NHS
Barking and Dagenham, Havering and Redbridge
Clinical Commissioning Groups

Serious Incident Reporting and Management Policy

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APPROVAL RECORD

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Approved by Committees:	CCGs' Quality & Safety Committee	11/12/18

Contents

1. Introduction

1.1. The CCGs as Commissioners, seek to assure that all services which may be commissioned meet nationally identified standards and this is managed through the local contracting process. Compliance with Serious Incident (SI) and Never Event (NE) reporting are standard clauses in all contracts and Service Level Agreements (SLA), as part of a quality schedule.

1.2. The role of the CCGs as Commissioners is to gain assurance that incidents are properly investigated, that action is taken to improve clinical quality, and that lessons are learnt in order to minimise the risk of similar incidents occurring in the future. It is intended that intelligence gained from SIs will be used to influence quality and patient safety standards for care pathway development, service specifications and contract monitoring.

1.3. This policy is intended to reflect the responsibilities and actions required for dealing with SIs and NEs and the tools available.

1.4. It outlines the process and procedures to ensure that SIs and NEs are identified, investigated and learned from as set out in the Serious Incident Framework 2015/16 and Never Event Framework 2015/16. These revised Frameworks replace the Serious Incident Framework and Never Event Framework published in 2013. Additionally the Never Events List was updated in 2018 to include two new Never Event types.

2. Scope

2.1. The purpose of this policy is to define a SI or NE and to describe the role of the CCGs when a SI or NE occurs.

2.2. This policy aims to ensure that the CCGs comply with current legislation as well as current national guidance, NHS England guidance and requirements with regard to accident/incident reporting generally, but in particular reporting, notifying, managing and investigating SIs and NEs.

2.3. This policy applies to all employees of the CCGs and is recommended to independent contractors e.g. GPs, GP Federations, Independent Healthcare Sector Providers, Dental Practitioners, Optometrists and Pharmacists.

2.4. All NHS providers including Independent Healthcare Sector Providers, where NHS services are commissioned, need to comply with the CCGs' reporting requirements within this policy, which reflects the Serious Incident Framework 2015/16 & Never Events Framework 2015/16 and the Never Events List 2018.

2.5. It is the duty of each NHS body to establish and keep in place arrangements for the purpose of monitoring and improving the quality of healthcare provided by and for that body. The CCGs as commissioners of services are committed to this policy and the implementation of a consistent approach to ensure robust arrangements for the management of SIs and NEs.

2.6. Commissioners must also assure themselves that care providers know about and adhere to relevant CQC Standards. Contract monitoring must have a clear focus on safeguarding and robustly follow up any shortfalls in standards or other concerns about patient safety.

2.7. Commissioners will also want to be assured that when abuse or neglect occurs, responses are in line with local multi-agency safeguarding procedures, national frameworks for Clinical Governance and investigating patient safety incidents.

2.8. Therefore these services must produce clear guidance to managers and staff that sets out the processes for initiating action and who is responsible for any decision making.

3. Definitions and Terms

3.1. Definition of a SI & NE

3.2. A SI is a single distinct event or circumstance that occurs within the organisation which leads to an outcome that was unintended, unplanned or unexpected.

3.3. NHS England has produced an information resource to support the reporting and management of serious incidents which can be found in the SI Framework.

3.4. Whilst the definition of a SI is quite broad, the following criteria outline the type of incidents which should be included:

3.5. Unexpected or avoidable death of one or more people. This includes:

- Suicide/self-inflicted death
- 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.

3.6. 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
- Serious harm
- Actual or alleged abuse; sexual abuse, physical or psychological ill- treatment or acts of omissions which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery.

3.7. Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death, due consideration must also be given to about the potential to cause serious harm.

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

- Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues
- Property damage
- Security breach/concern
- Incidents in population-wide healthcare activities such as screening or immunisation programmes where the potential for harm may extend to a large population;
- Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS) (2009);
- Systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/unit/surgery closure or suspension of services); or
- Activation of Major Incident Plan (by provider, commissioner or relevant agency)

4. Working with other Organisations/Sectors

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

4.2. Deaths in Custody – where health provision is delivered by the NHS

- People in custody, including those detained under the Mental Health Act (1983) or those detained under the police and justice system, are owed a duty of care by relevant authorities. The obligation on the authorities to account for the treatment of an individual in custody is particularly stringent when that individual dies.
- In prison or police custody, any death will be referred to the Prison and Probation Ombudsman (PPO) or the Independent Police Complaints Commission (IPCC) who are responsible for carrying out the relevant investigations. Healthcare providers must fully support these investigations where required to do so.
- In NHS Mental Health services, providers must ensure that any death of a patient detained under the Mental Health Act (1983) is reported to CQC without delay. However, providers are responsible for ensuring that there is an appropriate investigation into the death of a patient detained under the Mental Health Act (1983) or where the Mental Capacity Act (2005) applies. In circumstances where the cause of the death is unknown and/or where

there is reason to believe the death may have been avoidable or unexpected then the death must be reported to the provider's commissioner(s) as a SI and investigated appropriately.

5. Serious Case Reviews (SCR) and Safeguarding Adult Reviews (SAR)

- The Local Authority via the Local Safeguarding Children Board (LSCB) or Local Safeguarding Adult Board (SAB) has a statutory duty to investigate certain types of safeguarding incidents/concerns.
- Healthcare providers must contribute towards safeguarding reviews as required to do so by the Local Safeguarding Board, where it is indicated that a serious incident within healthcare has occurred.
- The interface between the serious incident process and local safeguarding policies must therefore be articulated in the local multi-agency safeguarding policy and protocol.

6. Domestic Homicide Reviews (DHR)

6.1. Where a Domestic Homicide is identified by the police, the Community Safety Partnership (CSP) will consider whether the case meets criteria for Domestic Homicide Review (DHR)

6.2. Homicide by patients in receipt of mental health care.

6.3. Where patients in receipt of mental health services commit a homicide, NHS England will consider and, if appropriate, commission and investigation. This process is overseen by NHS England's Regional investigation teams.

6.4. CCG Designated Professionals for Children and Adults are required to notify NHSE whenever a SCR, SAR or DHR is commissioned with their CCG attributable area.

6.5. Appendix 1 outlines the process of notification of SCRs, SARs and DHRs to NHSE via the Strategic Executive Information System (StEIS) system.

6.6. Appendix 4 contains the SI Reporting Document as mentioned within the process flowchart.

7. Serious Incidents in National Screening Programmes

7.1. There are a number of immunisation or screening programmes which require a broader approach to handling incidents.

7.2. The Screening Quality Assurance Service is responsible for surveillance and trend analysis of all screening incidents. It will ensure that the lessons learned from incidents are collated and disseminated nationally.

7.3. SIs are often very complex, multi-faceted incidents that require robust coordination and oversight by Screening and Immunisation Teams working within Sub-regions and specialist input from Public Health England's Screening Quality Assurance Service.

7.4. Further details on the management of incidents within the screening programme are available in "Managing Safety Incidents in NHS Screening Programme"

7.5. SIs linked to national screening programmes (e.g. ante natal and child health screening, retinal screening etc.) the Regional Screening Lead will provide advice to local organisations and will inform the national coordinating bodies as appropriate.

Managing Safety Incidents in NHS Screening Programmes

7.6. Flow chart for managing screening incidents can be found in Appendix 2

8. Additional guidance for personal data related (Information Governance) SIs

8.1. The General Data Protection Regulation (GDPR)/UK Data Protection Bill imposes legal obligations on controllers to comply with the requirement to report specific breaches to the Information Commissioner's Office (ICO) without undue delay and no later than 72 hours of becoming aware of such a breach, where the breach is likely to result in a risk to the rights and freedoms of individuals.

8.2. GDPR/UK Data Protection Bill requires that a controller informs individuals affected by a breach of their personal data of the breach without undue delay, where the breach is likely to result in a risk to the rights and freedoms of individuals.

8.3. Any incident involving the actual or potential loss of personal information that involves a high risk to the rights and freedoms of individuals should be considered as potentially serious and advice should be sought from the Information Governance (GI) service.

8.4. Where an IG incident impacts upon a patient's rights and freedoms it must be reported to the Quality Team so they can report it through the StEIS system as soon as possible (and no later than 24 hrs. after the incident during the working week). These must be categorised in StEIS using the "Confidential Information Leak/IG Breach" category. NHS England is responsible for notifying the Department of Health of any category 3-5 incident and will do this as soon as possible after they have been made aware of such an incident (either through STEIS or other means)

8.5. Individual organisations are responsible for following the Health and Social Care Information Centre's (NHS Digital) Checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents

Requiring Investigation. Incidents which score Level 2 or above must be reported centrally via the Information Governance Toolkit. If a CCG is unsure of the level of the incident, further guidance can be sought from the CCGs' Information Governance Team.

8.6. Consideration should always be given to informing patients/service users when person identifiable information about them has been lost or inappropriately placed in the public domain.

8.7. Loss of encrypted media should not be reported as a SI unless the data controller has reason to believe that the encryption did not meet the Department of Health Standards that the protections had been broken, or were improperly applied.

9. Additional Guidance for SIs involving controlled drugs.

9.1. SIs that involves controlled drugs should be reported to the CCG's Medicines Management Team and must also be notified to the NHSE Controlled Drugs Accountable Officer: england.londoncdaccountableoffice@nhs.net

10. Accountabilities

10.1. Provider Serious Incidents

10.2. For main providers (who are themselves responsible for logging, investigating and learning from their SIs), the CCGs are accountable for ensuring information is used from SIs for continuous improvement across the wider health economy. There should also be clear lines of communication and nominated individuals for the quality management of the SI process.

10.3. Arrangements should also be explicit for co-commissioning and, where necessary, a Memorandum of Understanding developed or built in to joint policies to ensure clarity of management.

11. Reporting and Management of Serious Incidents

11.1. For GP Surgeries and GP Federations the CCGs are accountable for ensuring that appropriate reporting arrangements are in place for Primary Care related SIs.

11.2. The process for effective SI reporting for GP Surgeries and GP Federations is outlined in Appendix 3

11.3. Appendix 4 contains the SI Reporting Document as mentioned within the process flowchart.

11.4. The Independent Healthcare Sector (IHS) should be subject to contractual obligations for the reporting of SIs. The CCG should ensure that appropriate reporting arrangements are in place with the IHS in relation to SIs.

11.5. The CCG should ensure that IHS SIs are reported via StEIS and investigated appropriately.

12. Guidance for Commissioned Services/Providers

12.1. Each NHS Trust/organisation must nominate a single point of contact or lead officer for managing all SIs.

12.2. Organisations should ensure that mechanisms are in place to report all incidents meeting the criteria.

12.3. The SI lead officer must report a SI through StEIS within 2 working days of Identification of the SI, completing all relevant sections. At this stage it is important that any immediate learning is included in this report.

12.4. If appropriate, the SI lead officer must liaise with the organisations communications team who will liaise directly with NHS England Communications team.

12.5. When requested the organisation must then provide a 72 hour report, which should be sent to NEL NELCSU.Incidents@nhs.net as the responsible delegate for CCGs. The report should include more information regarding the event, immediate learning and how the Root Cause Analysis (RCA) will be conducted including Terms of Reference.

12.6. Organisations need to be open and transparent with regards to investigation processes, unless there are specific exceptions. Arrangements may need to be put in place to support patients and family members through the investigation process and sharing of the outcomes of investigations. The appointment of a Family Liaison Officer may be appropriate.

12.7. If an incident spans organisational boundaries, **it is the responsibility of the organisation where the incident took place** to formally report it through StEIS. All other additional organisations involved must contribute and fully cooperate with the process in line with the agreed timescales. Where there is doubt about who should report the incident then clarity must be sought through NELs Clinical Quality Team.

12.8. If an incident involves more than one NHS organisation a decision will be made (mutually agreed) as to which is the lead investigating organisation. Where an incident involves the independent sector or contracted services, it is the role of the commissioning CCG to lead. The (Responsible, Accountable, Supporting, Consulted, Informed) model (RASCI) model should be completed in order to assign accountability.

12.9. This guidance must not interfere with existing lines of accountability and does not replace the duty to inform the police and/or other organisations or agencies where appropriate. Further guidance can be obtained from the Department of Health publication *Memorandum of Understanding: Investigating Patient Safety Incidents* June 2004 and accompanying NHS guidance of December 2006. The need to involve outside agencies should not impede the retrieval of immediate learning.

12.10. Incidents which have impacted, or have had potential to impact on children and/ or adults at risk must be investigated in conjunction with the identified designated professional and in accordance with related guidance.

12.11. Where an incident is subject to the involvement of a Coroner, an independent inquiry, serious case review or any safeguarding issues, this should be highlighted clearly within the StEIS report as this may affect closure date.

12.12. Organisations should undertake investigation procedures/root cause analysis (RCA) as per organisation policy and submit to the responsible body within the agreed timescales. To ensure confidentiality all reports submitted to the CCG or NELs Clinical Quality Team should be anonymous and sent via the agreed STEIS NHS-net account. NEL will conduct a quality assurance check on all RCAs on behalf of the CCG in order to ensure the 20 day deadline is met.

13. Independent Contractors

13.1. Once a SI is identified in a CCG commissioned service, the NHS Serious Incidents Framework should be followed, or where applicable NHS England should be notified.

13.2. Where a SI raises professional concerns about a GP, CCG local arrangements for assuring high standards of professional performance should be invoked, where this is applicable or NHS England notified.

13.3. Independent contractors should have systems in place to ensure that staff are supported appropriately following the identification of a SI.

13.4. Most healthcare providers have to register with CQC and most providers of NHS funded care have to be licensed by NHS Improvement. The regulators will use the details of incident reports to monitor an organisations compliance with essential standards of quality and safety and their licence terms.

13.5. CQC registered organisations are required to notify CQC about events that indicate or may indicate risks to compliance with registration requirements, or that lead or may lead to changes in the details about the organisation in CQC's register. They are required to report serious incidents as defined in CQC's guidance, Essential Standards of Quality and Safety (2010). Most of these requirements are met by reporting via the National Reporting and Learning

System (NRLS), who will forward relevant information to CQC. The exception is for independent sector providers and primary medical service providers who must report serious incidents directly to CQC. They can also report to the NRLS.

14. NHS Providers

14.1. Once a SI is identified, the Providers' Procedure for the Reporting and Management of SIs should be followed.

14.2. Providers should have systems in place to ensure that staff are supported appropriately following identification of a SI.

15. Independent Healthcare Sector Providers

15.1. Once a SI is identified, the NHS SI or NE Frameworks should be followed.

16. CCG Serious Incidents

16.1. Any internal incident meeting the SI criteria must be escalated to the CCGs' Quality Team for logging on StEIS using the form in **Appendix 4**. The investigation and subsequent production of a Root Cause Analysis (RCA) Report is the responsibility of the CCG, sign off and closure of the SI must be carried out by NHS England Sub Region office, however, the Quality Team will update StEIS prior to any request for closure.

17. Staff involved in Serious Incidents

17.1. SIs can be distressing for those involved.

17.2. The appropriate manager should ensure that staff are supported at all stages of a SI with reference to CCG Human Resources (HR) policies.

17.3. The appropriate manager is responsible for ensuring that a de-briefing session occurs at an appropriate stage following a SI.

17.4. If, during the course of a SI investigation, it becomes apparent that a member of staff may be subject to a disciplinary hearing, appropriate advice and support should be taken via HR and the relevant policy followed.

18. Information for Education and Training Organisations

18.1. In the event an incident involves a student or trainee, the relevant academic institution will be notified by the NHS Trust/CCG as appropriate.

18.2. Where a SI concerns the commissioning or provision of medical or dental education or training, or a medical or dental trainee or trainees, there will be appropriate communication between the CCGs and NHSE.

19. CCG Management & Closure of Serious Incidents

19.1. There is greater emphasis on providers completing a 72 hour review/update. The aim is for an initial incident review to be undertaken by a clinician/manager with relevant expertise (but not directly involved in the delivery of care/service) which will:

- Identify and provide assurance that any immediate action has been taken to ensure safety of patients/staff/public;
- Assess the incident in more detail to clarify whether it does meet the reporting requirements of a SI;
- Propose a proportionate level of investigation (this must be agreed with the commissioner)
- This information should be updated on StEIS.

19.2. NEL is responsible for quality assuring the robustness of providers' serious incident investigations and the suggested action plan detailed within the final investigation report.

19.3. The CCG is responsible for evaluating investigations and gaining assurance that the processes and outcomes of investigations include identification and implementation of improvements that will prevent the recurrence of serious incidents.

19.4. In order to achieve this, the CCG has established the Joint SI Panels.

20. Information Governance Serious Incidents

20.1. The General Data Protection Regulation (GDPR)/UK Data Protection Bill imposes legal obligations on controllers to comply with the requirement to report specific breaches to the Information Commissioner's Office (ICO) without undue delay and no later than 72 hours of becoming aware of such a breach, where the breach is likely to result in a risk to the rights and freedoms of individuals.

20.2. GDPR/UK Data Protection Bill requires that a controller informs individuals affected by a breach of their personal data of the breach without undue delay, where the breach is likely to result in a risk to the rights and freedoms of individuals.

20.3. Any IG incident which involves a high risk to the rights and freedoms of individuals is likely to be a SI and must be reported as per the NHS SI Framework.

21. Serious Incident Investigation Process

21.1. The reporting organisation is responsible for ensuring that all SIs are investigated and documented. Investigations should follow the NPSA's best practice on conducting investigations using Root Cause Analysis (RCA) methodologies. The principles of RCA will be applied to all investigations, but the scale, scope and timescales of investigation will be appropriate to the incident. Advice, where required or identified, will be given to providers in the completion of RCAs by the NEL Patient Safety Team.

22. Level of Investigation

22.1. There are three levels of investigation:-

Level 1- concise; internal - for less complex incidents manageable by individuals or a small group at local level;

Level 2 - comprehensive; internal - for complex issues manageable by a multi-disciplinary team – it can involve experts/specialists and the provider can involve external members to add a level of scrutiny/objectivity;

Level 3 - independent – two types.
The first is a provider–focussed investigation where the provider has been unable to carry out an effective/objective and timely investigation due to the complexity or involvement of other agencies and where significant systemic failures appear to have occurred. There may also be conflicts of interest identified. This investigation will normally be commissioned by the CCG and undertaken by individuals independent of the provider.

The second type is SIs that involve the examination of the roles of wider commissioning systems or configuration of services including multi-agency and multiple SIs. Any investigation will be independent of the directly involved commissioners and will usually be led by a regional or centrally led team identified by NHS England.

22.2. There are three levels of investigation: - There are three levels of investigation:- The levels should be agreed between provider and commissioner within the first 72 hours following the reporting on StEIS. Commissioners may decide to undertake an independent investigation at any stage including following the outcome of a providers own internal investigation.

22.3. The level of investigation may need to be reviewed and can be changed as new information emerges-with the agreement of the commissioner/provider.

23. Initial Reporting

23.1. When an organisation identifies an incident which is assessed as meeting the definition of a SI, that organisation should report the incident via the StEIS within two working days of the SI being identified. Any delay in notifying the CCG/CSU should be explained.

23.2. Timescales - The timescale of the investigation, including notification to NHS BHR CCGs, in normal circumstances will not exceed the 60 working day deadline (for Level 1 and 2 incidents. Level 3 external investigation may take up to 6 months), and should be completed within the terms of the agreed contract.

23.3. Extension Requests - In view of the timescale nationally of 60 days for the completion and submission of the RCA, it is not expected that extensions will routinely be required. However, if the reporting organisation faces unavoidable delays in its investigation of a SI, then the NEL should be notified of the reason for the delay, the anticipated delay period and a new reporting timescale will be negotiated on a case by case basis but there must be compelling reasons for doing so e.g. where new information comes to light during the RCA process which requires further investigation. Agreement of the commissioner must be obtained before the expiry of the original deadline and any extension will be effective from the date on which the SI Report was originally due.

23.4. De-escalation - If, at any stage during a SI investigation, it becomes apparent that the incident does not constitute a SI it can be de-escalated by formal notification, including reasons for de-escalation, and agreement with the CCG /NEL. At this point the SI will be removed from StEIS and the NEL database noted accordingly.

24. Action Plans

24.1. Assurance will be sought by the CCGs that action plans resulting from a SI investigation are completed within appropriate timescales. Therefore evidence demonstrating that actions have been completed may be requested by the CCG/NEL as part of their quality schedule monitoring processes by the quality team during visits. Providers must reference in action plans how shared learning will be implemented both in the specialty involved and across the wider organisation.

25. Duty of Candour

25.1. In October 2014, the Department of Health introduced regulations for the Duty of Candour (Health and Social Care Act 2008 (Regulated Activities) Regulations 2014) in response to recommendation 181 of the Francis Inquiry report into Mid Staffordshire NHS Foundation Trust. It requires providers to notify anyone who has been subject (or someone lawfully acting on their behalf, such as families and carers) to a ‘notifiable incident’ i.e. incident involving moderate or severe

harm or death. This notification must include an appropriate apology and information relating to the incident and should be given in person as soon as reasonably practicable (guidance states within 10 days of the incident being logged). This should be followed up with a written account and any further actions since the meeting. Failure to do so may lead to regulatory action by the CQC. This effectively applies to all SIs where a patient has suffered serious harm or death.

25.2. Moderate harm means - a moderate increase in treatment such as an unplanned return to surgery, an unplanned re-admission, a prolonged episode of care, extra time in hospital or as an outpatient, cancelling of treatment, or transfer to another treatment area (such as intensive care).

25.3. Compliance with the Duty of Candour in cases below the SI threshold can be recorded on the provider's local incident reporting system. However, in all cases a written record should be kept of when and what was conveyed to the patient or their family/carer and by whom.

25.4. Importantly, these Regulations have, from 1st April 2015, been extended to all other healthcare providers registered with the Care Quality Commission. E.g. GPs, Nursing homes, independent providers.

25.5. The StEIS system has been updated to record compliance with the Duty of Candour and this should be completed by providers when logging a Serious Incident. Compliance should also be referenced in the RCA Report.

26. Stop the Clock

26.1. It is acknowledged that whilst every effort should be made to ensure that all SI investigations are completed in a timely manner, in accordance with the National Framework, there are instances when this is impossible due to circumstances which are beyond the immediate control of the reporting organisation due to issues of primacy.

26.2. Where unavoidable delays are due to an external party, e.g. where the Police, HM Coroner or Judge has requested that any internal investigation is placed on hold as it may potentially prejudice any criminal investigation and subsequent proceedings. In such cases discussion between the organisation undertaking the investigation and the CCGs/NEL are required with the rationale for the request to stop the clock. It is the decision of the CCGs/NEL whether or not a SI meets the criteria for a 'stop the clock'. This rationale will be reported on StEIS.

In order to ensure robust governance the CCGs will regularly monitor/review Stop the Clock agreements. In cases where such delays are evident it is essential that a clear entry is made onto StEIS by the provider to explain the rationale for the delay.

27. Process for restarting the clock

In order to ensure that RCA investigations progress in a timely manner, once the outcome of the recorded delay is known e.g. outcome of court proceedings, post mortem findings, the provider and CCGs/NEL will discuss the removal of the clock-stop and agree a timeframe for completion of the RCA investigation. This date will then become the timeframe for closure of that incident and an entry made on StEIS by NEL. This timeframe whilst negotiated with the provider will be required to be a realistic yet prompt timeframe in order to ensure timely closure of the incident.

28. Fair Responsibility

The CCGs are committed to a policy of 'fair responsibility'. In particular formal disciplinary procedures will only be invoked following an incident where:

- there are repeat occurrences involving the same person where their actions are considered to contribute towards the incident
- there has been a failure to report an incident in which a member of staff was either involved or about which they were aware (failure to comply with organisation's policy and procedure)
- in line with the organisation and/or professional regulatory body, the action causing the incident is removed from acceptable practice or standards, or where
- there is proven malice or intent

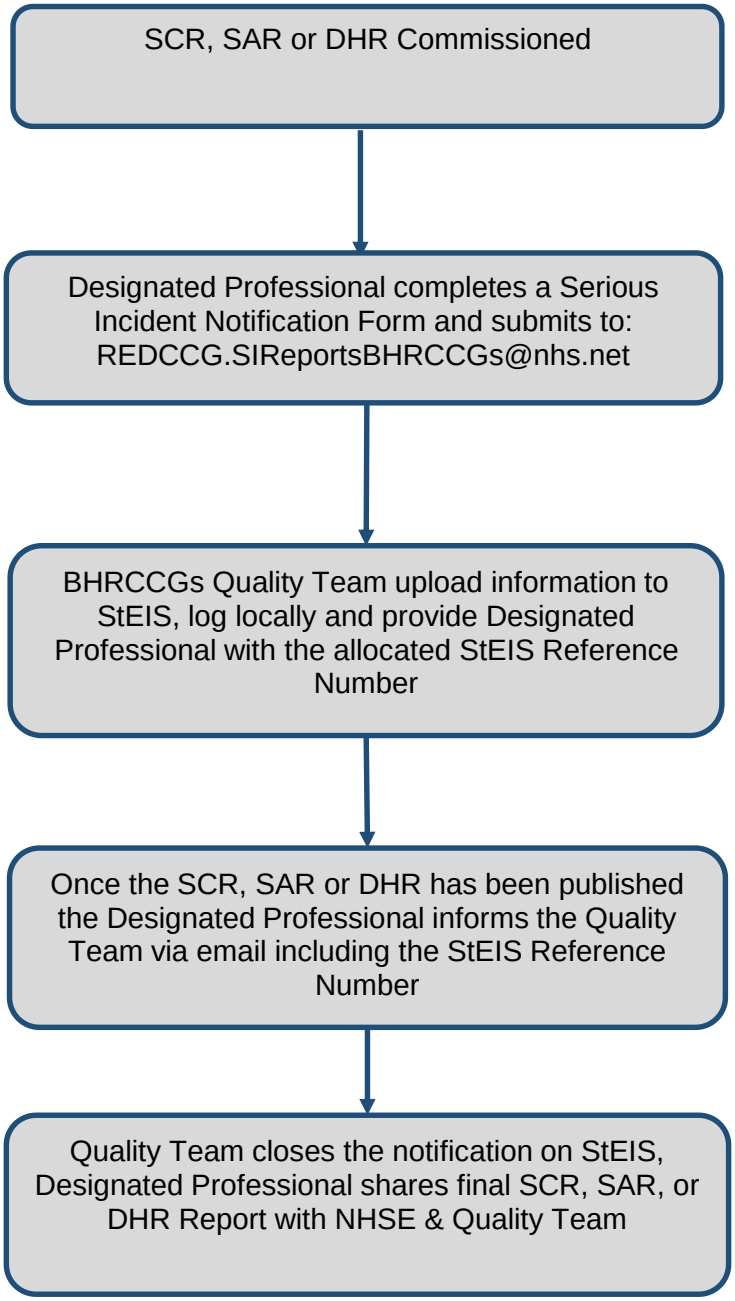
Fair responsibility means that the organisation:

- operates its incident reporting policy in a culture of openness and transparency which fulfils the requirements for integrated governance
- adopts a systematic approach to an incident when it is reported and does not rush to judge or 'blame' without understanding the facts surrounding it
- encourages incident reporting in the spirit of wanting to learn from things that go wrong and improve services as a result

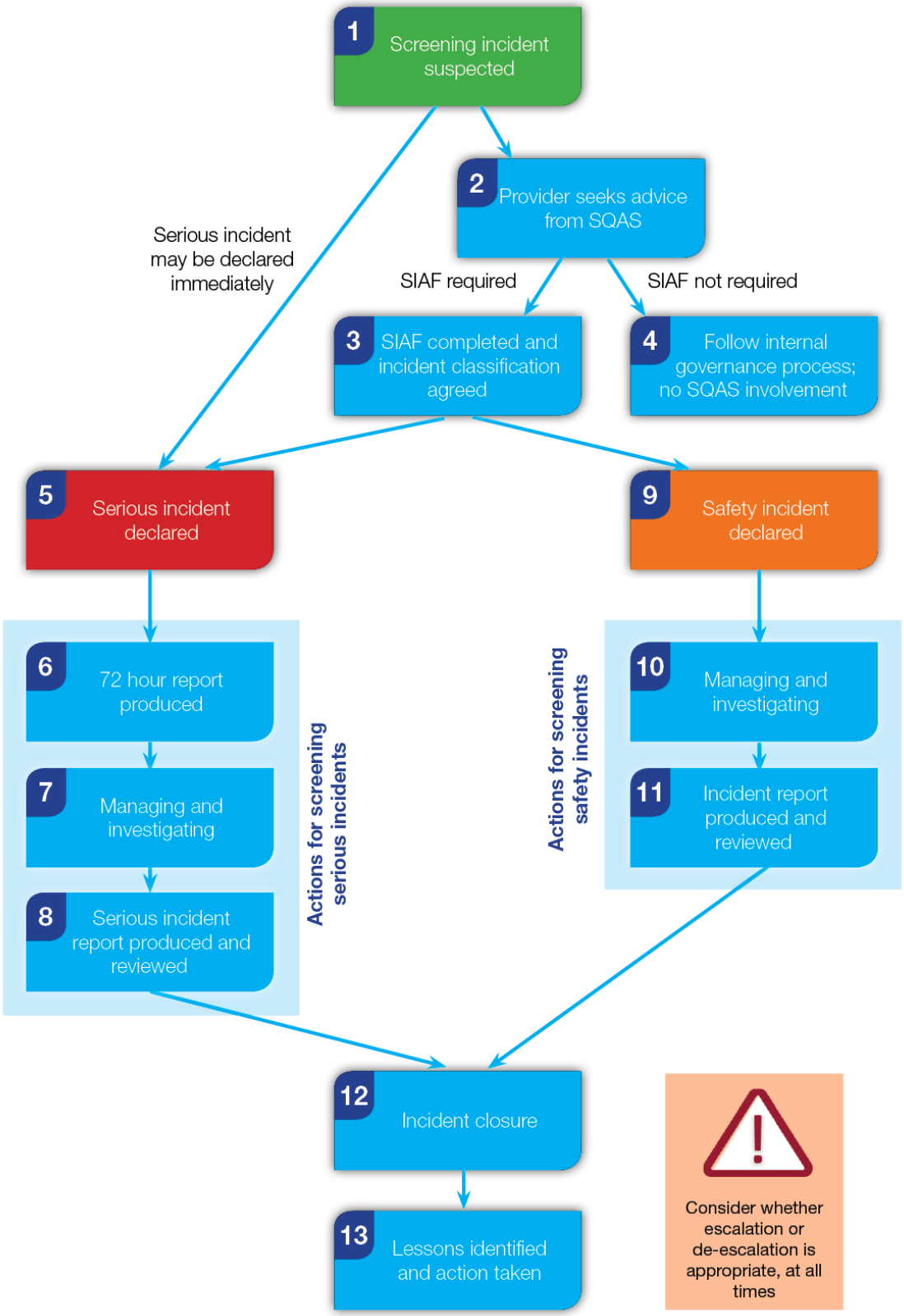
28.1. Support for staff and others

When an incident is reported it can be a stressful time for anyone involved, whether they are members of staff, a patient directly involved or a witness to the incident. They all need to know that they are going to be treated fairly and that lessons will be learned and action taken to prevent the incident happening again.

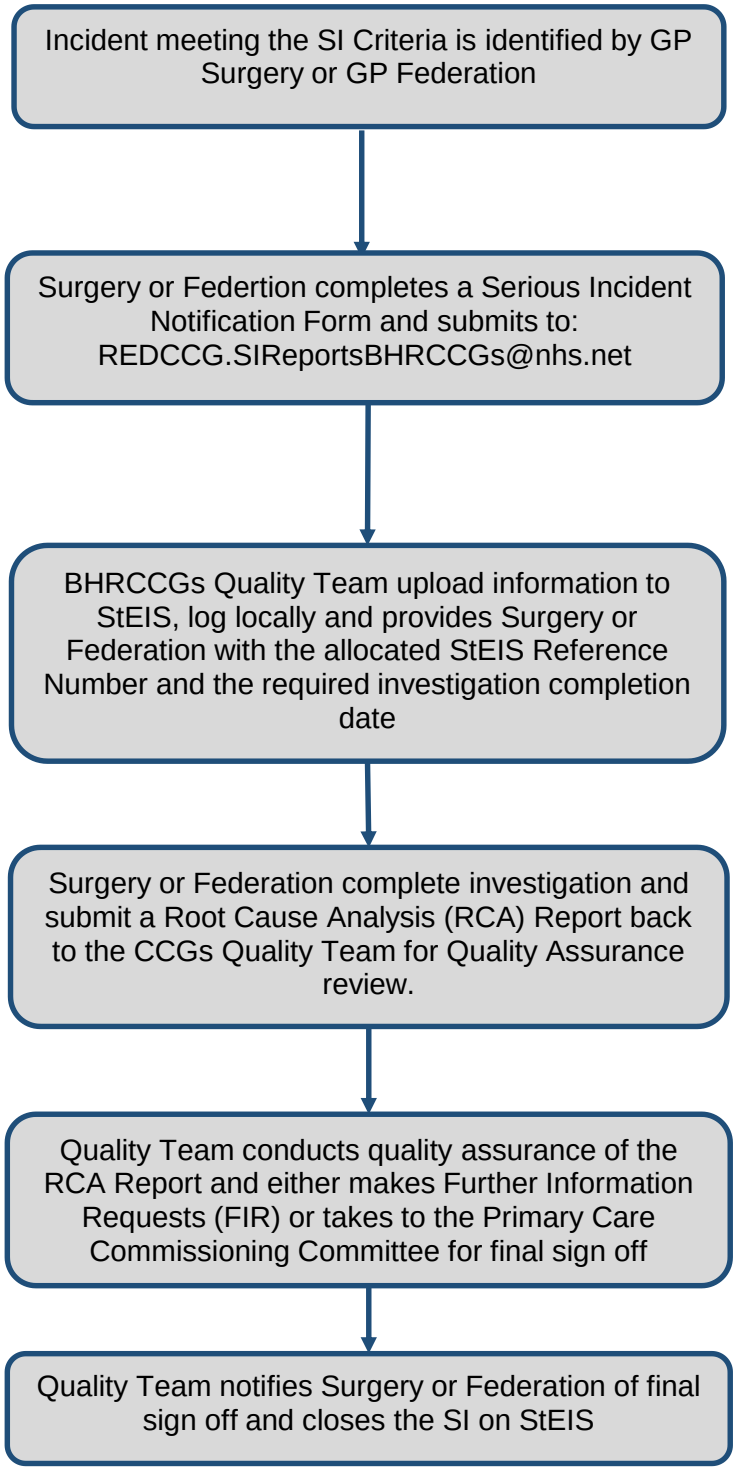
Appendix 1
Process of Notification of SCRs, SARs and DHRs through StEIS



Appendix 2
Process of Reporting & Managing Screening Incidents



Appendix 3
Process of Reporting and Management of SIs from GP Surgeries and GP Federations



Appendix 4
SI Reporting Document

SERIOUS INCIDENT (SI) REPORTING DOCUMENT			
Surgery Name and Practice Code:		**StEIS No:**	**LEAVE BLANK**
Region:	LONDON	**Status:**	**LEAVE BLANK**
CCG:	**Choose an item.**	**CCG Lead for Oversight of Investigation:**	**Head of Quality & Clinical Governance**
BF/wd Date:	**LEAVE BLANK**	**Organisation Leading the investigation:**	**LEAVE BLANK**
WHEN, WHERE & YOUR DETAILS			
Date of Incident:		**Reporter Name:**	
Time if Incident:		**Reporter Job Title:**	
Site of Incident:		**Reporter Tel, No:**	
Location of Incident:	**Choose an item.**	**Reporter Email (nhs.net):**	
Date Incident Identified:			
WHO			
Care Sector:	**Choose an item.**	**Type of Patient at time of incident:**	**Choose an item.**
Clinical Area:	**Choose an item.**	**Gender:**	**Choose an item.**
Date of Birth:		**Ethnic Group:**	**Choose an item.**
WHAT HAPPENED?			
Reason for Reporting:	**Choose an item.**		
Type of Incident:	**Choose an item.**		

Where is patient at time of reporting:	**Choose an item.**	**Never Event:**	**Choose an item.**
Internal Investigation Required:	YES	**Expected Completion Date:**	**LEAVE BLANK**
Description of what happened:			
Immediate Actions Taken:			
Patient Family/Victim Family Informed:		**Patient Informed:**	
Duty of Candour Comments – include steps taken to involve and support those affected (including patient (s), victims, families, staff etc.			
Media Interest:	**Choose an item.**	**Line being taken by Surgery:**	
Externally Reportable:	**Choose an item.**	**Externally Reportable to:**	**Choose an item.**
Have Relevant Organisations Been Notified:	**Choose an item.**	**Date of Notification:**	

SURGERY/CCG FILE

Surgery Lead:		**Surgery Lead Tel No:**	
CCG Lead:	**Head of Quality & Clinical Governance**	**CCG Lead Tel No:**	**020 3182 2951**
Date Internal Investigation Report and Action Plan Submitted:	**LEAVE BLANK**		
Has an Extension Been Agreed:	**LEAVE BLANK**	**State Reason for Extension:**	**LEAVE BLANK**
Agreed Extension Date:	**LEAVE BLANK**		

KEY FINDINGS

Key Findings (i.e. fundamental root	**LEAVE BLANK**

causes) and recommendations:			
How will Lessons be Disseminated to interested parties:	**LEAVE BLANK**		
Plan for Monitoring Action Plan in Place:			
Date Closed by CCG:			

Equality Impact Assessment

		Yes/No	Comments
	Does the policy/guidance affect one group less or more favourably than another on the basis of:	No	
1	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability-leaning disabilities, physical disability, sensory impairment and mental health problems	No	
2	**Is there any evidence that some groups are affected differently?**	No	
3	**If you have identified potential discrimination, are there any exceptions valid, legal and or justifiable?**	No	
4	**Is the impact of the policy/guidance likely to be negative?**	No	
5	**If so can the impact be avoided?**	N/A	
6	**What alternative are there to achieving the policy/guidance without the impact?**	N/A	
7	**Can we reduce the impact by taking different action?**	No	