

ADVERSE INCIDENT POLICY, INCLUDING SERIOUS INCIDENTS

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POLICY SUMMARY

This policy and associated procedures sets out the Trust arrangements for the reporting and management of Incidents including Serious Incidents within Essex Partnership University NHS Foundation Trust (EPUT). The main purpose of the policy is to ensure that the Trust takes appropriate steps in the best interests of safety and health for its patients, residents, staff, carers and visitors and considering the NHS as a whole.

This policy will ensure that appropriate reporting and investigation procedures are applied and also enable the Trust to learn from Incidents and thereby minimise the risk of similar incidents occurring in the future. This supports the Trust's philosophy on clinical risk management and clinical governance and helps achieve and maintain a safety culture within the organisation. All care delivered is intended to be safe, effective and result in a positive experience for patients.

The policy encompasses the work of Professor Don Berwick, following a review of patient safety in England in response to the Francis Inquiry report February 2013 (A Promise to Learn: A Commitment to Act - August 2013) and the following recommendations:

Recommendation 1: The NHS should continually and forever reduce patient harm by embracing wholeheartedly an ethic of learning.

Recommendation 2: All leaders should place quality of care and patient safety at the top of their priorities for investment, inquiry, improvement, regular reporting encouragement and support.

Recommendation 7: Transparency should be complete, timely and unequivocal

The policy and related procedural guidelines apply to all staff employed within the Trust either permanent or on a temporary basis and to volunteers.

To ensure recognised national terminology is used throughout this document the national reporting system term “patient safety” is used in some references and refers to residents or patients.

The Trust monitors the implementation of and compliance with this policy in the following ways;

Regular audits take place of the incident reporting process by the risk management team.

Monitoring is via the risk management report to Health, Safety and Security Committee (HSSC) and escalated to the Quality Committee as required.

The serious incident (SI) team will regularly audit SI process and implementation.

Incident analysis and learning reports will be presented to HSSC monthly, Quality Committee Bi-Monthly and Trust Board of Directors Quarterly.

Action plans developed following serious incident investigations will be monitored by the relevant Directorate Service Boards and the Executive Operational Sub-Committee (EOSC).

Mandatory/Core Practice training requirements will be monitored by Workforce and Development via compliance reports to Workforce Service Management Board, Health, Safety and Security Committee, EOSC and Trust Board (see training section of procedural guidelines CPG3).

Services	Applicable	Comments
Trust wide	✓	

The Director responsible for monitoring and reviewing this policy is Executive Nurse

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ADVERSE INCIDENT POLICY

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ADVERSE INCIDENT POLICY

1.0 INTRODUCTION

Scope of this policy

- 1.1. This policy and associated procedural guidelines set out the arrangements for the reporting, management, investigation and learning from Incidents and Serious Incidents at EPUT.
- 1.2. This policy applies to all incidents - clinical and non-clinical, Serious Incidents (SIs), near misses and never events. An incident is any unplanned event that caused, or could have caused (near miss), harm to any person associated with the Trust, or to the Trust itself.

The NHS England Serious Incident Framework (March 2015) defines serious incidents as 'events in health care where the potential for learning is so great, or the consequences to patients, residents, 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 or residents, directly and include incidents which may indirectly impact patient safety or an organisations ability to deliver ongoing health care'.

This policy and associated documents outline the procedures which apply to all Foundation Trust staff, temporary staff, patients, residents, carers, relatives, visitors and contractors whilst on Trust premises or engaged in Trust business. This includes incidents, wherever they occur, to patients under the care of the Trust.

This policy operates together with other Trust policies on Clinical Risk Assessment and Management, Being Open, Whistleblowing and the Risk Management and Assurance Framework, Duty of Candour and Safeguarding.

- 1.3. **Supporting a safety culture, Clinical Governance and Risk Management**
- 1.4. The Chief Executive and Board of Directors fully support the continued development of a safety culture throughout the Trust, whereby the safety and health of all patients, residents, staff, carers and visitors is paramount. It is unacceptable to reach other objectives at the expense of safety.
- 1.5. It is not always possible to prevent things going wrong. But it is unforgivable not to learn from adverse events and take appropriate action to minimise risk of them happening again. To control this risk the Trust has provided clear procedures and resources for reporting and managing incidents and insists on a philosophy that promotes open and honest reporting when things go wrong. Trust staff have a duty to report all incidents to prevent harm in the future. The guidance contained in this document must be followed at all times as incidents within the local environment may have implications for the rest of the NHS.

- 1.6. This policy will ensure that the Trust takes appropriate steps in the best interest of its patients, residents, staff, visitors and the NHS as a whole, and that it learns lessons from when things go wrong. This approach is fundamental to Clinical Governance and effective Risk Management, both of which are everyone's duty.
- 1.7. The aim of the serious incident investigation is to ensure that weaknesses in a system and/or process are identified to understand what went wrong, how it went wrong and what can be done to prevent similar incident occurring again.
- 1.8. Investigations are not carried out to find fault or place blame, however investigations in relation to incidents and serious incidents may prompt further investigations to be considered in line with the Trusts Conduct and Capability Policies and Procedures (HR27) if one or more of the following apply:
 - There is a breach of criminal law
 - Professional misconduct has been identified
 - There are repeated unsafe occurrences in relation to the same individual
 - In the view of the Trust or professional body the action causing the incident was not acceptable practice
 - There is evidence that attempts were made to conceal or tamper with any evidence
- 1.9. In all cases the Trust will consider the most appropriate course of action prior to undertaking and further investigation using the NPSA incident decision tree (Appendix 15)
- 1.10. All staff are reminded that if they have concerns regarding the delivery or quality of clinical care these concerns should be raised by using the Trust Whistle Blowing policy and procedures (CP53).
- 1.11. **Working with and reporting to others**
- 1.12. Effective communication with internal and external stakeholders is vital and is part of the incident process.
- 1.13. This policy also aligns the Trust to the National Reporting & Learning System (NRLS), National Reporting and Learning Framework and Serious Incident Reporting and Learning Framework and sets out how incidents are reported to and information is shared with external bodies - commissioners, regulators and key agencies.
- 1.14. This policy does not interfere with existing lines of accountability, nor replaces the duty to inform the police, other NHS organisations, local and other authorities, such as social services or regulatory bodies where appropriate. The primary concern of all agencies is that of public safety. While there is nothing in law that says the police's duty to investigate takes precedence over the NHS's duty to ensure patient safety, interference with a police investigation has the potential to undermine potential legal proceedings. There is no obligation on the police to allow the NHS to work alongside them and it is

important to consider that when a joint investigation is proposed, to establish at the outset which organisation is taking the lead.

1.15. **Aims and objectives of the policy and procedure**

- To reduce harm
- To set out how to report, manage and investigate incidents
- To ensure that all incidents are reported on time by the correct method
- To ensure incidents are dealt with and investigated according to their severity
- To ensure that incident trends are identified, analysed and shared
- To analyse and learn from complaints, claims and incidents together
- To ensure lessons are learned and shared to minimise risk for the future
- To ensure risk reduction measures are implemented based on learning from incidents
- To ensure the Trust meets statutory and regulatory reporting obligations
- To comply with the reporting requirements of the NRLS
- To meet the needs of commissioners and local partners
- To meet the needs of external agencies
- To assure and support local stakeholders patients and families, carers and staff involved in an incident

2.0 DUTIES

2.1. **The Chief Executive**

The Chief executive will ensure that this policy is implemented across the organisation and that the necessary financial priority is allocated to maintain a safe system of care and work.

2.2. **The Board of Directors**

The Board will ensure there is a safety culture within the organisation and will monitor the number of incidents and Serious Incidents that occur within the Trust and ensure that organisational learning takes place.

2.3. **The Director of Compliance and Assurance**

This Director will ensure that a suitable aggregate analysis of the three information streams of complaints, incidents and claims is made and provided at least 6 monthly to the Quality Committee, Learning Overview and Scrutiny Committee and Senior Management Teams

2.4. **The Executive Director of Mental Health / Executive Nurse**

This Executive Director is responsible overall for ensuring that Serious Incidents are properly identified and managed within the Trust and that the needs of external stakeholders are met.

- Ensures that learning from the aggregate analysis of complaints, incidents and claims is used to support learning and improvement.
- Monitors the implementation of action plans arising from Serious Incidents.

2.5. Directors and Senior Management

They will implement this policy within their areas of responsibility through leadership, management systems and example. They will ensure their teams report and deal with incidents effectively, investigate them appropriately and implement timely measures to control risk for the future.

They will monitor the implementation of this policy via clinical audit and supervision and ensure services set robust objectives for harm reduction based on incident statistics and learning from investigations and that departmental managers in turn develop, progress towards and meet safety performance objectives.

They will implement the provisions within this policy for supporting staff involved in traumatic or stressful incidents.

2.6. Managers and other Persons in Charge/Team Leaders/Nursing Home

Managers will:

- Ensure that all staff, including new and temporary employees, are made aware of the procedures and principles detailed within this policy and that procedural guidelines are followed, to meet all relevant guidance.
- Ensure that staff are trained in the use of the Datix on-line, web based incident reporting system and have suitable access to Trust computer terminals to report incidents.
- Should Datix be offline and unavailable, a form can be found via the Trusts intranet for submission (to the Risk Department) within the 48 hours requirements. A copy should be discussed, immediately, with the manager in order to identify if immediate escalation is required.
- Ensure that all incidents deemed to be no harm or low harm, are assessed for accuracy and risk, before being saved using the “Approved” status ensuring the context of the details are not changed, A failure to comply will be treated as misconduct and as such may lead to formal action in accordance with the Trust’s Conduct and Capability Policy (HR32). Any incident that is moderate, severe or a death will be saved using the “Awaiting Risk Management Approval” status.
- Consider whether any incident meets Serious Incident or RIDDOR reporting criteria and reflect this on the Datix incident form. The Serious Incident team must be informed by telephone on [REDACTED] and the Risk Management team must be informed by telephone on [REDACTED], of any RIDDOR incidents. The decision to report to the Health and Safety Executive will be made by the Risk Management team. Managers are therefore required to comply with any requests from Risk Management for additional information to aid this decision making process, in a timely fashion. Notably a level one report will be required.
- Ensure all inpatient and community learning disability deaths are reported on Datix.
- Ensure that any required CQC notification form is completed and attached to the Datix on-line incident reporting form and the MHA office is advised by telephone [REDACTED].
- Take charge of incidents in their area in respect of making safe, quarantining faulty equipment, securing evidence and documentation, investigations, action

planning, escalating, gathering evidence (such as witness statements) and facilitating further investigation. They will ensure that residual risks are properly assessed and submitted for placing on the risk register if required.

- Feedback to and reflect on incidents and incident patterns with their staff to identify issues, support learning and reinforce a reporting culture.
- The manager in charge is responsible for ensuring that patients, residents, and relatives/carers are kept informed about an incident and any subsequent investigation as required.
- Contact LSMS as necessary for support.
- The manager in charge is responsible for ensuring all those involved in an incident are offered appropriate support.

2.7. Investigating officers

Investigating officers are responsible for investigating incidents to the depth required and within specified times. They write the report, including recommendations and work with the local managers and services leads to identify and assess residual risks (those which require further control).

2.8. The Associate Director of Risk and Compliance and the Risk Management Team

This team will ensure appropriate systems are in place throughout the organisation to report, action and monitor all incidents. They will maintain and develop the Datix incident management system and provide training and support in its use to report and process individual incidents as well as to analyse and report on patterns and trends by managers. They will encourage and promote a robust reporting culture across the organisation providing guidance and support where appropriate. They will ensure that all incidents with a moderate, severe or death degree of harm are assessed for accuracy and risk, before being saved using the “Approved” status.

They will carry out the process of preparing and sending reports in incidents to the National Reporting and Learning Service (NRLS).

The Risk Team will monitor and review incidents individually and collectively. A key requirement will be to alert the appropriate persons in the Trust of risk issues arising from an incident or the patterns of incidents. This will be done on their initiative or through routine reports, statistical and other analysis and by regular or ad hoc reporting to agreed committees, groups, teams or individuals at all levels. They will respond appropriately to requests for analysis of and information on incidents.

Ensure that in the event of a RIDDOR accident/incident an effective investigation is conducted as soon as possible and results in recommendations and corrective action to prevent re-occurrence of the event.

Where applicable appropriate internal stakeholders will be informed of the incident for example FOI, DPA & Litigation Manager, Head of Complaints & Customer Service Improvement, Infection Control Nurse, Safeguarding Lead, Estates etc. This will normally but not exclusively be via Datix.

2.9. The Head of Serious Incidents and Quality will

- Make a decision together with the Executive Director for Mental Health / Executive Nurse, the Medical Director and the Lead Director about whether an incident meets serious incident reporting criteria, as outlined in the Serious Incident Reporting and Learning Framework.
- In conjunction with the relevant Deputy or Locality Director, will appoint a Family/Carers/Liaison Officer to provide a contact point between the Trust and the service user's relatives/carers when unexpected deaths occur. A Family Liaison information pack will be sent to the next of kin.
- Ensure that the Duty of Candour Policy and Procedure (CP36) are initiated and followed for all incidents which have been identified as meeting the Duty of Candour criteria.
- Make a decision together with the appropriate Director regarding the appointment of a senior manager to lead the investigation of a serious incident.
- Make decisions together with the Executive Director of Mental Health / Executive Nurse regarding the reporting of incidents to external bodies as well as releasing of information. This will be those incidents relating to patient/resident deaths and those attracting media interest.
- Be responsible for assessing and notifying certain deaths, serious injuries and service interruptions to the CQC.

2.10. The Mental Health Act Administration Manager will

Be responsible for validating, completing and sending reports to the CQC for deaths and unauthorised absences.

2.11. Head of Safeguarding Children & Vulnerable Adults will

Be responsible for reporting any adult safeguarding incident or concerns regarding the Mental Capacity Deprivation of Liberty Safeguards to the CQC as appropriate.

2.12. Clinical Governance Sub-Committee will

Review clinical incident analyses on a bi monthly basis and disseminate findings to directorate sub-group meetings to facilitate organisational learning.

2.13. Health, Safety and Security Committee will

Review incident analyses on a monthly basis and disseminate findings to directorate Health and Safety sub-group meetings to facilitate organisational learning. The committee will aggregate analyses of complaints, incidents and claims data and ensure organisational learning

2.14. Learning Oversight Committee:

The group will ensure that the quarterly aggregate analysis of incidents, complaints and claims and learning arising is reviewed discussed and shared. The group may also recommend further action consideration or action by the clinical governance committee or specific leads for training, ongoing work streams, local service management boards and teams.

Group members will be asked to collate and share learning from their own areas to facilitate discussion at each meeting. This will include safeguarding, serious incidents, risk including adverse incidents, health and safety, medication errors, near misses, security issues, complaints, infection control, physical health care, information governance, records management, claims, inquests, audits, and external enquiry reports.

Consideration will then be given about how key information will:

- Be shared with staff
- Be shared with relevant groups or committees
- Inform and develop on-going work streams
- Inform and develop existing training
- Inform audit programmes
- Strengthen clinical practice
- Inform Trust policy and procedure

Learning Oversight Committee members will have a role in the monitoring of key action plans including serious incidents and will highlight any concerns to the relevant Director.

The Learning Oversight Committee will produce an annual summary report of work completed to include actions taken to share learning and actions taken to strengthen clinical practice and inform Trust policy.

2.15. Workforce Development & Training

Will liaise with the Risk Management Team to ensure that training for corporate induction and incident investigation is suitable.

2.16. All staff and contractors

Must ensure that the principles contained within this policy and associated guidelines are followed.

2.17. Whistle-blowing

If staff have concerns regarding the delivery of clinical care these concerns should be raised initially with their line manager however staff can also raise concerns via the Trust whistle blowing policy and procedure or make contact with the freedom to speak up guardian

2.18. Further detail – CPG3 Procedural Guidelines and appendices

For details setting out the roles and responsibilities and managing arrangements for the above and for individual staff throughout an Incident refer to the accompanying Procedural Guidelines CPG3.

Reference will be made to appendices. These can be found on the Trust Intranet page listing corporate policies and procedures below this policy and the accompanying procedural guidelines.

3.0 DEFINITIONS AND CLASSIFICATIONS

- 3.1. **All incidents** (including those where no harm has occurred) must be reported using the Datix on line web based incident reporting system immediately or as soon as practicable (within 48 Hours) after the incident has occurred or has been notified to the Trust. Incidents are defined as an event or circumstances which could have resulted, or did result in, unnecessary damage, loss or harm to a patient, resident, member of staff, visitor or member of the public under our care/on our premises.
- 3.2. An incident may be further defined as an untoward event which causes or had the potential to cause any of the following:
- Harm to an individual
 - Financial loss to an individual or the Trust
 - Damage to the property of an individual or the Trust
 - Disruption of services provided by the Trust
 - Damage to the reputation of the Trust
- 3.3. **Critical Incidents** are defined as incidents which do not meet the criteria for reporting externally as a serious incident, however have been identified by the Trust as an event where the opportunity to learn from the incident and to take action is likely to result in an improvement in the safety and quality of health care or reduce risks to staff or Trust Property / premises.
- 3.4. **Serious Incidents (SIRI)** are ‘events in health care where the potential for learning is so great, or the consequences to patients, residents, 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/residents directly and include incidents which may indirectly impact patient safety or an organisations ability to deliver ongoing health care’. (NHS England, 2015).
- 3.5. There is no definitive list of events or incidents that constitute a serious incident, all incidents must be considered on a case by case basis using the NHS England’s Serious Incident Framework (March, 2015) definitions for when a serious incident must be declared, detail of these events are included within the Adverse Incident Procedure.
- 3.6. **Never Events** are a subset of serious incidents and are a particular type of serious incident which have been identified as wholly preventable if guidance and strong systemic protective factors, identified nationally, have been fully implemented by health care providers. A detailed summary of NHS England’s Never Events are included within the Adverse Incident Procedure.

- 3.7. **Near Misses** can be defined as any event that has occurred, but which was not anticipated or planned, which did not actually lead to harm, loss or damage, but under different circumstances could have done. A near miss can still be considered as a serious incident. Deciding whether or not a near miss should be classified as a serious incident should therefore be based on an assessment of risk that considers:
- The likelihood of the incident occurring again if current systems/process remain unchanged; and
 - The potential for harm to staff, patients, residents, and the organisation should the incident occur again.
- 3.8. This does not mean that every near miss should be reported as a SIRI but, where there is a significant existing risk of system failure and serious harm, the serious incident process should be used to understand and mitigate that risk.
- 3.9. **Data Incidents** Person identifiable data incidents are incidents that involve the actual or potential loss of personal information that could lead to identity fraud or have other significant impact on individuals. The reporting of SIRI relating to breaches of confidentiality involving person identifiable data and data losses will be assigned a level of seriousness in line with the Department of Health Gateway letter 9571 dated 29 February 2008.
- 3.10. Further to this all Serious Incident Requiring Investigations (SIRI) involving data losses and breaches in confidentiality will be published in the Annual Governance Statement/ Quality Account.
- 3.11. **RIDDOR Incidents** The Reporting of Injuries Diseases and Dangerous Occurrences Regulation 1995 (HSE 1999). RIDDOR defines the type of incident, diseases and occurrences that must be reported to the Health and Safety Executive (HSE) to comply with statutory requirements. These are listed in full on the HSE website www.hse.gov.uk
- 3.12. **Trust determined events** these are incidents which the Trust has identified must be reported in all cases and include
- The death of an inpatient/resident in Trust services, this includes patients/residents who may have been on end of life care plans.
- 3.13. **Incidents that must be reported via Datix:**
- All expected and unexpected inpatient deaths Mental Health (MH)
 - All expected and unexpected inpatient deaths Community Health Services (CHS)
 - All expected and unexpected deaths Learning Disability (LD) inpatient and community.

3.14. NRLS grading of harm to patients/residents

The Trust has fully adopted the National Reporting & Learning Systems (NRLS) grading of incidents. These grades are further explained in CPG3 Adverse Incident Procedure Appendix 3

- No Harm
- Low Harm
- Moderate harm
- Severe Harm
- Death

From the 1st April 2016 the statutory patient safety functions transferred to NHS Improvement, functions include operating the National Reporting and Learning System (NRLS), and responsibility for using information from the NRLS, and elsewhere, to develop advice and guidance for the NHS on reducing risk to patients/residents.

3.15. Types of harm

The types of risk and harm faced by the Trust, its staff and patients, residents and carers/relatives includes:

Safety – pain, suffering, trauma, emotional impact, disability, poorer quality of life, shortened life or death.

Clinical Risk, service quality and effectiveness – where a failure to meet accepted standards of service leads to complaint, dissatisfaction, risk to patient safety, reduced clinical effectiveness and worse clinical outcomes.

Financial - which may impact on the effective control of the finances within the organisation or lead to financial loss.

Human resources/ organisational development/staffing/ competence – where staffing levels or staffing competence affect service quality, safety, and the meeting of organisational objectives.

Compliance/statutory duty/inspections– where a breach of the law or other duty may lead to intervention (such as prosecution) by a legal authority or regulatory body.

Adverse publicity/Reputation – where any incident damages the Trust’s reputation in the eyes of any person or organisation with an interest in the Trust, thereby affecting its ability to carry out its function or achieve its objectives.

Organisational - which may influence the Trust’s capacity to reach its objectives including the provision of services and the protection of its patients, residents, staff, stakeholders and environment.

Service/business interruption/Environmental impact – where the ability of the Trust to deliver its services and carry out its business is affected or where an incident has an effect on the environment.

Information - Any failure relating to the provision, security, confidentiality and integrity of data held by the organisation electronically, on paper format or otherwise.

Data Incidents: Person identifiable data incidents are incidents that involve the actual or potential loss of personal information that could lead to identity fraud or have other significant impact on individuals. The reporting of SIRI relating to breaches of confidentiality involving person identifiable data and data losses will be assigned a level of seriousness in line with the Department of Health Gateway letter 9571 dated 29 February 2008.

4.0 PROCEDURES

4.1. Incident reporting

All incidents that meet the definitions in this policy must be reported using the Datix on-line reporting system or, in the event this is unavailable, detailed in section 3.0 above. This is set out within the procedural guidelines CPG3.

All incidents should be reported within 48 hours of the incident occurring. However, in the event this is not possible, an incident report form should be completed and submitted as soon as possible. Nominated managers (handlers) will:

- Check and approve the information reported for accuracy
- Severity rate the incident
- Update the incident form to include follow up, learning lessons and actions
- Ensure all incidents severity rated as no and low harm are assessed for accuracy and risk, before being saved using the Approved status ensuring the context of the details are not changed, A failure to comply will be treated as misconduct and as such may lead to formal action in accordance with the Trust's Conduct and Capability Policy (HR32).
- Review and save all incidents that are Moderate, Severe or a Death in severity as Awaiting Risk Management Approval-

The Risk Management team will assess the report form, requesting further information if necessary. Once satisfied, the Risk Management team will approve, within a further five day period and submit for uploading to the NRLS if a patient safety incident.

4.2. Serious incident reporting

When it is possible that a serious incident has occurred there is a clearly defined method of identification and reporting that must be followed as set out within the procedural guidelines CPG3. This is in addition to reporting the incident by the normal method above.

4.3. Key tasks for incident management

If an incident takes place a number of key tasks fall to the staff involved and local managers. These include attending to anyone affected by the incident, making the area safe, assessing the severity and nature of the incident to guide further action, gathering information on the incident, reporting the incident as required, preservation

of items needed to support investigation, supporting patients, residents, and staff affected by the incident. These requirements are covered in more detail in procedural guidelines CPG3.

4.4. Other types of incident requiring special consideration and possible external reporting-

There are a number of incident types that require special consideration although they may not qualify as serious incidents. More detail is provided in Procedural Guidelines CPG3. These include:

- Issues of staff conduct and capability
- Security incidents (Security management Service reporting)
- RIDDOR incidents and the Health and Safety Executive.
- Safeguarding incidents
- Breaches of Information security
- Sharps injury / body fluid contamination incidents
- Incidents involving patients
- Same sex accommodation breaches

4.5. Onward reporting of incidents and Serious Incidents to external agencies and regulators

4.5.1. It is the Head of SIs and Quality's responsibility to give initial notification of SIs to the commissioning CCG within 2 working days.

4.5.2. The Head of SIs and Quality in conjunction with the appropriate Director will consider whether it is appropriate to disclose the report to external agencies such as Her Majesty's Coroner or those in partnership with the Trust, for example other NHS Trusts, Social Services and patients/residents, and their relatives/carers.

4.5.3. The FOI, DPA & Litigation Manager will notify the National Health Service Litigation Authority only when a formal claim has been received by the Trust.

4.5.4. Depending on their nature, incidents must be reported where appropriate by the Trust to other health-related organisations, including regulators.

4.5.5. The Trust will as necessary also inform organisations with an advisory or analytical function. Further detail on serious incidents requiring special consideration, such as onward reporting to an external agency is given in the next section and in procedural guidelines CPG3.

4.6. Additional external reporting requirements related to serious incidents

4.6.1. Some serious incidents have additional specific external reporting requirements. These include:

- Absences of leave/absconds of detained patients on low and medium secure or high secure wards-
- Unexpected deaths of services users detained or patients likely to be detained
- All grade 3 or 4 pressure ulcers/sores.
- Homicides by patients/ residents

4.6.2. Other external reporting may be required by the following external agencies in relation to any or all serious incidents.

- Coroner
- NHS England
- The Care Quality Commission (CQC)
- NHS Litigation Authority
- NHS Improvement (NHSI)
- Community Safety Partnerships (for domestic homicide reviews)
- Local Safeguarding Boards
- Responding to enquiries from the public
- Health and Safety Executive
- Commissioners

Further detail on serious incident management is given in Procedural Guidelines CPG3.

4.7. Incident investigation

All Incidents, including SIs must be appropriately investigated. The level of investigation will be determined by the severity of the incident, and on a case by case basis - see procedural guidelines CPG3. All incidents will, as a minimum, be investigated by the person in charge and findings recorded on the Datix incident form.

4.7.1. In summary,

- Incidents resulting in NRLS – defined patient harm of “No harm”, “Low” or “moderate” or the consequence to the Trust is according to the Risk management and Assurance Framework 1 (Negligible), 2 (Minor) or 3 (Moderate) will normally be investigated locally within the service involved, unless it meets the Serious Incident criteria-
- Any incident which does not meet the criteria of a serious incident may be deemed a critical incident requiring a level 1 investigation
- Any incident of NRLS - defined patient harm of “Severe” or “Death” is a Serious incident and will be investigated as such
- Independent of the level of patient harm, any incident of Trust Impact of 4 (severe) or 5 (catastrophic) will almost certainly already have been classified as a Serious Incident

4.7.2. There are three levels of serious incident investigation according to NHS England’s Serious Incident Framework.

- Level 1 – Concise Internal Investigation
- Level 2 – Comprehensive Internal Investigation
- Level 3 – Independent Investigation

The framework includes action required for each grade of serious incident, timeframes for completion of investigations and gives examples of serious incident types.

The Serious Incident grading and investigation process will be coordinated by the Executive Director of Mental Health / Executive Nurse and the Head of Serious Incidents & Quality.

Follow up of action plans following investigations

- 4.7.3. Action plans that are developed following any incident will be implemented and monitored by the responsible directorate and lessons learnt fed back to the Risk Management Department.
- 4.7.4. Responsibility and arrangements for follow up on action plans developed from an Incident Investigation will be determined by the Director that commissioned the investigation.
- 4.7.5. Action Plans following a Serious Incident investigation will be developed by the responsible directorate once the internal investigation report is signed off.
- 4.7.6. The actions will be developed from the report and monitored and updated by the responsible directorate and Service Board.
- 4.7.7. Compliance monitoring will be the responsibility of the Head of Serious Incidents and Quality. A regular report will be given to the Executive Operational Sub Committee via the weekly SI report and non-compliance highlighted.
- 4.7.8. Electronic evidence folders will be maintained for completed actions by the Head of Serious Incidents and Quality. Manual files will be held where appropriate.
- 4.7.9. Further detail is provided in procedural guideline CPG3.

4.8. Analysis of incidents

The monitoring of all adverse incidents, including serious incidents is an integral part of Clinical Governance. Details of all adverse incidents, including serious incidents will be collected into a central database. Suitable analysis will be conducted by the Risk team and reported to appropriate governance and performance structures.

Further detail on analysis and reporting can be found in procedural guideline CPG3.

4.9. Aggregated analysis of Incidents, claims and complaints

- 4.9.1. The Risk Management Team, Complaints Team and Claims Team will coordinate regular analysis of the three information streams of complaints, incidents and claims to ensure trends are identified across the three areas. The analysis will be reported to appropriate governance structures and management teams
- 4.9.2. Further detail on aggregated/coordinated analysis and reporting can be found in procedural guideline CPG3.

4.10. Process for implementing risk reduction measures

4.10.1. The Risk Management Team will monitor risks associated with incidents at key stages of the incident process.

4.10.2. The Trust's Risk Management and Assurance framework sets out how risks are identified, assessed and managed. Any outstanding risk (one that has not been reduced to an acceptable level) identified during the incident reporting, investigation, action planning, analysis (including coordinated/aggregate analysis) and learning process will be managed according to the framework.

4.11. Effective learning from all incidents and when things go wrong

The Trust is committed to effective learning from the lessons identified when things go wrong. Learning from patient safety incidents is a collaborative, decentralised and reflective process that draws on experience, knowledge and evidence from a variety of sources. It includes the active sharing of lessons within teams, within services, between services, across the organisation, with local partners and stakeholder and nationally. Learning encompasses sustainable changes and improvements in behaviour, beliefs, and attitudes and knowledge of workers at the front line of healthcare delivery and the same for process, policy, systems and procedures at the organisational level.

4.11.1. Team leaders should regularly identify lessons learned from their own incidents and share with their teams and implement improvements accordingly.

4.11.2. Senior service leads and directors will ensure that lessons from within and without are shared within services through local governance procedures and improvements made where possible.

4.11.3. There are enhanced procedures set out for Serious Incidents. Nevertheless it is policy of the Trust to ensure that learning from all incidents takes place.

4.11.4. The learning process will be enhanced by key advisers and groups.

4.11.5. It will be essential that all available communication channels are employed to share lesson both internally and externally.

4.11.6. More detail on Learning is provided in procedural guideline CPG3.

<h2>5.0 REFERENCE TO OTHER TRUST POLICIES</h2>
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5.1. The Trust has a number of policies and procedural guidelines that deal in detail with specific incidents. These policies should always be consulted. In particular:

- Major Incident Plan (RM14)
- Engagement and Observation Policy (CLP8)
- Clinical Risk Assessment and Management (CLP28)

- Human Resources/Departmental Policies, as appropriate for investigations
- Safeguarding Children Policy (CLP37) and Safeguarding Adult Policy (CLP39)
- Whistle-blowing Policy (CP53 and CPG53)
- Being Open Policy (CP36)
- Freedom of Information Act 2000 Policy (CP25)
- Care Programme Approach (CLP30)
- Induction/Mandatory Training Policy (HR21)
- Management of Sharps Injuries/Contamination Incidents Policy (ICPG1 section 9)
- Medical Devices Policy (CLP17)
- Safety Alert Bulletins Policy (RM10)
- Supervision and Appraisal (HR48)
- Complaints Policy (CP2)
- Record Management Policy (CP9)
- Conduct and Capability Policy (HR27)
- Information Governance and Security Policy (CP50)
- Information Sharing and Consent Policy (CP60)
- Health and Safety Policies e.g. RIDDOR
- Mortality Review Policy (CP64 and CPG64)

6.0 IMPLEMENTATION

6.1. Access to this policy and associated documents is through the Trust Intranet.

6.2. **This policy will be implemented and reinforced by the following means:**

- Formal induction of new staff at corporate and local level. Both will cover incident reporting
- Ongoing review of incident reporting, investigation, taking action and learning at local, directorate and Trust level through normal governance and risk management processes
- The training in and exercise of the duties of managers and team leaders. Managers' training includes incident reporting and investigation
- The training of staff in Root Cause Analysis throughout the Trust
- Monitoring the Trust's position in National benchmarking reports
- Resources on the Trust Intranet
- Trust communications such as Team Brief and Trust Today
- Advice and support from the Risk Management Team and Head of Serious Incidents and Quality
- The oversight of Trust investigation of Serious Incidents by the CCG and, where appropriate, regional groups

7.0 POLICY REVIEW

7.1. Any amendments to this policy will be submitted to the Health, Safety and Security Committee, Learning from Experience Group, Clinical Governance Committee and Executive Team prior to being ratified by the Trust Board.

7.2. This policy will be reviewed at a minimum of once every 3 years

8.0 REFERENCES

8.1. The following national guidelines have been considered in the development of this policy and procedural guideline:

- Being Open - Communicating patient safety incidents with patients and their carers, NPSA / 2005/010
- NHS England Serious Incident Framework 2015
- Seven Steps to Patients Safety, NPSA
- Health and Safety at Work etc Act 1974
- Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) amended 2004
- Management of Health and Safety at Work Regulations 1999
- Building a Safer NHS for Patients, DOH 2001
- Building a memory: Preventing Harm, Reducing Risks and Protecting Patient Safety, NPSA 2005
- General Data Protection Regulation 2016
- Freedom of Information Act 2000
- Systems Analysis of Clinical Incidents The London Protocol, 2004
- Independent Investigation of Serious Patient Safety Incidents in Mental Health Services Good Practice Guidance. NPSA 2008.

8.2. There are a number of guidelines from external organisations that have been considered in the development of this policy and procedural guideline:

- National Patient Safety Agency (NPSA)
- NHS England Serious Incident Framework, 2015
- Health & Safety Executive (HSE)
- Mental Health Act Commission (MHAC)
- Principles of Caldicott and National Confidential Enquiries
- NPSA independent investigation of serious patient safety incidents in mental health services February 2008.
- Monitor Compliance framework 2011/2012 (Monitor, March 2011, www.monitor-nhsft.gov.uk)
- Monitor's Risk Assessment Framework (updated August 15)

END
