Standard Operating Procedure for the Management of Serious Incidents and Never Events within Specialised Commissioning Acute Services for NHS England: South East and South West.

Title	Standard Operating Procedure (SOP) for the management of Serious Incidents within specialised commissioning acute services across NHS England South East and South West.
For	This SOP should be used by all Providers and Clinical Commissioning Groups (CCGs) of NHS funded care across the South East and South West regions of England.
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Internal SoP agreed by NHSE SMT	21 May 2019	Addition of NHSE internal SoP in Appendix 2.

Reviewers

This document must be reviewed by the following people:

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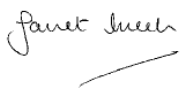
Janet Meek		Regional Director of Specialised Commissioning South		1.0
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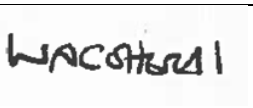
Wendy Cotterell		Director of Nursing Specialised Commissioning South		1.0

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Supporting Documents		
Evidence	**Hyperlink**	**Date**
Serious Incident Framework, NHS England	https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf	2015
Never Events Framework & Never Event List 2018	https://improvement.nhs.uk/resources/never-events-policy-and-framework/	2018
Being Open Framework and Guidance, NHS NPSA NRLS	https://improvement.nhs.uk/resources/learning-from-patient-safety-incidents/	2009
NHS England: Social Care Act Duty of Candour regulations.	http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted	2014
NHS England: Safeguarding Policy	https://www.england.nhs.uk/wp-content/uploads/2015/07/safeguard-policy.pdf	2015

Standard Operating Procedures are designed to promote consistency in delivery, to the required quality standards, across the NHS England. They should be regarded as a key element of the training provision for staff to help them to deliver their roles and responsibilities.

Contents

1 Purpose

This SOP should be used by all Providers and Clinical Commissioning Groups (CCGs) of NHS funded care across the South East and South West regions of England and applicable to specialised commissioned services across the six programmes of care: Women and Children; Cancer; Internal medicine; Trauma; Mental Health and Blood and Infection.

The purpose of the NHS England South East and South West Specialised Commissioning Serious Incident Reporting and Management standard operating procedure (SOP) is to define the process for the reporting and management procedure for Serious Incidents (SI) and Never Events for specialised commissioning.

The definition of Serious Incident is as per the NHS England Serious Incident Framework (March 2015).[1]

This procedure is not to act as a duplication of the comprehensive NHS England Serious Incident Framework (March 2015) and Revised Never Events Policy and Framework (January 2018). These frameworks should always be consulted alongside this procedure.[2]

This procedure ensures that all Serious Incidents which occur within NHS-funded health care which involve Specialised Commissioning within the South Region are reported, investigated and closed as per the requirements of NHS England SI Incident Framework.

This procedure will ensure that Providers and CCGs understand the process that Specialised Commissioning follows when a Serious Incident impacting on specialised services is declared.

This procedure has been developed in consultation with CCG colleagues and DCO Nursing and Quality teams across the South of England.

2 Specialised Commissioning South Structure

There are three Specialised Commissioning hubs responsible for the commissioning of specialised services across the South East and South West Regions of England.

[1] https://improvement.nhs.uk/resources/serious-incident-framework/

2 https://improvement.nhs.uk/resources/never-events-policy-and-framework/

3 https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour

3 Procedure

3.1 Serious Incident Reporting

All providers of NHS commissioned care are required to report Serious Incidents (SI) on the national database known as the Strategic Executive Information System (STEIS).

All Serious Incidents must be declared as soon as possible, and immediate action must be taken to establish the facts, ensure the safety of the patient(s), other services users and staff, and to secure all relevant evidence to support further investigation.

Serious Incidents should be disclosed as soon as possible to the patient, their family (including victims' families where applicable) or carers.
http://www.legislation.gov.uk/ukpga/2014/23/contents/enacted

An automated notice is sent by STEIS to a distribution list of colleagues entitled to view it when an incident is reported by a Provider. The distribution is based on the CCG geography where the incident occurred.

The information uploaded by the Provider will afford enough information to justify the rationale for raising the incident and the immediate actions taken.

From the initial information provided it is often difficult to identify incidents that involve patients in receipt of specialised commissioned care and at the point of uploading the incident onto STEIS the Provider does not differentiate between Commissioners of the service.

For clarity refer to the specialised service manual (2017) for the prescribed list of specialised services:
https://www.england.nhs.uk/wp-content/uploads/2017/10/prescribed-specialised-services-manual-2.pdf

Service Specialists in the three hubs receive regular Serious Incident summaries from STEIS from their respective Direct Commissioning Organisations (DCO) teams in which all Serious Incidents reported by providers of care within their geographical patches are shared.

The Service Specialists review the DCO SI summaries and make a judgement on whether or not an incident relates to a specialised commissioned service. This is not always obvious in the initial notification and the complexity of some commissioned clinical pathways. If more information is required, the Service Specialist is responsible for contacting the Lead CCG to request a copy of the 72 hour report. (Appendix 1 – serious incident flow chart)

[1] https://improvement.nhs.uk/resources/serious-incident-framework/

[2] https://improvement.nhs.uk/resources/never-events-policy-and-framework/

[3] https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour

3.2 Serious Incidents requiring involvement of Specialised Commissioning - Assigning Accountability: RASCI model. (Appendix 2 – NHSE internal SI SoP)

The lead CCG for that Provider is contacted and Specialised Commissioning's interest in the investigation is noted.

The Service Specialist is responsible for requesting a copy of the 72-hour report and liaising with the lead CCG to confirm and agree the scope of the investigation and whether the incident requires further input from Specialised Commissioning.

The Provider is required to submit the Root Cause Analysis (RCA) to commissioners within sixty (60) days of declaration of the incident. The lead CCG is responsible for sharing the final investigation report with the service specialist (NHSE) who requested it.

If there is an Operational Delivery Network (ODN) for the service, the Service Specialist is responsible for informing the network manager from the ODN of the incident, so they can coordinate any expertise the network can offer to the investigation and action plan. The final investigation report should also be shared with the network manager for review.

For incidents that have been agreed as requiring Specialised Commissioning input, Specialised Commissioning are responsible for reviewing the RCA, using the NHS England closure checklist for guidance, and liaising with the lead CCG regarding possible involvement at the Serious Incident review panel and closure process.

Once Specialised Commissioning is assured the report is comprehensive with the root causes being identified, recommendations, robust action plans and organisational learning will be embedded, NHSE is responsible for requesting that the incident is closed on STEIS by the lead CCG.

This process enables the lead CCG to maintain accountability and oversight of all Serious Incidents within individual Providers.

In exceptional circumstances where there is a provider with no lead CCG, NHSE specialised commissioning team will ensure that a RASCI model is developed and agreed by the relevant commissioning organisations to ensure roles and responsibilities in relation to managing the incident are clearly set out.

3.3 Serious Incidents not requiring involvement of Specialised Commissioning

If after requesting and reviewing the 72 hour report the Service Specialist finds there is no requirement for further involvement of Specialised Commissioning they will

[1] https://improvement.nhs.uk/resources/serious-incident-framework/

[2] https://improvement.nhs.uk/resources/never-events-policy-and-framework/

[3] https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour

notify the lead CCG and the incident will continue to be managed through the CCG Serious Incident process.

3.4 Providers without access to STEIS

Providers without access to STEIS must liaise with their lead Commissioner or directly with their regular contact at Specialised Commissioning who will be able to advise them on the process reporting the Serious Incident onto STEIS.

3.5 Never Events

All Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death. The management of Never Events follow the same principles as described in this SOP.

For further information on Never Events, refer to the Revised Never Event Policy and Framework, NHS England (2018).[2]

4 Safeguarding

In addition to serious incidents related to safeguarding children or adults following NHS SI reporting processes due consideration will be given to statutory multi agency processes for serious cases for investigation, review and closure. The most effective way to ensure that health organisations' assume full accountability is for the NHS Serious Incident process and the statutory safeguarding review process to be aligned. Liaison with the CCG Safeguarding Lead will ensure oversight of the multi - agency review process including shared learning, recommendations for practice and monitoring of action plans that may be relevant to specialised commissioned services.

5 Duty of Candour

Providers and Commissioners are expected to demonstrate a Duty of Candour, based on recommendations made by Francis (2013) and contained in mandate by the CQC (2015)[3] and in line with principle of "Being Open" which involve acknowledging, apologising and explaining what happened to patients and/or their carers who have been involved in a Serious Incident, whether or not the patient or their representative have asked for this information.

Following a verbal apology, a written apology should follow with clear arrangements for ongoing involvement and communication.

6 Mental Health Serious Incidents

Please refer to NHS England Management of Specialised Commissioning Mental Health Serious Incidents SOP South Region

[1] https://improvement.nhs.uk/resources/serious-incident-framework/

2 https://improvement.nhs.uk/resources/never-events-policy-and-framework/

3 https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour

7 Independent Investigations

All commissioners can request an independent investigation. An independent investigation is an investigation into an incident which is both commissioned and undertaken independently of those directly responsible for and directly involved in the delivery of the elements that the investigation is considering. If there is an Operational Delivery Network for the service, the network can aid in undertaking the independent investigation.
When considering when to conduct an independent investigation NHS England Serious Incident Framework (2015) should always be consulted.[1]

8 Reporting & Learning Mechanism

The Service Specialists (NHSE) for each hub will be responsible for reporting on Serious Incidents involving patients in receipt of specialised services within the following reports and meetings:

- NHSE performance and assurance reports
- NHSE South East/South West Monthly quality reports
- NHSE Quarterly regional report
- South Region Quality Surveillance Group Meetings (QSG) to share themes and trends and lessons learnt.

In addition, an annual report that identifies the trends and learning from Serious Incidents and Never Events across NHSE Quality Committee at the end of quarter 4. Lessons learnt will be used to drive improvements.

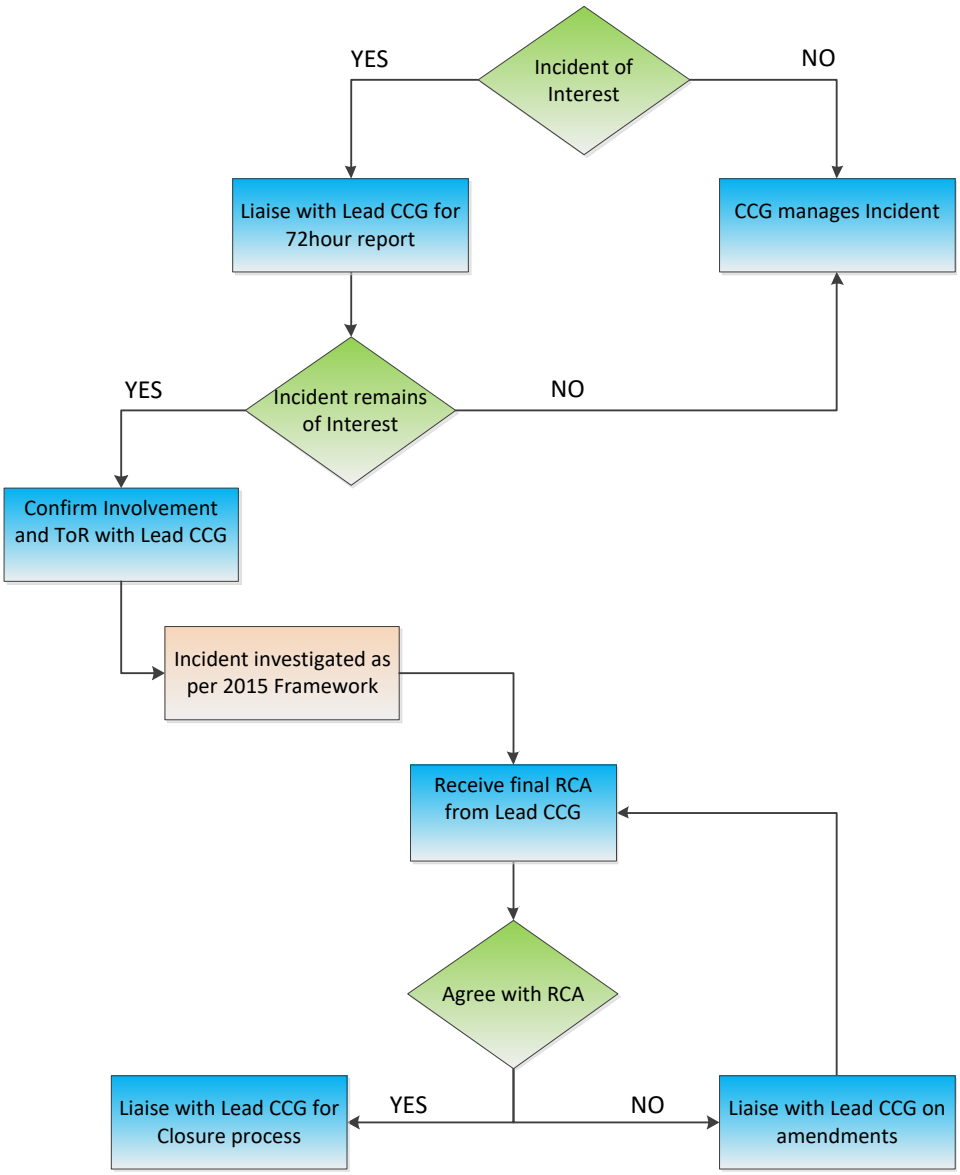
9 Conclusion

This Standard Operating Procedure describes the process for the management of Specialised Commissioning Serious Incidents across the South East and South West Regions

[1] https://improvement.nhs.uk/resources/serious-incident-framework/
2 https://improvement.nhs.uk/resources/never-events-policy-and-framework/
3 https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour

Appendix 1

SIRI SOP Flowchart



[1] https://improvement.nhs.uk/resources/serious-incident-framework/

2 https://improvement.nhs.uk/resources/never-events-policy-and-framework/

3 https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour

Appendix 2: NHS England Specialised Commissioning (South) Serious Incident internal SOP

ACUTE PROVIDERS – report serious incidents onto STEIS

STEIS SI notifications are received by the DCO NHSE Nursing teams across the South (Generic mailboxes). SI Summaries are compiled by the DCO team either daily or weekly

Service Specialists in the three hubs receive regular serious Incident summaries from STEIS from their respective Direct Commissioning Organisations (DCO) teams

Service specialists review the DCO SI summaries and make a judgement on whether an incident relates to a specialised commissioned service.

Spec comm teams can access the SI report by the link provided and entering login details. Access is available on a Hub basis.
Login via web browser
Password in separate email
https://steis.improvement.nhs.uk/

STEIS ID:
Password in separate email

Does the incident relate to a specialised commissioned service?

In exceptional circumstances where there is a provider with no lead CCG, NHSE specialised commissioning team will ensure that a RASCI model is developed and agreed by the relevant commissioning organisations to ensure roles and responsibilities in relation to managing the incident are clearly set out.

Yes

Service Specialists contact relevant CCG for assurance purposes & to clarify immediate actions taken and request 72 hr. report.

Unsure

Service Specialists contact relevant CCG for further information and request 72 hr. report

No

No further action, the DCO team will monitor via normal CCG SI processes. If after requesting and reviewing the 72 hour report the Service Specialist finds there is no requirement for further involvement of Specialised Commissioning they will notify the lead CCG and the incident will continue to be managed through the CCG SI Process

Inform NHSE Director of Nursing, COO and/or other senior member of staff as appropriate. Consider alerting the communication lead if there is likely to be media interest

Add to weekly hot spots report if:

- High profile serious incident
- Serious incidents that may attract media interest

Service specialists will log the SI in the hub database which includes STEIS number, date of incident, provider, whether 72-hour report has been received, immediate actions, mitigations and assurance.

Inform and share with relevant operational delivery network manager as appropriate.

Does the incident raise any safeguarding concerns?

Yes

Inform NHSE spec comm associate director of safeguarding and refer to the Safeguarding governance framework.

No

Final Investigation received via the CCG
The Provider is required to submit the Root Cause Analysis (RCA) to commissioners within sixty (60) days of declaration of the incident. The lead CCG is responsible for sharing the final investigation report, prior to closure, with the service specialist (NHSE) who requested it.

Reviewing the final investigation report
Service specialists are responsible for reviewing the RCA, using the NHS England closure checklist for guidance. If further scrutiny is required, the nursing and quality team should be contacted for further advice and review if necessary.

NHSE spec comm assured and agree to close?

No

The service specialist will request further information and clarity as required from the provider via the CCG

Yes

If the reviewers are assured the report is comprehensive with root causes being identified, recommendations, robust action plans and organisational learning will be embedded, NHSE will inform the lead CCG that they agree to close from a spec comm perspective. Attendance at individual CCG lead SI closure panels will be decided on a case by case basis or if there is a cluster of Spec comm SIs a member of the team will attend the panel.

The Service Specialists (NHSE) for each hub will be responsible for reporting on Serious Incidents involving patients in receipt of specialised services within the following reports and meetings:

- Performance Packs
- Quality Committee
- Quarterly quality report (national team)
- By exception to the South Region Quality Surveillance Group Meetings (QSG) to share themes and trends and lessons learnt.

In addition, an annual report that identifies the trends and learning from Serious Incidents and Never Events will be produced by the nursing team at the end of quarter 4.
Lessons learnt will be used to drive improvements via approaches de the quality strategy.

sources/serious-incident-framework/
vents-policy-and-framework/
ulations-enforcement/regulation-20-duty-candour