Policy for the reporting and management of serious incidents in services commissioned by Derbyshire County Council Public Health

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Contents

1. Introduction

Derbyshire County Council (DCC) commissions a range of healthcare services and interventions in the discharge of its public health responsibilities. Although rare, it is recognised that incidents occur within the healthcare system, which may have serious consequences for the safety of patients or others. DCC supports a systems-improvement approach to safety, which requires a culture of openness and trust, and a willingness to learn from such incidents.

As part of its clinical governance framework, DCC requires that systematic measures are in place to respond to serious incidents. This policy will define the responsibilities of the Council and of the service provider organisations it commissions, in relation to serious incidents.

The aim of the policy is to ensure that serious incidents are reported, investigated appropriately and the lessons learned lead to service improvements, which lessen the chance of re-occurrence.

2. Background

From 1st April 2013, upper tier and unitary local authorities became responsible for commissioning a range of public health services and interventions, which had previously been commissioned by NHS Primary Care Trusts. The Public Health Grant Conditions[1] state that 'local authorities should ensure that appropriate clinical governance arrangements are put in place'.

Clinical governance was originally defined as 'a system through which NHS organisations are accountable for continuously improving the quality of their services and safeguarding high standards of care by creating an environment in which excellence in clinical care will flourish'[2].

As part of their clinical governance responsibilities, NHS organisations were required to ensure that 'adverse events are detected, and openly investigated; and lessons learned promptly applied'[3].

In 2010, the National Patient Safety Agency (NPSA) developed a serious incident reporting framework to ensure consistency in definitions, roles and responsibilities for NHS commissioned services[4]. This framework was revised in 2013[5] and again in 2015[6]. It forms

[1] Department of Health (2013) *Local Authority Circular LAC(DH)(2013)3: Public Health Ring-Fenced Grant Conditions - 2014/15*
[2] Scally, G. and Donaldson, L.J. (1998) Clinical governance and the drive for quality improvement in the new NHS in England. *BMJ*; 317: 61-5
[3] Department of Health (1997) *The New NHS: Modern. Dependable*
[4] NHS National Patient Safety Agency (2010) *National Framework for Reporting and Learning from Serious Incidents Requiring Investigation.*
[5] NHS Commissioning Board (2013) *Serious Incident Framework*
[6] NHS England (2015) *Serious Incident Framework: Supporting learning to prevent recurrence*.

the basis for serious incident reporting procedures within clinical commissioning groups (CCGs) and NHS trusts.

3. Scope

The majority of public health services and interventions commissioned by DCC are delivered by NHS organisations. These organisations also have contracts with other NHS or Local Authority commissioning bodies, and are required to comply with their serious incident reporting procedures. The DCC Public Health serious incident procedure has therefore been designed to align with national and local frameworks.

While serious incident reporting frameworks were originally established within the NHS, DCC also commissions services from non-NHS organisations. The serious incident reporting and management procedures will apply to all DCC Public Health commissioned services and interventions, as provided by:

NHS Trusts
NHS Foundation Trusts
Independent practitioners, including general practitioners (GPs)
Community Pharmacists
Non-statutory health and social care organisations
Charities

It is expected that service provider organisations will have serious incident procedures which will align with this policy.

Organisations which provide public health services via DCC grant funding or on behalf of another commissioning body (e.g. NHS England or CCGs) will be excluded from these requirements.

The DCC Public Health serious incident procedure will align with the procedures of other Council departments and a mechanism for communication will be established, to ensure information is shared, as appropriate.

4. Accountabilities

The principal accountability of DCC and of any organisation it commissions to provide public health services is to patients/service users and their families/carers. The first consideration following a serious incident is the care and welfare of the patient(s)/service user (s) involved. Further risk to the patient(s)/service user(s) and others must be mitigated. Patients/service users must be fully involved in the response to a serious incident. Where a patient/service user has died or suffered serious harm, their family/carers must be similarly cared for and involved.

A statutory duty of candour was introduced for NHS bodies in England from 27 November 2014[7] and will apply to all other care providers registered with the Care Quality Commission (CQC) from 1 April 2015. All organisations, which are commissioned to provide services and interventions by DCC Public Health, are expected to adhere to a similar ethos of candour and apply the principles embodied in *Being Open*[8].

Providers are accountable via contracts to their Public Health commissioners. DCC will seek assurance from all providers that robust serious incident policies and procedures are in place.

The key organisational accountability for serious incident management is from the provider in which the incident took place to the commissioner of the service. For example, this may be from a substance misuse service to a Public Health commissioning manager.

Where a provider has multiple commissioners and it is not immediately clear which is the most appropriate commissioner to report the incident, the provider should seek advice from their Public Health commissioning manager.

Where more than one provider is involved in the serious incident, the relevant commissioning managers should agree with the providers, which provider and commissioner will manage the incident.

Within DCC, the line of accountability for the management of serious incidents sits with the Public Health Senior Management Team*; Adult Social Care and Health Management Team and ultimately with the Corporate Management Team.

* For reference the Public Health Senior Management Team is referred to as the line of accountability. However, the review of serious untoward incident reports lies with – Director of Public Health, Deputy Director of Public Health, Assistant Directors of Public Health, Commissioning Group Manager, Service Commissioning Manager, Public Health Lead for service area and any other relevant area eg mental health lead, 0-19 lead and registered clinical professional

5. Definitions

In order to align with the Derbyshire CCGs' serious incident procedures, this policy will adopt the definition of a serious incident as described in NHS England's *Serious Incident Framework* [6]. However, while the definition in this document refers to incidents which occur during NHS funded healthcare, for the purpose of this policy, the definition relates to incidents which occur during Public Health funded care.

It is important to note that there is no definitive list of events or incidents which constitute a serious incident. Serious incidents include:

[7] NHS England (December 2014) *NHS Standard Contract 2014/15. Service Conditions*
[8] National Patient Safety Agency (2009) *Being Open*

- 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[9] - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death.

- An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:

    - Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues;
    - Property damage;
    - Security breach/concern;
    - Incidents in population-wide healthcare activities like screening and immunisation programmes where the potential for harm may extend to a large population;
    - Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS);
    - Systematic failure to provide an acceptable standard of safe care; 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.

[9] http://www.england.nhs.uk/ourwork/patientsafety/never-events/

However, this list is not exhaustive and if providers are unsure whether an incident constitutes a serious incident, they should discuss with their commissioning manager or the DCC Public Health clinical governance lead.

Supplementary terms:

- Incident – an event or circumstance that could have resulted, or did result, in unnecessary damage, loss or harm such as physical or mental injury to a patient, staff, visitors or members of the public

- Unexpected death – where natural causes are not suspected

- Avoidable death - Caused or contributed to by weaknesses in care/service delivery (including lapses/acts and/or omission) as opposed to a death which occurs as a direct result of the natural course of the patient's illness or underlying condition where this was managed in accordance with best practice.

- Serious harm:
    - Severe harm – a patient safety incident that appears to have resulted in permanent harm to one or more persons receiving *Public Health* funded care;
    - Chronic pain (continuous, long-term pain of more than 12 weeks or after the time that healing would have thought to have occurred in pain after trauma or surgery); or
    - Psychological harm, impairment to sensory, motor or intellectual function or impairment to normal working or personal life which is not likely to be temporary (i.e. has lasted, or is likely to last for a continuous period of at least 28 days).

- Never events – serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by the healthcare provider

- Abuse – a violation of an individual's human and civil rights by any other person or persons. Abuse may consist of single or repeated acts. It may be physical, verbal or psychological, it may be an act of neglect or omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented or cannot consent.

Information Governance Serious Incidents

Since 1st June 2013, all organisations processing Health, Public Health and Adult Social Care personal data are required to use the IG Toolkit Incident Reporting Tool to report level 2 information governance serious incidents.

There is no standard definition of an information governance serious incident, but such an incident will:

- typically breach one of the principles of the Data Protection Act and/or the Common Law Duty of Confidentiality;
- include unlawful disclosure or misuse of confidential data, recording or sharing of inaccurate data, information security breaches and inappropriate invasion of people's privacy;
- include personal data breaches which could lead to identify fraud or have other significant impact on individuals;
- apply irrespective of the media involved and includes both electronic media and paper records relating to staff and service users.

Further information on the requirements, definitions and procedures can be found in the Department of Health's *Checklist Guidance for the Reporting, Managing and Investigating Information Governance Serious Incidents Requiring Investigation* (November 2014)[10].

6. Responsibilities

Derbyshire County Council Public Health

DCC Public Health will seek assurance and evidence from all organisations, commissioned to provide public health services or interventions, that robust systems are in place to report, investigate and implement learning from serious incidents.

DCC Public Health will specify requirements regarding serious incident reporting in all contracts.

DCC Public Health will designate an officer responsible for receiving serious incident reports.

Following the report of an incident, DCC Public Health will require oversight of the response of the provider organisation. The level of oversight will depend on the circumstances or complexity of the incident and DCC's confidence in the provider organisation's ability.

A higher level of involvement by DCC Public Health may be required for serious incidents with high complexity or incidents involving multiple organisations. This may range from advice to the direct participation of Public Health personnel in the provider organisation's management of the incident.

In exceptional cases of high public interest, DCC may commission an independent investigation.

DCC Public Health will maintain a register of all serious incidents, with oversight provided by the Public Health Senior Management Team.

[10] https://www.igt.hscic.gov.uk/resources/IGIncidentsChecklistGuidance.pdf

DCC Public Health will inform other Council departments (e.g. Adult Care, Children's Services) and external bodies (e.g. Public Health England/UK Health Security Agency, CCGs) as appropriate.

Serious incident files will be closed by the Public Health Senior Management Team, following receipt of investigation reports and assurance that any resulting actions have been or will be implemented. These actions will be followed up in the performance review meetings with the Public Health commissioner.

DCC Public Health will arrange for the dissemination of learning from serious incidents across other Council departments and external organisations as appropriate.

Provider organisations

The provider will designate a senior manager (director level or equivalent) to be responsible for patient safety, including the management of serious incidents.

The provider will have a formal mechanism in place, such as a serious incident group accountable to the board (or equivalent), to manage serious incidents and to ensure any actions from learning are implemented.

The provider will have a local policy and procedure, which clearly states how serious incidents are reported and managed within the organisation.

The provider will report the incident to the DCC Public Health within the required timeframe.

The provider will report the incident to other organisations as required. This may include:

- NHS England (through the Strategic Executive Information System (STEIS))
- CQC
- Monitor
- Call Derbyshire (children or adults safeguarding concerns)
- NHS Counter Fraud Service
- Police
- Health & Safety Executive
- Medicine and Healthcare products Regulatory Agency (MHRA)
- Information Commissioner's Office

The provider will inform other provider organisations of the incident as appropriate, considering the nature and impact of the incident.

The provider shall record all serious incidents on an auditable register. NHS Trusts should use a local risk management system, such as Datix.

The provider shall ensure the incident is investigated at a level (concise or comprehensive) that it is appropriate to the scale and circumstances of the incident, using a root cause analysis (RCA) approach[11].

[11] http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/

The provider shall ensure that they have sufficient staff trained in investigation and RCA methods.

Investigation reports must be submitted to DCC Public Health within the agreed timescale.

The provider shall ensure any actions derived from lessons learned will be implemented in a timely manner.

The provider shall manage any press or other media enquiries, in consultation with DCC Public Health/Communications.

7. Procedure

A flowchart for the reporting and management of serious incidents is shown in Appendix A.

Reporting

The provider organisation should report a serious incident to DCC Public Health as soon as possible, but at least within two working days. Reports should be sent by email to the commissioning manager responsible for that service and copied to the designated Public Health manager.

Serious incidents likely to have a serious impact on the operation of the service or attract media attention should be reported to the commissioning manager immediately by telephone.

If the provider is unclear whether the incident qualifies as a serious incident, they should contact the appropriate commissioning manager or the Public Health manager leading on serious untoward incidents.

Reports should give the time and location of the incident, brief details of the incident, the immediate consequences of the incident, any actions taken by the provider, other organisations informed.

The commissioning manager or the Public Health manager may contact the provider for further information if required.

The Director of Public Health and the Deputy Director of Public Health (with responsibility for clinical governance) will be informed of all serious incidents. Depending on the nature, scale and impact of the incident, notification will be further escalated to the Adult Social Care &Health Directorate Management Team and the Corporate Management Team, as appropriate.

Depending on the incident, DCC Public Health may request an initial investigation report. Minimum standards of this report are given in Appendix B. The report shall be submitted to DCC Public Health within 72 hours.

In the case of a safeguarding incident, the Public Health commissioning manager will liaise with the DCC children's or adult safeguarding lead to ensure local procedures are followed. However, the provider must report any safeguarding concerns directly to the Children's or Adult Social Care.

The incident will be entered on the DCC Public Health Serious Incident log by the designated business services officer.

Investigation final reports

Providers are required to submit the investigation final report to DCC Public Health within 60 working days. Reports of independent investigations are to be submitted within 26 weeks.

In exceptional circumstances, extensions to the above timeframes can be agreed. Providers a required to submit the extension request form (Appendix C) to outline the reasons for the request.

Reports should adhere to the minimum standards outlined in Appendix D. All person identifiable data will be anonymised.

The investigation final report will be reviewed by DCC Public Health Senior Management Team within 20 working days.

The Senior Management Team will close the incident if it is satisfied that the investigation has been carried out appropriately, and an action plan to implement any recommendations has been submitted.

The closure of an incident marks only the completion of the investigation process. DCC will agree a process with the provider for monitoring the implementation of the action plan.

If the Group is unwilling to close the incident due to concerns about the investigation, it may request further actions. These would normally be addressed through contract management routes.

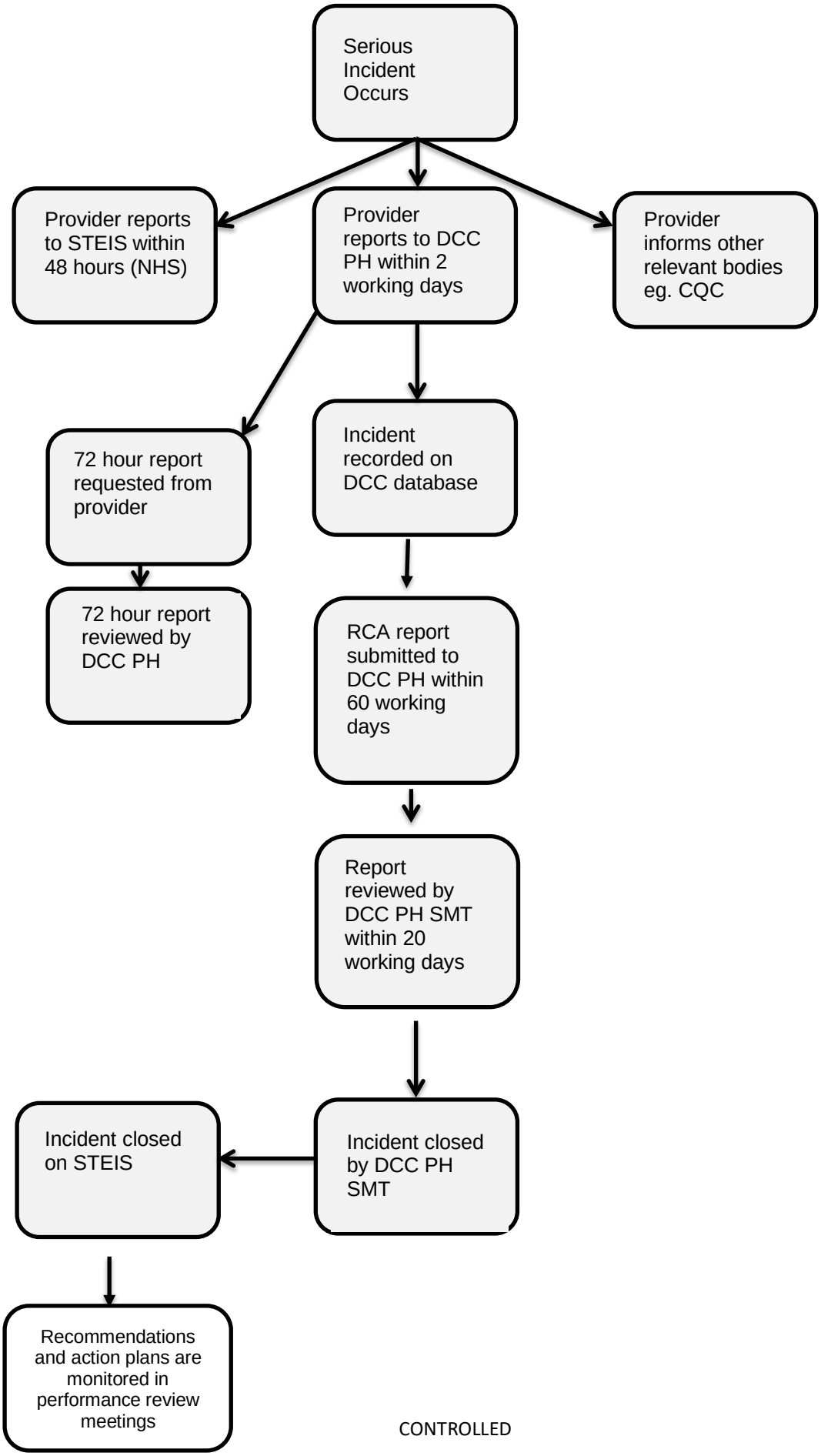
The incident may be closed on STEIS by the provider once it has been confirmed closed by DCC Public Health.

Communications

Serious incidents may attract media interest, immediately following the incident or at a later date. Depending on the nature of the incident, a communications plan may need to be developed.

DCC Public Health will liaise with the DCC Communications Team and the communications department or appropriate senior manager of the provider organisation, in order to give a consistent and coordinated response.

Appendix A: Serious incident flowchart



Appendix B: Minimum standards for 72 hour report

Body of report must contain**:**

Cover Page	Organisation Logo Author(s) Incident Number (STEIS) Headline Report date Pages and paragraphs should be numbered
Summary	Incident Description (What happened) Speciality / Service Actual effect on patient and or service (Any immediate risks must be identified and mitigation of outstanding risks) Severity of incident (e.g. Size of incident, number affected)
Investigation Information	Immediate Action(s) Taken Chronology of Events (including dates, events and notable practice) Investigation Plan (Terms of Reference if completed. Clearly state any other agencies involved and / or notified)
Being open	Description of anticipated support to the patients involved their relatives and staff.

Appendix C: Serious Incident Final Report Extension Request

1. ORGANISATION & SI INFORMATION

Reporting Organisation:	
Name of person completing the form:	
STEIS Number:	
Headline:	
Date extension request made:	

2. REASON FOR EXTENSION:

Reason for Request:	**Please tick one box:**
Short term sickness / absence	☐
Multi-agency involvement	☐
Other	☐
If 'Other' was selected, please specify details:	
Please specify the length of extension required by the number of working days	**days** (not to exceed 20 working days)

3. FORWARDING THE REQUEST

Once this form has been completed, please email it to DCC Commissioning Team at the following email address:
ASCH.publichealth.Commissioning@derbyshire.gov.uk

Appendix D. Minimum standards for investigation final reports

Cover Page	Organisation Logo Author(s) Incident Number (STEIS) Headline Report date Document Version Pages and paragraphs should be numbered
Executive Summary	Concise Incident description Root cause Recommendations
Terms of reference	
Summary of the incident	Outline briefly the incident and what makes this incident a SI. Incident type, specialty involved effect on patient and severity of incident should be included.
Background	Include a brief description of the patient, their medical needs, the care and treatment provided. The service type, size of clinical team, the experience and skills of the staff involved in the incident and their training records. Also explain the relevance of local and national policy / guidance at the time of the incident. Disclose only relevant confidential personal information for which consent has been obtained, or if patient confidentiality should be overridden in the public interest. This should however be considered by the Caldicott Guardian and where required confirmed by legal advice
Investigation methodology	Brief description of the type of investigation – narrow / broad, single / aggregate. How the information was gathered – e.g. interviews, clinical records, statements, management reports. Type of Root Cause Analysis tool used A description of how patients/victims and families have been engaged in the process
Being open	Description of support provided to the patients involved, their relatives and staff.
Chronology of events	Description of the event taken from the tabular timeline (this should be attached as an appendix)
Discussion – Analysis and findings	This section should demonstrate critical analysis of the event and provide findings and conclusions based on evidence. This section needs to clearly identify the care and service delivery problems and analysis of each using a recognised RCA methodology to identify the causal factors

	The contributory factors will fall into one of the NPSA taxonomies, it may be useful to identify these: • Individual Factors • Team and Social Factors • Communication Factors • Task Factors • Education and Training Factors • Equipment and Resource Factors • Working Conditions • Organisational and Strategic Factors • Patient Factors
Lessons Learnt	Things that went well and things that went badly. This could relate to the incident or the investigation process.
Recommendations	These need to directly link to the key learning points (care and service delivery problems) and address the problem not the symptoms. Be clear and concise and kept to a minimum and designed to reduce the likelihood of recurrence or severity. They need to be specific, measureable, realistic and timed (SMART)
Conclusion	Summary of the key findings and should answer the questions posed in the terms of reference. Identify root causes and recommendations; Ensure that conclusions are evidenced and reasoned, and that recommendations are implementable
Implementation, monitoring & evaluation	Describe the arrangements for the local monitoring of the action plan, arrangements for evaluating long term solutions i.e. risk register
Arrangements for sharing and learning	Describe how the lessons learned will be disseminated with staff, other organisations such as the Commissioner for local learning, the LAT for regional learning, and the NRLS for national learning.

Appendix E. Minimum standards for Action Plans

• NHS England recommends use of the NPSA Action Plan template available online: http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/

• Action plans must be formulated by those who have responsibility for implementation, delivery and financial aspects of any actions (not an investigator who has nothing to do with the service although clearly their recommendations must inform the action plan);

• Every recommendation must have a clearly articulated action that follows logically from the findings of the investigation;

• Actions should be designed and targeted to significantly reduce the risk of recurrence of the incident. It must target the weaknesses in the system (i.e. the 'root causes' /most significant influencing factors) which resulted in the lapses/acts /omissions in care and treatment identified as causing or contributing towards the incident;

• A responsible person (job title only) must be identified for implementation of each action point;

• There are clear deadlines for completion of actions;

• There must be a description of the form of evidence that will be available to confirm completion and also to demonstrate the impact implementation has had on reducing the risk of recurrence;