
Document name: Serious Incidents Policy
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Primary Eyecare Cheshire Ltd: Serious Incidents Policy

Primary Eyecare Cheshire Ltd ("the Company") has been established to specifically act as the lead ("prime contractor") for a network of local optical practices ("subcontractors") dedicated to delivering excellent eyecare in the local community. The company will also utilise a non-clinical subcontractor, Webstar Health.

The Company's clinical governance and performance lead will be the coordinating commissioner's main point of contact within the Company.

The Company is committed to responding to serious incidents in order to continually improve the safety of our service that we provide to patients. The Company will respond to serious incidents in a timely, comprehensive and systematic manner in order to reassure concerned parties and improve future service. This Serious Incidents Policy has been developed in accordance with the NHS Serious Incident Framework March 2015.

We recognise the seven key principles of serious incident management to be: open and transparent; preventative; objective; timely and responsive; systems based; proportionate; and collaborative.

The Company's policy incorporates full support for its subcontractors in ensuring they are part of the overall process, while seeking to avoid focus on particular individuals. Subcontractor practices must have in place and maintain staff suitably trained and competent in emergency preparedness, resilience and response. The Company's Incident Response Plan below demonstrates the process for subcontractor practices to notify the company in the event of a serious incident occurring.

The Company has incorporated transparency for all parties as a core theme in its serious incidents policy as the Company considers this is the only way to understand how serious incidents occur and how these can be mitigated in the future. The Company fully subscribes to the 'duty of candour' requirement in order to promote openness and honesty in raising early warning signs and demonstrate evidence of learning from incidents. The Company will ensure that patients are informed when things go wrong, why they have gone wrong and what steps the Company is taking to mitigate any issues, both immediately and in the future.

A mechanism for apology as part of duty of candour will also be implemented. The Company will notify the person concerned (and their GP where appropriate) when a reportable Patient Safety Incident occurs or is suspected to have occurred involving moderate to severe harm.

As the prime contractor, the Company recognises its accountability to the commissioning body.

The Company holds a separate Complaints Policy. Serious incidents and complaints are separate processes and the Serious Incidents Policy may be deployed while an associated complaint simultaneously activates the Complaints policy. Equally, one or the other may be activated while the other is not. In addition, a separate safeguarding policy exists for children and vulnerable adults.

Serious incidents may take the form of:

- Avoidable or unexpected death
- A never event
- A serious incident whereby the Company's ability to deliver the service is compromised
- Data loss
- Allegations of physical misconduct or harm.

If there is a suggestion that a criminal offence has been committed, the Company will contact the police as soon as it is made aware of the incident.

The Company will appoint a named accountable emergency officer. The accountable emergency officer will be responsible for patient safety, incident management and reporting to all appropriate bodies. The Company will work collaboratively with other bodies in managing serious incidents. It will:

- Publish data (excluding information affecting patient confidentiality).
- Support and train staff in communicating information to patients.
- Communicate with commissioners and all relevant bodies as appropriate.
- Implement actions as required.
- Close cases in a timely manner.
- Review and analyse incidents and responses in order to learn key lessons and embed systemic improvements, in accordance with the Company's Quality and Continuous Improvement Policy.

The Company will implement a root cause analysis protocol as a methodical and systematic process to identify the specific factors that contributed to an incident. The Company's root cause analysis protocol seeks to understand the underlying causes and environmental context which led to a serious incident occurring, strengthening systems in place for meeting the objective of fully securing patient safety.

The Company's subcontractor practices do not have access to Strategic Executive Information System (STEIS). The Company will therefore build in reporting via the appropriate commissioning body for incident logging.

The Operations Centre of the Company's subcontractor, Webstar Health, will be the Incident Coordination Centre.

The Company operates the following Serious Incident Response Plan for driving an appropriate learning experience to improve patient outcomes. This will enable the Company to ensure quality issues are raised in order to make improvements as required:

Examples, investigation level and timeframe

Example Incidents	RCA level	Timeframe
<p>Avoidable or unexpected death.</p> <p>Healthcare associated infections.</p> <p>Adult safeguarding incidents (see the Company's Safeguarding Policy for more information).</p> <p>Data loss and information security.</p>	<p><u>Investigation Level 1:</u></p> <p>Concise root cause analysis (RCA) for both No Harm and Low Harm and/or where the circumstances are very similar to other previous incidents.</p> <p>A concise RCA will enable the Company to ascertain whether unique factors exist, thus focusing resources on implementing service improvement.</p> <p><u>Investigation Level 2:</u></p> <p>Comprehensive RCA for incidents causing moderate to severe harm or death. The Company's policy is this will be the default investigation level for grade 1 incidents.</p> <p>Investigations will be carried out by directors of the Company and led by the clinical governance and performance lead who may seek advice and services from specialist external sources as required.</p>	<p>The Company to submit initial report within two working days.</p> <p>The Company will submit completed investigation within the single timeframe as per the Serious Incidents Framework document of 60 days.</p>
<p>Child protection incidents (see the Company's safeguarding policy for more information).</p> <p>'Never events'</p> <p>Accusation of physical misconduct or harm.</p> <p>Data loss and information security (DH Criteria level 3-5).</p>	<p><u>Investigation Level 2:</u></p> <p>Comprehensive RCA.</p>	<p>Initial report within 2 working days. The Company will submit a completed investigation within the single timeframe as per the Serious Incidents Framework document of 60 days</p>
<p>Selected incidents</p> <p>These might include major systemic failure with multiple stakeholders.</p>	<p><u>Investigation Level 3:</u></p> <p>Independent RCA.</p>	<p>Initial report within 2 working days. Independent investigators should be commissioned to complete an investigation within 6 months</p>

Root Cause Analysis Investigation Model

The Company will ensure it has sufficient expertise in root cause analysis. The clinical governance and performance lead will lead this process and report to the coordinating commissioner on progress and with the outcome. A model we will use is below:

	Action 1	Action 2	Action 3	Action 4	Action 5
Root CAUSE					
EFFECT on Patient					
Recommendation					
Action to Address Root Cause					
Level for Action (Org, Direct, Team)					
Implementation by:					
Target Date for Implementation					
Additional Resources Required (Time, money, other)					
Evidence of Progress and Completion					
Monitoring & Evaluation Arrangements					
Sign off - action completed date:					
Sign off by:					

This Serious Incidents Policy will be reviewed annually.