West Lancashire
Clinical Commissioning Group

Serious Untoward Incident Policy & Procedure

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Contents

Version	Date	Author	Detail of Change

1. Introduction

In March 2015, NHS England published a revised version of the Serious Incident (SI) Framework (March 2015). The fundamental principles remain unchanged, continuing to provide the detail of the responsibilities and actions for dealing with serious incidents and is relevant to all NHS funded care in the primary, secondary and tertiary sectors. In addition to a number of amendments, two key operational changes have been made in relation to timescale and removal of grading.

NHS West Lancashire Clinical Commissioning Group's (CCG) Serious Incident policy is based on this revised national framework and local arrangements agreed with the NHS England Area Team. This policy is intended to support the CCG's commitment to the provision of high quality care that puts the safety of patients and staff first.

Serious incidents requiring investigation in healthcare are rare, but when they do occur, everyone must make sure that there are systematic measures in place to respond to them. These measures must protect patients and ensure that robust investigations are carried out, which result in organisations learning from serious incidents to minimise the risks of the incident happening again. When an incident occurs, it must be reported to all relevant bodies, to ensure that patients are protected.

The role of NHS West Lancashire CCG is to gain assurance from the provider organisations that incidents are properly identified, reported and then investigated to identify lessons learnt in order to ensure that the risk of a similar incident happening again is minimised as much as possible.

It is a requirement of all registered organisations to report serious incidents to the Care Quality Commission. This process in no way replaces this requirement.

2. Purpose

The purpose of this document is to outline the overarching governance arrangements for the management of serious incidents reportable on the Strategic Executive Information System (StEIS) and ensure that patient safety and other reportable incidents are appropriately managed within commissioned and contracted NHS services in order to address the concerns of the patients and promote public confidence. This document describes the requirements for SI reporting and management.

3. Scope

This document applies to all staff employed by NHS West Lancashire CCG. It should also be complied with by all organisations whose services are commissioned by the CCG. Furthermore, this document applies to all third parties and others authorised to undertake work on behalf of the CCG, including any organisation commissioned to manage the process associated with the reporting of SIs.

The scope of this document has been expanded to include the process for managing Serious Incidents declared in GP practices following the CCG receiving delegated authority from NHS England to manage this process.

This document should also be read in conjunction with the following guidance:

- Serious Incident Framework – NHS England (March 2015)
- The NHS Patient Safety Strategy (2019)
- NHS England Revised Never Events Policy and Framework (2018)
- Information Governance Policy – NHS West Lancashire CCG

- Safeguarding Policy – NHS West Lancashire CCG

4. Serious Incident Requiring Investigation (SIRI)

Defined in the Serious Incident Framework (2015) 'serious incidents 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 directly impact patient safety or an organisation's ability to deliver ongoing healthcare'.

There is no definite list of events / incidents that constitute a serious indent and lists should not be created locally. The Serious Incident Framework (2015) sets out circumstances in which a serious incident must be declared stating that every incident must be considered on a case by case basis using the provided information. See Appendix 1 for further details.

In many cases it will be immediately clear that a serious incident has occured and further investigation will be required. Where it is not clear whether or not an incident fulfils the definition of a serious incident, providers and commissioners must engage in open and honest discussions to agree the appropriate and proportionate response.

The NHS Patient Safety Strategy 2019 describes the plan to move away from the focus on current thresholds for Serious Incidents. A project currently underway is to replace NRLS (National Reporting and Learning System) and StEIS (Strategic, Executive Information System) with a single, simple portal and aims to redefine patient safety learning across healthcare.

5. Never Events

All Never Events are defined as a Serious Incidents (see appendix 1). Never Events are defined as a particular type of serious incident that meet all the following criteria:

- They are **wholly preventable**, where guidance or safety recommendations that provide strong systematic protective barriers **are available at a national level,** and should have been implemented by all healthcare providers.

The Revised Never Events policy and framework (2018) can be accessed here

A Never Events list is defined by NHS England, updated annually and published on the Department of Health website here.

6. Interface with Other Sectors

There may be occasions where the principles set out in this document coincide with other procedures. In such circumstances it is important that cooperative and collaborative working is established to avoid duplication and confusion where possible. This may be challenging if investigations have different aims. Wherever possible, serious incident investigations should continue alongside criminal proceedings but this should be considered in discussion with the police. In exceptional cases the investigation may be put on hold following discussion with involved parties. More information can be found at Appendix 2.

7. Roles and Responsibilities

Chief Accountable Officer

The Chief Accountable Officer has responsibility for ensuring that the CCG has the necessary

processes and procedures in place to support the effective management of serious incidents.

Chief Financial Officer

The Chief Financial Officer has executive responsibility for ensuring that lessons learned from SIRIs influence quality and safety standards for finance. Chief Financial Officer is the CCG Senior Information Risk Owner (SIRO). The SIRO has a corporate responsibility for overseeing incidents relating to information governance breaches.

Chief Nurse

The Chief Nurse has executive responsibility for ensuring the necessary management systems are in place for the effective implementation of serious incident reporting for commissioned services.

Director of Strategy & Operations

The Director of Strategy and Operations is responsible for ensuring that there are specific references to Serious Incident reporting and management in all contracts. The Director of Strategy and Operations is also responsible for ensuring that lessons learned from incidents and SIs influence the quality and safety standards for care pathway and service development.

Quality Assurance Manager

The Quality Assurance Manager is responsible for the day to day management of the serious incident reporting processes described in Appendix 4 and ensuring there is a consistent and robust approach in line with policy. The facilitation of this will be through the Midlands and Lancashire Commissioning Support Unit (MLCSU). Specific responsibility will include:

- having the authority to make a decision regarding any extension requests received from provider organisations
- provide support in complex circumstances e.g. lead the process where no one provider organisation is best placed to assume responsibility for co-ordinating an investigation.
- disseminate the Root Cause Analysis to relevant CCG staff for comment in order to assess whether the Root Cause Analysis (RCA) and action plan submitted provide adequate assurance to close the Serious Incident (with agreement of the Chief Nurse). Where the decision is made not to close the serious incident the comments will be collated and fed back to the lead commissioner via the MLCSU. The lead commissioner will then inform the provider.
- ensure the analysis and triangulation of themes is undertaken and escalated appropriately and any learning is disseminated where necessary.
- act as a point of contact for provider organisations to report any never events or serious incidents via telephone or email, prior to reporting these via the StEIS.
  escalate concerns and exceptions in the management of serious incidents and/ or never events to the governing body of the CCG via the Chief Nurse and Quality and Safety Committee

Midlands and Lancashire Commissioning Support Unit (MLCSU)

MLCSU has responsibility for facilitating and supporting the serious incident investigation processes described in Appendix 4 on behalf of the CCG. When MLCSU are notified of a serious incident it is logged on the SI database and an email sent to CCG staff: Chief Nurse, Quality Assurance Manager, the safeguarding team and others as appropriate. MLCSU staff will facilitate communication

between lead commissioners and/ or providers and the CCG and update the database with progress of all serious incidents.

The MLCSU will undertake analysis of serious incident themes and organisational performance, based on timeliness of submission, report completeness and reporting levels. This analysis will take the form of a standard quarterly report agreed with the CCG and ad hoc reports.

MLCSU will escalate concerns and exceptions to the management of serious incidents by providers to the Quality Assurance Manager within the CCG.

Quality & Safety Committee

The committee will receive performance reports regarding serious incidents reportable on StEIS, trends and lessons learned to ensure organisational learning to prevent recurrence. If the Committee have any concerns the Chair of the committee will draw them to the attention of the Governing Body.

NHS England Area Team

NHS England (via its Area Team), as part of its assurance, will have oversight of serious incident investigations undertaken in NHS funded acute, community, mental health, primary and ambulance care including reviewing trends, quality analysis and early warnings via the Quality Surveillance Group (QSG). It will also hold to account providers of NHS funded specialised care and other directly commissioned services for their responses to serious incidents and, where appropriate, commissioning and co-ordinating serious incident investigations.

NHS West Lancashire CCG staff

Any internal incident that occurs within the CCG and meets the SI criteria must be escalated to the MLCSU team within 2 working days of identifying the incident by completing the form given in appendix 7 and emailing it to seriousuntowardincidents@nhs.net (the Quality Assurance Manager can be contacted for advice). 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 MLCSU will update StEIS prior to any request for closure.

Provider Organisations

Organisations providing NHS services must report any incident meeting the StEIS reportable criteria within a maximum of 48 hours post incident, or as soon as the incident comes to light, by inputting the incident onto the national StEIS database where available. This automatically notifies the lead commissioner for the provider who will notify the CCG of the patient involved. This is the CCG where the patient is registered with a GP in their area.

Providers of primary care services or independent sector healthcare providers without direct access to StEIS (e.g. Care Homes) should report any serious incident to the CCG via the MLCSU. Root Cause Analysis (RCA) investigations are usually carried out by the Nursing Home itself or by the CSU on behalf of the CCG. The logging on StEIS, management and monitoring is via the MLCSU SI team with any closure agreed by NHS West Lancashire CCG.

The organisation that identifies the serious incident is responsible for alerting other providers and commissioners even when they are not involved in the delivery of care during which the incident

occurred. Commissioners will help identify who is the most appropriate organisation to take responsibility for co-ordinating the investigation process.

All organisations and agencies involved should work together to support one single investigation wherever this is possible and appropriate.

Within 3 working days of the incident being identified, the reporting organisation must complete and submit an initial review. Confirmation of the level of investigation will be agreed. The recognised system-based method for conducting investigations, commonly known as Root Cause Analysis (RCA), should be applied for the investigation of serious incidents. An overview of the serious incident management process can be found within Appendix 4.

The CCG requires the providers they commission to fulfil the following requirements:

- collaborate with external scrutiny of investigations and any remedial work required following investigations, including full and open exchange of information with other investigatory agencies such as the police, Health and Safety Executive, Coroner and local safeguarding adult board and children safeguarding partnership;
- publish information about serious incidents including data on the numbers and types of incidents, excluding material that would compromise patient confidentiality, within annual reports, board reports and other public facing documents;
- comply with national requirements and guidance in relation to being open with patients or their representatives when things have gone wrong;
- support and enable staff in disclosing incidents to patients and their representatives;
- involve patients and families/carers in investigations, sharing findings and providing timely referral for specialist support and guidance where appropriate;
- provide relevant guidance and training for staff to help them identify and report and investigate incidents using recognised methodologies (e.g. RCA));
- include the reporting and management of serious incidents as part of staff induction and ongoing training;
- ensure timely closure of serious incident cases is enabled by effective communication with the relevant commissioner(s) and other healthcare providers involved in or leading the investigation;
- ensure that action plans are implemented and that there are mechanisms for Board oversight of overdue actions; and
- regularly review changes made as a consequence of learning from serious incidents to ensure the changes are embedded, sustained and effective

8. Out of Hours

Where the authorised named individual in the NHS organisation believes that an incident has significant implications for the NHS in terms of clinical care and management of media issues and warrants the immediate involvement of the CCG out of hours, the CCG on call manager should be contacted. They will agree the action that needs to be taken with the relevant NHS organisation.

9. Safeguarding

Whilst reviewing serious incidents, safeguarding adults, children and young people must be considered. Safeguarding is effectively protecting children and young people and adults at risk from abuse or neglect. All NHS commissioned services have a key role to play in safeguarding and promoting the welfare of children and young people and adults at risk, as safeguarding is everybody's business.

Safeguarding children is a statutory duty under section 11 of the Children Act 2004 and in accordance with government guidance in 'Working Together to Safeguard Children' 2018. Safeguarding adults is a statutory duty under part 1 of the Care Act 2014. The responsibilities in respect to safeguarding can be found in the CCG safeguarding policy.

10. Information Governance

All Information Governance serious incidents are to be handled in accordance with the guidance developed by the Department of Health 'Checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation' (May 2015).

This guidance includes details on assessing the severity of the incident and reporting requirements via the Data Security and Protection Toolkit (DSPT). An Information Governance Serious Incident Requiring Investigation (IG SIRI) deemed reportable to national bodies e.g. the Information Commissioner, should be recorded and communicated via the Data Security and Protection Toolkit (DSPT) Incident Reporting Tool.

11. Multiple Commissioners

In a commissioning landscape where multiple commissioners may commission services from providers spanning local and regional geographical boundaries a RASCI (Responsible, Accountable, Supporting, Consulted, Informed) model should be used to agree the identification of a 'lead commissioner'. They will have responsibility for managing the oversight of serious incidents with a particular provider. It is expected that where a lead commissioner is not NHS West Lancashire CCG, clear lines of communication are established to ensure NHS West Lancashire CCG can fulfil its requirements as a commissioning body in relation to serious incidents. This is described in appendix 4. A list of the main providers used by West Lancashire patients and their lead commissioner is given in appendix 5.

12. Duty of Candour

Central to the CCG's strategy to improve patient's safety is the commitment to provide good communication between healthcare organisations and patients and/or carers.

The CCG expects all providers to meet the requirements of the Duty of Candour as defined within the Regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). This includes providing reasonable support, truthful information and an apology to patients and /or their carers when they have been involved in a serious incident.

13. Serious Incident Extensions

It is acknowledged that whilst every effort should be made to ensure that all serious incident investigations are completed in a timely manner (60 working days for level 1&2 incidents, up to 6 months for level 3, see Appendix 4: The National Serious Incident Management Process). However, there are instances when this is impossible due to circumstances which are beyond the immediate control of the reporting organisation.

Such delays may be caused by:

- Awaiting outcomes of court proceedings;
- Awaiting Coroner Inquests;
- Awaiting forensic post-mortem findings;

- Awaiting Toxicology results;
- Awaiting completion of an external review;
- In direct response to a Police request under Memorandum of Understanding.

It is the decision of the lead CCG whether or not a serious incident meets the criteria for an extension. In order to ensure robust governance, the CCG will monitor/review extensions on a regular basis.

14. Closure of Serious Incidents

When the provider has submitted a completed investigation and Root Cause Analysis (RCA) with a request to close the incident, this is sent to the CCG for review. The CCG will make the decision to close based on evidence submitted by the provider. This will include ensuring that the action plan contains action points to address all root causes identified and that they include a named lead for each action and a timescale for completion.

If the CCG deems that further action or clarification is required this will be communicated to the provider via the lead CCG where appropriate. Feedback from individuals will be collated by the Quality Assurance Manager using The Critical Review/ Closure form as guidance in Appendix 8 and returned via the CSU either directly to the provider or via the lead commissioner when appropriate.

The CCG aims to respond to submitted RCAs within 10 working days and to give providers effective feedback if an SI is deemed not ready for closure.

A more detailed description of the processes involved in reviewing and closing StEIS, as well as the associated timescales can be found in Appendix 4.

If, at any stage during an SI investigation it becomes apparent that the incident does not constitute a SI it can be downgraded by formal notification, including reasons for downgrading and agreement with the CCG. At this point the SI will be removed from STEIS and the MLCSU database noted accordingly. Even after the serious incident is closed it remains the responsibility of the lead commissioner to ensure the action plan laid out in the RCA is completed.

15. Learning from Experience and Post Incident Review (PIR)

The CCG may request a Post Incident Review (PIR) for incidents where it is deemed appropriate. This review does not replace any internal mechanisms for a review the provider may have. The PIR will take place after the performance management process has concluded and following receipt of the internal investigation report from the provider organisation. The reviews will provide the opportunity to facilitate the sharing of good practice and lessons learned.

16. Dissemination of Learning

All organisations are responsible for ensuring that learning from serious incidents is disseminated appropriately. Depending on the outcome, it may be useful to share an anonymous version of learning more widely with other organisations if it could prevent harm coming to other patients in the future.

The Quality Assurance Manager will feed back any learning to the Quality & Safety Committee, Quality and Surveillance Groups (QSGs) and to NHS England and other bodies where relevant and liaise with the Communications team as appropriate.

17. Monitoring Compliance and Effectiveness

An annual review of this policy and associated processes shall be carried out to review the effectiveness of the performance management of SIs reportable on StEIS, the process of reporting, recording and lessons learned. The CSU produce an annual report that details whether providers' reporting timescales comply with national guidance. The CCG's Quality Team will undertake an annual audit (template in appendix 9) to evidence the CCG's compliance with this policy. This will be presented to the Quality and Safety Committee.

18. References and Associated Documents

The NHS Patient Safety Strategy (2019) https://improvement.nhs.uk/resources/patient-safety-strategy/

NHS England Serious Incident Framework (March 2015) https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf

NHS England Revised Never Events Policy and Framework (2018) https://improvement.nhs.uk/resources/never-events-policy-and-framework/

NHS West Lancashire CCG Information Governance Data Security and Protection Policy http://www.westlancashireccg.nhs.uk/wp-content/uploads/2018-09-25-WL-CCG-IG-Data-Security-and-Protection-Policies-v1.pdf

NHS West Lancashire CCG Safeguarding Policy http://www.westlancashireccg.nhs.uk/wp-content/uploads/Safeguarding-Children-and-Adults-Policy-final.pdf

The Health and Social Care Act 2008 (Regulated Activities) (Amendment) Regulations 2015

http://www.legislation.gov.uk/uksi/2015/64/made

The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014

http://www.legislation.gov.uk/ukdsi/2014/9780111117613/contents

Health & Social Care Information Centre, Checklist Guidance for Reporting, Managing and Investigating Information Governance and Cyber Security Serious Incidents Requiring Investigation (May 2015) https://www.igt.hscic.gov.uk/resources/HSCIC%20SIRI%20Reporting%20and%20Checklist%20Guidance.pdf

Appendix 1

Serious Incidents in the NHS; definitions

In broad terms, Serious Incidents in the NHS include:

- Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:
    - Unexpected or avoidable death of one or more people. This includes
        - suicide/self-inflicted death; and
        - homicide by a person in receipt of mental health care within the recent past;
    - Unexpected or avoidable injury to one or more people that has resulted in serious harm;
    - Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent:
        - the death of the service user; or
        - serious harm;
    - Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment; or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where:
        - healthcare did not take appropriate action/intervention to safeguard against such abuse occurring; or
        - where abuse occurred during the provision of NHS-funded care.
- A Never Event – all Never Events are defined as serious indents although not all Never Events necessarily result in serious harm or death.
- An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:
    - Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues;
    - Property damage
    - Security breach/concern
    - Incidents in population-wide healthcare activities like screening and immunisation programmes where the potential for harm many 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);
    - Systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/unit closure or suspension of services); or
    - Activation of major Incident Plan (by provider, commissioner or relevant agency)
- Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of health or an organisation

Appendix 2 Interfaces with Other Sectors

Deaths in Custody- where health provision is delivered by the NHS

People in custody, including either those detained under the Mental Health Act (1983) or those detained within the police and justice system, are owed a particular 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 and police custody, any death will be referred (by the relevant organisation) 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. The PPO has clear expectations in relation to health involvement in PPO investigations into death in custody. Guidance published by the PPO23 must be followed by those involved in the delivery and commissioning of NHS funded care within settings covered by the PPO.

In NHS mental health services, providers must ensure that any death of a patient detained under the Mental Health Act (1983) is reported to the 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 under the Mental Capacity Act (2005)). Where an individual dies at a time when they are deprived of their liberty under the Mental Capacity Act 2005 (MCA 2005) a coroner must investigate the death of an individual subject to a DoL. Under the MCA 2005 a person who lacks capacity and is in a hospital or care home for the purpose of being given care or treatment may be detained in circumstances which amount to deprivation of liberty. The court of protection may make similar authorization, authorising deprivation in a personal domestic setting (own home). A death in custody is automatically reportable to the coroner and a death certificate must not be issued.
In circumstances where the cause of death is unknown and/or where there is reason to believe the death may have been avoidable or unexpected i.e. not caused by the natural course of the patient's illness or underlying medical condition when managed in accordance with best practice - including suicide and self-inflicted death - then the death must be reported to the provider's commissioner(s) as a serious incident and investigated appropriately. Consideration should be given to commissioning an independent investigation.

Serious Case Reviews and Safeguarding Adult Reviews

The purpose of reviews of serious child safeguarding cases, at both local and national level, is to identify improvements to be made to safeguarding and promote the welfare of children. Reviews should seek out to prevent or reduce the risk of recurrence of similar incidents. The findings from reviews should be shared with the relevant parties locally and should regularly audit progress on implementation of recommended improvements. Improvement should be sustained through regular review monitoring and follow up on actions so that the findings from these reviews make a real impact on improving outcomes for children.

The local authority has a statutory duty to make relevant enquiries regarding safeguarding concerns as prescribed by the Care Act 2014. The Lancashire Safeguarding Adult Board (LSAB) will commission a Safeguarding Adult Review (SAR) where there is reasonable concern of how agencies have worked together regarding an adult with care and support needs who has died or experienced significant harm as a result of abuse or neglect. Healthcare providers have a statutory duty to cooperate with

safeguarding enquiries and SAR's and where a serious incident is indicated within a healthcare setting, the necessary declaration must be made.

Whilst the Local Authority and LSAB hold statutory functions for safeguarding enquiries and SAR's, healthcare must be able to gain assurance that, if a problem is identified, appropriate measures will be undertaken to protect individuals that remain at risk and ultimately to identify the contributory factors and the fundamental issues (in a timely and proportionate way) to minimise the risk of further harm and/or recurrence. The interface between the serious incident process and local safeguarding procedures must therefore be articulated in the local multi-agency safeguarding policies and protocols.

Providers and commissioners must liaise regularly with the local authority safeguarding lead to ensure that there is a coherent multi-agency approach to investigating and responding to safeguarding concerns, which is agreed by relevant partners. Partners should develop a memorandum of understanding to support partnership working wherever possible.

Domestic Homicide Reviews

A Domestic Homicide is identified by the police usually in partnership with the Community Safety Partnership (CSP) with whom the overall responsibility lies for establishing a review of the case. Where the CSP considers that the criteria for a Domestic Homicide Review (DHR) are met, they will utilise local contacts and request the establishment of a DHR Panel. The Domestic Violence, Crime and Victims Act 2004, sets out the statutory obligations and requirements of providers and commissioners of health services in relation to domestic homicide reviews.

Homicide by patients in receipt of mental health care

Where patients in receipt of mental health services commit a homicide, NHS England will consider and, if appropriate, commission an investigation. This process is overseen by NHS England's Regional investigation teams. The Regional investigation teams have each established an Independent Investigation Review Group (IIRG) which reviews and considers cases requiring investigation. Clearly there will be interfaces with other organisations including the police and potentially the Local Authority (as there may be interfaces with other types of investigation such as DHRs and/or SCRs/SARs, depending on the nature of the case). To manage the complexities associated with such investigations (and to facilitate joint investigations where possible), a clearly defined investigation process has been agreed. Central to this process is the involvement of all relevant parties, which includes the patient, victim(s), perpetrator and their families and carers, and mechanisms to support openness and transparency throughout.

Serious Incidents in National Screening Programmes

Serious Incidents in NHS National Screening Programmes must be managed in line with the guidance: Managing Safety Incidents in National Screening Programmes, which is aligned with the principles and processes set out in this Framework. The guidance provides further clarity with regards to the accountabilities, roles and processes for managing screening safety incidents and serious incidents in national screening programmes. These 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.

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

and disseminated. Where appropriate these will be used to inform changes to national screening programme policy and education/training strategies for screening staff.

Appendix 3

Levels of Investigations (currently referred to as a Root Cause Analysis (RCA) Investigation)

Level	Application	Product/Outcome	Owner	Timescale for Completion
Level 1 **Concise internal investigation**	Suited to less complex incidents which can be managed by individuals or a small group at local level	Concise/ compact investigation report which includes essentials of a credible investigation	Provider organisation (Trust Chief Executive / relevant deputy) in which the incident occurred, providing principles for objectivity are upheld	Internal investigations whether concise or comprehensive must be completed within 60 working days of the incident being reported to the relevant commissioner.
Level 2 **Comprehensive internal investigation** (this includes those with an independent element or full independent investigations commissioned by the provider)	Suited to complex issues which should be managed by a multidisciplinary team involving experts and/or specialist investigators where applicable	Comprehensive investigation report includes all elements of a credible investigation	Provider organisation (Trust Chief Executive / relevant deputy) in which the incident occurred, providing principles for objectivity are upheld. Providers may wish to commission an independent investigation or involve independent members as part of the investigation team to add a level of external scrutiny/objectivity	
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 due to the size of the organisation or the capacity/capability of the available individuals and/or number of organisations involved	Comprehensive investigation report includes all elements of a credible investigation	The investigator and **all** members of the investigation team must be independent to the provider. To fulfil independency the investigation must be commissioned and undertaken entirely independently of the organisation whose actions and processes are being investigated.	6 months from the date the investigation is commissioned.

Appendix 4: **STEIS processes**

Serious Incident Review Process for Providers with access to StEIS (WLCCG is NOT lead commissioner):

Provider reports the SI onto Steis. CSU notified and log and forward the SI summary to WLCCG (the CSU has standard distribution lists for the more common categories of SI eg. urgent care, maternity etc. and include the Quality Assurance Manager (QAM), Lead Nurse, safeguarding, GP and management leads). The QAM forwards the report to other staff as appropriate. Conflicts of interest need to be considered. QAM logs SI within Spreadsheet 'evidence of review' here. This spreadsheet tracks the CCG's process of reviewing SI reports from when the CCG is first informed.

Provider sends the completed 72hour report to the lead CCG who forward to CSU. CSU forwards the 72hour report to CCG. QAM forwards to other managers/ clinicians as appropriate. If a provider wishes to request a downgrade/ extension the request should be emailed with reasons to the CSU and forwarded to the CCG for agreement.

Provider sends the completed RCA report to the lead CCG who forward to CSU. CSU forwards the RCA and partially completed closure form requesting feedback within timescales requested by lead CCG (at least 5 working days). QAM forwards as appropriate.

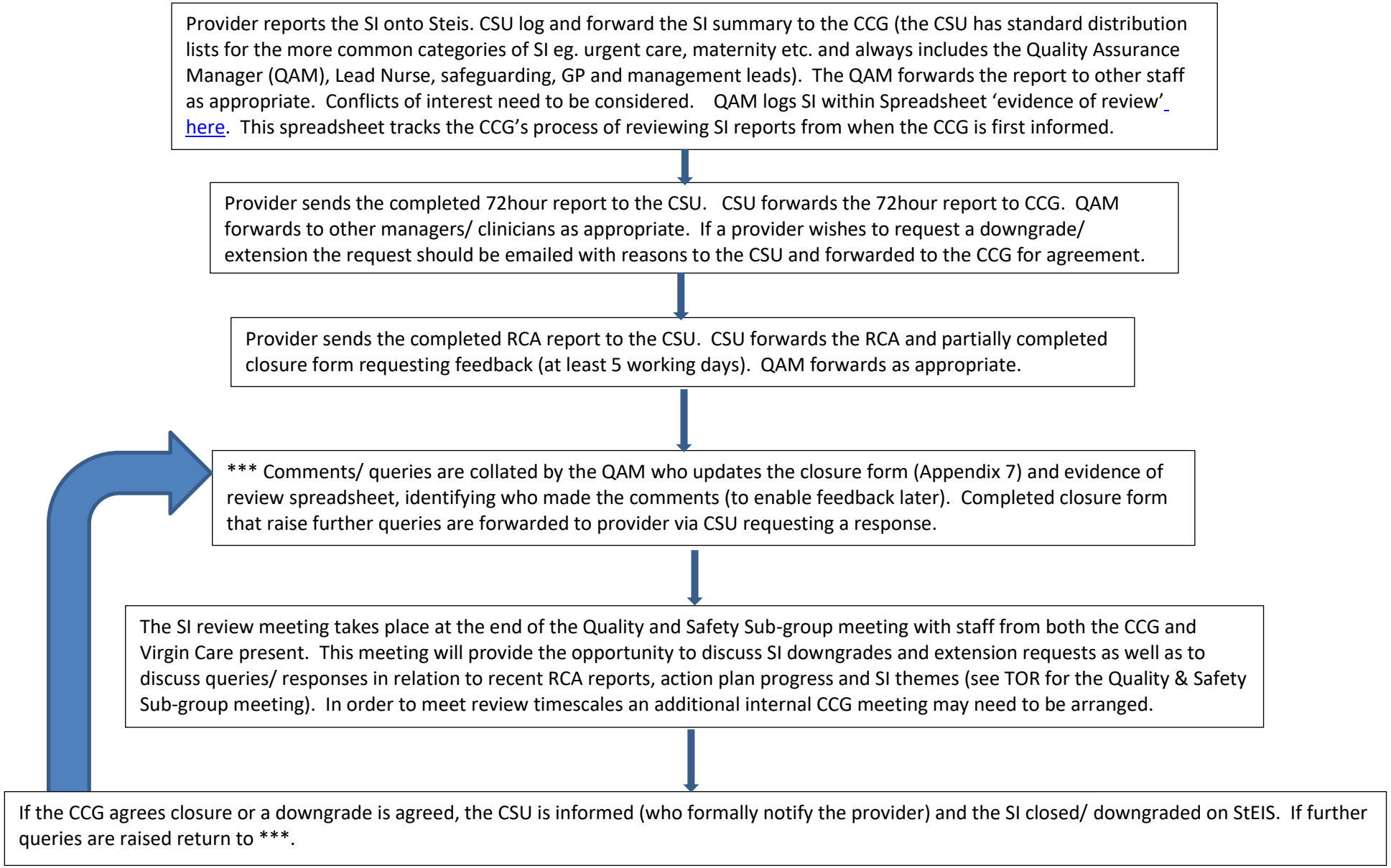
*** Comments/ queries are returned to the QAM for collation. Feedback is returned to the lead ccg via the CSU, either by email or formal letter stating whether closure is supported and raising any queries. The evidence of review spreadsheet is updated, identifying who made the comments (to enable feedback later).

The SI review meeting takes place hosted by the lead CCG with representatives from the provider present. Feedback from CCGs is presented/ discussed and a response from the provider requested if necessary. This may be provided at the meeting or formally by letter after the meeting. The response from the provider is forwarded to the QAM via the CSU.

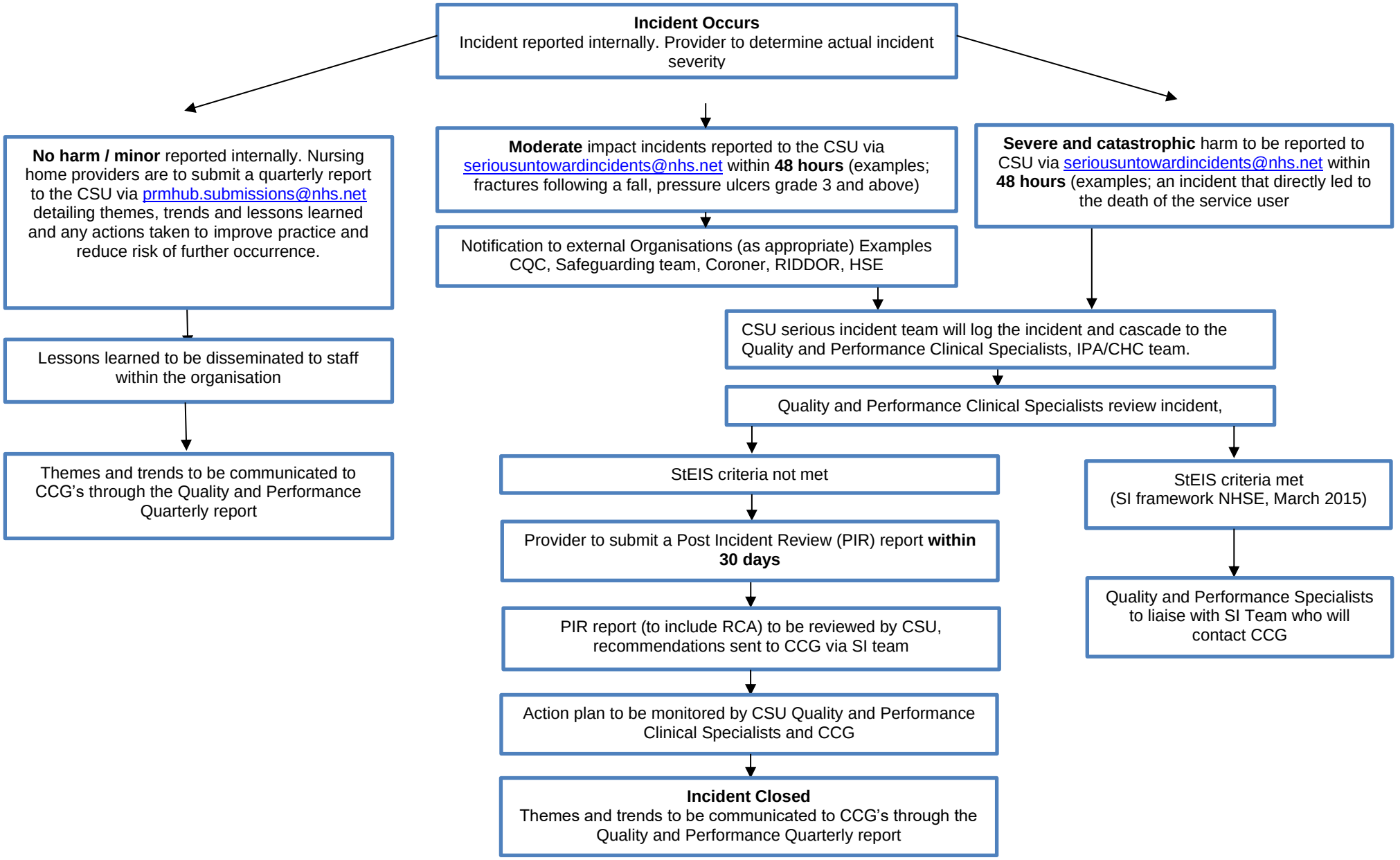
The QAM forwards the response to staff who originally raised the queries and asks for confirmation that they are satisfied with the responses and whether they agree closure. If closure is agreed the QAM informs the lead CCG via the CSU. If further clarification is required return to ***.

Serious Incident Review Process for Providers with access to StEIS (WLCCG as lead commissioner):

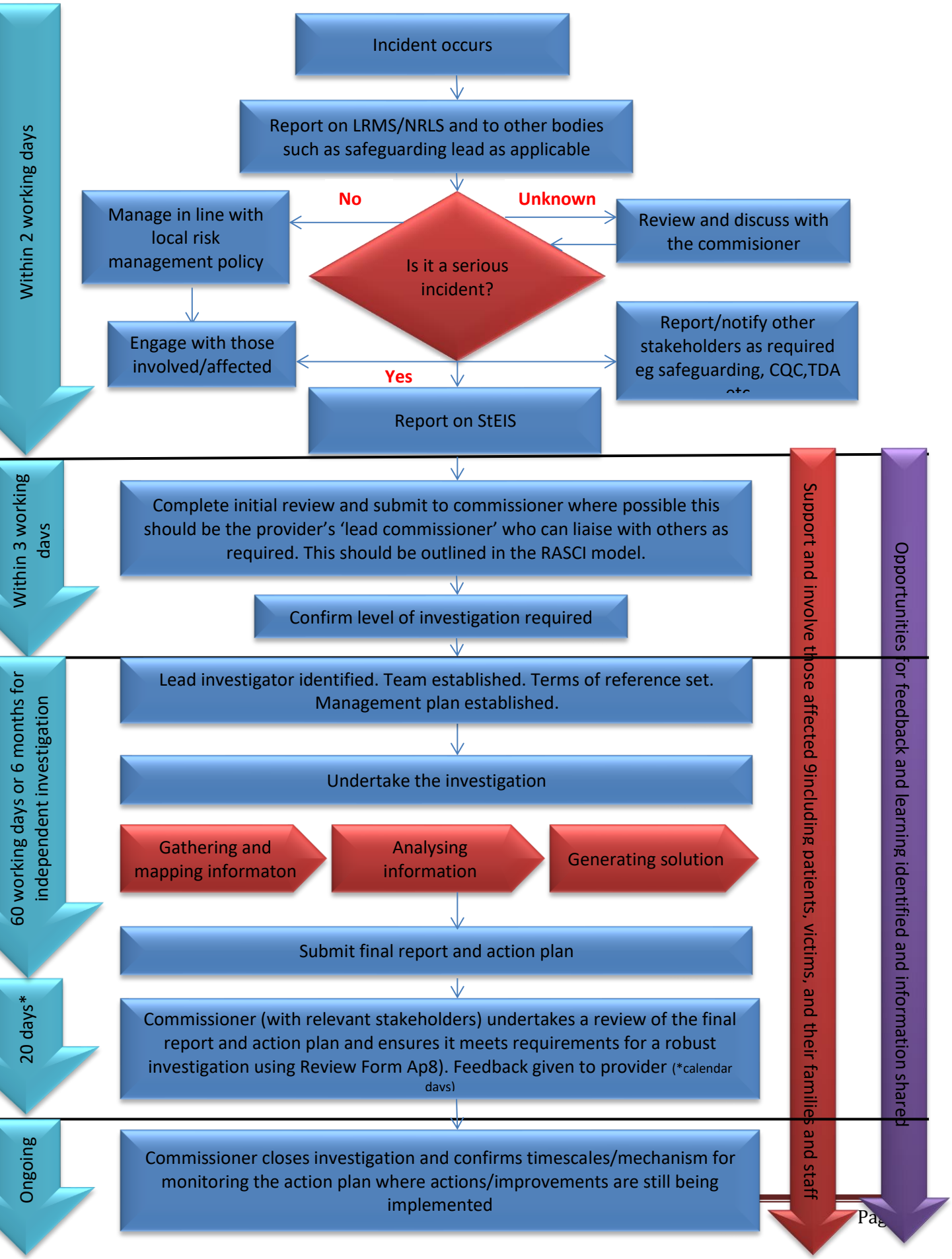
(currently only applies to Virgin)



Incident & Serious Incident Review Process for Care Homes (and other private providers with no access to StEIS)



The National Serious Incident Management Process, including timescales



Appendix 5: List of Providers and their Lead Commissioner for Serious Incident oversight

Contract Name	Contract Type	Lead Commissioner if not WLCCG
University Hospital Aintree	Acute	Southport & Formby CCG
Alder Hey Children's Hospital	Acute	Liverpool CCG
Blackpool Teaching Hospitals	Acute	Blackpool CCG
Wirral University Teaching Hospital	Acute	Liverpool CCG
East Lancashire Hospitals	Acute	East Lancashire CCG
Fairfield	Acute	St Helens CCG
Lancashire Teaching	Acute	Chorley & South Ribble CCG
Liverpool Heart & Chest	Acute	Liverpool CCG
Liverpool Women's	Acute	Liverpool CCG
Manchester University Hospitals	Acute	NHS Manchester CCG
NWAS - PES	Acute	BLACKPOOL CCG
The Pennine Acute Hospitals NHS Trust	Acute	Bury CCG
Euxton Hall & Fullwood	Acute	Preston CCG
Renacres	Acute	Southport & Formby CCG
Royal Liverpool & Broadgreen	Acute	Liverpool CCG
Salford Royal	Acute	NHS Salford CCG
Southport and Ormskirk Hospitals NHS Trust	Acute	Southport & Formby CCG
St Helens & Knowsley	Acute	St Helens CCG
University Hospital Morecambe Bay	Acute	Lancashire North CCG
Walton Centre	Acute	Liverpool CCG
Wirral University Teaching	Acute	Wirral CCG
Wrightington Wigan & Leigh	Acute	Wigan CCG
Phoenix Public Health Ltd	Acute - Tier 4 Bariatrics	C&SR CCG
GREATER MANCHESTER WEST MENTAL HEALTH NHS FOUNDATION TRUST	Mental Health	Bolton CCG
LANCASHIRE CARE NHS FOUNDATION TRUST (Mental Health Contract)	Mental Health	Blackburn with Darwen
MERSEY CARE NHS FOUNDATION TRUST - Main	Mental Health	Liverpool CCG
MERSEY CARE NHS FOUNDATION TRUST (SST)	Mental Health	East Lancashire CCG
NORTH WEST BOROUGHS HEALTHCARE NHS FOUNDATION TRUST	Mental Health	Knowsley CCG
Pennine Care NHS Foundation Trust - Mil Vets	Mental Health	Bury CCG

Complete Price (outside clinic)	AQP	East Lancashire CCG
Scrivens LTD (Audiology)	AQP	East Lancashire CCG
Southport (Audiology)	AQP	
Specsavers (Audiology)	AQP	East Lancashire CCG
Bridgewater	Community	Wigan CCG
Brief Therapy Support Service	Community	Chorley & South Ribble CCG
Lancashire Care	Community	Chorley & South Ribble CCG
Lancashire Teaching Hospital AQP Audiology	Community	Greater Preston
Marie Stopes International	Community	Fylde & Wyre CCG
Medequip Assistive Technology Limited	Community	Morecambe Bay CCG
NWAS - PTS	Community	Blackpool CCG
PDS Direct access	Community	
PDS Tier 2 Cardiology	Community	
Southport and Ormskirk - Paediatrics	Community	This will be built into main contract so S&FCCG
SPA Medica - Macular Service	Community	
VIRGIN CARE SERVICES LTD - Community	Community	
VIRGIN CARE SERVICES LTD - Urgent Care	Community	
Youth Sport Trust	Community	West Lancshire
A - sign posting service	Other	Blackpool CCG
Asda Stores Limited - Palliative Care Drugs	Other	
Aspire Pharmacy	Other	
British Pregnancy Advisory Serevice (BPAS).	Other	North Lancs CCG
CHC - Care Homes	Other	MLCSU
Fishlocks	Other	
InHealth - IHELP Design	Other	
ISIGHT - Tier 2 Opthalmology	Other	
Lancashire Mind - CYP Project	Other	
NUPAS	Other	BLACKPOOL CCG
OWLs - Social Prescribing	Other	
Stocks Hall - Step down/ step up beds	Other	
Age UK Lancashire - Contract	Vol Sector	
Alzheimer's Society Central Lancashire Branch - Contract	Vol Sector	Chorley & South Ribble CCG
Autisim Adventures CIC - Grant	Grant	
Crossroads Care North West	Vol Sector	
PULSE - Grant	Grant	

Queenscourt - Grant	Grant	
Stroke association - Grant	Grant	
Twinkle House - Sleep Clinics - Contract	Vol Sector	
Twinkle House - Immersive interactive equipment - Grant	Grant	
West Lancs Counselling Service - Acacia (Anticipatory Grief) - Contract	Vol Sector	
West Lancs Counselling Service - Bereavement - Contract	Vol Sector	
West Lancs CVS - Adult Carers	Vol Sector	
Yewdale Counselling Service - Contract	Vol Sector	
Birchwood Centre - Junk food café	Grant	
Birchwood Centre - Tanhouse together	Grant	
Connector Media CIC - Growing strong	Grant	
Divine Days	Grant	
Macmillen	Grant	Grant Agreement
Alan Bowen Ltd, Skelmersdale	PC - pre cateract assess	
Family eye care Ltd	PC - pre cateract assess	
Heyes Opticians Ltd, Burscough & ormskirk	PC - pre cateract assess	
Mayer & Mayer Optometrists Ltd, Tarleton	PC - pre cateract assess	
Specsavers Opticians, Ormskirk	PC - pre cateract assess	
Specsavers Opticians, Skelmersdale	PC - pre cateract assess	
Vision Express Ormskirk	PC - pre cateract assess	
Ashurst Primary Care	Primary care	
Aughton Surgery	Primary care	
Beacon Primary Care	Primary care	
Bisarya & Bisarya	Primary care	
Burscough family practice	Primary care	
Parkgate Surgery (Ormskirk) used to be County Road too	Primary care	
Elemental - Social Precribing	Primary care	
Excel Primary Care (Birleywood & Mathew Ryder& Skelm FP)	Primary care	
Hall Green Surgery	Primary care	
Lathom House	Primary care	

Manor Primary Care - Dr Sharma	Primary care	
Ormskirk medical practice	Primary care	
OWLs CIC	Primary care	
Parbold Surgery	Primary care	
Parkgate surgery	Primary care	
Stanley court surgery	Primary care	
Suzanne Dennis - Opticians (Parbold)	Primary care	
Tarleton Practice	Primary care	
The Elms	Primary care	

Appendix 6: Serious Incident Reporting Form

NHS West Lancashire CCG template for reporting Serious Incidents

Completed forms should be returned to: seriousuntowardincidents@nhs.net

Serious Incident Reference Number: (leave blank)	
STEIS Identification Number: (leave blank)	
Date/Time/Location of Incident including hospital / ward / team level information	
Incident type	
Type of investigation expected to be required: Level 1, 2 or 3	
Description of incident including reason for admission and diagnosis (for mental health please include Mental Health Act status and date of referral and last contact)	
Details of any police or media involvement/interest	
Details of contact with or planned contact patient/family or carers	
Immediate actions taken including actions to mitigate any further risk	
Details of other organisations/individuals notified	
Lead Commissioner	
Report completed by	
Designation	
Date / time report completed	
A brief chronology of key events (to be inserted) if required	

Appendix 7: CSU/ CCG StEIS Critical Review/ Closure Form

CSU/ CCG StEIS CRITICAL REVIEW / CLOSURE FORM			
StEIS number :		Date of Incident:	
Incident category:		Grade	
Name of Home CCG			
Provider			
Name of person completing the Form:			
Initial Description of Incident on StEIS:			
Root cause:			
Lessons learned:			
Areas of Good Practice:			
Incident areas of on- going concern:			
Trends and Areas:			
Does the Action Plan offer assurance that the risks have been reduced?			
Duty of Candour Fulfilled:	☐Yes ☐ No		
NHS England (Local Area Team) informed:	☐ Yes ☐ No		
Additional comments:			
Date findings reviewed with the Provider			
Date findings reviewed with the CCG			
Date received by CSU SI team			
Date Closed by the CCG			
Closed by whom			
Date provider Informed of the decision	☐ Yes ☐ No		

Appendix 8:
SERIOUS INCIDENT REVIEW GROUP (NHS Southport and Formby CCG) - TERMS OF REFERENCE

SFCCG SIRG ToR 3.0 Sept 2018.docx

Appendix 9: Annual Audit of CCG compliance with Serious Incident Policy

Ask the CSU to provide a random sample of 8 Serious Incidents, 2 from each quarter (equating to approximately 20% of all SIs). To include a minimum of 4 acute, 2 community, 1 mental health. Audit to be completed by the end of Q1.

SI Ref.	SI Sector/ Area	Feedback on SI report received from (min 3 to include 1 x clinician)					Response submitted within 20 calendar days?	Closure confirmed with CSU?	Action plan completed? (Only for services where WL is the lead)
		Q Team	SG Team	Lead Mgr	GP Lead	CSU			
No. compliant: (/8)									

MIDLANDS AND LANCASHIRE
COMMISSIONING SUPPORT UNIT

Equality Impact and Risk Assessment Policy Development and Review

Equality Impact and Risk Assessment

Serious Untoward Incident Policy & Procedure

Equality & Inclusion Team, Corporate Affairs
For enquiries, support or further information contact
Email: equality.inclusion@nhs.net

EQUALITY IMPACT AND RISK ASSESSMENT ALL SECTIONS MUST BE COMPLETED SECTION 1 – DETAILS OF POLICY			
Date of commencing the assessment: 24th June 2019			
Date for completing the assessment:			
Policy implementation Date: 2019			
Responsible Director/CCG Board Member: **Claire Heneghan, Chief Nurse**			
Directorate/Team: Quality			
Policy Assessment Lead and Contact Details: Allison Sathiyanathan, Quality Assurance Manager 01695 588320			
Who else will be involved in undertaking the assessment? **N/A**			
EQUALITY IMPACT ASSESSMENT			
Please tick which group(s) this policy will or may impact upon?	**Yes**	**No**	**Indirectly**
Patients, service users			Y
Carers or family			Y
General public		N	
Staff	Y		
Partner organisations	Y		
How was the need for the policy identified? **National requirement**			
What are the aims and objectives of the policy? To outline the overarching governance arrangements for the management of serious incidents reportable on the Strategic Executive Information System (StEIS) and ensure that patient safety and other reportable incidents are appropriately managed within commissioned and contracted NHS services in order to address the concerns of the patients and promote public confidence. It describes the requirements for SI reporting and management.			

SECTION 2
In this section you will need to consider:

What activities you currently do that help you to comply with the Public Sector Equality Duty (three aims).

Will your policy affect your ability to meet the Public Sector Equality Duty?

How you will mitigate any adverse impact?

- Eliminate, unlawful discrimination, harassment, victimisation and any other conduct prohibited by the Act;
- Advance equality of opportunity between people who share a protected characteristic and those who do not;
- Foster good relations between people who share a protected characteristic and those who do not.

Please answer 'Yes' or 'No' and explain your answer	Yes	No	Explain
Does the policy aim to eliminate discrimination, harassment and victimisation? What do we mean? Unlawful discrimination takes place when people are treated 'less favourably' as a result of having a protected characteristic (age, race, ethnic group, disability, etc.)	**Y**		**From the policy: Section 9. Safeguarding incidents** Safeguarding is effectively protecting children and adults at risk from abuse or neglect. All NHS commissioned services have a key role to play in safeguarding and promoting the welfare of children and vulnerable adults, as safeguarding is everybody's business. Safeguarding children is a statutory duty under section 11 of the Children Act 2004 and in accordance with government guidance in 'Working Together to Safeguard Children' 2018. Safeguarding adults is a statuary duty under part 1 of the Care Act 2014. In addition to reporting serious safeguarding incidents, there are specific arrangements in place for safeguarding. The responsibilities of investigating Safeguarding incidents can be found in the CCG Safeguarding policy.

Does the policy aim to consider advance equality of opportunity between people who share a protected group and those who don't share it? What do we mean? Equality of opportunity is about making sure that people are treated fairly and given equal access to opportunities and resources. Promoting is about: • Encouraging people/services to make specific arrangements • Take action to widen participation • Marketing services effectively • Remove or minimise disadvantages • Take steps to meet different needs Securing special resources for those who may need them	**Y**		**From the policy: section 12. Duty of Candour** Central to the CCG's strategy to improve patients safety is the commitment to provide good communication between healthcare organisations and patients and/or carers. The CCG expects all providers to meet the requirements of the Duty of Candour as defined within the Regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014). This includes providing reasonable support, truthful information and an apology to patients and /or their carers when they have been involved in a serious incident.
Does the policy aim to foster good relations between people who share a protected characteristic and those who don't share it What do we mean? Foster Good Relations between People: This is about bringing people from different backgrounds together by trying to create a cohesive and inclusive environment for all. This often includes tackling prejudice and promoting understanding of difference. • Tackle prejudice • Promote understanding • Community cohesion (involvement, engagement)	**Y**		**Under section; provider organisations:** The CCG requires the providers they commission to fulfil the following requirements: • comply with national requirements and guidance in relation to being open with patients or their representatives when things have gone wrong; • support and enable staff in disclosing incidents to patients and their representatives; • involve patients and families/carers in investigations, sharing findings and providing timely referral for specialist support and guidance where appropriate;
Has engagement/involvement or consultation	**Y**		CCG and CSU staff have been

been carried out with people who will be affected by the policy?			consulted while producing this policy.
Has the engagement/involvement or consultation highlighted any inequalities?		**N**	The safeguarding team made changes to the policy at an early stage that reinforces their involvement.

SECTION 3

Does the 'policy' have the potential to:

- Have a positive impact (benefit) on any of the equality groups?
- Have a negative impact / exclude / discriminate against any person or equality groups?
- Explain how this was identified? Evidence/Consultation?
- Who is most likely to be affected by the proposal and how (think about barriers, access, effects, outcomes etc.)

Equality Group / Protected Group	Positive effect	Negative effect	Neutral effect	Please explain
Age			**Y**	Lessons learnt from serious incidents are used to improve services for the protected groups identified The purpose of this policy is to outline the overarching governance arrangements for the management of serious incidents reportable on the Strategic Executive Information System (StEIS) and ensure that patient safety and other reportable incidents are appropriately managed within commissioned and contracted NHS services in order to address the concerns of the patients and promote public confidence irrespective any of the protected equality groups. No disproportionate impact affecting any particular age group has been identified as a result of the policy review.

Disability			**Y**	No disproportionate impact affecting people with disabilities
Sexual Orientation			**Y**	No disproportionate impact relating to sexual orientation has
Gender Reassignment			**Y**	No disproportionate impact relating to gender reassignment
Sex (Gender)			**Y**	No disproportionate impact relating to sex (gender) has been identified
Race			**Y**	No disproportionate impact relating to race and ethnicity has been
Religion or Belief			**Y**	No disproportionate impact relating to religion or belief has been
Pregnancy and Maternity			**Y**	No disproportionate impact relating to pregnancy and maternity has
Marriage and Civil Partnership			**Y**	No disproportionate impact relating to marriage and civil partnership has been identified as a result of
Carers			**Y**	No disproportionate impact relating to carers has been identified as a
Deprived Communities			**Y**	No disproportionate impact relating to deprived communitois has been
Vulnerable Groups e.g. Homeless, Sex Workers, Military Veterans			**Y**	No disproportionate impact relating to vulnerable groups has been identified as a result of the policy review.

SECTION 4: EQUALITY IMPACT AND RISK ASSESSMENT CHECKLIST

This is the end of the Equality Impact section, please use the embedded checklist to ensure and reflect that you have included all the relevant information

EI&RA checklist_V1.0_11091

SECTION 5: HUMAN RIGHTS ASSESSMENT

How does this policy affect the rights of patients set out in the NHS Constitution or their Human Rights?

If the Stage 1 Equality Impact and Risk Assessment highlighted that you are required to complete a full Human Rights Assessment, please request a Stage 2 Human Right Assessment form the Equality and Inclusion Team, and bring the issues over from Stage 1 into this section. Once completed, please embed the Human Rights Stage 2 into this section:

SECTION 6: PRIVACY IMPACT ASSESSMENT

If the Stage 1 Equality Impact and Risk Assessment highlighted that you are required to complete a Privacy Impact Assessment, please request a Stage 2 Privacy Impact Assessment either from the Equality and Inclusion Team or the Information Governance Team, and email your completed Stage 2 to your Information Governance Support Officer either at the CCG or the CSU, once finalised embed your completed PIA into this section:

SECTION 7: RISK ASSESSMENT

Please identify any possible risk for patients and / or the Clinical Commissioning Group if the policy is implemented without amendment. All risks will be monitored for trends and provided to the policy author when the policy is due to be reviewed.

IMPLEMENTATION RISK: CONSEQUENCE SCORE

DOMAIN	INSIGNIFICANT	MINOR	MODERATE	MAJOR	CATASTROPHIC
Impact on the safety of patients, staff or public (physical/psychological harm)	**Minimal injury requiring no/minimal intervention or treatment.**	Minor injury or illness, requiring minor intervention	Moderate injury requiring professional intervention RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long- term incapacity/disability Mismanagement of patient care with long-term effects	Incident leading to death An event which impacts on a large number of patients
Complaints / Audit	**Informal complaint / inquiry**	Formal complaint (stage 1) Local resolution Single failure to meet internal standards Reduced performance rating if unresolved	Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards	Multiple complaints / independent review Low performance rating Critical report	Inquest / ombudsman inquiry Gross failure to meet national standards Severely critical report
Statutory Duty / Inspections	**No or minimal impact or breech of guidance/ statutory duty.** **For example: unsatisfactory patient experience which is not directly related to patient**	Breech of statutory legislation Reduced performance rating if unresolved. For example: a minor impact on people with a protected characteristic	Single breech in statutory duty Challenging external recommendations/ improvement notice. For example: a moderate impact on people with a protected characteristic has been identified.	Multiple breeches in statutory duty Enforcement action Low performance rating Critical report. For example: a major impact on people with a protected characteristic has been identified. Consideration	Multiple breeches in statutory duty Prosecution Zero performance rating Severely critical report. For example: a catastrophic impact on people with a protected characteristic has been identified that

	No action required.	has been identified that was agreed to be accepted within the scope of the policy. No action required.	This can be resolved by making amendments to the policy or providing an objective justification for not amending the policy (This must be published with the policy and EIA).	should be given to remove the policy from the website and review it immediately. Q. Can we make amendments to the policy or provide objective justifications? If yes, this must be published with the policy and EIA. If no, the policy should be removed from the website and reviewed immediately.	may lead to litigation or impact on patient safety. The policy should be removed from the website and reviewed immediately.
Adverse Publicity / Reputation	**Rumours Potential for public concern**	Local media coverage short-term reduction in public confidence Elements of public expectation not being met	Local media coverage Long-term reduction in public confidence	National media coverage <3 days service well below reasonable public expectation	National media coverage >3 days MP concerned (questions in the House) Total loss of public confidence
Business Objectives / Projects	**Insignificant cost increase No impact on objectives**	<5 per cent over project budget Minor impact on delivery of objectives	5–10 per cent over project budget	Non-compliance with national 10–25 per cent over project budget Major impact on delivery of strategic objectives	Incident leading >25 per cent over project budget Failure of strategic objectives impacting on delivery of business plan
Finance Including Claims	**Small loss Risk of claim remote**	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million	Loss of >1 per cent of budget Claim(s) >£1 million

IMPLEMENTATION RISK: LIKELIHOOD SCORE					
	RARE	**UNLIKELY**	**POSSIBLE**	**LIKELY**	**ALMOST CERTAIN**
Frequency: How often might it / does it happen?	Not expected to occur for years	**Expected to occur annually**	Expected to occur monthly	Expected to occur weekly	Expected to occur daily
Probability	<1%	1-5%	6-20%	21-50%	>50%
	Will only occur in exceptional circumstances	Unlikely to occur	Reasonable chance of occurring	Likely to occur	More likely to occur than not occur

RISK MATRIX					
	RARE	**UNLIKELY**	**POSSIBLE**	**LIKELY**	**ALMOST CERTAIN**
Negligible	**1**	**2**	**3**	**4**	**5**
Minor	**2**	**4**	**6**	**8**	**10**

Moderate	3	6	9	12	15
Major	4	8	12	16	20
Catastrophic	5	10	15	20	25

RISK SCORE ON DRAFT POLICY	RISK SCORE ON FINALISED POLICY
2	2

What are the key reasons for the change in the risk score?

No change as only minor updates to the policy and unlikely to equalities score.

EQUALITY IMPACT AND RISK ASSESSMENT AND ACTION PLAN

Risk identified	Actions required to reduce / eliminate the negative impact	Resources required* (see guidance below)	Who will lead on the action?	Target completion date

'Resources required' is asking for a summary of the costs that are needed to implement the changes to mitigate the negative impacts identified

SECTION 8
FINAL SECTION

Date completed: 24th June 2019

Date received for quality check: 24th June 2019

Signature of person completing the assessment: Allison Sathiyanathan

Date reviewed by Equality and Inclusion Team: 27th June 2019

Signature and Date signed off by Equality and Inclusion Team:
Travis Peters – Equality and Inclusion Business Partner - MLCSU

Date signed off by CCG / CSU Committee:

This is the end of the Equality Impact and Risk Assessment process: By now you should be been able to clearly demonstrate and evidence your thinking and decision(s).

Save this document for your own records, once this is signed off by your organisation you should published on your website.

Send this document and copies of your completed Stage 2 Human Rights Screening document and Stage 2 Privacy Impact Assessment to the Equality & Inclusion Team equality.inclusion@nhs.net