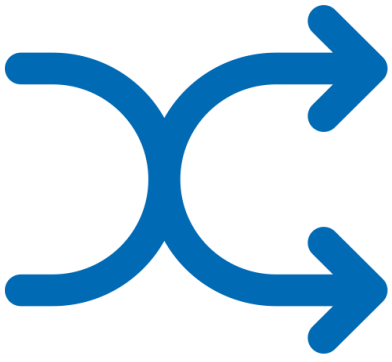
NHS England

Reporting and Management of Incidents and Serious Incidents in Primary Medical Services

A Working Guide for CCGs

December 2018



Reporting and Management of Incidents and Serious Incidents in Primary Medical Services

A Working Guide for CCGs

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1 Introduction

Clinical Commissioning Groups (CCGs) which have fully delegated responsibility for primary medical services (which is all CCGs in London, from April 2018) adhere to the NHS England Scheme of Delegation which sets out the functions reserved for NHS England under the scheme. Incident and serious incident management are not identified as reserved functions under full delegation and therefore management and oversight of these processes in primary medical services has become the responsibility of CCGs in the London Region.

Primary medical services, as care providers registered with the Care Quality Commission (CQC), are required to notify the regulator about certain events and incidents in line with the CQC Regulations. In addition, CQC requires providers to have regard to their guidance in relation to incident reporting and investigation. This includes ensuring that appropriate action is taken to remedy the situation, prevent further occurrences and to make sure that improvements are made as a result. Registered healthcare professionals, including medical and nursing staff, also have a responsibility to comply with systems to protect patients and promote patient safety in line with the standards set out by their professional body.

This guide addresses the reporting and management of patient safety incidents and serious incidents in primary medical services. NHS England remains responsible for patient safety incident management and oversight in the remaining three primary care contractor patient groups of dental, optometry and community pharmacy services.

Providers of NHS funded healthcare can have several commissioners sometimes within the same clinical area and equally, serious incidents can involve a number of care providers. Determining which commissioning organisation is responsible for overseeing the investigation and approving the report and actions is not always straightforward and commissioners should work collaboratively to agree how best to manage serious incidents for their services.

Where an incident or serious incident involves a number of providers or commissioners an initial discussion should be held involving all stakeholders to agree lead provider and commissioner functions including the governance arrangements. The RASCI model (see Serious Incident Framework, March 2015) sets out the framework for assigning key roles and functions.

This guide is supplementary to the following two documents or subsequent revisions, which should be consulted as the primary resource for managing incidents:

- Serious Incident Framework (March 2015) https://improvement.nhs.uk/resources/serious-incident-framework/

- Managing Safety Incidents in NHS Screening Programmes (August 2017) https://www.gov.uk/government/publications/managing-safety-incidents-in-nhs-screening-programmes

2 Serious Incidents (SIs)

Primary medical services, as care providers registered with the Care Quality Commission (CQC), are required to notify the regulator about serious incidents in line with the CQC Regulations.

When a Serious Incident (SI) occurs in primary medical services it may be reported to the CCG through a variety of routes including verbal or written communication directly with the CCG or via NRLS incident reporting.

SI management and oversight is undertaken by the practice and commissioners in line with the requirements and standards set out in the SI Framework. It is, however, recognised that knowledge of the SI investigation process and resources available to conduct the investigation may be limited in some practices, necessitating additional input or support during the process from commissioners or other system partners (see **Appendix 1**).

Where the SI relates to screening or immunisation programmes the incident should be managed in line with the following guidance in addition to the Serious Incident Framework: https://www.gov.uk/government/publications/managing-safety-incidents-in-nhs-screening-programmes

Where the SI involves concerns around GP performance or when it is anticipated that an incident may generate media interest CCGs are required to inform the relevant contacts at NHS England (see section 5).

3 Incident reporting via the National Reporting and Learning System (NRLS)

GP practices should be encouraged to report patient safety incidents via the National Reporting and Learning System (NRLS) GP e-form system at the following web page:
https://report.nrls.nhs.uk/GP_eForm

Each CCG in London has identified individuals registered with NRLS to access incidents reported on the system by the CCG's practices. When a practice reports to NRLS using the GP e-form a notification e-mail, containing a link to the NRLS account is sent to the designated individual/s within the CCG. The CCG is then able to log in to NRLS via the link to access and view the incident report. Having reviewed

the details of the incident the commissioners undertake any additional actions or follow up required with the practice (see **Appendix 2**).

The CCG is able to identify areas for quality improvement through broader review of the issues reported by their practices and to support wider sharing of learning from patient safety incidents across the CCG and Sustainability and Transformation Partnership (STP) when relevant.

CCGs should ensure that they have robust arrangements in place for accessing and reviewing the e-forms submitted to NRLS by practices in a timely way.

Any queries relating to accessing NRLS to view GP e-forms should be directed to NHS Improvement at:
NHSI.patientsafetyhelpdesk@nhs.net

4 Key Responsibilities

NHS England's Primary Care Commissioning Team in London has worked with CCG primary care commissioning colleagues to produce a London wide operating model for the co-commissioning of primary care services.

The version of the model agreed at the Primary Care Management Board on 8 June 2018 details the roles and responsibilities for NHS England and CCGs in relation to incident reporting and management in primary medical services (see **Appendix 3**).

In line with the London wide Operating Model for Co-Commissioning of Primary Services, NHS England retains responsibility for functions relating to incidents in NHS screening and immunisation programmes (section 7a programmes) and individual GP performance management.

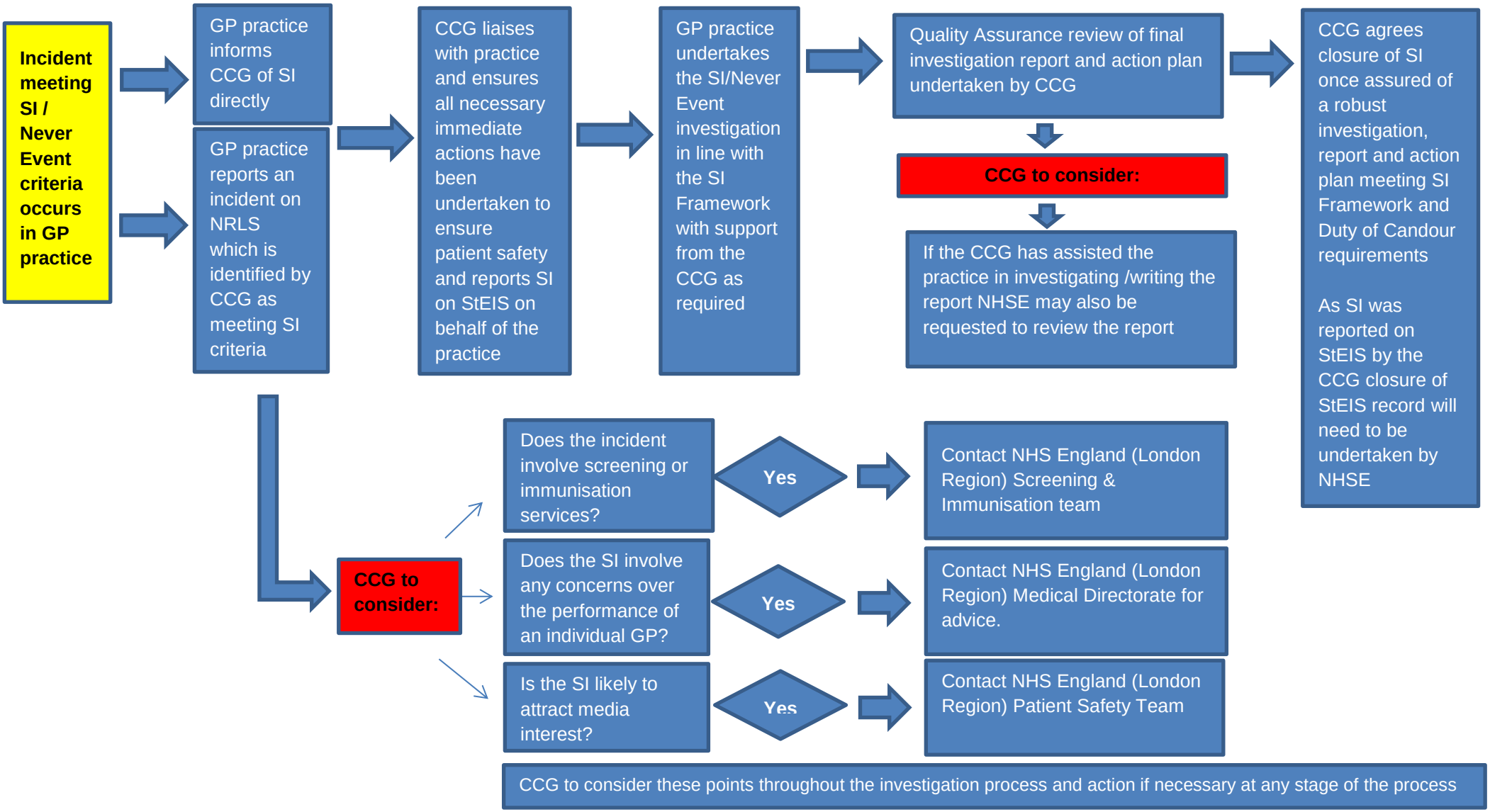
When an incident or serious incident occurs in primary medical services relating to these functions, or when it is anticipated that an incident may generate media interest CCGs should inform NHS England using the points of contact listed in section 5 below.

NHS England retains responsibility for patient safety incident management and oversight in the remaining three primary care contractor patient groups of dental, optometry and community pharmacy services.

5 Points of Contact at NHS England (London Region)

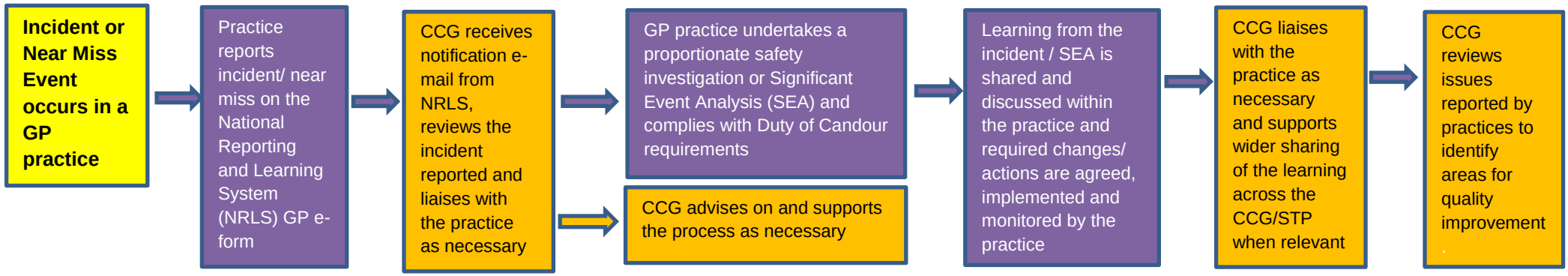
	Key Points of Contact at NHS England (London Region)
Incidents relating to NHS Screening or Immunisation programmes	E-mail: england.londonscreening-incidents@nhs.net
	Additional information available at: https://www.england.nhs.uk/london/our-work/immunis-team/
Performer Concerns	E-mail: england.pract-perf-london@nhs.net
Actual/Anticipated Media Interest	E-mail: england.londonpatientsafety@nhs.net
General queries in relation to Incidents / SIs in Primary Medical Services	E-mail: england.londonpatientsafety@nhs.net

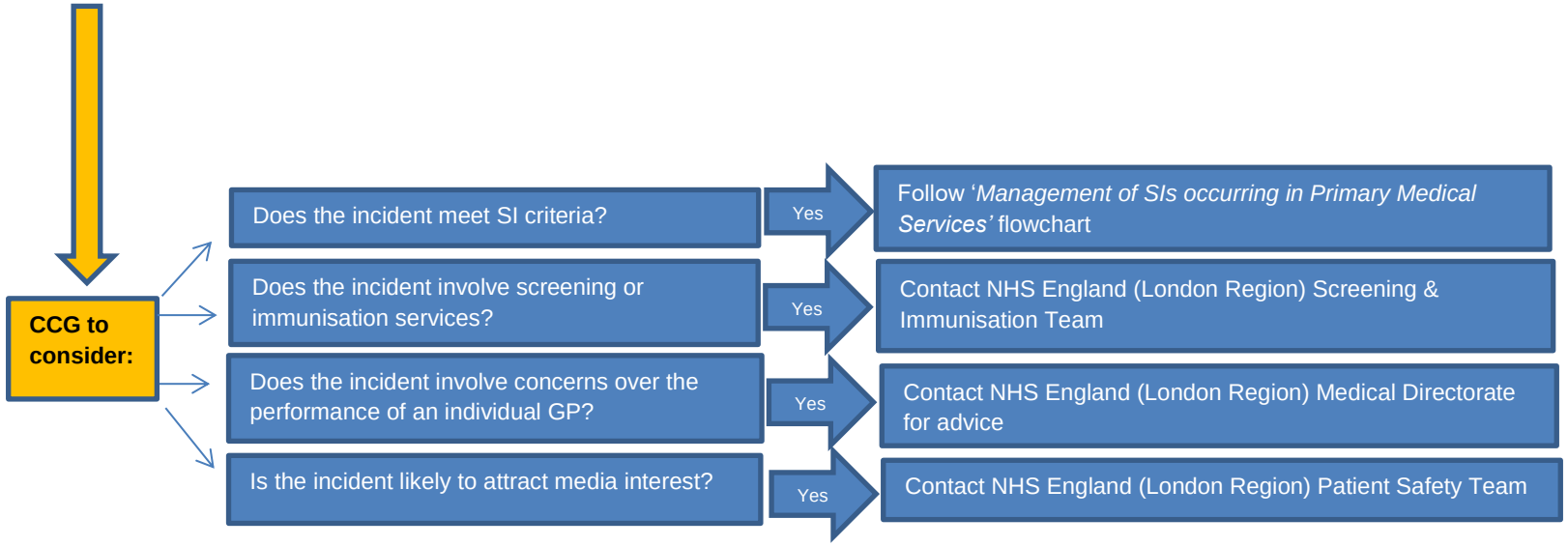
APPENDIX 1
Management of Serious Incidents occurring in Primary Medical Services



APPENDIX 2

Management of Incidents and Near Miss Events reported on the National Reporting and Learning System (NRLS) by Primary Medical Services





APPENDIX 3
Co-Commissioning of Primary Care Services Operating Model v16
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With effect from 8th June 2018, the following text replaces previous versions in London wide Operating Model v16 in relation to Serious Incidents and Incident Management.

	Responsibilities			Tasks/ Standard		
Definition	**The Committee**	**CCG**	**NHS E**	**The Committee**	**CCG**	**NHS E**
Serious incidents	The Committee is responsible for ensuring that there are processes in place for the reporting and review of incidents, so that serious incidents can be identified and managed in accordance with national and regional guidance. This includes notifying NHS England of incidents which involve screening or immunisation services, could attract media attention and /or which relate to individual GP performance concerns.	To support and facilitate practices to establish processes for identifying and learning from serious incidents. This includes quality assuring the robustness of their serious incident investigations and the action plan implementation.	To maintain oversight and surveillance of serious incident management, and derive assurance that CCGs have systems in place to appropriately manage serious incidents in practices. Functions relating to screening and immunisation, individual GP performance management (medical performers' lists for GPs, appraisal and revalidation).			The RT will support The Committee to comply with its obligations under the Serious Incident Framework and other relevant patient safety guidance.
Incident management	The Committee is responsible for ensuring that there are processes in place for the reporting and review of incidents, so that they can be identified and managed in accordance with national and regional guidance. This includes notifying NHS England of incidents which involve screening or immunisation services, could attract media attention and /or which relate to individual GP performance concerns.	To support and facilitate practices to establish processes for identifying and learning from incidents. This includes encouraging practices to report incidents on the National Reporting and Learning System (NRLS), or its successor. Review of issues reported by practices to identify areas for quality improvement.	To maintain oversight and surveillance of incident management systems, and derive assurance that CCGs are fulfilling their responsibilities. Functions relating to screening and immunisation, individual GP performance management (medical performers' lists for GPs, appraisal and revalidation).			The RT will support The Committee to comply with its obligations under the Serious Incident Framework and other relevant patient safety guidance.