/A |

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| **5.** | Implementation |  |
| 5.1 | How and to whom will the policy be distributed? | Staff will be made aware of all new policies via the Weekly Bulletin. Policies will be available on the intranet. |
| 5.2 | If there are implementation requirements such as training please detail. | In team updating and for new staff, training and supervision required. |
| 5.3 | What is the cost of implementation and how will this be funded | N/A |
| **6.** | Monitoring |  |
| 6.1 | How will this be monitored | By the Quality Assurance Committee |
| 6.2 | Frequency of Monitoring | Annually or as required by National policy and guidance |

1. **Introduction**
	1. **The NHS Constitution states that patients have the right to:**
	* Be treated with a professional standard of care, by appropriately qualified and experienced staff, in a properly approved or registered organisation that meets required levels of safety and quality.
	* Expect NHS organisations to monitor, and make efforts to improve, the quality of healthcare they commission or provide.
	1. Sheffield Clinical Commissioning Group (SCCG) is committed to working with the NHS England (NHSE) Yorkshire and the Humber (NHS Y&H) patient safety team and our Providers to continually improve services for patients.  This includes ensuring that when things go wrong, any incidents are reported and appropriately investigated by the Provider(s) and reviewed by SCCG to show that learning and action designed to reduce or eliminate recurrence has taken place.

1.3 This policy outlines the SCCG’s role and responsibilities for the performance management of Serious Incidents (SIs) reported by Providers

1.4 Also included is the process for where an SI arises within the SCCG Commissioning function.

1.5 It is based on and compatible with the NHSE Serious Incident Framework and guidance (2015): <http://www.england.nhs.uk/ourwork/patientsafety/serious-incident/>

1.6 Providers commissioned by SCCG must ensure that their own procedures for reporting and handling incidents reflect and support this document and that their staff are clear about individual roles and responsibilities.

In addition, Providers must ensure that policies and procedures are in line with the National Police and Crime Commission (NPCC) guide to police investigations of unexpected deaths and serious harm in Healthcare settings

<http://library.college.police.uk/docs/NPCC/2015-SIO-Guide-Investigating-Deaths-and-Serious-Harm-in-Healthcar-Set.pdf>

1.7 SCCG is responsible for the performance management of SIs at all Sheffield NHS and Independent Providers, that undertake NHS funded care.

Note that there is a Memorandum of Understanding with the NHS Y&H that SCCG will act as co-ordinating Commissioner where an incident at a Sheffield Provider also involves a Specialised Commissioned service.

1.8 SCCG will involve and liaise with any other co-commissioning CCG at all relevant stages, where an incident affects a patient from outside of Sheffield.

1.9 Note that for any SI arising in a GP practice, it has been agreed that the lead for performance management will be NHS England. NHSE will notify SCCG of any GP SI and will liaise with SCCG throughout the period of management. This includes any GP related screening SI.

1.10 The policy covers:

* + SCCG’s internal process for the management of SIs
	+ Contractual obligations
	+ Initial action and reporting following a SI
	+ Investigation
	+ Record keeping
	+ Performance management and monitoring
1. **Definition of a Serious Incident (SI)**

The 2015 definition has been refined and now says:

Serious Incidents in the NHS include:

* Acts and / or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:
* Unexpected or avoidable death of one or more people. This includes
	+ suicide/self-inflicted death; and
	+ homicide by a person in receipt of mental health care within the recent past;
* Unexpected or avoidable injury to one or more people that has resulted in serious harm;
* Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent:
* the death of the service user; or
* serious harm;
* Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where:
* healthcare did not take appropriate action/intervention to safeguard against such abuse occurring; or
* where abuse occurred during the provision of NHS-funded care.

This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS funded care caused/contributed towards the incident

* A Never Event (See 2.2 below).
* An incident (or series of incidents) that prevents, or threatens to prevent, an organisation’s ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:
	+ Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues
	+ Property damage;
	+ Security breach/concern;
	+ Incidents in population-wide healthcare activities like screening and immunisation programmes where the potential for harm may extend to a large population;
	+ Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS);
	+ Systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/ unit closure or suspension of services); or
	+ Activation of 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

**2.2** Never Events. The national policy framework and list was revised in March 2015 and now contains 14 types of Never Event

<http://www.england.nhs.uk/wp-content/uploads/2015/04/never-evnts-pol-framwrk-apr.pdf>

 Never Events are a particular type of serious incident that meet **all the following criteria:**

1. 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

1. Each Never Event type **has the potential to cause serious patient harm or 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.

1. There is evidence that the category of Never Event **has occurred in the past**, for example through reports to the National Reporting and Learning System (NRLS), and a risk of recurrence remains.
2. **Occurrence of the Never Event is easily recognised and clearly defined** – this requirement helps minimise disputes around classification, and ensures focus on learning and improving patient safety.

The Never Event list will be reviewed annually by NHS England.

1. **SCCG Accountability**
	1. The Chief Nurse is accountable for SI management of Provider generated SIs and the Senior Quality Manager (SI lead) is responsible for the overall performance management of the SIs of Providers.
	2. There is a nominated SCCG Quality Manager (and nominated deputy) who will act as the performance manager for reported SIs for each Provider.
	3. SI closures are agreed at the SCCG SI closure panel, in conjunction with the NHS Y&H / other CCGs as required.
	4. In the event that SCCG identifies that it has caused an SI, then as for any other NHS body, SCCG is required to report, investigate and develop action plans to mitigate against further occurrences as a Commissioning body.
	5. The Accountable Officer is accountable for management of SCCG generated SIs and the responsibility to ensure reporting, investigation and action planning rests with the relevant Director of the function which generated the SI. Due account needs to be taken of the need to ensure that any investigation meets the requirements of the SIF including sufficient independence of the investigating team. This may require experts from the same function in another CCG to be involved in the investigation.
	6. Any Commissioner generated SI will be performance managed by NHSE Y&H, which will apply all relevant requirements and timescales within the SIF.
2. **Responsibilities**
	1. SCCG is required to performance manage Providers in the reporting and management of SIs and where necessary act as a linkbetween them and the NHS Y&H.

As a lead Commissioner, SCCG has a responsibility to ensure that all of our Providers have the capacity and capability to:

* + Promptly and fully report SIs;
	+ Effectively manage SIs so as to minimise harm and damage;
	+ Investigate SIs, identify learning and share that learning as appropriate;
* Put in place measures to minimise the risk of recurrence.
	1. It is recognised that SIs represent a tiny proportion of all incidents reported. Data on all incidents which result in patient harm, including Serious Incidents, should be regularly uploaded to the National Reporting and Learning System (NRLS). Note that some smaller Providers may not have NRLS compatible in-house incident logging systems.
	2. Providers who are subject to the national standard contract must comply with the NHS England Serious Incident Framework and contract Service Conditions (specifically, SC3 – service Standards and SC 33 Incidents Requiring Reporting).

Note that SC 3 incorporates a broader requirement for Providers ‘to implement Lessons Learned from reviews and evaluations, from feedback, complaints, Patient Safety Incidents, Never Events, and Service User, Staff and public involvement (including the outcomes of Surveys), and must demonstrate at Review Meetings the extent to which Service improvements have been made as a result’.

* 1. Schedule 6D the contract sets out the specific obligations of both parties for the management and reporting of SIs. Providers are required to submit up to date copies of their SI management procedures to SCCG.
	2. Monitoring of compliance with these obligations is through a formal contract Quality Review Meeting held with each Provider.
	3. All Providers with access to the DH Strategic Executive Information System (STEIS) are responsible for logging and updating information on the STEIS system, through a unique account log-on.
	4. Not all commissioned services have access to STEIS. In these cases, agreed SI details will be logged on STEIS for them by SCCG.
	5. It is the responsibility of Providers to inform the Care Quality Commission (CQC) of specific types of incidents, according to CQC notification guidance, however the SCCG may also inform the CQC if appropriate.
	6. SCCG and the NHS Y&H will identify any similarities in SIs within the reporting Provider and/or similar incidents in other Providers, and identify trends and themes which may require further investigation/action on a cluster / trend basis.
1. **Action Following Reporting of an SI**
	1. The organisation which generates an SI must log this (or arrange for this to be logged), on the STEIS system.
	2. The STEIS report completed by the Provider triggers an automatic email notification cascade. The SCCG Quality team will send an acknowledgement to the Provider, for all SI’s logged on STEIS within 2 working days, setting out the expectations of investigation report and remedial action plan timescales. Any additional information requirements or requirements for interim reports will be set out in this acknowledgment.
	3. An internal briefing will be provided, in line with the SCCG SI briefing cascade list. Any other involved Commissioner will be identified and notified and supplied with a copy of the STEIS form in addition to the briefing.

All correspondence must be filed as per the requirements under ‘record keeping’ below.

1. **Investigations**
	1. Investigations must follow a systems-based approach to ensure any issues/problems with care delivery are fully understood from both human and systems factors perspectives and that the ‘root causes’ of lapses in patient safety systems are identified (where it is possible to do so) in order to produce focused recommendations that result in SMART (specific, measurable, attainable, relevant, time-bound) actions and learning, designed to reduce or prevent recurrence.
	2. In more serious cases, particularly where there is likely to be significant public interest, it may be advisable for the Provider to commission an external review or include an external representative on the panel conducting the internal investigation.
	3. Where it is deemed necessary, SCCG may consider the need for and commission an independent, Provider-focussed investigation considering the specific care given to a patient or patients by one or more Providers. This type of investigation will be undertaken by individuals who are all independent of the provider(s) in question.
	4. For those SIs which meet the criteria for an Independent Investigation under the requirements of HSG (94) 27 (as amended), NHS England will determine the need and commission the investigation.
	5. The Memorandum of Understanding (MoU) between the DH, HSE and Association of Chief Police Officers (February 2006) and supporting guidelines for the NHS (November 2006) on investigating patient safety incidents involving unexpected death or serious untoward harm, has now been withdrawn

Guidance within the MoU has been incorporated into the NPCC guidance to police guide for investigating unexpected death and serious harms in Healthcare settings. <http://library.college.police.uk/docs/NPCC/2015-SIO-Guide-Investigating-Deaths-and-Serious-Harm-in-Healthcar-Set.pdf>

This states that:

The NHS should only refer cases to the police when either or both of the following apply:

* 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

It should however also be noted that there are many other sources of referral to the police including coroners, relatives and representatives, safeguarding boards, regulators and whistleblowers.

* 1. SCCG requires the Provider to submit an initial review (72 Hr report) followed by a full report on the investigation and an action plan within 60 working days of the logging of the SI**,** to show what has been done or will be done to minimise the risk of recurrence.
	2. The Provider internal investigation report and all other SI correspondence should be submitted to the SCCG Quality Managers using secure email addresses to the SHECCG.SIManagement@nhs.net mailbox.
	3. If the incident is an SCCG generated SI, then the investigation report should be submitted to the NHS Y&H generic mailbox (england.syb-qps@nhs.net) for review and performance management.
	4. The Provider must complete the ‘Key Findings’ section on the STEIS system, even if it is to indicate that learning was not identified in a particular case.
1. **Extension requests**

* 1. Where it is not possible for the Provider to complete the investigation and submit a final report within 60 working days, e.g. where something outside of the control of the Provider has occurred, a written request for an extension should be submitted using the SCCG proforma. This must be done at least 5 working days before the initial deadline.
	2. SCCG will respond in writing, either agreeing a revised deadline or declining the request. The response to the Provider should normally be made within 5 working days of receipt of the request
	3. In most cases where an extension is granted, SCCG will require an interim report within the original 60 working day deadline, to set out progress made, investigation findings and actions taken to date.
	4. The Provider is required to keep the SCCG Quality Manager informed of any significant developments in investigations.  Where the STEIS system is updated with significant developments, the Provider is required to email SCCG to notify them of this.
1. **SCCG Record keeping**
	1. All records must be kept in electronic form. These are for reference only and are not the primary record.
	2. Providers have the responsibility to maintain a complete and comprehensive file on all SI’s in accordance with the requirements of Records Management: NHS Code of Practice (updated 29th July 2016)

<http://systems.hscic.gov.uk/infogov/iga/resources/rmcop/index_html> and as set out in Schedule 6 D. of the contract.

* 1. Electronic files will be kept in the SI sub folder set up for the specific Provider on the protected SI area of the SCCG M drive. Access rights are restricted to those SCCG staff who are authorised to access the files.
1. **Performance Management** **by** **SCCG**
	1. The nominated SCCG Quality Manager is responsible for ongoing monitoring of the Provider’s progress with the investigation of an SI and of the implementation of agreed remedial action plans as well as any performance management of Providers required in relation to this.
	2. If the action plan spans a long period, then a progress check should be made at agreed intervals. Where an action will take up to 12 months or more to complete progress check intervals must not be longer than 6 months at maximum.
	3. If the applicable report receipt deadline has lapsed since the initial STEIS report and no progress has been reported, then the Provider must give an explanation for the delay and action to be taken to comply with their obligation to provide a report and action plan. This should normally have been pre-empted by an extension request.
	4. On receipt of the internal investigation report, the SCCG Quality Managers will review it, using the approved review process. For quality control purposes, each review will have a second stage review by a second experienced member of the quality team.

SCCG may utilise specialist clinical or other advice as necessary, to determine whether all aspects of the incident have been adequately investigated and whether the action plan is comprehensive and of acceptable quality.

* 1. SCCG will provide written feedback to the Provider, usually within 20 calendar days, setting out any issues requiring a response and including a quality grade for the report and action plan. A deadline for the Provider response will be given, which will be up to 20 working days.

9.6 SI performance data will be reported and discussed both informally with the Provider and at the formal quarterly contract Quality Review meetings held between Providers and SCCG.

9.7 Any significant concerns highlighted either by SCCG as the lead Commissioner, or by any Associate Commissioner, which indicates a possible breach of contractual obligations, may be escalated to the monthly Contract Management Group (CMG) meeting for formal discussion and agreement on further action, including any contract sanctions.

On such occasions, the Quality Manager should attend the CMG.

9.7 The SCCG Quality Team will provide regular reports on Provider performance to the SCCG Governing Body and Quality Assurance Committee.

1. **Closure of SIs**
	1. SCCG will not normally consider closing an incident until there is confirmation that the action plan has been fully implemented.

However, where plans are of long duration, there may be agreement to close the incident, with monitoring of the progress of longer term actions.

Progress monitoring will be geared to the timescales for likely achievement of remedial action plan milestones [(see 9.2 above)](#Para9).

* 1. A key part of the decision to close a SI will be that wherever possible, root causes of safety system failures were identified, lessons were learned and that these will be or have been shared within the Provider’s organisation and where appropriate with others who provide similar services.

The SCCG SI Closure Panel Terms of reference set out the full criteria for closure [(see Appendix 1)](#Appendix1).

* 1. All involved Commissioners will be included in the discussions on closure. In practice, this will normally be achieved through email discussion, which will be taken fully into account at SI Closure Panel meetings.
	2. Once all interested Commissioners have confirmed that there is sufficient assurance, the nominated Quality Manager will present the SI to the SCCG SI Closure Panel. A decision to close, including any conditions to the closure will be communicated to the provider in writing and monitored by the Panel.
	3. It is the responsibility of the nominated Quality Manager to ensure that the incident is closed on the STEIS system and that the Provider and all interested Commissioners have been notified within 5 working days that this has been done.
1. **De-logging**
	1. De-logging an incident. There are occasions when it is appropriate to de-log a STEIS record. Examples include where an incident was logged by a Provider who is not the prime ‘owner’ of the incident or, in retrospect, the apparent incident is not deemed serious enough to warrant SI status.
	2. The Quality Manager will contact the STEIS systems administrator by email (SUI@dh.gsi.gov.uk) and ask them to de-log the SI, giving the rationale. Following de-logging, there will be no STEIS record. SCCG electronic records should be kept and the file marked de-logged.
	3. Once confirmed as carried out, de-logging must be confirmed to the Provider, the NHS Y&H and to any other commissioner as applicable within 5 working days.
	4. A summary of the relevant timescales is as follows:

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| **Report type** | **Reporting deadline / frequency** |
| Initial report on STEIS | **Provider**: Within 2 working days of known / suspected incident occurrence **SCCG:** Acknowledge & internal briefing within 2 working days of STEIS alert |
| Initial Incident Review report | **Provider**: Within 3 working days of identification of incident.  |
| Final investigation report and remedial action plan | **Provider**: Within 60 working days  |
| Extension request  | **Provider**: At least 5 working days before the 60 day deadline**SCCG:** Response within 5 working days |
| Interim incident report. (For agreed, complex cases, or agreed extended deadlines only) | **Provider:** Within 60 working days followed by final report & remedial action plan, at agreed time |
| Review of investigation report and response to review | **SCCG**: Review within 20 calendar days**Provider:** Response within 20 working days |
| Closure or de-logging | **SCCG:** notification to Provider and any Co-Commissioner within 5 working days of panel decision |

1. **Freedom of Information Act 2000**
	1. Providers and SCCG should inform the NHS Y&H of any requests for information regarding SIs submitted to them under the Freedom of Information Act 2000.
2. **Policy Review**

This policy will be reviewed annually or following the publication of new National or NHS Y&H guidance or policy.

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**Serious Incident Closure Panel**

**Terms of Reference**

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| **NAME OF GROUP** | **Serious Incident Closure Panel**  |
| **TYPE OF GROUP** | **Sub Group of the Quality Assurance Committee.** |

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| **1** | **Purpose of the Group** |
| On behalf of SCCG, to review and where satisfied with the reports and evidence presented, agree the closure of Serious Incidents or identify additional assurances required. |

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| **2** | **Objectives of the Group** |
| 1. To discuss and reach an agreement on whether individual Serious Incidents (SIs) may be closed by consideration of:
* The incident investigation report.
* Action plans and assurances on implementation.
* Provider responses to investigation report review questions and comments.
* Where available, Coroner’s Determination and Conclusions.
1. To encourage the sharing of individual and organisational learning.
2. To identify any conditions to closure (e.g. requires post inquest review / feedback on long term action implementation)
3. To receive and consider responses to any conditions placed and determine whether any incident file should be re-opened or remain closed.
4. To record all decision making on closures and ensure that decisions are communicated to Providers
5. Provide information to the Quality Assurance Committee & CCG Governing Body through provision of data on closures.

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| **3** | **Membership**  |
| * Senior Quality Manager (Chair)
* Medicines Governance Pharmacist
* Quality Managers/Senior Quality Managers (x5)
* Clinical Audit and Effectiveness Assistant

Other key expert individuals may be invited to attend meetings where their expertise is required.  |

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| **4** | **Quorum**  |
| Three members to be present: One Senior Quality Manager to act as Chair, in absence of the nominated Chair plus two other members. |
| **5** | **Frequency of Meetings** |
| Two weekly or more frequently as required. |

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| **6** | **Accountability and Authority**  |
| The group will be accountable to the Quality Assurance Committee and has the authority to:Formally agree or recommend the closure of Serious Incidents  |
| **7** | **Meeting administration**  |
| SI information for closure will be collated and provided not less than two working days before the meeting. Outcome and action notes will be prepared and made available as required. |

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| **8** | **Inception of group and review responsibilities** |
| Date of group inception | December 2010 |
| Date of last review in terms of membership | July 2016 |
| Name of Chair/Lead who is responsible for reviewing terms | 2 x Senior Quality Manager |
| Date of next review | July 2017 |

**NHS SHEFFIELD CCG**

**SI Closure panel**

**Closure Criteria**

1. Provision of information to the Panel
2. The investigation report and CCG review will be entered onto the SI Closure Panel template together with any assurances / responses from the provider relating to any of the review requirements and shared with Panel members not less than two working days before the meeting.

Note that, for information relating to fulfilment of conditions for closed incidents, the investigation report & review will not be re-provided.

1. Quality Manager to ensure that prior to presentation of information to the SI Closure Panel:
2. The investigation report is deemed acceptable and identifies learning for the organisation and the route & means of sharing that learning
3. The action plan is deemed acceptable and there are assurances that the short term actions have been implemented. Long term actions which are identified as requiring follow up, will be identified, should closure be agreed
4. Responses to any investigation report review queries have been received and are deemed satisfactory
5. Any forthcoming Coroner’s Inquest is identified. The date may be unknown but the Provider will have been requested to provide that information when known
6. Any other Commissioner/interested party is identified and their views sought on closure or may be invited to the meeting

14th July 2016

SI closure panel

**NHS Sheffield CCG Equality Impact Assessment 2013**

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| **Title of policy or service**  | **Policy for the Management of Serious Incidents reported by commissioned service providers or the commissioning function**  |
| **Name and role of officers completing the assessment** | Tony Moore, Senior Quality Manager |
| **Date assessment completed** | 15/07/16 |  |

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| **1. Outline** |
| **Give a brief summary of your policy or service*** Aims
* Objectives
* Links to other policies, including partners, national or regional
 | This policy outlines the SCCG’s role and responsibilities for the reporting and performance management of Serious Incidents (SIs) reported by Providers Also included is the process for where a SI arises within the SCCG commissioning function. It is based on and compatible with the NHSE Serious Incident Framework and guidance (2015):<https://www.england.nhs.uk/patientsafety/serious-incident/>  |

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| **2. Gathering of Information** This is the core of the analysis; what information do you have that indicates the policy or service might *impact on protected groups, with consideration of the General Equality Duty*.  |
|  | **What key impact have you identified?** | **What action do you need to take to address these issues?** | **What difference will this make?** |
| **Positive****Impact**  | **Neutral****impact** | **Negative****impact** |
| **Human rights** |  | X |  | None |  |
| **Age** |  | X |  | None |  |
| **Carers** |  | X |  | None |  |
| **Disability** |  | X |  | None |  |
| **Sex** |  | X |  | None |  |
| **Race** |  | X |  | None |  |
| **Religion or belief** |  | X |  | None |  |
| **Sexual orientation** |  | X |  | None |  |
| **Gender reassignment** |  | X |  | None |  |
| **Pregnancy and maternity** |  | X |  | None |  |
| **Marriage and civil partnership** (only eliminating discrimination) |  | X |  | None |  |
| **Other relevant group** |  | X |  | None |  |

Please provide details below on the actions you need to take

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| **3. Action plan** |
| **Issues identified** | **Actions required** | **How will you measure impact/progress** | **Timescale** | **Officer responsible** |
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| **4. Monitoring, Review and Publication** |
| **When will the proposal be reviewed and by whom?** |  |
| **Lead Officer**  | **Tony Moore** | **Review date:** | **August 2017** |