NHS
West Hampshire
Clinical Commissioning Group

SERIOUS INCIDENTS (SI) POLICY

Version 3.01

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Policy statement:	Mechanism for the performance management of serious incidents reported by the Healthcare Providers commissioned by WHCCG.
Responsibility for dissemination to new staff:	Line Managers as appropriate
Mechanism for dissemination:	All new and updated policies are published on the CCG website and are promoted to staff through the CCG staff newsletter.
Training implications:	Appropriate staff need to be trained in root cause analysis
Resource implications:	There are no resource implications in relation to this policy.
Further details and additional copies available from:	Senior Quality Manager, South West https://westhampshireccg.nhs.uk/document-tag/ig-and-security-policies/
Equality Analysis Completed?	Yes
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Amendments Summary:

Amend No	Issued	Page(s)	Subject	Action Date
1	10 Mar 14	2 & 16	Change references from Media Relations Policy to Communications Strategy (V1.02)	10 Mar 14
2	16 Jun 15	Throughout	Changes after the publication of the revised NHSE Framework May 2015	Jun 15
3	29 Jun 18	Throughout	Complete review and changes throughout	Jun 18
4				
5				

Review Log:

Include details of when the document was last reviewed:

Version Number	Review Date	Reviewer	Ratification Process	Notes
2	Jun 2015	Senior Quality Manager	Corporate Governance Committee	Complete review in light of new National SI Framework guidance
3	Jun 2018	Senior Quality Manager	Clinical Governance Committee	Complete review

SERIOUS INCIDENTS (SI) POLICY

SUMMARY OF THE KEY POINTS TO NOTE

This policy details the mechanism for the performance management of the serious incidents requiring investigation reported by the Healthcare Providers commissioned by WHCCG. Specifically:

- This policy does not include the management of SIs that have been raised by WHCCG. This is covered in the WHCCG Incident Management Policy and Guidance
- This policy does not apply to primary care
- This policy is related to those SIs which have a direct or indirect impact on the safety of one or more residents of WHCCG.
- All contracts must include detail regarding the healthcare provider's obligation to meet its SI management requirements. WHCCG will seek assurance from all its providers, via contract arrangements, that serious incidents are reported by them to the National Reporting and Learning System (NRLS) and other bodies as appropriate
- All SIs have a timeframe of 60 working days for the completion of investigation reports
- In many cases SIs can lead to a high level of media attention not only in the immediate aftermath but possibly for months and in some cases, years, after the incident itself. WHCCG will follow its own communications strategy which will include action to be taken in relation to serious incidents. Communication regarding serious case reviews (child abuse) will be managed by the chair of the Local Children's Safeguarding Board (LCSB)

More information is available from the Senior Quality Manager, South West Directorate

SERIOUS INCIDENTS (SI) POLICY

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SERIOUS INCIDENTS (SI) POLICY

1. INTRODUCTION AND PURPOSE

1.1 This policy is based on the revised 'Serious Incident Framework, supporting learning to prevent recurrence', produced by NHS England in March 2015. It is based on the principles set out in the National Patient Safety Agency (NPSA)'s 2010 'National Framework for Reporting and Learning from Serious Incidents Requiring Investigation', and NHS England's Serious Incident Framework (March 2013).

1.2 West Hampshire Clinical Commissioning Group (WHCCG) recognises that in a healthcare environment, things will sometimes go wrong. When they do, the CCG supports the view that the response should not be one of blame and retribution, but of organisational learning with the aim of encouraging participation in the overall process and supporting staff, rather than exposing them to recrimination.

1.3 The CCG is committed to developing an open and fair culture and to encouraging a willingness to admit mistakes without fear of punitive measures.

1.4 This policy will define the process that WHCCG will follow in the performance management of the Serious Incidents (SIs) that have been raised by the main providers of healthcare commissioned by WHCCG.

1.5 The aim of the policy is to ensure that lessons are learned and actions are taken by the provider in which the SI occurred in order to prevent them happening again and so reducing the impact on patient safety.

1.6 WHCCG also believe that it has a fundamental role in cascading the lessons learnt to the wider health economy.

2. SCOPE AND DEFINITIONS

SCOPE

2.1 This policy covers all WHCCG employed staff. As a commissioner of services for the local population, WHCCG is responsible for commissioning high quality services from other organisations. It therefore expects, and will stipulate within contracts with providers, to be informed of SIs within these provider organisations and to receive the full investigation report of any SI investigation, which involved WHCCG residents.

2.2 This policy does not include the management of SIs that have been raised by WHCCG. This is covered in the WHCCG Incident Management Policy and Guidance.

2.3 This policy is related to those SIs which have a direct or indirect (in the case of a disruption to utility services or data loss, for example) impact on the safety of one or more residents of WHCCG.

2.4 Where WHCCG takes the lead commissioning role for a provider it will also follow this policy for the performance management of that provider for SIs raised regarding all Clinical Commissioning Groups (CCGs) that it has the lead commissioning role for. These commissioning responsibilities are detailed in Appendix A.

2.5 Where more than one provider is involved in a serious incident, the relevant commissioners should take a decision with those providers on who will act as the lead provider and who will act as the coordinating commissioner for the purposes of reporting, investigation and incident management.

2.6 The commissioning responsibilities between the CCGs have been determined along the same principles as the contract assurance and negotiation arrangements across the Hampshire CCGs. The first five of these principles are applicable to SI management as follows:

1. That in order for patients to be kept safe and for risks to be managed proactively; there should be full agreement to sharing of relevant quality information and resultant increase of trust and openness across the whole health system.
2. That CCGs need to work together to gain the full picture of assurance across all but the very small provider contracts.
3. That in assuring quality there should be minimal duplication of CCG effort and the smart use of reporting, for example, one report/multiple uses.
4. That there needs to be absolute clarity about who holds responsibility for provider quality assurance, with shared understanding of this across all CCGs.
5. That the sharing of information be based around an exception reporting model.

2.7 Transferring these principles into operational management of provider SIs, the five CCG's in Hampshire have agreed that the lead for provider SI performance management will be by the lead CCG for that contract.

2.8 The policy will clearly describe the responsibilities of WHCCG and how it will execute these responsibilities as a commissioner of healthcare services from:

- University Hospitals Southampton NHS Foundation Trust,
- Southern Health NHS Foundation Trust
- Hampshire Hospitals NHS Foundation Trust
- Royal Bournemouth and Christchurch NHS Foundation Trust
- Salisbury NHS Foundation Trust

- Any other provider commissioned by WHCCG

2.9 The specific provider responsibilities by each CCG are included in Appendix A and may be subject to change as future year's contracts are negotiated.

2.10 Services which are commissioned by WHCCG (however large or small) are expected to have in place policies and practices which reflect national best practice with regard to the management of SIs and this is also included in the quality schedules of the contract held between WHCCG and those providers.

2.11 Although WHCCG commissions services from a number of different providers WHCCG is not always the lead commissioner of the provider contracts. When an SI is reported by a provider where WHCCG is not the lead commissioner the relevant WHCCG quality lead will ensure that in the first instance they will receive notification of the initial SI via the StEIS system. Following this they will have appropriate communication links in place with the lead commissioner to ensure that they can monitor the provider's adherence to the National SI framework including the development of an action plan to prevent recurrence

DEFINITIONS

2.12 The SI framework does not give a definitive list of events or incidents that constitute a serious incident and suggests that lists should not be created locally as this could lead to inconsistent or inappropriate management of incidents. Where lists are created there is a tendency to not appropriately investigate things that are not on the list even when they should be investigated, and equally, a tendency to undertake full investigations of incidents where that may not be warranted.

2.13 The definition of a SI is as described in the 'Serious Incident Framework' (March 2015). Serious incidents in the NHS include:

- Acts or omissions
- Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:
    - Unexpected or avoidable death[1] 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[2]
    - Unexpected or avoidable injury to one or more people that has resulted in serious harm

[1] 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.

[2] This includes those in receipt of care within the last 6 months but this is a guide and each case should be considered individually - it may be appropriate to declare a serious incident for a homicide by a person discharged from mental health care more than 6 months previously.

- 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[3]; 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 (see Part One; sections 1.3 and 1.5 for further information).

- A Never Event - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death. See Never Events Policy and Framework for the national definition and further information[4]

- 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 (see Appendix 2 for further information)
  - Property damage
  - Security breach/concern[5]
  - Incidents in population-wide healthcare activities like screening[6] and immunisation programmes where the potential for harm may extend to a large population

[3] This may include failure to take a complete history, gather information from which to base care plan/treatment, assess mental capacity and/or seek consent to treatment, or fail to share information when to do so would be in the best interest of the client in an effort to prevent further abuse by a third party and/or to follow policy on safer recruitment.

[4] Never Events arise from failure of strong systemic protective barriers which can be defined as successful, reliable and comprehensive safeguards or remedies e.g. a uniquely designed connector to prevent administration of a medicine via the incorrect route - for which the importance, rationale and good practice use should be known to, fully understood by, and robustly sustained throughout the system from suppliers, procurers, requisitioners, training units, and front line staff alike. See the Never Events Policy and Framework available online at: https://improvement.nhs.uk/documents/2266/Never_Events_list_2018_FINAL_v5.pdf

[5] This will include absence without authorised leave for patients who present a significant risk to themselves or the public.

[6] Updated guidance will be issued in 2015. Until that point the Interim Guidance for Managing Screening Incidents (2013) should be followed.

- 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[7]); or
- Activation of Major Incident Plan (by provider, commissioner or relevant agency)[8]

- Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation[9].

2.14 **Never Events** are patient safety incidents that are preventable because:

- There is national guidance that explains what the care or treatment should be
- There is national guidance to explain how risks and harm can be prevented
- There has been adequate notice and support to put systems in place to event them from happening.

2.15 Never Events are one of the indicators that can be used to demonstrate how safe an organisation is and its patient safety culture. Continued occurrence of Never Events can be considered an indicator of an organisation that has not put the right systems and processes in place to prevent them from happening. A Never Event is always reportable as an SI. The current list of what constitutes a Never Event (2018) is in Appendix B.

3. PROCESS / REQUIREMENTS

3.1 As a commissioner, WHCCG must be assured and be able to demonstrate that its commissioned services have appropriate frameworks in place to govern, report, investigate and learn from SIs.

3.2 All contracts must include detail regarding the healthcare provider's obligation to meet its SI management requirements. WHCCG will seek assurance from all its providers, via contract arrangements, that serious incidents are reported by them to the NRLS and other bodies as appropriate.

[7] It is recognised that in some cases ward closure may be the safest/ most responsible action to take but in order to identify problems in service/care delivery , contributing factors and fundamental issues which need to be resolved an investigation must be undertaken

[8] For further information relating to emergency preparedness, resilience and response, visit: http://www.england.nhs.uk/ourwork/eprr/

[9] As an outcome loss in confidence/ prolonged media coverage is hard to predict. Often serious incidents of this nature will be identified and reported retrospectively and this does not automatically signify a failure to report.

3.3 WHCCG will undertake different levels of oversight depending on a range of local circumstances, including their confidence in the relevant provider's ability. Complex serious incidents or those involving multiple organisations, locations or events, will require more hands-on coordination of the response at commissioner level.

3.4 The WHCCG quality managers will upload details of all the WHCCG SIs reported by the provider for which they are responsible, onto a spreadsheet.

3.5 The spreadsheet is used to keep track of the deadline dates for reports, dates of panels and outcomes and to provide data for trend analysis.

Timescales

3.6 The provider should report an SI as soon as possible, but at least within two working days onto the Strategic Executive Information System (STEIS) and, in addition, are encouraged to make contact with the quality lead for the trust, but always where there is a likelihood of media interest, uncertainty of grading or where a Never Event has occurred.

3.7 All SIs have a timeframe of 60 working days for the completion of investigation reports.

3.8 On rare occasions, extensions to the above timescales can be agreed with the provider. The circumstances for an extension must be those that are outside the normal working arrangement such as witnesses being unable to be interviewed due to absence or Police investigations. Extensions must be formally agreed with the CCG quality manager. The reason for the extension must be included on the Strategic Executive Information System (STEIS) incident form.

3.9 The WHCCG quality lead who has responsibility for the performance management of the specific provider will receive an automatic alert from the STEIS system and a link to the details uploaded by the provider.

Process when an SI is reported

3.10 A diagrammatic representation for the notification and management by WHCCG if a SI involving a WHCCG patient occurs, is in Appendix C in the form of a flowchart. This process is as follows:

3.10.1 When the CCG quality lead for the provider opens up the STEIS form it automatically records that the CCG has seen the form. This will highlight to NHS England South East that West Hampshire is leading the review.

3.10.2 The quality lead will contact the provider for further information as necessary and will add the details onto STEIS and the WHCCG internal SI log appropriate for that provider.

3.10.3 The provider is encouraged, via the contracting SI schedule, to follow the procedure and tools for undertaking a root cause analysis investigation and the Duty of Candour[10] (Health and Social Care Act 2008, regulation 20)

3.10.4 Once the provider has formally accepted the final report via their internal assurance processes, the provider will alert the WHCCG quality lead by e-mail, to confirm that they have completed their investigation and have updated the STEIS system with the root causes analysis report. In some cases it may be more appropriate for the provider to send an electronic copy of the root cause analysis report to the quality lead and update the STEIS system with the key details.

3.10.5 The quality lead will set up SI review panels to determine if the investigation report is ready for closure. The report should include the following criteria and will be used to make the decision for closure:

- An appropriate investigation that identifies findings, based on root causes and recommendations
- A satisfactory action plan with action points to address each root cause recommendation(s) and with a named lead and timescale for implementation
- Lessons learned, including partners or stakeholders with whom the learning has been shared
- Full completion of the STEIS record covering the above points, such as date investigation completed, population of RCA/lessons learned field.

3.10.6 The review panel will consist of the WHCCG quality lead and appropriate clinician or specialist such as a GP, safeguarding lead, Deputy Director or Director of Quality or Mental Health Commissioner.

3.10.7 To ensure consistency of review the Quality Checklist will be used for each investigation report (Appendix H)

3.10.8 If the panel feels that the criteria are not met or there are unanswered questions, these will be fed back to the provider for a response before the SI can be closed. The CCG quality lead will also update STEIS with this information. Formal notes will be taken at each panel which will be sent to the provider.

3.10.9 Once the WHCCG panel is confident that all of the criteria have been addressed, the quality lead will add the response to the STEIS system, close it and inform the provider.

[10] Regulation 20: Duty of candour | Care Quality Commission

3.10.10 In some circumstances the WHCCG panel may close the SI but may feel that they would like to review the progress against the action plan at a later date. In this case the WHCCG SI log will be annotated to ensure this occurs.

3.10.11 Quality Managers will monitor themes and trends from SIs and will seek assurance through internal provider mechanisms that action plans have been completed and embedded as business as usual.

Process when a Never Event is reported

3.11 A diagrammatic representation for the notification and management by WHCCG if a Never Event involving a WHCCG patient occurs is in Appendix D in the form of a flowchart. The process follows the route as for SIs with the following additions:

3.11.1 When a Never Event is reported involving harm to a resident of WHCCG, the provider will telephone the CCG quality lead to give the initial alert. The quality lead will then alert the following WHCCG staff on the same or next working day by email or face to face:

- Chief Officer
- Director of Quality and Safety (Board Nurse)
- Lay Members
- Specialist Commissioning Lead (if appropriate)
- Communications and Engagement Lead

3.11.2 When the provider reports a Never Event SI, they will carry out an initial investigation and provide a report to the WHCCG quality lead within 72 hours.

3.11.3 The full report will follow within 60 working days from the date at which the incident was reported onto STEIS or 6 months (or longer) with the approval of the quality manager if the SI involves external investigations for example by safeguarding boards, police, Health & Safety Executive or Coroners.

3.11.4 Once the provider has completed the root cause analysis report, WHCCG will convene a SI panel which will include:

- WHCCG Director or Deputy Director of Quality & Safety
- WHCCG Quality Manager (lead for the provider)

3.11.5 The panel will review the report looking for the same criteria as for an SI with the addition of:

- A review of previous 2 years Never Events for analysis of trends and learning.

- A summary of each never event for inclusion in the commissioner's annual reporting arrangements.

3.11.6 The panel may ask for provider representation as appropriate. If the panel feels that the criteria are not met or there are unanswered questions, these will be fed back to the provider for a response.

3.11.7 Once the CCG panel is confident, and in agreement that all of the criteria have been addressed, the SI can be closed, however, in accordance with the 'NHS England Serious Incident Framework' (March, 2015) the lead CCG will monitor the action plan until evidence is provided that all actions have been implemented.

3.11.8 If appropriate, where the SI involves external investigations/ agencies, WHCCG will close these SIs on STEIS where all immediate actions for the health care services derived from internally conducted or commissioned investigations are satisfactorily in hand and where organisations are assured that processes are in place for ensuring any outcomes from the external investigation will be communicated and acted upon.

Media Relations

3.12 In many cases SIs can lead to a high level of media attention not only in the immediate aftermath but possibly for months and in some cases, years, after the incident itself. WHCCG will follow its own communications strategy which will include action to be taken in relation to serious incidents, including protocols with other local organisations and agencies on media handling and strategies for on-going and longer term management of media coverage.

3.13 Communication regarding serious case reviews, for example, child death will be managed by the chair of the Local Children's Safeguarding Board (LCSB).

3.14 The communications leads in WHCCG will work closely with the communications team at NHS England (South) Area or Regional team on agreeing appropriate media handling strategies. The associate director of communications and corporate affairs or on call communications lead at NHS England (South) Regional team is responsible for briefing the Department of Health Media Centre as necessary. In forensic/criminal cases the police lead all communications with the media.

WHCCG Monitoring

3.15 SIs will be monitored by the WHCCG Clinical Governance Committee (CGC) on a bi-monthly basis. This will consist of a dashboard showing, per provider, per month:

- Number of SIs reported
- Number of SIs that are breaching the report deadline

- Number of Never Events
- Number of unexpected deaths meeting the SI criteria
- Number of high harm falls reported as SIs
- Number of provider-acquired pressure ulcers

3.16 Within the part 2 (non-public) section of the Clinical Governance Committee the quality reports will include a more detailed report on those SIs that are graded as a Never Event or may attract media attention.

3.17 These reports are also reported to the CCG Board so that they are aware and assurance regarding management of the SIs can be provided.

3.18 Reporting trusts should have mechanisms in place to ensure that learning is disseminated across the organisation. This will be monitored via the Clinical Quality Review Meetings with the provider.

Communicating with patients, carers and families

3.19 All organisations must have adopted the Duty of Candour principles and processes. The detail of the approach with the patients, families and/or carers should be included in all investigation reports.

Investigation and management of WHCCG SIs

3.20 The WHCCG Incident Management Policy and Guidance gives detailed information on the process to be followed.

Any Qualified Provider (AQP) SIs

3.30 If an SI is identified by a non-NHS provider NHS England will be informed by the lead commissioner so that they can make arrangements with the provider for reporting onto STEIS. The provider will then undertake the investigation and the WHCCG will follow the normal processes for closure as described in this policy.

Safeguarding SIs

3.31 All safeguarding alerts are scrutinised by the WHCCG safeguarding team who will decide if they constitute an SI and, if so, will raise it on the STEIS form. Learning from safeguarding SI's will be shared with the quality managers by the safeguarding team for dissemination

3.32 The quality managers will inform the CCG Safeguarding team if a safeguarding issue is identified from the reported SI. When considering whether the concern constitutes a SI, psychological harm and emotional harm must be considered as well as any physical harm

3.33 A screening tool for the identification of a Safeguarding incident is in Appendix G.

3.34 The Safeguarding Adults team will raise their own SIs on the StEIS form and fully conclude the process as this runs in parallel with other safeguarding processes. Due to safeguarding incidents usually involving a number of agencies and the possibility of a police investigation, these SIs may take longer than 60 working days to resolve

3.35 Any children's safeguarding SIs will be raised by the respective provider and the investigation will follow the same process as other SIs. If the incident also follows the Serious Case Review (SCR) process this will not stop or delay the provider investigation as this may help to inform the SCR.

Disputes

3.36 If there is a dispute as to whether an SI should be raised by a provider but the CCG considers that it should, then WHCCG will raise it on STEIS and it will be discussed at the next Clinical Quality Review Meeting with the provider.

Specialised Commissioning

3.37 When an SI is reported by a provider which is regarding a service commissioned by NHS England South East regional team, i.e. specialised services, the quality manager will inform NHS England. The SI will be included in the usual CCG SI review panels and NHS England specialised commissioning will be expected to attend when the specialised commissioning SIs are being reviewed. The final decision regarding closure of the SI will rest with NHS England specialised commissioning.

4. ROLES AND RESPONSIBILITIES

4.1 All WHCCG staff are required to comply with this policy as required. There are some staff who have additional responsibilities:

4.1.1 The director of quality and patient safety has responsibility to ensure compliance with this policy, to ensure that all investigations are dealt with effectively and appropriately and to attend the Never Event panel when required.

4.1.2 The quality managers are responsible for the performance management of the SIs reported by their respective providers. This includes arranging SI panels, challenge and feedback to the provider, closing the SI on the STEIS system, arranging Never Event panels within the WHCCG and providing summary reports to Clinical Governance Committee and Board.

5. TRAINING

5.1. Key people within WHCCG who are involved in the performance management of SIs will undertake specialist training on root cause analysis.

6. EQUALITY ANALYSIS

6.1 This policy applies to all incidents that meet the SI criteria and there are no discriminatory issues. However an Equality Impact Assessment has been undertaken to demonstrate that the needs of all people have been considered by commissioners when reviewing the investigation reports. (see Appendix G for the Equality Impact Assessment).

7. SUCCESS CRITERIA / MONITORING THE EFFECTIVENESS OF THE POLICY

7.1 The success of this policy will be determined by the review of the internal WHCCG SI log, the presentation of the SI data including numbers of SI's overdue, closed and breaches per provider at Clinical Governance Committee meetings and the minutes of Never Event Panel meetings. In addition the success of the policy will also be measured by the providers following the correct procedures as detailed in the NHS SI Framework and contractual requirements.

8. REVIEW

8.1 This document may be reviewed at any time at the request of either staff side or management, but will automatically be reviewed with any change in national guidance or every three years.

9. REFERENCES AND LINKS TO OTHER DOCUMENTS

This policy should be read in conjunction with the WHCCG Incident Management Policy (August 2015).

References used for the production of this policy:

[1] National Patient Safety Agency, 'Seven Steps to Patient Safety'', 2004 – 2009. Available at http://www.nrls.npsa.nhs.uk/resources/collections/seven-steps-to-patient-safety/

[1] Royal Colleague of Surgeons (2014) Building a culture of candour: A review of the threshold for the duty of candour and of the incentives for care organisations to be candid. Available online https://www.rcseng.ac.uk/policy/documents/CandourreviewFinal.pdf

[1] Human Rights Review (2012) Article 2: The Right to Life http://www.equalityhumanrights.com/sites/default/files/documents/humanrights/hrr_article_2.pdf

[1] National Patient Safety Agency, 'Being Open: communicating patient safety incidents with patients, their families and carers', November 2009, available at: http://www.nrls.npsa.nhs.uk/resources/?EntryId45=83726

[1] Maria Dineen (2011) *Six Steps to Root Cause Analysis* (third edition) ISBN:978-0-9544328-2-9

[1] NHS England (2014) Principles for managing quality in specialised commissioning (including RASCI template) available at: https://nhsengland.sharepoint.com/TeamCentre/Operations/_layouts/15/WopiFrame.aspx?sourcedoc={1CAE2D20-BB4F-47A3-BFB6-3371A4D7AE6A}&file=Principles%20for%20managing%20quality%20in%20specialised%20commissioning%20including%20RASCI%20template.docx&action=default

[1] NPSA, RCA toolkit, available at: https://report.nrls.nhs.uk/rcatoolkit/course/iindex.htm

[1] Work related deaths: A protocol for liaison (England and Wales). Available at: http://www.hse.gov.uk/pubns/wrdp1.pdf

[1] Health and Social Care Information Centre guidance HSCIC Checklist Guidance for Reporting, Managing and Investigating Information Governance Serious Incidents Requiring Investigation (2015) Available at: https://www.igt.hscic.gov.uk/KnowledgeBaseNew/HSCIC%20SI%20Reporting%20and%20Checklist%20Guidance.pdf

NHS Serious Incident Framework March 2015. Available at: https://improvement.nhs.uk/resources/serious-incident-framework/

APPENDIX A: RESPONSIBILITIES FOR PERFORMANCE MANAGEMENT OF HAMPSHIRE PROVIDER SIS

Hampshire Hospitals NHS Foundation Trust
Joint panel (WHCCG and North Hampshire CCG) managed by West Hampshire CCG under the joint quality manager arrangements

University Hospitals Southampton NHS Foundation Trust
Joint panel (WHCCG and Southampton City CCG) managed by SCCCG, both CCG's responsible for own SI's

Royal Bournemouth & Christchurch NHS Foundation Trust
Joint panel led by Dorset CCG, each CCG responsible for its own SI's

Salisbury NHS Foundation Trust
Joint panel led by Wiltshire CCG, each CCG responsible for its own SI's

Southern Health NHS Foundation Trust - Mental Health Services
Panel led and managed by WHCCG, with attendance from Hampshire Partnerships CCG

Southern Health NHS Foundation Trust - Integrated Community Service
Each CCG responsible for its own SI's

Out of Hours Service
Panel led and managed by West Hampshire CCG

Independent Provider
These SIs will be raised by the commissioning CCG of the patient.
Each CCG will be responsible for own their SI and panel.

Southampton Treatment Centre
These SIs will be raised by the commissioning CCG of the patient.
Joint panel (WHCCG and Southampton City CCG) managed by Southampton City CCG, both CCG's responsible for their own SI's

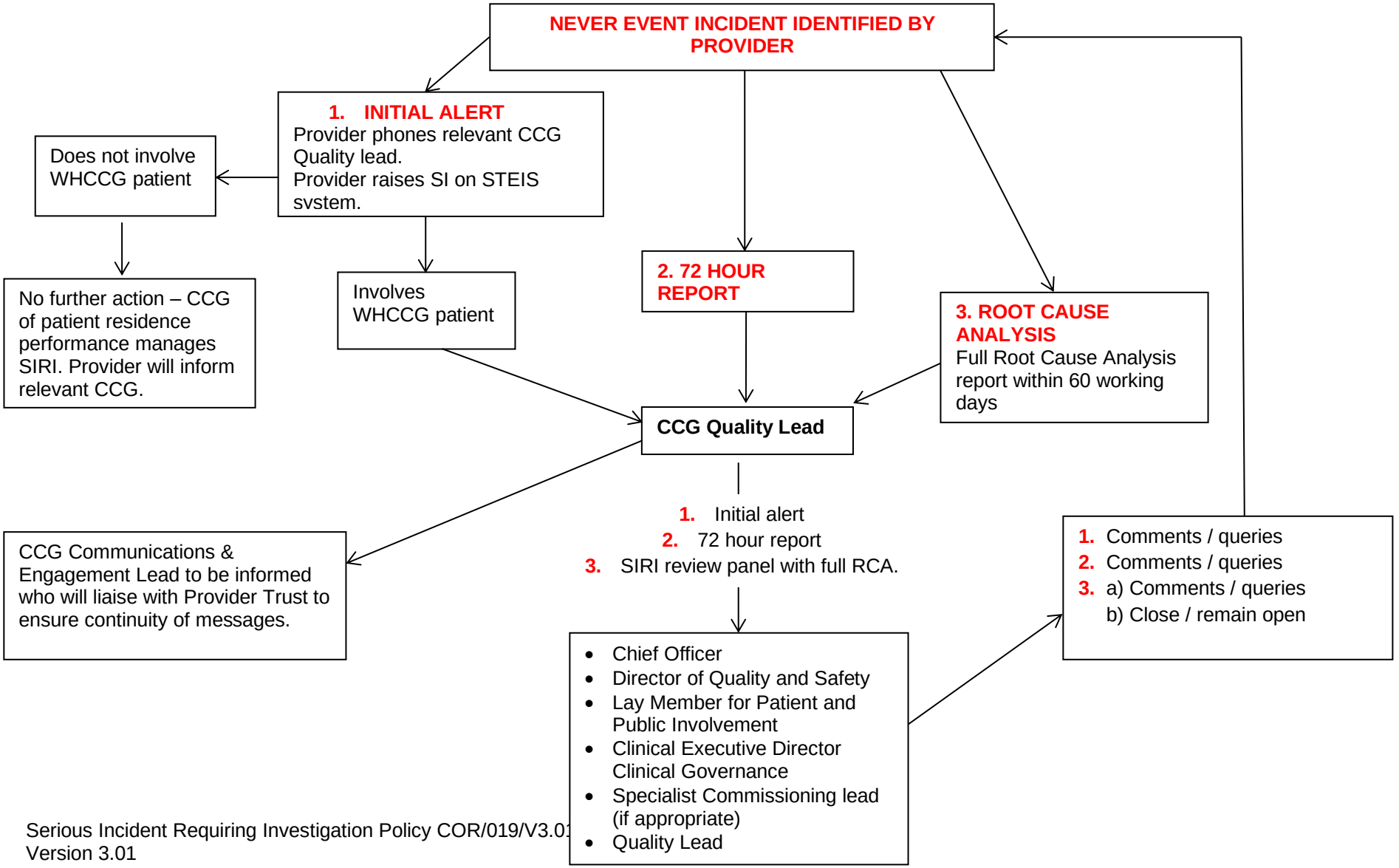
Any Qualified Provider (AQP)
These SIs will be raised by the commissioning CCG of the patient.
Each CCG will be responsible for their own SI and panel.

Out of Area Provider
These SIs will be managed by the main CCG for the provider where the SIR occurred.

APPENDIX B PROCESS FOR RECEIVING AND PERFORMANCE MANAGING A SERIOUS INCIDENT GENERATED BY A PROVIDER

48 hrs	**PROVIDER REPORT SI ON STEIS**	The provider reports the incident on STEIS.
	↓	
Following STEIS report	**WHCCG REVIEW STEIS REPORT**	WHCCG quality managers review their respective provider SIs on STEIS
	↓	
Following STEIS review	**SPECIALIST ADVICE SOUGHT**	Where necessary, the quality manager will discuss SI report with relevant specialist for review.
	↓	
60 working days following SI being reported	**RECEIPT OF SI ROOT CAUSE ANALYSIS REPORT**	The quality manager will be alerted by the provider that either STEIS has been updated with the RCA report or the RCA report will be sent to the quality manager along with a request for closure.
	↓	
As soon as possible after receipt of RCA.	**REVIEW OF SI**	The quality manager will convene a SI review panel to review the RCA. If it is a SHFT MH/LD SI the quality manager will inform the relevant CCG so they can attend the panel. If reviewers have outstanding concerns the quality manager will raise with the relevant provider.
	↓	
As soon as possible after receipt of RCA.	**PROVIDER INFORMED OF AGREEMENT TO CLOSE**	Once it has been agreed to close the SI, the quality manager will inform the provider and close on STEIS.

APPENDIX C PERFORMANCE MANAGEMENT FLOWCHART OF NEVER EVENTS IN WHCCG



APPENDIX D TERMS OF REFERENCE FOR THE WHCCG NEVER EVENTS REVIEW PANEL

1. Background

West Hampshire CCG (WHCCG) is responsible for the performance management of Serious Incidents Requiring Investigation SIs) reported by the healthcare services associated with its resident population.

2. Role and Function

The WHCCG Never Events review panel is responsible for:

- reviewing the Never Events SI root cause analysis / final reports.
- agreeing closure of the Never Events SIs.

3. Remit

The Never Event SI panel will:

- review the Never Event root cause analysis (RCA) investigation reports and action plans submitted following investigation by the commissioned healthcare provider.
- determine if the final root cause(s) has/ve been identified
- agree that appropriate action plans have been implemented
- agree that lessons learned have been shared across the relevant organisation/organisations
- agree closure/non-closure of performance managed SIs
- update relevant risk register with any commissioning risks that may be highlighted following the review of the Never Event SIs.

4. Composition/Membership

Membership of the Never Event SI panel will comprise:

- WHCCG Director or Deputy Director of Quality & Safety
- WHCCG Quality Manager (lead for the provider)

Co-opted members:

Where the group considers that it requires other specialist knowledge it is at liberty to co-opt any relevant specialist to provide advice, for example, this may include:

- Clinical Director or Medical Director
- Consultant Nurse for Safeguarding adults
- Nurse in Infection Control and Prevention
- Designated Professional Safeguarding Children

- Information Governance Lead
- Primary Care Governance Manager
- Relevant Commissioning Manager

6. Quorum

The group is quorate when both members are present.

7. Accountability

The Never Event SI panel reports to the Clinical Governance Committee (CGC).

8. Administrative support

The meeting will be serviced by a member of the WHCCG central administration team. Given the confidentiality of the subject matter, the minutes of the meeting will be written in such a way that any patient identifiable information will be anonymised.

Papers will be sent out 5 days prior to the meeting.

9. Terms of Reference approval and review date

These terms of reference will be approved and reviewed at the same time as the Serious incident Requiring Investigation Policy.

10. Frequency of meetings

The panel will be convened as and when a Never Event RCA report is required to be reviewed.

APPENDIX E TERMS OF REFERENCE FOR WHCCG SI REVIEW PANELS

1. Background

West Hampshire CCG (WHCCG) is responsible for the performance management of Serious Incidents Requiring Investigation (SIs) reported by the healthcare services associated with its resident population.

2. Role and Function

The WHCCG review panel is responsible for:

- reviewing the SI root cause analysis / final reports reported by its commissioned healthcare organisations which involve a WHCCG patient.
- agreeing closure of the SI.

3. Remit

The SI panel will:

- review the root cause analysis (RCA) investigation reports and action plans submitted following investigation by the commissioned healthcare provider.
- determine if the final root cause(s) has/ve been identified
- agree that appropriate action plans have been implemented
- agree that lessons learned have been shared across the relevant organisation/organisations
- agree closure/non-closure of performance managed SIs
- update relevant risk register with any commissioning risks that may be highlighted following the review of the SIs.

4. Composition/Membership

Membership of the SI panel will comprise:

- WHCCG Quality Manager (for the provider)
- Quality Manager from other CCG(s) if holding a joint panel
- WHCCG Specialist Commissioning lead (as appropriate) eg.
    - Lead for Safeguarding vulnerable adults
    - Nurse in Infection Control and Prevention
    - Lead for Safeguarding Children
    - Information Governance Lead
    - Primary Care Governance Manager
    - Relevant Commissioning Manager
- GP

6. Quorum

The group is quorate when the WHCCG Quality lead and one other member is present.

7. Relationship with and reporting to the Clinical Governance Committee and Board

The SI panel will report exceptions to the Clinical Governance Committee (CGC) and in the form of a dashboard.

10. Terms of Reference approval and review date

These terms of reference will be approved and reviewed at the same time as the Serious incident Policy.

11. Frequency of meetings

Panels will be convened when a number of RCA reports are ready to be reviewed.

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APPENDIX F SCREENING TOOL FOR SAFEGUARDING CONCERNS WITHIN SERIOUS INCIDENTS, INCIDENTS, CONCERNS AND COMPLAINTS

SI NUMBER	
Incident Number	
Complaints/Concern reference number	
Reviewer (name and designation)	
Date	

See Appendix for guidance regarding categories of abuse and causes of concern

Any Concerns in Relation to:	Yes/No	Comments
Physical abuse		
Domestic Violence		
Sexual abuse (including Sexual Exploitation)		
Psychological/ Emotional abuse		
Financial/Material		
Modern Slavery		
Discriminatory		
Organisational		
Neglect and Acts of Omission		
Self- Neglect		
Wilful Neglect		
Deprivation of Liberty		
Child in the care of the Local Authority (LAC)		
Hate Crime		
Mate Crime		
Poor use of the MCA (2005)		
Radicalisation		

If you have answered **YES** to any of the above screening questions, then you must notify the Safeguarding Team who will advise on the safeguarding element of the concern, incident or complaint.

Concern raised with the Safeguarding Adult or Safeguarding Children Team?	
Date	
Team Member	

Categories of Abuse and Causes of Concern

Concerns may include one or more categories of abuse or concerns. The following is not an exhaustive list but provides guidance. The safeguarding adult and children team can be contacted to discuss any concerns.

Type of abuse	Examples may include:
Physical abuse	• hitting • slapping • pushing • misuse of medication • malnutrition • restraint • inappropriate physical sanctions
Domestic violence	• psychological • physical • sexual • financial • emotional abuse • 'honour' based violence • coercive and controlling behaviour in intimate and familial relationship
Sexual abuse	• rape • indecent exposure • sexual harassment • inappropriate looking or touching • sexual teasing or innuendo • sexual photography (sexting) • subjection to pornography or witnessing sexual acts • indecent exposure • sexual acts to which the adult/child has not consented or was pressured into consenting or is unable to consent to.
Financial or material abuse	• theft • fraud • internet scamming • coercion in relation to an adult's financial affairs or arrangements, including in connection with wills, property, inheritance or financial transactions • the misuse or misappropriation of property, possessions or benefits

Type of abuse	Examples may include:
Modern slavery	• slavery • human trafficking • forced labour and domestic servitude • traffickers and slave masters using whatever means they have at their disposal to coerce, deceive and force individuals into a life of abuse, servitude and inhumane treatment
Psychological abuse	• emotional abuse • threats of harm or abandonment • deprivation of contact • humiliation • blaming • controlling • intimidation • coercion • harassment • verbal abuse • cyber bullying • isolation • unreasonable and unjustified withdrawal of services or supportive networks
Discriminatory abuse	• harassment • slurs or similar treatment: • because of race • gender and gender identity • age • disability • sexual orientation • religion
Organisational abuse	• neglect and poor care practice within an institution or specific care setting such as a hospital or care home • neglect or poor professional practice as a result of the structure, policies, processes and practices within an organisation
Neglect and acts of omission	• Self-neglect (adults) • Failure of parents/carers to provide food, clothing and shelter to children. • Missing health care appointments/immunisations/dental etc • Inappropriate care afforded to the child or vulnerable adult e.g. leaving children with a registered sex offender • Children home alone • Wilful Neglect (MCA, 2005): This means that the healthcare worker had to either deliberately or recklessly neglect or mistreat the patient. Reckless neglect or

Type of abuse	Examples may include:
	mistreatment will involve the healthcare worker pursuing a course of action while consciously disregarding the fact that the action gives rise to a substantial and unjustifiable risk to the patient, even if the harm risked was not intended. This means that an honest belief that a course of action was in the best interest of the patient may serve as an excuse or even justification, and the defendant may not be found guilty.
Deprivation of Liberty Safeguards - post Cheshire West	• Is the person objectively deprived of their liberty or is there a risk that cannot be sensibly ignored that they are objectively deprived of their liberty? • There are two key questions to ask – the 'acid test': 1. Is the person subject to continuous supervision and control? 2. Is the person free to leave? • In all cases, the following are not relevant to the application of the test: 1. The person's compliance or lack of objection; 2. The relative normality of the placement (whatever the comparison made); and 3. The reason or purpose behind a particular placement.
Mate Crime	• A 'mate' crime is when vulnerable people are befriended by members of the community who go on to exploit and take advantage of them. • 'Mate' covers a wide number of people including friends, family and supporters.
Hate Crime	• Any non-crime incident which is perceived by the victim or any other person, to be motivated by a hostility or prejudice based on a person's race or perceived race, religion or perceived religion, or sexual orientation or perceived sexual orientation, person's disability or perceived disability, or a person who is transgender or perceived to be transgender
Radicalisation to Terrorism	• Any concerns about this must be referred directly to the safeguarding adult or children team.

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APPENDIX G QUALITY CHECKLIST

Commissioner SI Closure Checklist

All elements need to be present to enable closure of the investigation

STEIS NUMBER: **CCG PANEL DATE:** **CLOSED/NOT CLOSED** (circle one)

IF NOT CLOSED, CCG REVIEWED ON (DATE): CLOSED/NOT CLOSED (circle one)

IF NOT CLOSED, CCG REVIEWED ON (DATE): CLOSED/NOT CLOSED (circle one)

Phase of investigation	Element	Present: Y / N	Comments
1. GATHERING AND MAPPING	a) Was the appropriate evidence used (where it was available) i.e. patients notes/records, written account?		
	b) Were interviews conducted?		
	c) Is there evidence that those affected (including patients/staff/victims/ perpetrators and their families) were involved and supported appropriately?		
	d) Has Duty of Candour been met?		
	e) Has a timeline of events been produced?		
	f) Are good practice guidance and protocols referenced to determine what should have happened?		
	g) Are care and service delivery problems identified?		
2. ANALYSING INFORMATION	a) Is there evidence that the contributory factors for each problem have been explored?		
	b) Is there evidence that the most fundamental issues/ or root causes have been considered?		
	c) Have appropriate lessons been identified for learning?		
	d) Are there clear procedures for effective communication to facilitate sharing of learning across the organisation(s)?		

Phase of investigation	Element	Present: Y / N	Comments
3. GENERATING SOLUTIONS	a) Is there an action plan?		
	b) Does the action plan reflect all recommendations?		
	c) Is there a responsible person identified for each action?		
	d) Is there as timeframe for completion?		

West Hampshire Clinical Commissioning Group

Equality impact assessment

Title of policy, project or proposal:
Serious Incidents (SI) Policy

Name of lead manager: Carole Berryman
Directorate: Quality

What are the intended outcomes of this policy, project or proposal?
The policy sets out the mechanism for the performance management of serious incidents reported by healthcare organisations commissioned by West Hampshire Clinical Commissioning Group (CCG). The ultimate aim of the policy is to ensure that lessons are learnt following serious incidents, so that recurrences are prevented. Although a number of the protected characteristics below are not captured by the national database, the Strategic Exchange and Information System (StEIS), and therefore we cannot provide evidence of their impact, the policy makes it clear that when the CCG scrutinises the investigation reports submitted by the providers they will also identify if equality and diversity issues have played a part in the incident and will ensure that any gaps in care are included in the provider action and improvement plans.

Evidence

Who will be affected by the policy, project or proposal?

Identify whether patients, carers, communities, CCG employees, and/ or NHS staff are affected.

Serious Incidents in health care are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified.

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

- A Never Event
- 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
- Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation.

Serious incidents are reported by healthcare providers onto the national database, the Strategic Exchange and Information System (StEIS) against set criteria and they could happen to any patient at any time irrespective of any equality or diversity elements. However there are certain types and categories of patients who have a higher likelihood of suffering a serious incident due to challenges with communication (for example, blind, deaf, non-English speaking) or cognitive impairment (for example, learning difficulties, dementia, certain mental illnesses).

Although StEIS is able to capture some of the protected characteristics such as ethnicity, age and gender, the cognitive and communication elements are not included. These are only able to be identified during the investigation process and the CCG will be made aware of these when the report is received and scrutinised.

Attempts have been made to change the StEIS system but this has proved not to be possible.

Age

Consider and detail (including the source of any evidence) the impact on people across the age ranges.

The majority of SI's happen to people in the adult age groups however SIs of babies, children and adolescents are also reported.

Disability

Consider and detail (including the source of any evidence) the impact on people with different kinds of disability (this might include attitudinal, physical and social barriers). Certain medical conditions are automatically classed as being a disability – for example, cancer, HIV infection, multiple sclerosis.

Evidence suggests that people with learning disabilities die in hospital and at a younger age than the general population and this may be due to poor healthcare. However evidence gathered from the use of this policy over the last three years does not indicate that a significant proportion had learning disabilities. All deaths in hospitals are now subject to review, investigation and reporting (ref: *National Guidance on Learning from Deaths*, National Quality Board, March 2017) and if any are identified as meeting the SI criteria they will be reported on StEIS and a more detailed investigation (root cause analysis, RCA) will take place. In addition, all deaths of people with a learning disability are reported to the national Learning Disability Mortality programme (LeDeR) and will have a full review undertaken whether they are also subject to a SI investigation or not.

Patients with a sensory disability (deaf or visual impairment) or a physical impairment may be at greater risk of serious incident due to communication difficulties or mobility issues. There is also some evidence that people with disabilities may be more likely to be exploited, abused or discriminated against.

Dementia

Given the CCGs commitment to commissioning 'Dementia Friendly' services, consider and detail any impact on people with dementia.

Evidence gathered from the use of this policy over the last three years does not indicate that a significant proportion had a dementia-related illness. This information is not specifically captured, however it will be included in the RCA and scrutinised by the CCG.

Gender reassignment (including transgender)

Consider and detail (including the source of any evidence) the impact on transgender people. Issues to consider may include same sex/ mixed sex accommodation, ensuring privacy of personal information, attitude of staff and other patients.

There is no evidence to suggest that this is a significant cause for concern of SI's.

Marriage and civil partnership

Note: This protected characteristic is only relevant to the need to eliminate discrimination within employment. Where relevant, consider and detail (including the source of any evidence) the impact on people who are married or in a civil partnership (for example, working arrangements, part-time working, infant caring responsibilities).

Not relevant as this policy does not cover employment practices.

Pregnancy and maternity

Consider and detail (including the source of any evidence) the impact on women during pregnancy and for up to 26 weeks after giving birth, including as a result of breastfeeding.

This is captured on the StEIS system and has been a cause for some concern over the past three years and this has / is being addressed though the usual contractual processes with the relevant providers.

Race

Consider and detail (including the source of any evidence) the impact on groups of people defined by their colour, nationality (including citizenship), ethnic or national origins. Given the demography of west Hampshire this will include Roma gypsies, travellers, people from Eastern Europe, Nepalese and other South East Asian communities. Impact may relate to language barriers, different cultural practices and individual's experience of health systems in other countries.

People from ethnic minorities may be more likely to face discrimination and abuse. Local community involvement work has found that older women from minority ethnic backgrounds (for example Asian and Nepalese people) are more likely to speak or understand little English. We have no evidence to suggest that this is a significant cause for concern of SI's.

Religion or belief

Consider and detail (including the source of any evidence) the impact on people with different religions, beliefs or no belief. May be particularly relevant when service involves intimate physical examination, belief prohibited medical procedures, dietary requirements and fasting, and practices around birth and death.

People from minority faiths may be more likely to face discrimination or harassment. We have no evidence to suggest that this is a significant cause for concern of SI's.

Sex (gender)

Consider and detail (including the source of any evidence) the impact on men and women (this may include different patterns of disease for each gender, different access rates).

There is no evidence to suggest that this is a significant cause for concern of SI's. This information is captured via the StEIS system.

Sexual orientation

Consider and detail (including the source of any evidence) the impact on people who are attracted towards their own sex, the opposite sex or to both sexes (lesbian, gay, heterosexual and bisexual people).

There is evidence that lesbian, bi-sexual and gay people may be more likely to face discrimination or harassment. We have no evidence to suggest that this is a significant cause for concern of SI's.

Carers

Consider and detail (including the source of any evidence) the impact on people with caring responsibilities. This must include people who care for disabled relatives or friends (as they are protected by discrimination by association law), but you should also consider parent/ guardian(s) of children under 18 years. Carers are more likely to have health problems related to stress and muscular-skeletal issues, they may have to work part-time or certain shift-patterns, or face barriers to accessing services.

There is no evidence to suggest that this is a significant cause for concern of SI's.

Serving Armed Forces personnel, their families and veterans

The needs of these groups should be considered specifically. The CCG has a responsibility to commission all secondary and community services required by Armed Forces' families where registered with NHS GP Practices, and services for veterans and reservists when not mobilised (this includes bespoke services for veterans, such as mental health services).

There is no evidence to suggest that this is a significant cause for concern of SI's.

Other identified groups

Consider and detail (including the source of any evidence) the impact on any other identified groups. Given the demography of west Hampshire this should include impact of:

- Poverty
- Living in rural areas
- Resident status (migrants and asylum seekers).

There is no evidence to suggest that this is a significant cause for concern of SI's.

Involvement and consultation

For each engagement activity, briefly outline who was involved, how and when they were engaged, and the key outputs

How have you involved stakeholders with an interest in protected characteristics in gathering evidence or testing the evidence available?

Requested changes to be made to the national StEIS system – this has not been possible however there is a possibility that a new system is being designed.

Responded to the national consultation on the national SI Framework.

Involvement in the LeDeR programme to ensure that any learning from SIs are fedback to the relevant providers for improvement.

How have you involved/ will you involve stakeholders in testing the policy, project or proposals?

Equality statement

Considering the evidence and engagement activity you listed above, please summarise the findings of the impact of your policy, project or proposal. Consider whether the evidence shows potential for differential impact, if so state whether adverse or positive and for which groups.

Impact summary (statutory considerations)	
Age	Positive
Disability	Positive
Sexual orientation	Positive
Race	Positive
Religion or belief	Neutral
Gender reassignment	Positive
Sex	Neutral
Marriage and civil partnership	Neutral
Pregnancy and maternity	Positive

Other policy considerations	
Poverty	Positive
Place (Rural versus urban living)	Positive
Serving Armed Forces/ veterans	Positive
Other factors	Positive
Have you identified any positive or negative impacts?	**Yes** No If 'Yes' please provide details below

Positive impacts

Where there is evidence, provide a summary of the positive impact the policy, project or proposal will have for each protected characteristic, and any other relevant group or policy consideration. This should include outlining how equal opportunities will be advanced and good relations fostered between different groups.

The CCG policy aims to ensure that the numbers of serious incidents are reduced and that when they do occur, that action is taken to prevent further incidents. This should have a positive impact for all protected characteristic groups

Negative impacts

Where there is evidence, provide a summary for each protected characteristic and any other relevant group or policy consideration. If the evidence shows that the policy, project or proposal will or may result in discrimination, harassment or victimisation this **must be** outlined.

The evidence suggests that certain equality groups may be more likely to be involved in a serious incident either because of death or injury, or because of abuse or discrimination:

- People with cognitive impairments as a result of learning disability, dementia, serious mental health problems
- People who are deaf due to communication difficulties if an interpreter is not available
- People with visual impairments or poor mobility
- People with limited English
- People from minority faiths
- People who are lesbian, gay, bi-sexual and transgender.

Evidence suggests that people with learning disabilities die in hospital and at a younger age than the general population and this may be due to poor healthcare. However evidence gathered from the use of this policy over the last three years does not indicate that a significant proportion had learning disabilities. All deaths in hospitals are now subject to review, investigation and reporting (ref: *National Guidance on Learning from Deaths*, National Quality Board, March 2017) and if any are identified as meeting the SI criteria they will be reported on StEIS and a more detailed investigation (root cause analysis, RCA) will take place. In addition, all deaths of people with a learning disability are reported to the national Learning Disability Mortality programme (LeDeR) and will have a full review undertaken whether they are also subject to a SI investigation or not.

Evidence gathered from the use of this policy over the last three years does not indicate that a significant proportion had a dementia-related illness. This information is not specifically captured, however it will be included in the RCA and scrutinised by the CCG.

Health inequalities

Please outline any health inequalities highlighted by the evidence (for example, differential access to services or worse health outcomes for particular groups or localities).

Certain groups are more likely to face discrimination or abuse such as people with learning disabilities, dementia or mental illness; all SIs are scrutinised for any safeguarding issues where these will be captured. The policy identifies the relationships with the safeguarding teams at the CCG.

Action planning for improvement, and to address health inequalities and discrimination

Please give an outline of the key actions based on any gaps, challenges and opportunities you have identified. Include here any general action to address specific equality issues and data gaps that need to be addressed through consultation or further research.

Action	Person responsible	By date
Update policy	Senior Quality Manager: South West	End June 2018 (complete)
Feedback about the SI framework consultation	Senior Quality Manager: South West	12 June 2018 (complete)

For your records

Role of person who carried out this assessment:	**Senior Quality Manager: South West**
Date assessment completed:	**8 June 2018**
Date to review actions:	
Name of responsible Director:	**Director of Quality & Nursing (Board Nurse)**
Date assessment was approved:	