Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

NHS 70 YEARS OF THE NHS 1948 - 2018

Meeting of Governing Body

Date: Tuesday 5th June 2018
Time: 13.30am
Location: the Vassall Centre, Gill Avenue, Downend, BS16 2QQ

Agenda item: 11.3

Report title: Corporate Quality Policies

Report Author: Marie Davies, Associate Director of Quality
Report Sponsor: Anne Morris, Director of Nursing and Quality

1. Purpose

This paper presents a number of key policies affecting Quality; that of:

- Serious Incident Policy
- Management of Compliments, Concerns and Complaints Policy

2. Recommendations

The Governing Body is asked to:

- Review and ratify the following policies the individual policy
- Note the plan for implementation in the CCG

3. Background

From the 1st of April 2018 Bristol, North Somerset and South Gloucestershire Clinical Commissioning Groups to form the BNSSG CCG. In moving to this there is a work programme overseen by the Corporate Policy Group to review and revise the existing policies from each CCG to then agree a single version for the new organisation.

The attached policies have been subject to review by the Quality Committee and Corporate Policy Group and are put forward for ratification by the Governing Body. It should also be noted that further work has been requested by the group to develop an 'Easy Read' version of key patient focused policies such as the Management of Compliments, Concerns and Complaints and ensure these are available for public access through the CCG website.

4. Financial resource implications

The policies do not have direct financial implications.

5. Legal implications

Where applicable reference to national guidance and any legal responsibilities are outlined in the individual policy

6. Risk implications

Where applicable reference to national guidance and any risks are outlined in the individual policy

7. Implications for health inequalities

Both policies presented by this paper have been subject to an Equality Impact Assessment screening. Details are provided in each policy

8. Implications for equalities (Black and Other Minority Ethnic/Disability/Age Issues)

Both policies presented by this paper have been subject to an Equality Impact Assessment screening. Details are provided in each policy

9. Consultation and Communication including Public Involvement

Both policies are based on national guidance and frameworks. Where the policies engage with patients this is detailed in each policy.

10. Appendices

Appendix 1 - Management of Compliments, PALs Enquiries and Complaints Policy
Appendix 2 - Serious Incidents Requiring Investigation Policy

Glossary of terms and abbreviations

Serious Incident Requiring Investigation	Serious Incident Requiring Investigation are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.
Compliment	Praise for an individual or a service provided or commissioned
Informal Complaint	A matter that can be dealt with on the spot or can be satisfactorily resolved no later than the end of the next working day Or A complaint received by the CCG which does not relate to the CCG and is passed on to another organisation for investigation and response.
Formal Complaint	A matter relating to CCG business which cannot be resolved within 24 hours and requires investigation. A response from the Chief Executive will then be provided.

NHS
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Clinical Commissioning Group

70 YEARS OF THE NHS 1948 - 2018

Policy on the management of Compliments, PALs enquiries and Complaints

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Please complete the table below: *To be added by corporate team once policy approved and before placing on website*	
Policy ref no:	
Responsible Executive Director:	Anne Morris, Director of Nursing and Quality
Author and Job Title:	Lucy Jones, Customer Services Manager
Date Approved:	XX/2018
Approved by:	
Date of next review:	XX/2018

	Yes/No/NA	**Supporting information**
Has an Equality Impact Assessment Screening been completed?	Yes	Assessment Screening completed
Has the review taken account of latest Guidance/Legislation?	Yes	Referenced in policy
Has legal advice been sought?	No	Guided by national complaints process
Has HR been consulted?	No	Guided by national complaints process
Have training issues been addressed?	Yes	
Are there other HR related issues that need to be considered?	No	
Has the policy been reviewed by JCC?	NA	Policy does not apply to employment
Are there financial issues and have they been addressed?	NA	
What engagement has there been with patients/members of the public in preparing this policy?	No	Guided by national complaints process
Are there linked policies and procedures?	No	
Has the lead Executive Director approved the policy?	Yes	
Which Committees have assured the policy?	Yes	Quality Committee
Has an implementation plan been provided?	Yes	
How will the policy be shared with: • Staff? • Patients? • Public?		The Hub CCG Website
Will an audit trail demonstrating receipt of policy by staff be required; how will this be done?	No	

Version Control		
Version	Date	Consultation
V1	27 February 2018	Draft policy written
V2	9 March 2018	Comments from Fiona Cummings,
V3	9 March 2018	Complaints Manager included Comments from PPI team regarding
V4	14 March 2018	Equality Impact Assessment Included Job titles and team names updated.
V5	22 May 2018	Minor format changes

Contents

Policy on the management of Compliments, PALS enquiries and Complaints

1. Introduction

1.1 Bristol, North Somerset and South Gloucestershire (BNSSG) CCG is committed to ensuring that services in the local area meet and exceed the expectations of our local population. To help us understand where processes do and do not work, we actively encourage feedback, both positive and negative, so that we can use this to maintain, improve and if necessary change the services we commission. The CCG will always seek to learn from any feedback provided.

1.2 This policy is compliant with the Local Authority Social Services and National Health Services Complaints (England) Regulations which came into effect on 1 April 2009, and the principles of the complaints process are based on those of the Parliamentary and Health Services Ombudsman which are:

1. Getting it Right
2. Being Customer Focused
3. Being Open and Accountable
4. Acting Fairly and Proportionately
5. Putting things Right
6. Seeking Continuous Improvement

1.3 This policy also takes into account the recommendations of the Francis Report including:

- Openness, transparency and candour
- The importance of data narrative as well as numbers within the data and,
- Complaints amounting to serious untoward incidents should trigger an investigation
- Active encouragement of both positive and negative feedback about services

1.4 All contacts with the CCG which fall within the remit of this policy will be handled in the strictest of confidence and details will only be shared with other relevant partners once consent has been received from the appropriate person (please see section 6).

2. Purpose and scope

2.1 The purpose of this policy is to clearly describe how BNSSG will manage patient experience to ensure that complimentary feedback is shared and negative feedback is learnt from. The CCG will take all feedback seriously and will endeavour to listen, assist and advise those who make contact to ensure their concern is addressed appropriately. All complaints will be

properly investigated in an unbiased, open and transparent manner and complainants will receive a timely response, including any action being taken as a result in a timely manner.

2.2 This policy is applicable to all staff and stakeholders.

3. Duties and responsibilities

3.1 **The Chief Executive** is responsible for ensuring compliance with the complaint regulations and for approving and signing all complaint response letters, or appointing an appropriate deputy.

3.2 **The Director of Nursing and Quality** has delegated responsibility from the Chief Executive for oversight of the management of PALS and Complaints function and management of the Customer Services Team.

3.3 **The BNSSG Customer Services team** is responsible for the processing and handling of all compliments, PALS contacts and complaints and ensuring that any learning identified is implemented by the appropriate manager.

3.4 **Executive Directors** are responsible for identifying an investigating officer and ensuring that complaint investigations are thorough, fair and transparent. Upon completion of the investigation, the Executive Director must approve a draft response prior to Chief Executive sign off and ensure that where possible, learning is identified from the feedback received to improve services in the future.

3.5 **All BNSSG staff** and those working in a temporary capacity for the CCG have a duty, and a responsibility to ensure that any patient feedback they receive is handled in line with this policy, and brought to the attention of the BNSSG Customer Services team in the first instance.

3.6 **Support, Empower, Advocate and Promote (SEAP) and Swan Advocacy** offer an independent complaints advocacy service to advise complainants and support them through the complaints process. Advocacy details will be included in all complaint acknowledgement letters.

4. Definitions of terms used

Compliment	Praise for an individual or a service provided or commissioned
Informal Complaint	A matter that can be dealt with on the spot or can be satisfactorily resolved no later than the end of the next working day *Or*

	A complaint received by the CCG which does not relate to the CCG and is passed on to another organisation for investigation and response.
Formal Complaint	A matter relating to CCG business which cannot be resolved within 24 hours and requires investigation. A response from the Chief Executive will then be provided.
PALS	Patient Advice and Liaison Service.
Health Watch	Advisory and signposting service commissioned by the Local Authority in Bristol, North Somerset and South Gloucestershire. It also provides the opportunity for local people to have a say about, and influence the design and delivery of local health and social care services.
Support, Empower, Advocate and Promote (SEAP)	Complaints advocacy service for Bristol and North Somerset residents.
Swan Advocacy	Complaints advocacy service for South Gloucestershire residents.
Stakeholders (Customers)	A person, group, professional body or organisation with an interest in the service being provided, for example, members of the public including service users, GPs, Dentists, Opticians, Pharmacists and the Local Authority.
The Regulations	Local Authority Social Services and National Health Service Complaints (England) Regulations 2009
Learning Outcome Form	The form which upon completion of an investigation, documents the actions to be taken by the Investigating Officer and confirms these have been completed.
Parliamentary and Health Service Ombudsman	An independent body established to provide a service to the public by undertaking independent investigations into complaints that public bodies, including the NHS in England, have not acted properly or fairly or have provided a poor service.

5. Types of feedback and how these are handled

5.1 Compliments

5.1.1 The CCG strives to meet and exceed the expectations of its service users and it is extremely rewarding for managers and their staff to know when they have achieved this.

5.1.2 A compliment can be made verbally or in writing to the Customer Services Team using the details in Appendix 1. Upon receipt, compliments will be acknowledged wherever possible and will be shared with the service lead / staff member involved and their line manager. This information will be retained on file and shared with the Quality Committee as part of the quarterly reporting process.

5.2 PALS Enquiries

5.2.1 If a service user, friend or relative has a concern, query or would like some advice regarding healthcare, the PALS service should be contacted using the contact details in Appendix 1.

5.2.2 Upon receipt, the Customer Services team will discuss with the person the most appropriate way to assist them and will either signpost them to the correct place or liaise with the necessary people in order to provide a response. All information will be treated confidentially, however, details will be retained on file and themes, changes and any learning identified will be reported on a quarterly basis to the Quality Committee.

5.3 Complaints

5.3.1 Under the Regulations, a complaint can be made to either the provider or the commissioner of the service.

5.3.2 When a complaint is received regarding a commissioned service, the Customer Services Team will discuss with the complainant which is the most appropriate organisation to handle the complaint.

5.4 Informal Complaints

5.4.1 The CCG understands that sometimes things go wrong and the matter can be rectified swiftly and without the need to go through the formal complaints process. As long as the CCG is able to put the problem right, and the outcome meets the customer's satisfaction by the end of the next working day, this will be recorded as an informal complaint.

5.4.2 In the event the problem cannot be resolved by the end of the next working day it will be taken forward as a formal complaint, unless the customer prefers a less formal route, in which case the feedback will be handled as a PALS enquiry.

5.4.3 For recording purposes, any complaint received which is not directly investigated or responded to by the CCG will be logged as an informal complaint. The Organisation to which the complaint relates will record this as a formal complaint and will take the issues forward in line with the complaint regulations.

5.4.5 Where a complaint relates to another NHS organisation or Trust, subject to consent, the details will be shared with the organisation to which the complaint relates and the organisation involved will take this forward directly with the complainant.

5.5 Formal complaints

5.5.1 There are times when things go wrong and the nature of the problem causes an individual to pursue a more formal process in order for their concerns to be addressed.

5.5.2 A complaint can be made orally, in writing or electronically. Where a complaint is made verbally, the member of staff receiving the complaint must make a written record of the details and send this to the BNSSG Customer Services team within 24 hours. Where a complainant wishes to make their complaint in person, the Customer Services team must be contacted in advance using the details in Appendix 1.

5.5.3 Upon receipt of a complaint, the BNSSG Customer Services team will acknowledge it within 3 working days and will take it forward in line with the regulations and the process set out in Appendix 2. Where possible a member of the team will have a conversation with the complainant to discuss:

a) How the complaint will be handled,
b) The anticipated timescale for a response to be sent from the Chief Executive
c) The complainant's desired outcome(s) from the complaint

5.5.4 If it is not possible to make verbal contact with the complainant, the BNSSG Customer Services team will write to acknowledge receipt and will include an anticipated timescale for response within this.

5.6 Complaints which are outside of the scope of this policy

- A complaint made by a Local Authority, Primary Care Provider, Independent Provider of NHS body
- A complaint made by an employee about any matter relating to employment
- A complaint which is the same as a complaint previously investigated and resolved
- A complaint which has been previously investigated under the 2004, 2006 or 2009 regulations
- A complaint which is or has been investigated by a Health Service Commissioner under the 1993 Act
- A complaint regarding the alleged failure to comply with a request under the Freedom of Information Act 2000.

6. Who can make a complaint

6.1 Anybody can make a complaint; however when the complaint is not being made directly by the service user, their consent will be required.

6.2 In the event that a person discloses physical or sexual abuse, the CCG lead for Safeguarding must be consulted. This action is required even if the person does not wish to make a formal complaint. In instances where financial misconduct is disclosed, the Chief Finance Officer must be consulted in the first instance.

7. Timescale for making a Complaint or raising a concern

7.1 A complaint or concern must be made not later than 12 months after:

- The date on which the matter which is the subject of the complaint or concern occurred; or
- The date on which the matter which is the subject of the complaint came to the attention of the person complaining.

8. Complaints that involve more than one organisation

8.1 The NHS can be very complex and it is sometimes difficult for individuals to know who to direct their complaint to, particularly when more than one service is involved. Therefore, when the CCG receives a complaint which also requires input from other organisations, upon receipt of service user consent, the details will be shared and a single overall response will be coordinated. The Organisation responsible for coordinating the response will be the one to which the complaint mostly relates and where this is not the CCG, confirmation will be provided at the time the complaint is acknowledged.

9. Support for Complainants during the complaints process

9.1 Support and advice can be sought from the BNSSG Customer Services team at any time. This service is completely confidential and no information will be shared without service user consent, or for someone who lacks mental capacity to consent, a determination that to share the information would be in the person's best interests.

9.2` If independent complaints support is required, SEAP or Swan Advocacy can be contacted using the details in Appendix 1.

10. Support for staff during the complaints process

10.1 All statements, letters, phone calls and actions taken in an investigation must be documented and kept in a complaint file. A complete complaint file is required should the complaint be referred to the Parliamentary and Health Service Ombudsman.

10.2 Members of staff named in a complaint, either personally or by role, should be informed of the complaint by their line manager. Staff should be fully supported by their line manager and consulted during the investigation. The investigation should be full, fair and timely and should not apportion blame.

10.3 The following sources of support are available to staff:

- Line Manager
- Directorate Executive Director
- Complaints Manager and PALS staff
- Occupational Health
- Professional Bodies

11. Parliamentary and Health Service Ombudsman (PHSO)

11.1 The PHSO aims to provide a service to the public by undertaking independent investigations into complaints where government departments, a range of other public bodies in the UK, and the NHS in England have not acted properly or fairly or have provided a poor service.

11.2 Where a complainant remains dissatisfied with the response provided by the Chief Executive and they feel the CCG is unable to resolve their concern locally, they can ask the PHSO to review the case. A complaint must have exhausted the local complaints procedure before it can be escalated to the PHSO.

11.3 Details for contacting the PHSO will be included in the Chief Executive's response letter but can also be found in Appendix 1.

11.4 Where a complaint is escalated to the PHSO the CCG will be notified along with a request to submit any relevant information to them for their consideration. The PHSO will notify the CCG of the outcome and the Customer Services team will in turn notify the Chief Executive and relevant Director.

12. Confidentiality and user consent

12.1 Where a concern or a complaint is made on behalf of a third party, or where there is a need to share the details outside of the CCG, consent from the service user will be required in the first instance, unless the person making the complaint holds Lasting Power of Attorney (LPoA) for the service user's welfare or is a Court Appointed Deputy (CAD) with the relevant decision making power. In such instances proof will be required before the concern or complaint can be taken forward.

12.2 In the event a complaint is made on behalf of a deceased patient, consent from the next of kin or person who holds LPoA for the patient's welfare will be required before the complaint can be taken forward.

12.3 Without consent, LPoA or CAD with the relevant decision making power, the CCG will be unable to provide a personal response. However we will consider the information given and where possible, attempt to address the situation anonymously.

12.4 Where a complaint has been made on behalf of a child, i.e. somebody under 18, the CCG will not consider the issues unless it is satisfied that there are reasonable grounds for this not being made by the child themselves. Likewise, if the service user is a child or is a person who lacks capacity within the meaning of the Mental Capacity Act 2005 and the CCG believes that the representative is not conducting the complaint in the service user's best interest, the complaint will not be considered further. In such circumstances, an explanation of the reasons will be provided in writing to the representative who will need to contact the Health Service Ombudsman if they are unhappy.

12.5 Any information regarding a person who lacks capacity to provide consent will only be shared on the basis that it is in that person's best interests. A clear record of the best interests determination process will be made, including details of how the views of the person and relevant others have been taken into consideration.

12.6 Any member of staff involved in the complaint or enquiry or with whom the information is shared is expected to maintain service user confidentiality at all times. Any breaches of this that are brought to the attention of the CCG will be investigated and may be treated as a disciplinary matter.

13. Implementation Plan (Including training, resources)

13.1 The complaint regulations have been effective since the 1 April 2009 and this policy provides a formal description of the process now in place. Upon approval of the policy, it will be published on the CCG website and all staff will be made aware that it is available. Advice is always available from the BNSSG Customer Services team and training can be provided on request.

14. Audit

14.1 One month after a formal complaint has been responded to, the Customer Services team will write to all complainants to seek their feedback. This information will then be used to inform how the complaints process can be improved to ensure it adequately fulfils its purpose.

The learning identified from complaints will be reviewed on a six monthly basis to ensure that the same issues are not repeated.

15. Training Requirements

15.1 All Customer Services team members will be trained in the handling of compliments, PALS and complaints on appointment.

15.2 All other staff will be made aware of their responsibilities in relation to this policy through regular updates and specific training, if required

16. Equality Impact Assessment

16.1 This policy is an amalgamation of the Complaints and PALS policies that were in place across Bristol, North Somerset and South Gloucestershire CCG's and is based on the requirements of the National Complaint Regulations 2009. An Equality Impact Assessment was undertaken for the South Gloucestershire CCG policy however, it is unclear if this was undertaken is for Bristol and North Somerset.

16.2 An initial Equality Impact Screening Assessment has been undertaken on the revised policy which has identified that a full assessment is not required at this stage. However, in consideration of the wider population that this policy will apply to, a further review will be undertaken in 6 months to determine whether any feedback received has highlighted any issues in terms of how it is made available to individuals.

16.3 In recognition of the diverse culture of the BNSSG area, and in meeting our obligations under the Accessible Information Standard, this policy can be made available in a larger font or alternative colour and in recognition that PDF documents are not generally compatible with screen readers used by people with sight impairments; it can also be made available using an alternative software package i.e.Microsoft Word.

16.4 In addition, a leaflet containing the key information can also be provided in braille or an alternative spoken language if required. We are also mindful that we serve a higher than average deaf population in Bristol (in comparison with other UK locations), and we are committed to providing British Sign Language interpretation support if this is required to make our policy more accessible.

17. Monitoring Compliance and effectiveness

17.1 The Customer Services team will be monitored on their compliance with agreed key performance indicators (KPIs) which reflect the complaint regulation standards. A quarterly report detailing this performance, along with a summary of the patient feedback received, steps taken and any learning that was identified as a result will be produced and shared with the Quality Committee and Governing Body.

17.2 In addition, quarterly returns (KO41a) are also submitted to the Health and Social Care Information Centre (HSCIC) regarding complaints performance.

17.3 To ensure the continued effectiveness of the Customer Services team, every formal complaint responded to by the CCG will be followed up with a feedback form one month later. Where necessary, action will be taken to address any shortfalls in service.

18. References, Acknowledgements and associated documents

18.1 Local Authority Social Services and National Health Services Complaints (England) Regulations

19. Appendices

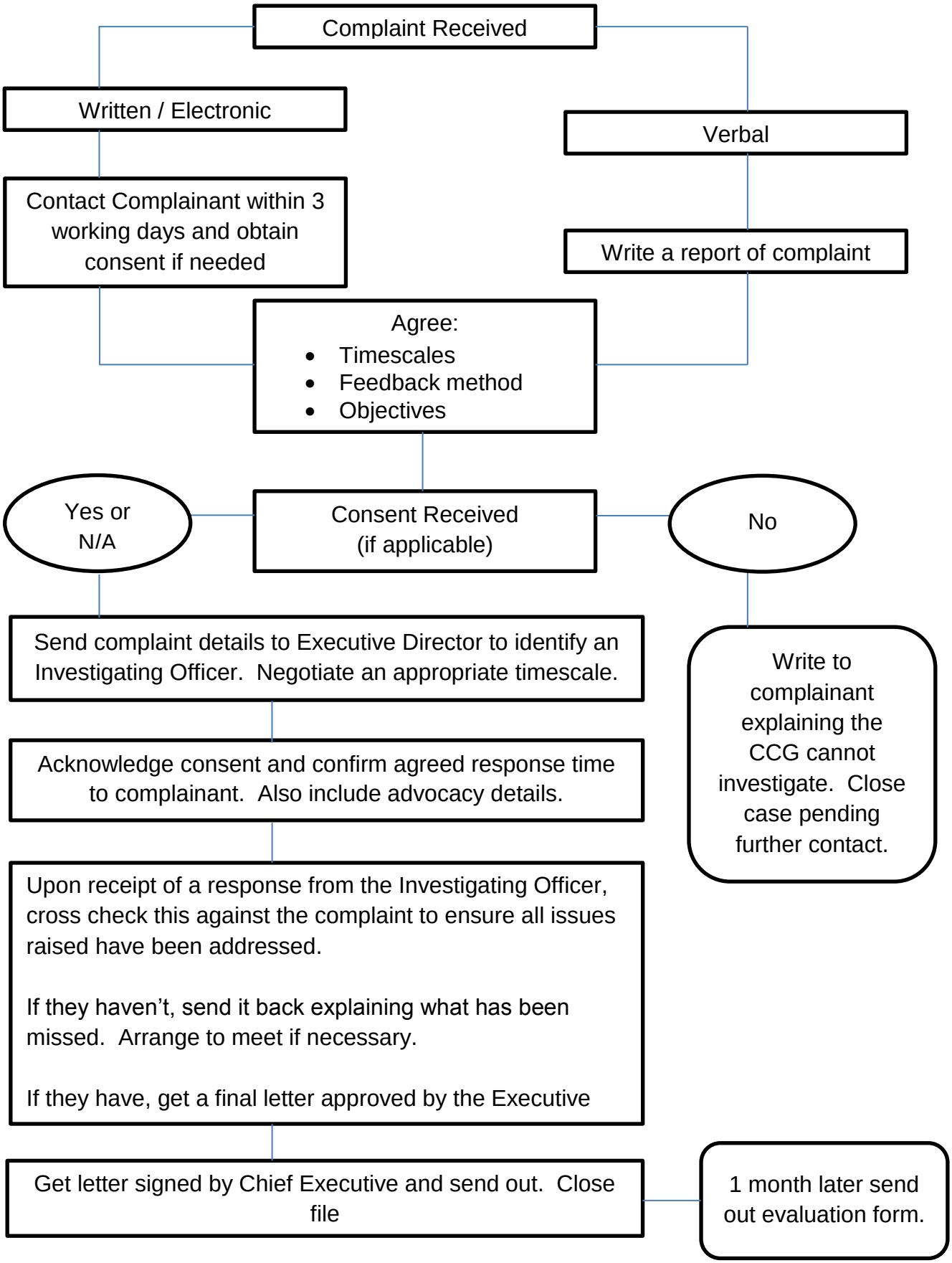
Appendix 1 Contact Details
Appendix 2 Flow chart detailing the formal complaints process

APPENDIX 1

Contact Details

Customer Services Team 5th Floor South Plaza Marlborough Street Bristol BS1 3NX **Telephone:** 0117 947 4477 or 0117 900 2475 **Email:** BNSSG.PALS@nhs.net or *tbc for complaints*
Support Empower Advocate Promote ***(For Bristol and North Somerset residents)*** **Telephone:** 0330 440 9000 **Email:** info@seap.org.uk
Swan Advocacy ***(For South Gloucestershire residents)*** **Telephone:** 0333 447928 **Email:** southglos@swanadvocacy.org.uk
Parliamentary and Health Service Ombudsman Millbank Tower Millbank London SW1P 4QP **Telephone:** 0345 015 4033 **Email:** phso.enquiries@ombudsman.org.uk

Appendix 2 - How the Customer Services team will handle a complaint



Bristol, North Somerset and South Gloucestershire Clinical Commissioning Group

70 YEARS OF THE NHS 1948 - 2018

[SERIOUS INCIDENTS REQUIRING INVESTIGATION POLICY

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Please complete the table below: *To be added by corporate team once policy approved and before placing on website*	
Policy ref no:	
Responsible Executive Director:	Anne Morris, Director of Nursing and Quality
Author and Job Title:	Heidi Buck, Quality and Patient Safety Support Manager
Date Approved:	XX/2018
Approved by:	
Date of next review:	XX/2019

	Yes/No/NA	**Supporting information**
Has an Equality Impact Assessment Screening been completed?	Yes	EIA Screening document
Has the review taken account of latest Guidance/Legislation?	Yes	National Serious Incident Framework, NHSE 2015 Never Events, NHSI 2015
Has legal advice been sought?	No	National Framework
Has HR been consulted?	No	National Framework
Have training issues been addressed?	Yes	
Are there other HR related issues that need to be considered?	No	National Framework
Has the policy been reviewed by JCC?	No	National Framework
Are there financial issues and have they been addressed?	No	National Framework
What engagement has there been with patients/members of the public in preparing this policy?	NA	National Framework
Are there linked policies and procedures?	No	Safeguarding Children Policy and Safeguarding Adults Policy Information Governance Policy
Has the lead Executive Director approved the policy?	Yes	
Which Committees have assured the policy?	Yes	Quality Committee Corporate Policy Group
Has an implementation plan been provided?	Yes	
How will the policy be shared with: • Staff? • Patients?	Yes	National Framework

• Public?		
Will an audit trail demonstrating receipt of policy by staff be required; how will this be done?	No	National Framework already in place. Due for revision this year. On revision audit trail will be required.

Version Control		
Version	Date	Consultation
V1	February 2018	Draft Policy Written
V2	March 2018	Reviewed by Quality
V3	April 2018	Committee. Requested completion of EIA.
V4	May 2018	Reviewed by Corporate Policy Group

Contents

SERIOUS INCIDENTS REQUIRING INVESTIGATION POLICY

1. Introduction

1.1 In March 2015 NHSE published a revised Serious Incident Framework along with a Never Events Policy and Framework for commissioners and providers providing NHS funded care. This document supersedes all previous guidance published by NHS England and the National Patient Safety Agency (NPSA).

1.2 In March 2016 NHSE published the Serious Incident Framework – frequently asked questions which provide additional guidance to support implementation of the Serious Incident Framework (March 2015).

1.3 In January 2018 NHS Improvement (NHSI) published new guidance on the management of Never Events which now supersedes the published document in March 2015 by NHSE.

1.4 The organisation where the incident occurred has overall responsibility for the investigation, the immediate dissemination of learning and implementation of subsequent action plans.

1.5 BNSSG CCG Quality Team is responsible for monitoring the management of Serious Incidents reported within the boundaries of the BNSSG CCG areas including University Hospital Bristol (UHB), Weston Area Health NHS Trust (WAHT), North Bristol Trust (NBT), Avon and Wiltshire Mental Health Partnership Trust (AWP), Bristol Community Health (BCH), North Somerset Community Partnership (NSCP), Sirona Community Health Provider, and all providers commissioned to deliver NHS funded care. Where a Serious Incident relates to a patient who is undergoing treatment that is commissioned by the NHS Southwest Specialist Commissioning Group (SCG), the CCG must contact the SCG to notify them of the incident.

2. Purpose and scope

The purpose of this policy is to provide guidance to the BNSSG CCG on the required elements of reporting Serious Incidents Requiring Investigation (Serious Incident). It highlights the processes that should be followed on receipt of notification from NHS Commissioned service providers that a Serious Incident has taken place.

3. Executive Summary

3.1 This policy provides a detailed description of procedures and processes that should be followed by BNSSG CCG on the reporting and management of Serious Incidents.

3.2 The process will support the provision of a uniform approach to the reporting and management of Serious Incident reported whilst fulfilling the requirements of the NHS England (NHSE) Serious Incident Framework published in March 2015 and the NHS Improvement (NHSI) new Never Events Policy and Framework published in January 2018.

4. Responsibilities

Within BNSSG CCG:

4.1 The **Chief Executive Officer** has responsibility for ensuring that the CCG has the necessary processes and procedures in place to support the effective management of implementation of all risk management and governance policies and delegates the responsibility for the management of Serious Incidents to the BNSSG CCG Director of Nursing and Quality.

4.3 The **Director of Nursing and Quality** has executive responsibility for ensuring the necessary management systems are in place for the effective implementation of Serious Incident reporting for commissioned services and for ensuring that areas identified as high risk are transferred to the BNSSG CCG Risk Register or the Board Assurance Framework as necessary.

4.4 **BNSSG CCG commissioning leads** are responsible for ensuring that there are specific references to Serious Incident reporting in all contracts and the expectations of reporting.

4.4 **NHS England** is responsible for assuring itself that CCGs have effective systems for Serious Incident management and for supporting CCGs to hold their providers to account appropriately. They can also provide oversight including review of trends, quality analysis and early warning systems via Quality Surveillance Groups (QSGs). Where an incident is high profile or wide-ranging – for example, incidents which have extensive media interest, NHS England may take a lead in coordinating a response to the incident.

4.5 **NHS Improvement** is working in collaboration with NHSE and will going forward oversee and monitor the Serious Incident process. New guidance is expected in late 2018.

5. Serious Incident reporting and monitoring

5.1 Reporting Serious Incident Requiring Investigations

The following paragraphs are taken from the NHS England National Serious Incident Framework published in March 2015, which must be adopted by Providers.

5.1.1 In broad terms, Serious Incident Requiring Investigation are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious Incidents can extend beyond incidents which affect

patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare.

5.1.2 The occurrence of a Serious Incident Requiring Investigation demonstrates weaknesses in a system or process that need to be addressed to prevent future incidents leading to avoidable death or serious harm to patients or staff, future incidents of abuse to patients or staff, or future significant reputational damage to the organisations involved. Serious Incident Requiring Investigation therefore require investigation in order to identify the factors that contributed towards the incident occurring and the fundamental issues (or root causes) that underpinned these. Serious Incident Requiring Investigation can be isolated, single events or multiple linked or unlinked events signalling systemic failures within a commissioning or health system.

5.1.3 There is no definitive list of events/incidents that constitute a Serious Incident Requiring Investigation and lists should not be created locally as this can 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 simply because they seem to fit a description of an incident on a list. Serious Incidents in the NHS include:

- Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:
- Unexpected or avoidable death of one or more people. This includes
  - Suicide / self-inflicted death; and
  - Homicide by a person in receipt of mental health care within the recent past.
- Unexpected or avoidable injury to one or more people that has resulted in serious harm;

Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent:

- The death of the service user; or
- Serious harm;

Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where:

- Healthcare did not take appropriate action/intervention to safeguard against such abuse occurring; or
- Where abuse occurred during the provision of NHS-funded care. This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS funded care caused/contributed towards the incident

5.1.5 All Serious Incident Requiring Investigations, must be reported in 2 working days of the Provider being aware of the incident onto the Strategic Executive Information System (STEIS) and then produce a preliminary report within three working days of identification to BNSSG CCG that includes the following:

- STEIS identification number
- The principal facts/description of the incident (including date, description, location, background and consequences)
- Initials, gender and date of birth of the client, where appropriate;
- Level of investigation to be undertaken and whether it is a Never Event;
- Details of the initial investigations undertaken including the scope, methodology and the individuals involved (including relatives/carers);
- Immediate action taken
- Initial recommendations; and proposals for the full investigation (including scope, methodology and details of the review team with clear timeline and accountability)
- Duty of Candour has been initially undertaken.

5.1.6 All Investigation reports for level 1 and 2 investigations must be completed within 60 working days of the Serious Incident Requiring Investigation being reported. The Provider must submit an approved Root Cause Analysis (RCA) and action plan to BNSSG CCG for commissioner review. Level 3 Independent Investigation time line is 6 months from reporting the Serious Incident Requiring Investigation onto the STEIS system.

Levels of Investigations for Serious Incident Requiring Investigations are as follows:

Level 1
Concise internal investigation
Suited to less complex incidents which can be managed by individuals or a small group at a local level

Level 2
Comprehensive internal investigation
Required where the integrity of the investigation is likely to be challenged or where it will be difficult for an organisation to conduct an objective investigation internally due to the size of organisation or the capacity/ capability of the available individuals and/or number of organisations involved

Level 1 & 2 Timeline - Internal investigations, whether concise or comprehensive must be completed within 60 working days of the incident being reported to the relevant commissioner

All internal investigation should be supported by a clear investigation management plan

Level 3
Independent investigation

Required where the integrity of the investigation is likely to be challenged or where it will be difficult for an organisation to conduct an objective investigation internally due to the size of organisation or the capacity/ capability of the available individuals and/or number of organisations involved

Level 3 Timeline - 6 months from the date the investigation is commissioned

5.1.7 Some Serious Incident Requiring Investigations are classed as Never Events and should be reported in the same way as a Serious Incident Requiring Investigation. Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare Providers. The aim of the Department of Health is to drive the incidence of Never Events to zero. A new Never Events policy has been published by NHS Improvement in January 2018 that should be read in conjunction with the Serious Incident policy guidance published by NHS England in May 2015.

5.1.8 A key component of the Never Events framework is its inclusion in the NHS Standard Contract, which ensures that never events are discussed as part of the contract negotiation process. This also ensures that each provider is contractually required to respond to Never Events in a nationally consistent manner, as set out in the relevant guidance.

5.1.9 The framework also states that failure to learn the lessons of a single Never Event or a prevented Never Event could be perceived as organisational failure on grounds of patient safety for which Board leaders, particularly the Chief Executive and Medical and Nurse Directors are accountable.

5.1.10 Some Serious Incident Requiring Investigations relate to vulnerable adults and children. Alignment of processes is required to ensure that patient's safety is maximised and the leaning that is gained can be disseminated across the wider arena (refer to the CCG Safeguarding Children Policy and Safeguarding Adults Policy).
If abuse or neglect is suspected, an incident form must be completed and discussed with the line manager and reported as an alert to the relevant safeguarding team.

There are four key questions to help determine whether the incident is abuse or neglect.

- Are there concerns that all reasonable steps have NOT been taken to prevent the incident?
  Care given should be assessed against available local and national guidelines. A second opinion should be sought if necessary – advice available from relevant Specialist.
- Is the person a Vulnerable Adult?
  i.e. is aged over 18 and is or may be in need of community care or support services by reason of mental or other disabilities, age or illness and who is unable or may be unable to take care of him / herself or unable to protect him / herself against significant harm or exploitation.

- Is the person a vulnerable child or young person at risk of harm?
  i.e. is aged under 18 who may be at risk of significant harm from parents, carers or others with a duty of care towards the child
- Is there evidence of neglect?
  Neglect is the deliberate withholding OR unintentional failure to provide appropriate and adequate care and support such as; Lack of Appropriate equipment, Manual handling, Risk Assessment (e.g. Nutritional Assessments and falls assessments), Development of care plans following risk assessments, , Staff awareness of related development and care. Consider the person's capacity and concordance to planned treatment.

5.1.11 BNSSG CCG has a clear structure in place for giving advice and support to Provider staff through their Named Professional / Designated Nurses for Safeguarding Children and Adults. The Named Professional / Designated Nurses meet frequently to confirm that all are aware that progress is being made on on-going incidents.

5.1.12 All Information Governance (IG) SERIOUS INCIDENTs are to be handled in accordance with the guidance developed by the Department of Health "Checklist for reporting Managing and Investigating information Governance Serious Untoward Incidents". This guidance includes details on assessing the severity of the incident and reporting requirements via the Information Governance (IG) Toolkit.

5.1.13 All members of BNSSG CCG staff should report any IG incidents to the Information Governance Manager, who would then:

- Inform the Senior Risk Information Officer (SIRO) and Caldicott Guardian as appropriate
- Record the initial facts on the IG Toolkit reporting Tool
- Record any investigation and follow up on the IG Toolkit reporting Tool
- Reporting upwards and onwards using the data recorded on the Tool on the IG Toolkit reporting Tool.

5.1.14 All organisations have a responsibility to ensure that members of staff are treated fairly and with consistency.

5.1.15 Where the incident involves more than one organisation the investigation will involve representatives from those other agencies e.g. the ambulance service, primary or acute care with agreement, via the BNSSG CCG Director of Nursing and Quality, as to who will be the lead agency.

5.1.16 BNSSG CCG will report Serious Incidents Requiring Investigations on behalf of the Providers who do not have access to STEIS. This may include independent hospitals and health services commissioned by the Public Health Team in the Local Authority. In these situations BNSSG CCG will have to fulfil the responsibilities outlined within this policy for Providers. The responsibility for the investigation still lies within the organisation where the incident occurred. The Public Health Team will liaise with Public Health England as

required. NHSE and NHSI will monitor Serious Incidents Requiring Investigations relating to the business of BNSSG CCG.

5.2 Actions for BNSSG CCG

5.2.1 BNSSG CCG will need to undertake different levels of oversight depending on a range of local circumstances, including their confidence in the relevant Provider's ability. Closer monitoring involving more step-by-step information and assurance around the response to individual incidents may be required for smaller providers with lower capacity, for example, or those with a history of responding insufficiently or in a non-robust manner to Serious Incidents.

5.2.2 BNSSG CCG will only lead an investigation by exception or where the Serious Incidents sre deemed to be extremely complex. The decision as to whether BNSSG CCG will lead an investigation will only be taken by the BNSSG CCG Director of Nursing and Quality.

5.2.3 BNSSG CCG will maintain the Serious Incidents monitoring and Action Plan Monitoring Databases to provide the Director of Nursing and Quality with all available information when required as well as regular progress reporting to ensure deadlines are met.

5.2.4 Once a satisfactory final, executive signed off, Root Cause Analysis (RCA) report and time-bound action plan has been received it will be put forward for the next scheduled CCG Serious Incidents Review Panel to ensure it meets the requirement to be reviewed within 20 calendar days by the CCG (and following the completion of all relevant entries on STEIS by the Provider), the incident will be closed on STEIS following agreement at the CCG Review Panel. It is the responsibility of the Provider to provide assurance of completion of the action to BNSSG CCG Quality Leads on a monthly basis with any exceptions reported by the Provider to the relevant Quality Sub Group Meetings (QSG) with the potential to escalate to the Integrated Contract, Quality and Performance Management Group Meeting (ICQPMG).

5.2.5 Feedback from the Serious Incidents Panel will be communicated back to the Provider to ensure that sufficient assurance has been gained by the Provider in relation to the investigation, that there is clear identification of lessons learnt including recommendations and actions to be taken along with specific timelines for this to take place. A request to the Provider will be made if further assurance is required along with a timeline for the assurance to be provided. Once assurance has been received it will be returned to the CCG panel process until closure is agreed.

5.2.6 BNSSG CCG will provide regular reports to the appropriate CCG Quality Committee on a quarterly basis and as requested on the management of Serious Incidents. These will:

- Clearly communicate performance against targets at key stages within the process
- Identify where there are recurring delays/problems in the process

- Analyse the age of overdue Serious Incidents in order that long overdue cases may be identified and progress closely monitored.
- Use Serious Incidents trend analysis to identify areas requiring a more focused review by the CCG
- Include details of any actions taken, follow-ups and/or discussions that have taken place with Providers where the data suggests areas of concern or non-compliance.

5.2.7 The CCG will also monitor reports for compliance with the principles of Being Open and the contractual Duty of Candour and highlight breaches to be discussed at Quality Sub Group Monitoring Meetings.

6. Communicating with Patients, Carers and Families

6.1 The Government has reinforced the principles of Being Open by the requirement of a contractual 'Duty of Candour' which came into place on 1 April 2013. This is now included in all NHS contracts. A follow up to this was new guidance for all NHS bodies being published in November 2014 by the Care Quality Commission known as regulation 20 detailing out clear expectations for all providers that should be adhered to and information included in the RCA reports.

7. Equality Impact Assessment

7.1 This policy is an amalgamation of the Serious Incident policies that were in place across Bristol, North Somerset and South Gloucestershire CCG's and is based on the requirements of the National Serious Incidents that require Investigation 2015. An Equality Impact Assessment was undertaken for the merged policy.

7.2 An initial Equality Impact Screening Assessment has been undertaken on the revised policy which has identified that a full assessment is not required at this stage.

8. Dissemination of Learning

8.1 The NHS has a responsibility to ensure that when Serious Incidents or incident occurs, there are systematic measures in place for safeguarding people, property, NHS resources and reputation, for understanding why the event occurred and ultimately to ensure steps are taken to reduce the chance of a similar incident happening again.

8.2 Provider organisations will have systems in place to ensure that learning is disseminated within their organisation as detailed in the Action Plans attached to the RCA reports. Assurance is to be provided to the Commissioner of completed implementation of actions.

8.3 The CCG will ensure that it has processes in place to share learning more widely within the local area. These processes will include dissemination of learning via: - Reporting of themes

and trends and issues requiring prompt action, arising from analysis, through the CCG governance structure. The Public Health Team within the Local Authority will be responsible for dissemination as appropriate via their networks.

8.4 For Safeguarding Children dissemination of learning from Serious Incidents takes place through the local Safeguarding Children Board. Identified learning is disseminated as soon as it is recognised and the CCG publishes details of learning from Serious Incidents within their annual quality reporting arrangements. Quarterly reports on learning from Serious Incidents to ensure that trends are identified are also published.

9. Monitoring compliance and effectiveness

The policy will be evaluated on annual basis by BNSSG CCG. Occasionally more frequent evaluation may be required in response national direction or local identification of issues. A review of the national framework is underway and it is expected that a revised framework will be issued from NHS Improvement by the end of 2018.

10. Resources

NHS England Serious Incident Framework 2015. Available at :
http://www.england.nhs.uk/?s=serious+incident+policy

NHS England Serious Incident Framework – frequently asked questions (March 2016).
https://www.england.nhs.uk/patientsafety/serious-incident/.

NHS Improvement Never Events Policy and Framework January 2018.
https://improvement.nhs.uk/resources/never-events-policy-and-framework

Care Quality Commission (2010): Essential Standards of Quality and Safety. Available at:
www.cqc.org.uk

Care Quality Commission Regulation 20: Duty of Candour Nov 2014 Available at:
www.cqc.org.uk

National Patient Safety Agency (2004):. Seven Steps to Patient Safety. Available at:
http://www.nrls.npsa.nhs.uk/resources/?entryid45=59787&q=0%c2%acseven+steps+to+patient+safety%c2%ac

National Patient Safety Agency (2009): Being Open: Communicating Patient Safety Incidents With Patients, Their Families and Carers. Available at: http://www.nrls.npsa.nhs.uk/resources

National Patient Safety Agency (2008): Three Levels of RCA Investigation - Guidance. Available at: www.npsa.nhs.uk/rca

National Patient Safety Agency (2008): Good Practice Guidance 'Independent Investigation of Serious Patient Safety Incidents in Mental Health Services'. Available at http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59836

NHS Connecting for Health (2010): Checklist for Reporting, Managing and Investigating Information Governance Serious Untoward Incidents. Available at http://www.connectingforhealth.nhs.uk/systemsandservices/infogov/links/suichecklist.pdf

NHS Commissioning Board's Framework for Collaborative Commissioning, Model agreement and FAQs. Available at http://www.commissioningboard.nhs.uk/resources/resources-for-ccgs/