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NHS Sheffield Clinical Commissioning Group

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

August 2017

Version:	1.9
Date ratified:	13 November 2017
Policy Number	CL008/08/2019
Name of originator/author:	Senior Quality Manager - Commissioning
Name of Sponsor:	Chief Nurse
Name of responsible committee	Quality Assurance Committee
Date issued:	August 2016
Review date:	August 2019
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

disability confident EMPLOYER

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

1.	**Details of Policy**	
1.1	Policy Number	CL008/08/2019
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	Chief Nurse
1.4	Author:	Senior Quality Manager - Commissioning
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

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

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 16	Senior Quality Manager	FINAL	Supersedes 1.6
1.8	August 2017	Senior Quality manager	FINAL	Updated policy in response to process and procedural process: 1.7 including General Practice (new) 4.0 Sheffield CCG Generated SI's (New) 5.0 Responsibility for SI's (Updated) 7.0 Investigations (Updated) 9.0 Record Keeping (Updated) 12.0 Delogging Incidents (Updated) Appendix A (Updated)
1.9	August 2019	Senior Quality Manager	FINAL	Updated policy: 2.2 Never Events Policy and framework published January 2018

Contents

1.0 Introduction

1.1. **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.

1.2. Sheffield Clinical Commissioning Group (SCCG) is committed to working with the NHS England (NHSE) Yorkshire and the Humber (NHS Y&H) patient safety team, Co-commissioners 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 (SIF) 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 Providers and Independent Providers that undertake NHS funded care including General Practice.
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 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

2.0 Definition of a Serious Incident (SI)

2.1 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. Following consultation on changes to the Never Events Policy and framework and the corresponding list of Never Events, NHS Improvement published a revised policy and framework in January 2018. This came into force on 1st February 2018. Full document available from: https://improvement.nhs.uk/resources/never-events-policy-and-framework/

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

a. 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

b. 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.

c. 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.

d. ***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.

3.0 SCCG Accountability - Provider Generated SIs

3.1 The Chief Nurse is accountable for performance management of Provider generated SIs and the Senior Quality Manager (SI lead) is responsible for the overall performance management of the SIs of Providers.

3.2 There is a nominated SCCG Quality Manager who will act as the performance manager for reported SIs for each Provider.

3.3 SI closures are agreed at the SCCG SI closure panel (appendix A), in conjunction with the agreement of NHS Y&H / other CCGs as required

4.0 SCCG Accountability - SCCG generated SIs

4.1 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.

4.2 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.

4.3 Note that any level of incident generated by SCCG must be reported and recorded on the SCCG local incident management system (DATIX) in line with the requirements of the SCCG incident reporting policy (accessible at http://www.intranet.sheffieldccg.nhs.uk/policies.htm

4.4 Any SCCG generated incident that meets the definition of an SI must be reported onto the DH Strategic Executive Information System (STEIS) system using the SCCG log on detail. Help with this can be obtained from the Clinical Quality Team.

4.5 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.

4.6 A Commissioner generated SI will be performance managed by NHSE Y&H, which will apply all relevant requirements and timescales within the SIF. NHSE has the right, should it be deemed necessary, to commission an Independent Investigation into serious failures of SCCG commissioning processes.

4.7 NHSE Y&H will be responsible for the eventual closure on the STEIS system.

5.0 Responsibilities for Provider SIs

5.1 SCCG is required to performance manage Providers in the reporting and management of SIs and where necessary act as a link between 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.

5.2 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.

5.3 Providers, who are subject to the terms of the NHS standard contract 2017/18, should note that in the contract Service Conditions there is a requirement for providers to implement lessons learned from incidents, as well as from complaints, audits etc. (Service Condition 2.1.4),

There is a requirement that Never Events should not occur (Service Condition 3.1.4) and there is also a requirement to comply with the NHS England Serious Incident Framework (Service Condition 33 Incidents Requiring Reporting).

The requirements for compliance with Duty of Candour are set out in Service Condition 35

5.4 Schedule 6C of the contract sets out the specific obligations of both parties for the management and reporting of SIs, including that Providers are required to submit up to date copies of their SI management procedures to SCCG.

5.5 All Providers with access to the DH Strategic Executive Information System (STEIS) are responsible for logging and updating information on the STEIS system, through their unique account log-on.

5.6 Not all commissioned services have access to STEIS. In these cases, agreed SI details will be logged on STEIS for them by SCCG.

5.7 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 felt necessary.

5.8 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.

6.0 **Action Following Reporting of an SI**

6.1 The organisation which generates an SI must log this (or arrange for this to be logged), on the STEIS system.

6.2 The STEIS report completed by the Provider triggers an automatic email notification cascade, including to NHSE. The SCCG Clinical 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.

6.3 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.

7.0 Investigations

7.1 Investigations must follow a systems-based approach to ensure any issues/problems with treatment or care delivery are fully understood from both human and systems factors perspectives and that the 'root causes' (fundamental contributory factors) 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.

7.2 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.

7.3 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.

7.4 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.

7.5 The National Police and Crime Commission guidance to police 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

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 whistle-blowers.

7.6 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.

7.7 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.

7.8 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.

7.9 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.

7.10 In the event that it is agreed that there will also be a Sheffield city wide Multi Agency Review (MAR) and that this includes the Provider concerned, then that process will take precedence over any SI investigation, which will be suspended.

7.11 The SCCG representative on any MAR will liaise with the Clinical Quality Team. Once the MAR process is completed, assurances from it will be provided to the SCCG SI closure panel to enable the STEIS file to be closed.

8. Extension Requests

8.1 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.

8.2 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

8.3 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.

8.4 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.

9.0 SCCG Record Keeping

9.1 All records must be kept in electronic form. These are for reference only and are not the primary record.

9.2 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 6C of the contract.

9.3 Historic 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. Current files are located within the DATIX system.

10.0 Performance Management by SCCG

10.1 The nominated SCCG Quality Manager is responsible for ongoing monitoring of the Provider's progress with the investigation of an SI and of their implementation of agreed remedial action plans as well as any performance management of Providers required in relation to this.

10.2 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.

10.3 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.

10.4 On receipt of the Provider 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.

10.5 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.

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

10.7 Any significant concerns highlighted either by SCCG as the lead Commissioner, or by any Co-Commissioner, which indicates a possible breach of contractual obligations, may be escalated to the monthly Contract Management Board (CMB) meeting for formal discussion and agreement on further action, including any contract sanctions.
On such occasions, the Quality Manager should attend the CMB or brief the agreed attendee.

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

11.0 Closure of SIs

11.1 SCCG will not normally consider closing an incident until there is confidence that the requirements of the SCCG SI Closure Panel criteria (see appendix A) are met. This would usually include 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).

11.2 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.

11.3 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.

11.4 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.

11.5 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.

12.0 De-logging an Incident

12.1 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, following the initiation of investigation fact finding, the apparent SI does not meet the SIF criteria.
This can be established and agreed at any stage, up to and including the process of full investigation. A decision to request a de-log should be made in agreement with any Co-commissioner

12.2 The Quality Manager will contact the STEIS systems administrator by email (SUI@dh.gsi.gov.uk) and ask them to de-log the SI. Following de-logging, there will be no STEIS record. SCCG electronic records should be kept and the file marked de-logged.

12.3 Once confirmed, de-logging must be confirmed to the Provider and any other commissioner. This should be copied to NHS Y&H for their performance management purposes and must include the rationale. This should be completed with 5 working days.

12.4 A summary of the SI management timescales is as follows:

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

13.0 Freedom of Information Act 2000

13.1 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.

14.0 Mental Capacity Act

14.1 Having considered and completed the MCA compliance statement at Appendix B, the MCA is not applicable to this policy.

15.0 Equality Impact Assessment

15.1 The policy is underpinned by a clear process (see Appendix C). No patient, for any reason, either individually or by group, will be discriminated against by this policy.

16.0 Policy Review

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

Working with you to make Sheffield HEALTHIER

NHS Sheffield Clinical Commissioning Group

Appendix A

Serious Incident Closure Panel
Terms of Reference

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

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.

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.
2. To encourage the sharing of individual and organisational learning.
3. To identify any conditions to closure (e.g. requires post inquest review / feedback on long term action implementation)
4. To receive and consider responses to any conditions placed and determine whether any incident action plan requires additional action(s) and assurance.
5. To record all decision making on closures and ensure that decisions are communicated to Providers
6. Provide information to the Quality Assurance Committee & CCG Governing Body through provision of data on closures.

3	**Membership**

	• Senior Quality Manager (Chair) • Medicines Governance Pharmacist • Quality Managers /Quality Officer / Senior Quality Managers (x5) • Clinical Audit and Effectiveness Assistant Other key expert individuals may be invited to attend meetings where their expertise is required.

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.

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.

8	**Inception of group and review responsibilities**	
	Date of group inception	December 2010
	Date of last review in terms of membership	June 2017
	Name of Chair/Lead who is responsible for reviewing terms	2 x Senior Quality Manager
	Date of next review	July 2018

NHS SHEFFIELD CCG
SI Closure panel

Closure Criteria

A. Provision of information to the Panel

The investigation report and CCG review will be entered, by the Quality Manage for that Provider, onto the SI Closure Panel template, together with any assurances / responses from the provider relating to any of the review requirements, including any action plan completion confirmation / ongoing actions update 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.

B. The Quality Manager must have sufficient assurance that prior to presentation of information to the SI Closure Panel:

- The review of the Provider investigation report and action plan was complete and thorough and that any queries or concerns raised through the review process have been fully addressed by the Provider.

- The Provider has confirmed that short terms actions are complete and an update on longer term actions has been supplied.

- Any forthcoming inquest is identified and where possible, the date is known. If the Inquest conclusion & determination is already known, any concern should have either have been covered by the investigation or the Provider required to confirm how the concern is being / has been addressed.

The Quality Manager must have also solicited the views of any co-commissioner(s), regarding their willingness to have the incident closed and have confidence that the information presented will assure the Panel that closure is appropriate.

16th June 2017

SI closure panel

Appendix B - Mental Capacity Act Compliance Statement

Any policy, guideline or procedure which deals with circumstances where a service user has a decision to make, or has to be consulted, or their agreement is required, must include a **Mental Capacity Act policy compliance statement** setting out:

Mental Capacity Act Compliance Statement	Number of paragraph in policy, guideline or procedure where referenced or N/A
What service user decisions / consent / agreement may need to be sought during the operation of the policy / guideline or procedure	**N/A**
For each level of decision-making, who will be required to assess the client's mental capacity at each level	**N/A**
What decisions staff may **not** make under the policy / guideline / procedure	**N/A**
How the existence of advance decisions, an Enduring Power of Attorney, Lasting Power of Attorney or deputy will be identified and recorded	**N/A**
Any other specific guidance that the policy / guideline / procedure requires staff to follow in relation to mental capacity	**N/A**

To provide practical support for staff, a link to the Mental Capacity Act 2005 Implementation Guidance can be found at: http://nww.sheffield.nhs.uk/policies/clinical.php#m and can be included in the electronic version of the document being developed.

This **Mental Capacity Act compliance statement** is a consideration for all policies, guidelines and procedures. Where the MCA does not apply, authors need to make this clear in a statement to this effect inserted at the Mental Capacity Act section of the policy, guideline or procedure.

Appendix C **NHS Sheffield CCG Equality Impact Assessment 2017**

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	20/07/17	

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/

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

3. Action plan				
Issues identified	**Actions required**	**How will you measure impact/progress**	**Timescale**	**Officer responsible**

4. Monitoring, Review and Publication			
When will the proposal be reviewed and by whom?			
Lead Officer	**Tony Moore**	**Review date:**	**August 2018**