SBC Children, Families and Community Health – Clinical Incident Reporting Policy & Procedures

(including serious incidents)

1.0 Introduction

This policy and procedure sets out the requirements in relation to the reporting of any clinical incident affecting service users or staff linked to the delivery of our CQC regulated activities in SBC Children, Families and Community Health service. It promotes the consistent reporting of all incidents and outlines the reporting arrangements that will ensure that lessons can be learned and practice altered accordingly. It provides the framework for reporting **all types of** incidents and **all degrees of** severity including detailed information on how any serious incident should be managed. Incidents that are not clinical and those linked to Health and Safety should be reported using the SBC Incident reporting policy and procedures available on the SBC Intranet.

Serious incidents are uncommon but when they occur SBC has a responsibility to ensure there are systematic measures in place for safeguarding service users, employees, property, resources and reputation.

One of the building blocks for doing this within UK healthcare is a clear, nationally agreed approach to notifying, managing and learning from serious incidents. The National Patient Safety Agency has developed a system-wide perspective on serious incidents occurring in the NHS and for all providers of commissioned NHS services in England. This framework is now a national requirement as part of the Department of Health's safety agenda. SBC will use this system to manage **all** serious incidents linked to clinical activities In Children, Families and Community Health.

2.0 Purpose

The purpose of this policy is to ensure consistency in definitions, roles and responsibilities and to clarify legal and regulatory requirements. The framework uses a system wide perspective for notification, management and learning from incidents. It supports openness, continuous learning and service improvement. Where relevant, it highlights where engagement with relevant bodies for full investigation and identification of learning from a serious incident is needed.

3.0 Regulatory Framework

Health and Social Care Act 2008, (Regulated Activities) Regulations 2009
Criminal Justice Act 2003
Corporate Manslaughter Act 2007 and Corporate Homicide Act 2007
Health & Safety at Work Act 1974
Data Protection Act 1998
NHS Swindon Clinical Commissioning Group Serious Incident Policy September 2015

4.0 Glossary

CQC	Care Quality Commission
HSE	Health and Safety Executive
MHRA	Medicine and Healthcare products Regulatory Agency
QSPU	Quality and safety Performance Unit

RCA	Root cause analysis
SI	Serious incident
IG SIRI	Information Governance Serious incident requiring investigation
SIRP	Serious incident review panel

5.0 Definitions

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

Serious incident requiring investigation is nationally defined as an incident that occurred which involves severe harm, for example, unexpected or avoidable death, a scenario or events that threatens an organisation's ability to continue to deliver healthcare services, allegations or incidents of physical abuse and sexual assault or abuse or a never event – see Appendix A for details of never events.

Information Governance related Serious Incident Requiring Investigation (IG SIRI) is any incident which involves actual or potential failure to meet the requirements of the Data Protection Act 1998 and/or the Common Law of Confidentiality. This includes unlawful disclosure or misuse of confidential data, recording or sharing of inaccurate data, information security breaches and inappropriate invasion of people's privacy.

6.0 Principles

All clinical incidents will be reported through the incident reporting system (Sentinel) within 2 working days.

All clinical incidents will be graded according to the severity of harm caused to enable the identification of all serious incidents. This will ensure that the required notifications can be made to the Care Quality Commission (CQC), Commissioners and other relevant agencies.

All incidents will be investigated according to the attached procedures within the required timescales and the results reported to the Risk Manager through the Sentinel risk management reporting system.

SBC will comply with the arrangements for notification and investigation of Serious Incidents agreed with the relevant Commissioner and as set out in Schedule 33 (*Serious Incidents framework*) of the Standard NHS Contract for Services.

SBC Children, Families and Community Health is committed to promoting a culture of openness and honesty as a prerequisite to improving safety and quality of care by adopting the (NHS) Being open process and framework

http://www.nrls.npsa.nhs.uk/beingopen/?entryid45=83726 as an integral part of incident investigation and management.

7.0 Duties

All employees

It is everyone's duty to report adverse incidents, of any kind to their immediate manager and then to the Risk Manager through the incident reporting systems detailed in the procedures.

All employees also have a duty to report any incident which may be considered a risk of abuse or neglect in relation to an adult at risk or a child immediately to the appropriate safeguarding team.

All employees have a duty to attend training on the reporting and monitoring of serious incidents as part of induction and on-going updates

SBC Children, Families and Community Health Service is regulated by CQC and accountable to the relevant commissioning organisations through national and local contracting and commissioning arrangements.

Principal Officer for Health and Well-Being is responsible for assuring the Head of Service and Director of Children's Services on the following:

- Patient safety and Management of serious incidents
- Appropriate closure of serious incidents
- Ensuring the Children's senior management team (CSMT) has oversight of any overdue actions

Professional Leads, Operational managers and Team co-ordinators are responsible for:

- Ensuring that their teams report all adverse clinical events immediately according to the agreed procedure
- Ensuring that their staff understand what constitutes a serious incident so that these are identified and managed as required by CQC and the Commissioners
- Notifying CQC of serious incidents as required by Outcomes 18-20 via the Principal Officer For Health and Well-Being
- Notifying other agencies as required e.g. Public Health England, Police, MHRA, HSE,ICO etc. via the Principal Officer for Health and Well-Being

- Ensuring that any required investigations are undertaken within the necessary timescales and reported accordingly

- Ensuring any resulting action plans are implemented within the required timescales and reported accordingly

- Ensuring any learning from incidents is cascaded to their staff and embedded in their practices

Risk Manager is responsible for:

- monitoring incident reports and associated action plans

- ensuring that incident reporting policies, protocols and procedures are updated and embedded throughout the organisation

- ensuring that identified training needs are highlighted to the Principal Officer for Health and Well-Being and suitable solutions offered

- identifying and evaluating patterns and trends of incidents and bringing them to the attention of the Principal Officer for Health and Well-being so that appropriate escalation plans can be implemented

Information Governance Lead is responsible for:

- the management of IG SIRIs making sure they conform to the processes and procedures set out for managing all Serious Incidents Requiring Investigation

- ensuring there is a consistent approach to evaluating IG SIRIs

- early reporting of IG SIRIs to decide the appropriate escalation, notification and communication to interested parties

- ensuring appropriate corrective action is taken to prevent recurrence in line with the open data transparency strategy

Children's Senior Management Team (CSMT) has responsibility to ensure that when a (serious) clinical incident does happen, there are systemic measures in place:

- for safeguarding people, property, the organisation's resources and its reputation

- to understand why the event occurred and that learning is shared throughout the service and if relevant with and external organisations

- ensuring that steps are taken to reduce the chance of a similar incident happening again

- to report to other bodies where necessary

8.0 Ratification

This policy will be reviewed and updated and ratified by CSMT.

9.0 Training

- Clinical Incident reporting must form part of local induction so that all relevant employees are able to identify when an incident has occurred, assess the severity and know how to instigate a report

- Specific training about the policy and application of the process can be tailored to the needs of a particular service and can be made available through discussion with the Principal Officer for Health and Well-Being

- All managers will need to maintain their own record of all incident reporting training delivered and received for their areas of responsibility

10.0 Monitoring framework

Minimum requirements to be monitored	Total number of incidents reported Number of serious incidents reported Number closed within required timescale Completion of subsequent action plans Lessons learned
Process for monitoring e.g. audit	SBC Children, Families and Community Health CQC leads group will receive performance reports (from the Risk Manager) on all incidents, including serious (clinical) incidents and will endorse the signing off and closure of the serious incidents. Quarterly reports will go to the Early Help Performance Board
Responsible individual/group/committee	SBC CQC Leads group
Frequency of monitoring	Quarterly
Responsible individual/group/committee for review of results	Children's Senior Leadership Team SCCG Quality Lead
Responsible individual/group/committee for development of action plan	Action plans will be developed by the Professional Leads/ managers/ co-ordinators as relevant
Responsible individual/group/committee for monitoring of action plan	SBC CQC Leads group

11.0 References

1. World Health Organisation (2009). The Conceptual Framework for the International Classification for Patient Safety. Version 1.1. http://www.who.int/patientsafety/taxonomy/icps_full_report.pdf

2. NHS Commissioning Board (2013) Serious Incident Framework. http://www.england.nhs.uk/wp-content/uploads/2013/03/sif-guide.pdf

3. National Patient Safety Agency (2009). Data Quality Standards. Guidance for organisations reporting to the reporting and learning system. http://www.nrls.npsa.nhs.uk/

4. National Patient Safety Agency (2004). Seven Steps to Patient Safety. Your guide to safer patient care. http://www.nrls.npsa.nhs.uk/

5. Care Quality Commission Health and Social Care Act 2008 (Regulated Activities) Regulations 2014 http://www.cqc.org.uk/

1. McGraw Hill Concise Dictionary of Modern Medicine (2002). The McGraw-Hill Companies Inc.

2. Department of Health and Home Office (2000). No Secrets. Guidance on developing and implementing multi-agency policies and procedures to protect vulnerable adults from abuse. http://www.dh.gov.uk/en/AdvanceSearchResult/index.htm?searchTerms=publications+policy+and+guidance

3. NHS Security Management Service (NHS SMS) (2010). The Security Incident Reporting System (SIRS). http://www.nhsbsa.nhs.uk/SecurityManagement.aspx

4. Department of Health (2010) Checklist for reporting, managing and investigating Information Governance Serious Untoward Incidents. http://www.dh.gov.uk/en/Publicationsandstatistics/index.htm

5. National Screening Committee, NHS Cancer Screening Programmes (2010). Managing Serious Incidents in National Screening Programmes. http://www.screening.nhs