ADVERSE INCIDENT PROCEDURE, INCLUDING SERIOUS INCIDENTS

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PROCEDURE SUMMARY
These procedural guidelines set out the arrangements for the reporting and handling of Adverse Incidents, including Serious Incidents within Essex Partnership University NHS Foundation Trust (EPUT).

The main purpose of these guidelines 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.

These guidelines 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 anyone who is involved with our services.
These procedural guidelines should be read in conjunction with the Trust Adverse Incidents Policy, Including Serious Incidents CP3.

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.

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.

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 section 17).

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The Director responsible for monitoring and reviewing this policy is Executive Nurse
# ESSEX PARTNERSHIP UNIVERSITY NHS FOUNDATION TRUST

## ADVERSE INCIDENT PROCEDURE

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1.0 INCIDENT DETECTION

1.1. **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.

1.2. 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

1.3. **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.

1.4. **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).

1.5. 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 NHS England’s Serious Incidents Framework (March, 2015) (Appendix 06A) definitions for when a serious incident must be declared, reproduced below:

- 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 patient/resident; 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.

This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS funded care caused/contributed towards the incident

- A Never Event - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death. See NHS England Revised Never Events List (Appendix 06B) for further information;

- 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 may extend to a large population;
  - Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS);
  - 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 healthcare or an organisation

1.6. Specialised Commissioning - NHS England have identified a number of events which may occur in services directly commissioned by them which would in addition to the above meet the criteria as Serious Incidents. A full breakdown of these events is included in Appendix 06C.

1.7. 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.
1.8. The following never events list has been produced by NHS England and is reviewed on an annual basis:

- **Wrong site surgery**

An invasive procedure performed on the wrong patient or at the wrong site (e.g. wrong knee, eye, limb, tooth). The incident is detected at any time after the start of the procedure.

- **Wrong implant/prosthesis**

Placement of an implant/prosthesis different from that specified in the procedural plan, either before or during the procedure. The incident is detected any time after the implant/prosthesis is placed in the patient.

- **Retained foreign object post-procedure**

Retention of a foreign object in a patient after a surgical/invasive procedure.

- **Mis-selection of a strong potassium containing solution**

Mis-selection refers to when a patient is intravenously given a strong potassium solution rather than the intended medication.

- **Wrong route administration of medication**

The patient is given one of the following:

- intravenous chemotherapy by the intrathecal route
- oral/enteral medication or feed/flush by any parenteral route
- intravenous administration of an epidural medication that was not intended to be administered by the intravenous route

- **Overdose of insulin due to abbreviations or incorrect device**

Overdose refers to when:

- a patient is given a 10-fold or greater overdose of insulin because the words ‘unit’ or ‘international units’ are abbreviated; such an overdose was given in a care setting with an electronic prescribing system
- a healthcare professional fails to use a specific insulin administration device – that is, an insulin syringe or pen is not used to measure the insulin
- a healthcare professional withdraws insulin from an insulin pen or pen refill and then administers this using a syringe and needle.

- **Overdose of methotrexate for non-cancer treatment**

Overdose refers to when a patient is given a dose of methotrexate, by any route, for non-cancer treatment that is more than the intended weekly dose; such an overdose was given in a care setting with an electronic prescribing system.
• **Mis-selection of high strength midazolam during conscious sedation**

Mis-selection refers to when:

- a patient is given an overdose of midazolam due to the selection of a high strength preparation (5 mg/mL or 2 mg/mL) instead of the 1 mg/mL preparation, in a clinical area performing conscious sedation
- excludes clinical areas where the use of high strength midazolam is appropriate; these are generally only those performing general anaesthesia, intensive care, palliative care, or areas

• **Failure to install functional collapsible shower curtains or rails**

Involves either:

- failure of collapsible curtain or shower rails to collapse when an inpatient attempts or completes a suicide
- failure to install collapsible rails and an inpatient attempts or completes a suicide using non-collapsible rails.

• **Falls from poorly restricted windows**

A patient falling from a poorly restricted window. This applies to:

- windows ‘within reach’ of patients; this means windows (including the window sills) that are within reach of someone standing at floor level and that can be exited/fallen from without needing to move furniture or use tools to climb out of the window
- windows located in facilities/areas where healthcare is provided and that patients can and do access
- where patients deliberately or accidentally fall from a window where a fitted restrictor is damaged or disabled, but not where a patient deliberately disables a restrictor or breaks the window immediately before they fall
- where patients can deliberately overcome a window restrictor using their hands or commonly available flat-bladed instruments as well as the ‘key’ provided.

• **Chest or neck entrapment in bedrails**

Entrapment of a patient’s chest or neck between bedrails or in the bedframe or mattress, where the bedrail dimensions or the combined bedrail, bedframe and mattress dimensions do not comply with Medicines and Healthcare products Regulatory Agency (MHRA) guidance.

• **Transfusion or transplantation of ABO-incompatible blood components or organs**

Unintentional transfusion of ABO-incompatible blood components.

**Excludes** where ABO-incompatible blood components are deliberately transfused with appropriate management.
Unintentional ABO-mismatched solid organ transplantation.

**Excludes** situations in which clinically appropriate ABO-incompatible solid organs are deliberately transplanted.

- **Mis-placed naso- or oro-gastric tubes**
  Misplacement of a naso- or oro-gastric tube in the pleura or respiratory tract that is not detected before starting a feed, flush or medication administration.

- **Scalding of patients by water used for washing or bathing**
  Patient scalded by water used for washing/bathing.

**Excludes** scalds from water being used for purposes other than washing/bathing (e.g. from kettles).

- **Unintentional connection of a patient requiring oxygen to an air flowmeter**
  This applies when a patient who requires oxygen is connected to an air flowmeter when the intention was to connect them to an oxygen flowmeter.

**Excludes** unintentional connection to an air cylinder instead of an oxygen cylinder as robust barriers to prevent this have not yet been identified.

- **Undetected oesophageal intubation** – *This Never Event has been temporarily suspended pending further clarification*

Further guidance on never events and the criteria for each of these is included in the NHS England Revised Never Events List (Appendix 06B)

1.9. **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.

This does not mean that every near miss should be reported as a Serious Incident Requiring Investigations (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.

1.10. **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.

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.

1.11. **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](http://www.hse.gov.uk) (Appendix 14A).

1.12. **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.

All deaths of an inpatient/resident in Trust services, irrespective of whether the death is determined as a Critical / Serious Incident or not will be subject to the Trust mortality review processes, detailed in the Mortality Review Policy (CP64)

1.13. **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.

1.14. **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.

2.0 **OVERVIEW OF THE SERIOUS / CRITICAL INCIDENT MANAGEMENT PROCESS**

2.1 Any member of staff involved in, or who becomes aware of a potential Serious or Critical Incident must immediately report the incident to the person in charge within working hours. Outside of working hours on call reporting arrangements apply.

2.2 It is often clear that a serious incident has occurred but where this is not the case staff and the Trust should engage in open and honest discussions with their commissioners (and others as required) to agree the appropriate and proportionate response.

2.3 Where it is not known whether or not an incident is a serious incident it is better to err on the side of caution and treat the incident as a serious incident until evidence is available to demonstrate otherwise.
2.4 Where staff select possible serious incident at the time of reporting on Datix the Serious Incident Team will review the incident form the next working day.

2.5 The Executive Director of Mental Health/Executive Nurse, the Executive Medical Director and/or the relevant Executive Director or nominated deputy, will consider each possible serious incident.

2.6 Where a decision is made that an incident does not meet serious incident reporting criteria a decision monitoring tool will be completed to record the rationale. The form will be uploaded to the Datix record by the Serious Incident Team.

2.7 When a decision is taken that an incident meets serious incident reporting criteria the Head of Serious Incidents and Quality or nominated deputy will be responsible for reporting to the relevant CCG using the STEIS reporting system. This will then trigger the investigation process in keeping with the national framework for Serious Incidents discussed later within this procedure.

2.8 Serious incident reports can be downgraded. However this must be agreed with the relevant commissioner on a case by case basis.

2.9 Incidents that are found not to meet the threshold of a serious incident must be managed in line with the Trust’s Risk Management and Patient Safety Policies.

2.10 On occasion where an incident does not meet the serious incident reporting criteria following review, it may be determined to still investigate the incident further in order to establish any learning. Such incidents will be called critical incidents and will follow the critical incident investigation process discussed later in this procedure, see Appendix 06D.
NHS ENGLAND’s SERIOUS INCIDENT MANAGEMENT FLOW CHART

Incident occurs

Report on LRMS/ NRLS and to other bodies such as safeguarding lead as applicable

Manage in line with local risk management policy

Is it a serious incident?

No

Engage with those involved/affected

Unknown

Review and discuss with commissioner

Yes

Report on STEIS

Complete initial review and submit to commissioner where possible this should be the provider’s ‘lead commissioner’ who can liaise with others as required. This should be outlined in the RASCI model.

Confirm level of investigation required

Lead investigator identified. Team established. Terms of reference set. Management plan established

Undertake the investigation

Gathering and mapping information

Analysing information

Generating solution

Submit final report and action plan

Commissioner (with relevant stakeholders) undertakes a review of the final report and action plan and ensures it meets requirements for a robust investigation (see appendix 8). Feedback given to provider (‘calendar days)

Commissioner closes investigation and confirms timescales/mechanism for monitoring the action plan where actions/improvements are still being implemented.

Support and involve those affected (including patients, victims and their families and staff)

Opportunities for feedback and learning identified and information shared

3.0 KEY TASKS FOR IMMEDIATE INCIDENT MANAGEMENT

3.1 After an incident has taken place the first priority is to ensure that the area is, where appropriate and safe to do, made safe and scene preserved. (Refer to Section 4.1.7) and any needs of the people involved are met. This may include first aid, medical intervention, in the case of personal injury or other action such as removal of faulty equipment or otherwise making the local environment safe. It is the responsibility of any staff that are present at the incident and the team/lead manager to ensure that these needs are addressed immediately.

3.2 The lead manager is responsible for taking any immediate actions following the incident that are necessary in order to safeguard the patient/resident and prevent further harm occurring.

3.3 Any faulty equipment, supplies or drugs should also be preserved in a safe place to support later investigation.

3.4 Any CCTV of the area and local area, if required, must be requested at the earliest opportunity and within 30 days of the incident date.

3.5 If medicine is found to be defective, or suspected of being defective, the process set out in paragraph 15.22.1 of the Trust’s Procedural Guidelines for the Safe and Secure Handling of Medicines (CLPG13-MHJS or CLPG13-CHS as appropriate) must be followed.

3.6 The staff member either directly involved in the incident or present for the entire incident (hereby known as the nominated staff member) is responsible for reporting the incident via the Datix Incident System and reporting the incident to the ward/department/team manager or senior nurse in charge (hereafter known as lead manager) immediately.

3.7 Where and incident is not observed the person who receives the information about the incident or discovers that an incident has occurred (hereby known as the nominated staff member) is responsible for reporting the incident via the on-line Datix web form and for reporting the incident to the ward/department/team manager or senior nurse in charge (hereafter known as lead manager) immediately.

3.8 In the event of the staff member, directly involved in the incident, not able to continue on shift or be available for greater than 48 hours (i.e. sickness) then their line manager must report the incident via Datix in their absence.

3.9 A decision must be made as to whether this incident is RIDDOR reportable, by the lead manager in conjunction with the Risk Management Team. If RIDDOR reportable the lead manager is to notify the Risk Management Team as detailed in the web based on-line Datix reporting form on [redacted]. See also Appendix 14.

3.10 The lead manager will be responsible for identifying who will act as the family liaison officer who will subsequently make initial contact with those involved or their family/carers.
3.11 Where an individual has been harmed by the actions of a patient/resident, particular thought should be given to who is best place to make contact with the victim and/or their family.

3.12 Where a crime may have been committed, the lead manager should alert the LSMS and where indicated contact the police and agree with them who will make contact with the victim(s), their family/carer(s) and/or the perpetrator’s family. Those involved in such incidents should also have a single point of contact within the Trust via a family liaison officer.

3.13 A decision on the level of investigation will be made by the Executive Director of Mental Health / Executive Nurse and the Executive Medical Director using the NHS England Serious Incident framework:

3.14 **Levels of Investigation and actions required**

3.14.1 **Does not meet SI Criteria** –
To be reviewed by team manager and actions updated on Datix prior to closure.

3.14.2 **Does not meet SI Criteria but identified as a critical incident by the Trust**
To be investigated in line with Trust Critical Incident process as outlined in this procedure.

3.14.3 **Meets SI Criteria**

**Level 1** – Concise Internal Investigation required
Suited to less complex incidents which can be managed by individuals or a small group at a local level.

**Level 2** – Comprehensive Internal Investigation required
Suited to complex issues which should be managed by a multidisciplinary team, involving experts and/or specialist investigators, where applicable. This includes investigations with an independent element or full independent investigation commissioned by the Trust.

**Level 3** – Independent Investigation required
Required where the integrity of the investigation is likely to be challenged or where it would be difficult for an organisation to conduct and objective investigation internally due to the size of the organisation or capacity/capability of the available individuals and/or number of organisations involved.

3.14.4 **Recording of Accident/Incident Information on Medical Records**

3.14.5 If the incident involved a patient /resident then the nominated staff member involved is responsible for ensuring all details of the incident have been documented in the systems appropriate areas in accordance with Trust
approved user guides and CP9 Record Management policy and to encourage the patient / resident to record their experience into their case notes.

3.14.6 All recorded incidents must be traceable wherever the person concerned may be. This ensures the appropriate action and protection can be provided. Therefore the Web reference number provided by Datix must be noted within any records made. This number will start with an E. Copies of Datix entries do not need to be placed in the record.

3.14.7 All patient safety incidents require the patients NHS number this facilitates the Datix automatically copying into the patients Mobius record.

3.15 Harm Grading and Risk Rating of Incidents

3.15.1 All incidents will be graded for the degree of harm experienced in line with the requirements of the National Reporting and Learning System. Depending on local procedures, this will be done by the incident reporter, or the manager dealing with the incident. (See Appendices 3 and 5).

3.15.2 All incidents must be risk rated according to the Trust’s Risk Management and Assurance Framework, which conforms to National Reporting and Learning Systems (NRLS) guidance. This is set out in Appendix 04. Depending on local procedures this may be completed by the reporter of the incident or by the manager/handler for the incident.

3.15.3 All no and low harm incidents will be finally approved by the manager/handler of the incident.

3.15.4 All moderate and above incidents will be reviewed by the manager and all relevant sections completed as appropriate and placed in Awaiting Risk Management Approval for the risk management team. (Appendix 05).

3.15.5 The lead manager must investigate all incidents and recommend and co-ordinate appropriate corrective actions. The lead manager is responsible for:

- Accessing the incident report on the Datix on-line system
- Completing the managers section of the form (DIF2) including review and further actions.
- Finally approve the Datix incident form within five working days for all incidents that are no and low harm in severity
- Where an incident relates to a suspected deep tissue injury it may not be possible to approve this within the five working days, however automatic reminders will continue to be sent by Datix. Suspected deep tissue incident Datix reports must however be regularly reviewed and a decision made about the nature of the injury within 10 working days.
- Review and send for approval to the Risk Management Team for all incidents that result in moderate, severe and death harm within five working days.
- Consider any escalation requirements via the Datix incident reporting system including investigation, support and advice and investigation by an outside agency
3.15.6 The lead manager is responsible for ensuring witness statements are taken as soon as possible and returning these to the Risk Management Team (see Appendix 02 Witness Statement). They may be supported in this by the nominated staff member responsible for reporting the incident. This can be done

- By electronic attachment on the Datix on-line system
- By hard copy as soon after the incident as possible (only in circumstances where Datix is unavailable for 24 hours)

3.15.7 The Risk Management Team is responsible for reviewing through regular audit all incident reports. Part of this review includes ensuring all internal stakeholders have been sent a Datix email notification alert as appropriate this includes:

- FOI, DPA & Litigation Manager
- Estates/Facilities
- Infection Control
- Executive Team
- Information Governance Manager
- Head of Serious Incidents and Quality
- Head of Customer Complaints & Customer Service Improvement
- Associate Director for Safeguarding

3.15.8 The Risk Management Team will assess if further investigation is required following the lead managers investigation, and will initiate such investigations (Appendix 13). The Lead Manager will notify other departments of any actions/investigations required in the event of an adverse incident i.e. Estates Services, Occupational Health, Infection Control, Executive Team and the Claims Department.

3.15.9 The Risk Management Team will provide patient safety incident statistics to the National Reporting and Learning Systems (NRLS) on a two weekly basis (Appendix 03 for NRLS incident grading).

4.0 KEY TASKS FOR SERIOUS INCIDENT MANAGEMENT

4.1 Team Manager/Nurse in Charge and/or Senior Manager and/or On Call Manager

4.1.1 When a senior manager on duty within working hours or the on call manager out of hours is alerted to a possible serious incident the senior manager or on call manager is responsible for the management of the incident and must take actions to ensure safety of any persons involved and secure the immediate area.

4.1.2 Evidence such as case notes, medication charts, observation charts, duty rota’s etc. must be secured by the senior manager or clinical lead as soon as practically possible. Clothing or any relevant equipment involved must also be preserved in a safe place.
4.1.3 In the event of a Serious Incident involving a potential safeguarding concern, the responsible manager or senior clinician on duty must ensure that the person is safe and that the Safeguarding Team are alerted as soon as practically possible. Further information can be accessed via the the Safeguarding Adults Policy (CLP39) or Safeguarding Children Policy (CLP37).

4.1.4 The Head of Serious Incidents & Quality must also be informed by the Associate Director for Safeguarding about potential Serious Case Reviews, Domestic Homicide Reviews or where staff have been suspended in relation to safeguarding allegations.

4.1.5 An informed decision can then be made on a case by case basis about whether the incident also needs reporting as a Serious Incident to the CCG.

4.1.6 Consideration must be given on a case by case basis whether the scene needs to be preserved for example if there has been an unexpected inpatient/resident death or a serious safeguarding allegation on the ward and police have been called.

4.1.7 Staff should safeguard the room /scene but, under exceptional circumstances, if equipment needs to be moved for the sake of patient/resident safety then a sketch must be made of the layout of the room. This is the responsibility of a Senior Manager or Clinician.

4.1.8 In the event of a death on an inpatient ward/ Nursing Home the Care of Deceased Patients Procedural Guideline must be followed by staff. The person in charge must ensure that the incident is reported on Datix.

4.1.9 Further details in terms of notification and reporting requirements for a death on an inpatient ward / Nursing Home are included in the Notification and Reporting of Deaths Process attached as part of The Mortality Review Policy (CP64).

4.1.10 The person in charge must ensure in a timely manner that the patient /resident, their family or carers are fully informed of the incident in accordance with the Trust’s Duty of Candour, contained within the Being Open Policy and Procedures. Any contact or attempts to contact must always be documented in patient/resident notes.

4.1.11 In line with Duty of Candour principles, contact with the patient /resident/carer/family must be attempted as soon as practically possible and within 10 days of the incident occurring. The initial contact should alert the patient /resident that a notifiable safety incident has occurred and provide a factual account of what is known about the incident to date and include an apology that the event occurred.

4.1.12 Written record must be maintained in the patient file and FLO (Family Liaison Officer) Contact Record (Appendix 21) must be completed and uploaded on to the relevant Datix report.

4.1.13 Following this, the Trust must send written notification to the relevant person.
4.1.14 The Head of Serious Incidents will co-ordinate this with the director of service or Family Liaison Officer (FLO). Further details of applicable incidents are contained within the Trust’s Being Open Policy (CP36).

4.1.15 Advice about the allocation of a Family Liaison Officer can be obtained from the Associate Director of Risk and Compliance or the Head of Serious Incidents & Quality within normal working hours. Advice can be sought out of hours through on-call arrangements.

4.1.16 Within working hours if an incident is likely to cause adverse publicity, the Communications Team and the Head of Serious Incidents and Quality must be notified to ensure that the Executive Team are suitably briefed.

4.1.17 Outside of working hours, staff should use on call arrangements to notify the on-call manager who will make a decision on a case by case basis about whether the Director on Call must be notified.

4.1.18 It is important where a criminal offence is suspected that evidence is retained in a secured environment where it should remain uncontaminated and Police are notified. Failure to do so may mean that legal proceedings are undermined.

4.1.19 The most senior member of staff must keep a brief summary of events and actions taken as soon as practically possible. They must also liaise with the patient/resident’s Responsible Medical Officer or Duty Doctor to consider whether a review of care and treatment is required or any further actions to ensure safety of the patient/resident or others is required.

4.2 Head of Serious Incidents

4.2.1 During working hours the Head of Serious Incidents & Quality or nominated deputy will be the responsible person for briefing the CCG and any other internal and external stakeholders.

4.2.2 Outside of reporting hours a decision about whether to brief the CCG or NHS England Communications Team will be made by the on-call director.

4.2.3 Once notified of an incident that appears to meet Serious Incident criteria the Head of Serious Incidents & Quality will share a copy of the internal notification form and any other pertinent information with the Executive Director of Mental Health/Executive Nurse, the Medical Director and the Lead Director.

4.2.4 The Head of Serious Incidents & Quality or nominated deputy will notify relevant internal stakeholders including the Risk Management Team to ensure the incident is uploaded to the NRLS within the 48 hour Timeframe.

4.2.5 The Head of Serious Incidents & Quality will ensure that all relevant internal and external stakeholders are informed. A decision will be made on a case by case basis about who these stakeholders may be.

4.2.6 In the event of a Serious Incident likely to attract media interest key members of the Executive Team and the Associate Director of Communications will be
notified by telephone by the Head of Serious Incidents and Quality or nominated deputy within working hours. Outside of working hours this will be considered in accordance with on-call procedures.

4.3 **The On-Call Manager and On-Call Director**

4.3.1 The manager on-call and the director on-call will follow on-call procedures relating to serious incident reporting and management.

4.4 **Responsibility for Family Liaison**

4.4.1 It is desirable for staff who know the family member, or the most senior member of staff available, to make initial contact to offer condolences and identify any immediate support needs. This person must keep a record of any discussions and actions taken during contact and will be responsible for handing over any relevant information to the Family Liaison Officer (FLO) once identified. (Appendix 21).

4.4.2 The Head of Serious Incidents and Quality or nominated deputy, in conjunction with the Operational Director, will oversee the FLO process where a serious incident has taken place.

4.4.3 In accordance with Being Open and Duty of Candour principles the Trust is committed to offering support to bereaved families and carers and those affected by serious incidents.

4.4.4 Ideally the FLO will have received appropriate training for this role but on some occasions a decision will be made to allocate a suitable person to undertake the FLO role taking into consideration experience and seniority.

4.4.5 Family liaison should include contact with the victim and the suspected perpetrators families by letter or telephone when an alleged homicide has been committed. Homicide Victim Support Service or the Police Family Liaison Officer can also be contacted by the identified FLO to assist in attempting to make contact with the families. This should be arranged through the Head of Serious Incidents and Quality or nominated deputy.

4.4.6 Support and advice for the FLO throughout the duration of their role should be provided by the relevant Operational Service Director. Advice about the FLO role can also be obtained from the Head of Risk and the Head of Serious Incidents and Quality or nominated deputy. Guidance and resources for staff undertaking the FLO role is available on the Trust intranet (InPut).

4.4.7 When a FLO is identified the name and contact details should be included in the Duty of Candour letter sent to bereaved families. This letter will be sent from the Director of the Service with support from the Serious Incident Team. Where a FLO is identified subsequently the FLO should attempt to make contact with the family as quickly as possible after the incident to make an introduction, explain the role, and provide contact details.
4.5 **Deputy Directors or Locality Directors**

4.5.1 Responsibility for ensuring that action plans arising from serious incident investigations are put in place, for their ongoing monitoring and updating until all recommendations and actions are completed, and for obtaining evidence of implementation of learning will sit with the Deputy Director or the Locality Director in the affected area. This responsibility can be devolved to a nominated Deputy as felt to be appropriate. The Head of Serious Incidents & Quality or nominated deputy will have a role in monitoring progress, reviewing target dates using a weekly serious incident position statement and holding the evidence within the serious incident folder once provided by the Operational leads.

4.6 **Media interest**

4.6.1 The Trust’s communication department, in liaison with the Executive Director of Mental Health/Executive Nurse and the Head of Serious Incidents & Quality, is responsible for developing a communications plan that covers all aspects of communication including the media, MPs, victims, perpetrators, their families, legal representatives, staff, pressure groups and other stakeholders for Serious Incidents. The Communications Team will also be responsible for briefing and liaison with other partner organisations including the CCG, NHS England and other stakeholders as required on a case by case basis.

4.6.2 The Head of Communications and the Executive Director of Corporate Governance will consider action to be taken in relation to any media contact and requests.

4.6.3 Out of hours the director on-call will be the contact point for any media enquiries.

4.7 **Claims and Serious Incidents**

4.7.1 The Head of Serious Incidents & Quality will liaise with the Trust’s Associate Director of Planning / FOI, DPA & Litigation Manager when it is suspected that a claim may arise from a Serious Incident.

4.7.2 The legal department will maintain oversight of any potential claim in preparation for notifying the NHSLA where there is a significant likelihood that a claim will arise out of a serious incident.

4.8 **Caldicott, data protection and information governance**

4.8.1 Staff must comply with Caldicott confidentiality principles and information governance requirements when reporting Serious Incidents. Reports should therefore not contain any identifiable information about staff or patients/residents. Person identifiers should be documented separately in the Serious Incident file.

4.8.2 It is the responsibility of the report author to ensure that reports are appropriately anonymised prior to submission to the Head of Serious Incidents upon completion. For some high profile serious incidents such as homicides
or deaths in custody there are likely to be independent investigations that follow.

4.8.3 Report authors are therefore required to produce a reference document that confirms the names of the staff involved that have been anonymised in the report and send to the Head of Serious Incidents & Quality to hold in the SI file.

4.9 Freedom of Information Act 2000

4.9.1 Trust staff must be aware that information relating to Serious Incidents including internal reports and incident data could potentially be subject to a request for disclosure under the Freedom of Information Act. Any request for information in relation to Serious Incidents must be sent to the FOI, DPA & Litigation Manager.

4.10 Incidents involving one or more provider organisations

4.10.1 If more than one organisation is involved in a Serious Incident the Head of Serious Incidents will be responsible for the coordination of the process with the identified leads in other organisations and for liaison with the CCG. This will include the decision about which organisation will report the serious incident on STEIS. The lead organisation will be identified and agreed in agreement with the CCG and clear roles and responsibilities established to ensure a coordinated approach.

5.0 INCIDENTS FOR SPECIAL CONSIDERATION AND POSSIBLE EXTERNAL REPORTING

5.1 Conduct and capability:

5.1.1 If at any time it is apparent that there are any immediate concerns related to the conduct or capability of a member of staff involved in an incident or serious incident these need to be considered without delay to ensure patient safety is maintained. In particular if suspension is being considered, duty or lead Directors should consider the NPSA’s Incident Decision Tree guidance in Appendix 15. They will nonetheless observe the relevant Conduct and Capability Policy and its attendant procedures. This may involve referral to the individual’s professional registration body, such as the Royal College of Nursing and NMC.

5.2 Security incidents and NHS Protect:

5.2.1 The Trust has a legal obligation to ensure the security of patient / residents and staff. This is overseen nationally by NHS Protect. Locally, this is the responsibility of the Security Management Director (SMD) and the Local Security Management Specialist (LSMS). If, during the course of an investigation of patient safety any incidents comes to light concerning poor security there is a criminal offence committed against Trust staff, property or assets the LSMS must be notified as soon as practicable, as per Trust Policy Criminal behaviour within a mental health environment (Zero Tolerance) (CP22).
5.3 Safeguarding incidents:

5.3.1 When an incident involves the safeguarding of a child or adult, staff should consult the Trust safeguarding procedures and contact the safeguarding team for advice on external reporting and serious incident. If the incident is reported on the Datix on-line reporting system, the Safeguarding option must be chosen and the on-screen instruction followed.

5.4 Sexual safety incidents:

5.4.1 The Trust will review sexual safety incidents within the Clinical Governance structure. Team managers will ensure that sexual safety incidents or allegations of sexual assault including rape are being graded for severity appropriately. No and low harm is not an appropriate grading for these events (NPSA 2010 CEO letter).

5.5 Sharps injury/body fluid contamination incident:

5.5.1 In addition to carrying out adverse incident reporting procedures, Occupational Health must be notified immediately if the incident occurred during working hours. If the incident occurred out of hours, the exposed individual must attend the nearest Accident and Emergency Centre for treatment. They will then advise the individual to report to Occupational Health the next working day. See Management of Sharps Injuries/Contamination Incidents Policy (ICPG 1 Section 9).

5.6 Failure of a medical device:

5.6.1 Breakdown of medical equipment. Any failure of a medical device or breakdown of medical equipment is potentially reportable to the Medicines Healthcare products Regulatory Agency (MHRA) by the Medical Device Safety Officer. Further guidance is provided in RM 10, Reporting and Disseminating Medical Device Alerts.

5.6.2 Where an incident has involved patient/ residents, reporting must comply with the Caldicott principles and Data protection legislation. External reports must not refer to patients/residents by name or by any other identifiable information. It is essential that staff reporting an incident on the Datix web on-line system only record personal details or identifiers, including location details, in the fields where required and not in free text response boxes used to describe incidents or follow up action. A patient resident number or identifier should be quoted as a reference on all forms/reports or associated correspondence.

5.6.3 The manager in charge is responsible for ensuring that the patient/residents and relatives/carers are kept informed about the incident and any subsequent investigation as required. This will include sharing the final report and an explanation of the final report, if appropriate. If it is desirable for staff who know the relative, or the most senior member of staff available, to make contact, ideally it should then be face to face.

5.6.4 Consideration should be given by staff to the Trust’s Being Open Policy (CP36) which also outlines the requirements of the Duty of Candour process.
5.7 RIDDOR and the Health and Safety Executive (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations, 1995, revised 2004, 2013):

5.7.1 This requires the Trust to report incidents that are reportable under RIDDOR to the HSE as detailed in Appendix 14. Incidents reported on Datix that are identified as RIDDOR reportable are notified directly to the Risk Management Team, who are responsible for reporting to the HSE.

5.7.2 The lead manager, or their deputy, will advise the Risk Management Team via the Datix incident reporting system, of all incidents that are considered reportable to the Health & Safety Executive (HSE), as soon after the incident as possible, but no later than 48 hours after the event.

5.7.3 For any incidents reported via the Datix on-line system, staff must indicate whether an incident is potentially RIDDOR reportable. If they do, the Risk Management Team will be automatically be notified by the Datix system.

5.7.4 The Risk Management Team will report this to the HSE immediately online using the HSE form F2508 in the case of a major injury or death and F2508A in the case of a disease within 10 working days. (Appendix 14).

5.7.5 Where an incident occurs, out of hours, the on-call Director will be contacted who will make the decision as to whether or not the incident requires immediate reporting to the HSE under RIDDOR. The lead manager will undertake responsibility of contacting the HSE call-centre 01245 706200 and advising the Risk Management Team immediately on the next working day.

5.7.6 The Risk Management Team will assist Managers and Directors in the formal investigation of all RIDDOR adverse incidents. To act as the specialist advisor to management during the investigation. Please see Appendix 14 for details of RIDDOR Reporting.

5.8 Breach of Information Security

5.8.1 An information security incident is defined as any event that could have or has or resulted in:

- Unauthorised disclosure of confidential information to any unauthorised individual
- Risk to the integrity or availability of data or an information system
- Harm such as legal obligation or penalty, financial loss, business or service disruption, or reputational damage

5.8.2 Information security breaches must also be reported to, investigated by and assessed by the Trust’s Information Governance Team. Incidents reported on the Datix reporting system will be forwarded automatically. Where an incident has been reported on a paper form, the reporter’s manager must contact the information governance team who will send an information security incident reporting form for completion and return.
5.8.3 Information security incidents involving loss or disclosure of personal information are potential Serious Incidents and must be reported without delay on Datix. This will enable the Information Governance Manager or nominated deputy to consider whether the breach meets criteria for reporting to the Information Commissioner’s Office (ICO) using the IG Toolkit. See CPG50 (d) Information Security Incident Management Procedures – attached to the Information Governance and Security Policy (CP50).

5.8.4 Any incident involving the loss of sensitive personal data must be reported as a possible Serious Incident to the Information Governance Manager and Head of Serious Incidents & Quality.

5.8.5 The Information Governance Manager must categorise each incident on a case by case basis according to Department of Health requirements (DoH Guidance 20th Feb 2008 Gateway 9571). The Information Governance Manager will agree on the required level of investigation and actions required by the Trust in the light of how many people are affected and the degree of loss or breach and inform the Head of Serious Incidents and Quality or nominated deputy to enable the serious incident to be reported within 48 hours of date of incident or knowledge.

5.8.6 A decision will be taken about whether there is a requirement to report the incident to the CCG using STEIS and the Information Commissioner on a case by case basis.

5.9 Maternal deaths

5.9.1 A maternal death is the death of a woman while pregnant or within 42 days of termination of a pregnancy, from any cause related to or aggravated by the pregnancy or its management; but not from accidental or incidental causes. In order to comply with NMC Midwives rules and standards all maternal deaths are to be reported to the Local Supervision Authority Midwifery Officer (LSAMO) via the LSA coordinator or via secure email.

5.10 Children on Adult Mental Health wards:

5.10.1 The National Service Framework for Children, Young People and Maternity Services (2004) highlights the importance of ensuring that “children and young people who require admission to hospital for mental health care have access to appropriate care in an environment suited to their age and development.” No child under 16 years must be treated on an adult psychiatric ward. In the exceptional case where a child of 16 or under is placed on an adult psychiatric ward, local managers must inform the Director for Mental Health and the Head of Serious Incidents on Datix, detailing how the ward and staffing have been made appropriate for the child’s needs. This is so that the Trust can use the STEIS reporting system to notify NHS England of the incident and actions taken to safeguard the young person and ensure they are receiving age appropriate services.

5.10.2 If staff are aware of the admission of a child aged 16 on an inpatient ward, the incident must be reported using Datix in accordance with the requirements set out in this procedure.
5.11 **Pressure Ulcers**

5.11.1 If a Grade 3 or 4 Pressure Ulcer is identified as acquired in care in Community Services, Nursing Home or Mental Health and Learning Disability Services, it must be reported on Datix as a serious incident. Once notified by Datix alert system any Grade 3 or 4 Pressure ulcers acquired in care will be reported to the CCG by the Serious Incident Team using StEIS.

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

5.12.1 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.

5.12.2 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 PPO must be followed by those involved in the delivery and commissioning of NHS funded care within settings covered by the PPO.

5.12.3 In NHS mental health services any death of a patient detained under the Mental Health Act (1983) must be reported to the CQC without delay.

5.12.4 An appropriate investigation into the death of a patient/resident detained under the Mental Health Act (1983) (or where the Mental Capacity Act (2005) applies).

5.12.5 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/residents 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 commissioner(s) as a serious incident and investigated appropriately.

5.12.6 Further information in terms of the reporting requirements and review process for deaths in custody is contained in The Mortality Review Policy (CP64).

5.13 **Serious Case Reviews and Safeguarding Adult Reviews**

5.13.1 The Local Authority via the Local Safeguarding Children Board or Local Safeguarding Adult Board (LSCB, LSAB as applicable), has a statutory duty to investigate certain types of safeguarding incidents/concerns where there is reasonable cause for concern that agencies could have worked more effectively to protect the child or adult.
5.13.2 In circumstances set out in Working Together to Safeguard Children (2013) the LSCB will commission Serious Case Reviews when a child has died or is seriously injured and non-accidental injury is suspected.

5.13.3 The Local Authority will also initiate Safeguarding Adult Enquiries, or ask others to do so, if they suspect an adult with Care and Support needs either died or experienced serious harm as a result of abuse or neglect.

5.13.4 The Trust will contribute towards safeguarding reviews (and enquiries) as required to do so by the Local Safeguarding Board. The Trust Associate Director of Safeguarding will instigate necessary notifications, reports and liaison during the review process. This includes working with the Trust Serious Incident Team to avoid duplication during parallel processes.

5.13.5 The Trust 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.

5.14 Domestic Homicide Reviews

5.14.1 A Domestic Homicide is identified by the police usually in partnership with the Community Safety Partnership (CSP) with whom the overall responsibility lays for establishing a review of the case.

5.14.2 A Domestic Homicide Review is a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a person to whom s/he was related or with whom s/he was or had been in an intimate personal relationship, or member of the same household as him/herself.

5.14.3 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 the Trust in relation to domestic homicide reviews.

5.15 Homicide by patients in receipt of mental health care

5.15.1 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.

5.15.2 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).

5.15.3 To manage the complexities associated with such investigations (and to facilitate joint investigations where possible), a clearly defined investigation process has been agreed.
5.15.4 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.

5.16 **Serious Incidents in National Screening Programmes**

5.16.1 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 the NHS England Serious Incident Framework.

5.16.2 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, multifaceted 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.

### 6.0 REPORT NOTIFICATION FOR SERIOUS INCIDENTS

6.1 The Head of Serious Incidents and Quality in conjunction with the appropriate Director will consider whether an SI report should be disclosed to external agencies.

6.2 The Director or nominated deputy will gather relevant information in order to assess the seriousness of the incident with the Head of Serious Incidents.

6.3 For level 1 Serious Incidents that are identified as meeting criteria for reporting to the CCG, the Head of Serious Incidents with assistance from the Executive Medical Director or nominated deputy, will identify a medical member of the review team to assist the identified investigating lead. The investigation will be undertaken using root cause analysis and/or human factors methodology. Completed reports must be sent to the Head of Serious Incidents & Quality who will ensure they are reviewed and approved before sending to the CCG.

6.4 For incidents graded in accordance with the grading matrix as level 2, the completed reports will be reviewed and approved by the Executive Operational Sub Committee. (See Appendices 07A, 07B, 07C and 07D for RCA reporting templates for each area and Appendix 08 for RCA investigation writing guidance).

6.5 The Operational Director, or Directors if more than one team is involved, are responsible for ensuring all available patient/resident records, current and historical, are secured for the duration of the serious incident investigation and inquest processes. The records need to be sent to the Records Teams by the team managers or clinical leads as soon as the SI 72 hour report is completed (Please see Appendices 9a, 9b and 13 for reporting templates for each area).
6.6 Where records are held on one of the Medical Records systems, the SI Team in conjunction with the Records Team will make arrangements for a copy to be made for the medical member of the review team and others as required. Other records not held on the Medical Records System will also be copied and sent to the review team. The Serious Incident Team will liaise with the Records Team when a serious incident is reported.

6.7 The appropriate Director will review and approve the 72 hour/7 day Serious Incident report before it is submitted to the Head of Serious Incidents & Quality or nominated deputy by the agreed internal target date. The report will then be sent to the Executive Director Mental Health & Executive Nurse and the Medical Director or nominated deputies for final review and approval prior to submission to the relevant commissioners.

6.8 The Associate Director of Risk and Compliance will be copied into all internal notifications for newly reported serious incidents to enable consideration to be given about whether it meets criteria as a patient safety incident to report to the National Patient Safety Agency through the National Reporting and Learning System. This will enable lessons to be shared nationally.

6.9 Once a decision is made that an incident meets serious incident reporting criteria, the Head of Serious Incidents & Quality or nominated deputy is responsible for the onward reporting using STEIS. This will ensure that the CCG is notified within 2 working days of the serious incident being identified.

6.10 Specialist Commissioners have access to STEIS using a specialist commissioning portal. All incidents relating to specialist commissioning will be reported using this portal.

6.11 Where a serious incident meets criteria for onward reporting to external agencies such as NHS Improvement (NHSI) or the CQC a copy of the email and any attachments sent will be recorded in the serious incident folder.

6.12 **Onward reporting of Serious Incidents to external Agencies**

6.12.1 Once a decision has been made by the Trust that it meets serious incident reporting criteria it is the responsibility of the Head of Serious Incidents and Quality or nominated deputy to report new serious incidents on STEIS to the relevant CCG within 2 working days of date of the incident or date of knowledge.

6.12.2 In accordance with Being Open principles, serious incident reports relating to deaths of patients/ residents and associated actions plans, once completed and submitted to the CCG, will routinely be shared by the Head of Serious Incidents with HM Coroner and families.

6.12.3 Where there is a risk of a potential claim the Head of Serious Incidents and Quality or nominated deputy will inform the Associate Director of Planning & the FOI, DPA & Litigation Manager.
6.12.4 Depending on their nature, incidents must be reported where appropriate by the Trust to other health-related organisations such as:

- Medicines Healthcare products regulatory Agency (MHRA)
- NHS Protect, Counter-fraud and Security Management Service
- Professional regulatory bodies e.g. General Medical Council, Nursing & Midwifery Council
- NHS Directorate of Health and Social Care
- Local Safeguarding Board
- Environmental Health
- NHSI, NRLS
- Local Representative Committees
- Medical Defence Organisations
- Care Quality Commission (including pressure ulcers and all unexpected deaths)
- NHS Improvement (NHSI)
- Health and Safety Executive
- Health Education East of England (HEEoE) /East of England (EoE) Deanery when a doctor in training is involved via Director of Medical education or Medical Director.

6.12.5 The Trust will, as necessary, also inform organisations with an advisory or analytical function such as:

- Department of Health – Patient Safety & Investigations Branch
- Serious Hazards of Transfusion (SHOT)
- Public Health England National Patient Safety Agency (NPSA), (to whom all incidents must be reported)
- NHS Litigation Authority
- National Confidential Inquiries
- NHSI


6.13.1 If a death occurs on an inpatient ward/ Nursing Home the Care of Deceased Patients Guideline must be followed by staff which outlines actions to be taken to ensure the death is reported to the Coroner without delay, where required. If death occurs the HM Coroner needs to be informed if:

a) the deceased died a violent or unnatural death,
b) the cause of death is unknown, or unexpected
c) the deceased died while in custody or otherwise in state detention (for example detained under the Mental Health Act or DoLs).

6.13.2 Where legal advice is required this will be provided in the first instance by the Associate Director of Planning / FOI, DPA & Litigation Manger. The Head of Serious Incidents and Quality will liaise with the Associate Director of Planning / FOI, DPA & Litigation Manager for those cases identified as potentially high risk for the Organisation or where staff preparation and support for attending an inquest as a witness is required.
6.14 **Commissioners**

6.14.1 When the decision is taken that an incident meets Serious Incident reporting criteria the Head of Serious Incidents and Quality or nominated deputy will be responsible for reporting using the STEIS system to the CCG within 2 working days of the date of incident or date of knowledge.

6.15 **National Reporting and Learning System**

6.15.1 The Risk Management Department will upload incidents using the National Reporting and Learning System.

6.16 **NHS England / NHS Improvement**

6.16.1 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.

6.16.2 When a homicide occurs, NHS England is responsible for identifying whether an incident meets Department of Health guidance HSG (94) 27 LASSL (Local Authority Social Services Letters ) (94) (4). Independent investigation of adverse events in mental health services. If a homicide is felt to meet criteria for an independent investigation NHS England will commission the investigation and be responsible for the publication of the report.

6.17 **The Care Quality Commission (CQC)**

6.17.1 The Trust is required to report the following incidents to the CQC:

- Unexpected deaths of services users detained or likely to be detained under the Mental Health act – managed by the Mental Health Act Administration Manager
- Absences of leave/absconing of a person detained or liable to be detained under the Mental Health Act – managed by the Mental Health Act Administration Manager
- All deaths of people using the Trust’s services – managed by the Head of Serious Incidents and Quality
- Allegations of abuse of patient /residents – managed by the Associate Director for Safeguarding
- Events that may stop services or stop them running properly– managed by the Head of Serious Incidents and Quality
- Serious injuries to patient /residents – managed by the Head of Serious Incidents and Quality

6.17.2 Further guidance on reporting to the CQC is given in Appendix 16, Protocol for reporting to the CQC, with forms for reporting.
6.18 **NHS Litigation Authority**

6.18.1 The FOI, DPA & Litigation Manger will notify the NHSLA when a formal claim has been made to the Trust in conjunction with the appropriate Director.

6.18.2 The Trust is committed to a “lessons learnt” strategy to identify trends and risk issues highlighted by any claims in order to avoid and/or reduce the chance of any future recurrence. The NHS Litigation Authority Policy and procedure (supports the identification of contributing factors to incidents and any trends of poor practice and will ensure that these are reported appropriately to the Trust’s Risk Management Team. Claims information also contributes to the aggregate analysis of claims, complaints and incident data.

6.19 **NHS Improvement (NHSI)**

6.19.1 NHSI is an independent body accountable to Parliament and regulates NHS Trusts to ensure compliance with the NHS Provider Licence and the NHSI Single Oversight Framework. The Single Oversight Framework details a number of performance and quality indicators applicable to services delivered by EPUT. The Executive Director lead will make recommendation in relation to which incidents will be notified to NHSI on a case by case basis in line with the Single Oversight Framework and Trust governance arrangements.

6.20 **Responding to enquiries from the public**

6.20.1 All enquiries relating to incidents made by the public must be handled sensitively. An appropriate response to the level of seriousness will be determined at Executive Director level. Where relevant a “Hotline” will be established.

7.0 **INVESTIGATION OF INCIDENTS**

7.1 It may be a matter of judgement as to the nature, severity and level of investigation. Local managers will be guided by this policy but should discuss as necessary any incident with their superiors and/or other staff/services such as the Risk Management Team, the Head of Serious Incidents and Quality, or the Infection Control and Safeguarding Teams to ensure that the incident is investigated appropriately. In general, incidents will be investigated as follows.

7.2 Where a patient/resident harm grading is no harm, near miss, or low harm the Datix incident report requires completion of the appropriate sections of the Datix manager’s form. Witness statements must be completed and attached. An explanation of what happened, why it happened, what action has been taken to prevent recurrence and any lessons learned should be recorded.

7.3 Where there is a patient/resident harm grading of moderate and not classified as a Serious Incident, then it will be investigated and requires the completion of an initial review report using the template in appendix 13. This report will be commissioned by the service director and will follow the principles of Root Cause Analysis (see Appendix 08). Once approved, learning from the incident will be fed back to the Learning Oversight Sub Committee to support
organisational learning. The report will be attached to the Datix record for the incident.

7.4 There may be cases where an incident has a high impact for the Trust but does not meet criteria for reporting as a Serious Incident. These are called Critical Incidents. In such cases the Executive Medical Director and Executive Director of Nursing will determine the appropriate level of investigation following review of the 3 day report.

7.5 Careful consideration needs to be given to the conduct of any NHS investigation once a matter has been referred to the police and/or HSE in accordance with the Memorandum of Understanding. (see Appendix 01). Immediate patient/resident and staff safety must be assured but further investigation will take place. The Executive Director of Mental Health/Executive Nurse and the Head of Serious Incidents & Quality or nominated deputy will determine what arrangements are required to coordinate with other agencies.

7.6 It may be necessary to access additional advice from specialist agencies such as: the Health and Safety Executive (HSE), the Medicines and Healthcare products Regulatory Agency (MHRA), the Police or Environmental Health Agency (EHA) etc. It will be the responsibility of the nominated investigator to contact such agencies where it is felt to be required and appropriate.

7.7 For all types of investigation consideration must be given to involving internal and external stakeholders, where identified as appropriate, by the review team.

8.0 INVESTIGATION OF CRITICAL / SERIOUS INCIDENTS – SUMMARY OF PROCEDURE

8.1 The Trust fully supports the Seven Key Principles in the management of all serious incidents:

- Open and Transparent
- Preventative
- Objective
- Timely and Responsive
- Systems Based
- Proportionate
- Collaborative

8.2 As such the principles and methodology of Root Cause Analysis will be applied to all critical and serious incident investigations to identify care and service delivery problems, contributory factors and a root cause or causes. Human Factors investigation methodology can also be used if staff have received the appropriate training.

8.3 The nominated investigating lead and a medical member of the review team will undertake investigations of all serious incidents other than falls, pressure ulcers, or information governance breaches. This list will be held and maintained by the Head of Serious Incidents. A commissioning email outlining
the type of investigation required & the due date for submission of the report will be sent to the review team and other relevant internal stakeholders by the Serious Incident Team.

8.4 For level 1 concise investigation (other than for falls, pressure ulcers or information governance breaches), the nominated investigating lead will be responsible for undertaking the investigation and producing a final report demonstrating the use of Root Cause Analysis methodology and making SMART (specific, measurable, attainable, realistic and timely) recommendations that relate to the findings.

8.5 Once completed the Serious Incident Team will send the draft final report to the relevant Associate Director or Locality Director to review and sign off the report from an Operational perspective prior to sending the report to the Head of Serious Incidents & Quality or nominated deputy. Sufficient time for this part of the process should be given.

The final report will then be sent to the Executive Medical Director, the Executive Director of Mental Health/Executive Nurse and the responsible Executive Director for final Executive review and approval.

8.6 For level 2 comprehensive investigations the same process for Operational review and approval will be followed by the Serious Incident Team. The report will then be presented to the Executive Operational Sub Committee for final approval.

8.7 **Level of Investigation and Timeframe for completion**

The information below sets out the types of investigation that should be carried out for level 1 and level 2 investigations as set out in the NHS England Serious Incident Framework.

8.8 **Level 1 – Concise Internal Investigation**

8.8.1 Concise root cause analysis (RCA) investigations may be commissioned for incidents involving No Harm and Low Harm and/or where the circumstances are very similar to other previous incidents.

8.8.2 In these cases it is more proportionate to use a concise RCA to ensure there are no unique factors and then focus resources on implementing improvement than conducting comprehensive investigations that will not produce new learning.

8.8.3 **Level 1 Critical Incident** the following reports are required

- Level 1 concise investigation report to be submitted to serious incident team within 30 working days of the date of reporting.

8.8.4 **Level 1 pressure ulcer serious incidents** the following reports are required:

- Pressure ulcer RCA submitted to CCG within 60 working days of date of reporting (RCA Template included as Appendix 12)
8.8.5 **Level 1 fall/fracture** serious incidents the following reports are required:

- Initial report submitted to CCG *within 3 working days* of date of reporting
- RCA final report submitted to CCG *within 60 working days* of reporting
  (RCA template included as Appendix 18)

8.8.6 **All other level 1 serious incidents** the following reports are required:

- Initial report submitted to CCG *within 3 working days* of date of reporting
- Final report to be submitted to serious incident team *within 40 working days* of reporting
- Final report and completed action plan submitted to CCG *within 60 working days* of reporting

8.9 **Level 2 Comprehensive Internal Investigation**

8.9.1 Comprehensive RCA for incidents involving moderate and severe harm or death. This should be the default level for most incidents.

8.9.2 For **level 2 critical incidents** the following reports are required:

- Initial report submitted to CCG *within 3 working days* of date of reporting
- Final report to be submitted to serious incident team *within 40 working days* of reporting

8.9.3 For **level 2 serious incidents** the following reports are required:

- Initial report submitted to CCG *within 3 working days* of date of reporting
- Final report to be submitted to serious incident team *within 40 working days* of reporting
- RCA final report submitted to CCG *within 60 working days* of reporting

8.9.4 The serious incident report templates are attached in the appendices of this procedure.

8.9.5 The NRLS has issued guidance on Root Cause Analysis investigations. (See Appendix 08). The Trust’s serious incident investigations teams are required to follow Root Cause Analysis methodology and use the templates developed to support these investigations. This process will be coordinated by the Head of Serious Incidents & Quality or nominated Deputy on behalf of the Executive Director of Mental Health/Executive Nurse.

8.9.6 A programme of Root Cause Analysis Training will be provided by the Trust for those staff required to undertake investigations using this methodology. In accordance with good practice guidance the Trust will ensure that at least one member of a review team is trained in Root Cause Analysis methodology when investigating serious incidents.
9.0 INVESTIGATION OF SERIOUS INCIDENTS WHERE A CRIMINAL INVESTIGATION IS ALSO ONGOING

9.1 Management of Serious Incident Investigations/criminal investigations

9.1.1 Careful consideration needs to be given to fulfilling the requirements for a Serious Incident investigation if it is also subject to a potential criminal investigation by the police and/or HSE in accordance with the Memorandum of Understanding. See Appendix 01. A decision will be taken on a case by case basis in conjunction with the relevant agencies about what actions are required to ensure patient/resident and staff safety and to enable NHS investigations to take place whilst not interfering with the criminal investigation process. This process will be coordinated by the Head of Serious Incidents & Quality on behalf of the Executive Director of Mental Health/Executive Nurse.

9.1.2 For homicide investigations the Chief Executive will commission an Executive Director to chair a review panel. Terms of Reference will be agreed by the Executive Operational Sub Committee.

9.1.3 In accordance with Being Open principles due consideration should be given by the review panel to involvement of the patient / resident and their family in the review process. Due consideration should also be given to contact with the victim and alleged perpetrators family through the Police Family Liaison Officer or Witness Support services to ensure their views are sought and considered.

9.2 Domestic Homicide Reviews

9.2.1 The Associate Director for Safeguarding is responsible for the corporate oversight of Domestic Homicide Reviews with the Executive Director of Mental Health/Executive Nurse.

9.2.2 Domestic Homicide Reviews (DHR’s) were established on a statutory basis under section 9 of the Domestic Violence, Crime and Victims Act (2004). This provision came into force on 13th April 2011. These are conducted via the Community Safety Partnership within the appropriate Council.

9.2.3 A DHR is a review of the circumstances in which the death of a person aged 16 or over has, or appears to have, resulted from violence, abuse or neglect by a :

- Person to whom he was related or with whom he was or had been in an intimate personal relationship, or
- A member of the same household as himself

9.2.4 The purpose of a DHR is to:

- Establish what lessons are to be learned from the domestic homicide regarding the way in which local professionals and organisations work individually and together to safeguard victims
Identify clearly what those lessons are both within and between agencies, how and within what timescales they will be acted on, and what is expected to change as a result

- Apply these lessons to service responses including changes to policies and procedures as appropriate
- Prevent domestic violence homicide and improve service responses for all domestic violence victims and their children through improved intra and inter-agency working.
- Where children are involved then a separate Serious Case Review for the children may take place via the Local Safeguarding Children Board and the Head of Serious Incidents and Quality will be notified.

9.2.5 Further details about the management of DHR’s and SCR’s by the Trust can be found in the Safeguarding Adult Policy and Procedure (CLP39) and Safeguarding Children Policy (CPG37)

10.0 OVERVIEW OF THE INVESTIGATION PROCESS

10.1 The Trust has fully adopted a Root Cause Analysis methodology for the investigation of all incidents. This methodology requires a questioning attitude that never accepts the first response and uses recognised tool and techniques to identify:

- The Problems (the what?) including lapses in care/acts/omissions
- The contributory factors that led to the problems (the how?) taking into account the environmental and human factors
- The fundamental issues/root causes (the why?) that need to be addresses

10.2 An investigation toolkit with helpful tools, techniques and resources to support an effective investigation has been developed by the NRLS and can be accessed from https://report.nrls.nhs.uk/rcatoolkit/course/iindex.htm

10.3 INVESTIGATION AND SIGN OFF PROCESS

- An investigator will be appointed by the relevant Director of the service involved and a medical practitioner will be appointed by the Deputy Medical Director to assist. At least one of the investigating team will be trained in Root Cause Analysis techniques.
- The Serious Incident Team will draft the Terms of Reference and commission the investigation giving timescales
- Once a draft report has been completed, this should be agreed by the relevant director of the service before sending to the SI Team
- The SI Team will arrange for a “Sign Off” meeting.
- This will be attended by Executive Director of Nursing, Executive Medical Director, Director of Mental Health and Learning Disability Services, Head of Serious Incidents, Consultant Nurse, Suicide Prevention and investigation lead, Director of Specialist Services (if appropriate). The investigators will also attend.
- Once the report has been agreed/amended, it is then sent for final approval by Executive Director of Nursing and Medical Director before being sent to the Commissioners with a populated action plan.
- Learning Oversite Committee where appropriate.
Those involved (including patients, staff, victims, perpetrators and their families/carers) must be informed, involved and supported appropriately throughout.

Opportunities for sharing safety critical information and learning must be shared throughout.

The investigation should be underpinned by a clear terms of reference, robust management plan and communication/media handling strategy (as required).

Those involved (including patients, staff, victims, perpetrators and their families/carers) must be informed, involved and supported appropriately throughout.

Opportunities for sharing safety critical information and learning must be shared throughout.

The investigation should be underpinned by a clear terms of reference, robust management plan and communication/media handling strategy (as required).
11.0 ACTION PLANS FOLLOWING INVESTIGATIONS

11.1 Action plans that are developed as a No/low or Moderate incidents will be implemented and compliance monitored by the responsible directorate and lessons learnt fed back to the Risk Management Department via the Datix reporting form.

11.2 For any Critical Incident, action plans will be developed by the responsible directorate once the internal investigation report is signed off. Monitoring arrangements and accountability for implementation will be specified by the responsible Director and overseen by the operational senior management team meetings. In addition the relevant sub committees will receive the learning and recommendations from the final reports. The Serious Incident Team will monitor the progress for compliance on times and evidence submitted.

11.3 For any Serious Incident where learning is identified, action plans will be developed by the responsible Directorate once the internal investigation report is approved, using the template in Appendix 11.

- The actions will be developed from the recommendations made in the report and progress monitored by the Operational Director though local governance arrangements.
- The Operational Director must ensure that an action plan is populated with leads, target dates, required actions and any progress to accompany the final investigation report when sent to the CCG.
- The Head of Serious Incidents and Quality has oversight of the serious incident action plan process and will escalate any action plans where target dates have not been achieved.
- Completed serious incidents action plans will be submitted to the relevant CCG for closure by the Head of Serious Incidents & Quality. A copy of the action plan and any supporting evidence submitted by Operational Services will be held in the serious incident file on Datix.
- All Serious Incident Action plans to be monitored for implementation/evidence by the SI Team.

12.0 SUPPORTING STAFF AND OTHERS AFFECTED BY AN INCIDENT

12.1 Supporting Staff

12.1.1 The Trust has a policy and procedure in place for Workforce Well-being (Procedural Guideline HRPG26). This provides guidance for arrangements for supporting staff, in line with this policy it is essential to ensure that immediate support and ongoing support is available for staff.

12.1.2 Staff may require differing levels of support during what may be a traumatic time. Every Manager therefore has the responsibility to support their staff on an individual basis. Immediate support must be offered through a 1:1 and ongoing support through regular supervision and 1:1’s as necessary. The zero tolerance policy includes a post incident procedure for violence.
12.1.3 The wellbeing policy provides for a personal support line service to staff. Should it be identified that a staff member involved needs additional support, the manager must make the staff member aware of the service and how to access it. Support offered must be recorded in the staff members’ personal file.

12.1.4 The Contact Freephone number is [redacted] or [link removed]. Username – [redacted]

12.1.5 Further assistance for staff is available through the Employee Assistance Programmes. These can be accessed through the Trust Intranet (InPut).

12.1.6 If there is any staff member at serious risk of personal criminal proceedings or action by any regulatory body they will be advised to contact their trade union for support.

12.1.7 Lead Managers (ward/department manager, Nursing Home managers or senior nurse in charge) are responsible for working to defuse the situation by immediately discussing with staff any concerns they have and following up concerns in 1:1 meetings and regular supervision.

12.1.8 Staff members that are required to make witness statements should refer to Appendix 02 for guidance.

12.1.9 Support from line managers is essential where staff may be called to be witnesses and as outlined above staff should be offered 1:1 sessions with line managers. Line Managers are responsible for ensuring that support has been offered.

12.2 General Considerations

12.2.1 When an Incident or a Serious Incident has occurred the immediate focus will be to ensure the safety and wellbeing of employees, patient, residents, carers/relatives and where possible to meet the practical, physical and emotional needs of all involved.

12.2.2 The responsible manager/nurse in charge has the role of ensuring that those involved in an incident are provided with the consideration, help and support they require. In the event of the responsible manager/nurse in charge being involved in the incident a designated person should take over responsibility for incident management.

12.2.3 The manager or director responsible should ensure a record is kept of support offered or provided to staff as part of the incident management process. Where a staff de brief/support session is held the session will be confidential and should not form any part of the Serious Incident investigation process.

12.2.4 Group defusing/supporting should include those individuals involved in the incident, Bank and Agency staff and staff working night shifts where identified, and other staff who may be affected, as felt to be appropriate by the manager or director leading the incident management process.
12.2.5 Communication with staff affected by a serious incident may need to be both pre and post investigation.

12.2.6 Immediately following a Serious Incident the senior manager or the on-call manager should discuss with staff the potential need for a de brief or support.

12.3 Patient /Residents/Carers

12.3.1 It is important that patients / residents involved or who witnessed the incident are contacted during and after any incident. Patients / residents should be offered immediate support by the lead manager and ongoing support by their Care Coordinator. This is to be recorded in their nursing and medical notes.

12.3.2 Carers and relatives must also be informed of the incident as soon as practicable. Contact should be face to face where possible and details of the discussion with relatives/carers must be recorded in the clinical notes. Other support needs can be considered as part of the Family Liaison Officer process. Patients/residents will be made aware of the services available and how to access these.

12.4 Visitors and Outside Contractors

12.4.1 In some circumstances support may need to be offered to visitors and outside contractors involved in a serious incident. The Lead Manager and Head of Estates should decide what level of support may be necessary. The Head of Serious Incidents can be contacted for advice on a case by case basis.

13.0 INCIDENT ANALYSIS AND LEARNING INCLUDING AGGREGATED ANALYSIS

13.1 The monitoring of all adverse incidents, including Serious Incidents is an integral part of Clinical and Corporate Governance. Details of all adverse incidents, including Serious Incidents will be collected into a central database (Datix) and discussed weekly.

13.2 The Risk Management Team will coordinate regular analysis of incident statistics, including as a minimum: trends, severity and locations and report these monthly to the Health, Safety and Security Committee, who are responsible for incident analysis.

13.3 The analysis will include both qualitative and quantitative data. Any lessons learnt/service changes made as a result of incident analysis will be outlined in the monthly analysis report.

13.4 Outcomes of the Health, Safety and Security Committee and the Clinical Governance Sub Committee will be cascaded by members to their sub committees and directorate meetings.

13.5 The Risk Management Team will provide monthly statistics to the Performance Department to enable the organisation to monitor effectiveness against key performance indicators and report to the Board of Directors.
13.6 Any risks identified through the analysis of incidents will be sent to the relevant directors for assessment and potential inclusion on the risk register.

13.7 The Risk Management Team, Complaints Team and Legal Department will coordinate regular analysis of the three information streams of complaints, incidents and claims to ensure trends are identified across all three areas.

13.8 Coordinated analysis will be undertaken a minimum of 6 monthly and will include both qualitative and quantitative data. Any lessons learnt/service changes made as a result of the coordinated analysis will be outlined in the 6 monthly report.

13.9 The analysis will show the monthly totals for the three streams, broken down into main types or categories, service area or geographical location and presented so that trends or outbreaks of events can be easily compared. The analysis will also seek to extract underlying themes, common to two or more of the information streams, and provide more detailed analysis in areas of interest to promote understanding. The analysis will additionally identify and compare lessons learned over the three streams, highlighting commonalities.

13.10 Coordinated analysis will be provided to the Health Safety and Security Committee, Clinical Quality Sub Committee, Learning Oversight Sub Committee and Senior Management Teams.

13.11 Any risks identified through the coordinated analysis will be sent to the relevant directors for assessment and potential inclusion on the risk register.

14.0 RISK MANAGEMENT AND RISK REDUCTION MEASURES

14.1 The Risk Management Team will monitor incident risks at key stages of the incident process:

- Receipt of the Datix incident form (according to category and severity)
- Following each level of investigation where appropriate
- When analysing incident trends
- From lessons learned
- From action plans

14.2 Following investigation the responsible manager or service lead will, in consultation with the investigating officer, assess any residual risk and submit for inclusion on the appropriate risk register for subsequent further control and monitoring in line with the Trust Risk Management Framework and:

- Notify the appropriate Director, service lead or other responsible Director/senior manager
- Risk assess according to the Framework and develop an action plan; Health and Safety risks will be assessed according to RM11 – General Workplace Risk Assessment Policy
- Submit for inclusion on either local risk registers or where appropriate in the trust risk register depending on the level of risk. This will be done via the identified service board
15.0 LEARNING FROM INCIDENTS INCLUDING SERIOUS INCIDENTS

15.1 One of the key aims of the incident reporting and learning process is to reduce the risk of recurrence, both where the original incident occurred and elsewhere in the NHS. The timely and appropriate dissemination of learning following an incident is core to achieving this and to ensure that these lessons are embedded in practice.

15.2 Learning from patient and organisational safety incidents is a collaborative, decentralised and reflective process that draws on experience, knowledge and evidence from a variety of sources. This will lead to co-production and national sharing of safety solutions and improvements, increased visibility to lessons learned and participation in the learning process leading to enhanced patient and organisational safety.

15.3 Learning can be demonstrated at organisational level by sustainable changes and improvements in process, policy, systems and procedures relating to patient safety within healthcare organisations.

15.4 Individual learning can be demonstrated by sustainable changes and improvements in behaviour, beliefs, and attitudes and knowledge of workers at the front line of healthcare delivery.

15.5 Team leaders and managers will regularly review their own incidents singly and collectively and identify lessons learned. They will share and discuss them with their team and implement improvements where possible. They will do the same with any lessons received from outside the team.

15.6 Senior service leads and Directors will ensure that lessons from incidents – again singly or collectively - will be shared within services through local governance procedures and improvements made where possible. They will do the same with any lessons received from outside the team.

15.7 Under the requirements of the National Serious Incident Framework all organisations with a responsibility for notifying or receiving details of Serious Incidents have a responsibility for the dissemination of learning.

15.8 One of the key aims of the National Reporting and Learning System (NRLS) from the investigation of Serious Incidents is to reduce the risk of recurrence both locally where the incident occurred, and the wider NHS. The Trust has adopted these principles and is committed to learning from all incident reporting, including Serious Incidents.
15.9 The learning process will also be enhanced by the following people and groups, through their various duties. Their contribution is to maintain and operate suitable systems for investigation, analysing incidents individually and collectively and identifying and communicating lessons for sharing. They will also monitor external sources of information to identify lessons and incorporate these into the learning process.

- The Head of Serious Incidents and Quality
- The Risk Management Team
- The Clinical Governance team
- The Clinical Quality Sub Committee
- The Learning Oversight Sub Committee
- The Health Safety and Security Committee
- Information Governance Group
- Other key specialist leads and groups in the Trust’s governance structure

15.10 The Risk Management Team and Head of Serious incidents and Quality will ensure:

- That all Serious Incident investigations aim to identify lessons learned, whether causal or additional, and make SMART recommendations that relate to the findings
- That the report, findings and recommendations are shared with the team or service to enable them to be discussed with the team and involve the team in their implementation
- Lessons learnt or service changes made following investigations and incident trend analysis are shared with those involved in the incident and other staff members.

15.11 The Risk Management Team will be responsible for ensuring that all lessons learnt from incident investigations and aggregation of incident and other data are shared both internally and externally via:

- The intranet (InPut)
- Reports to the Health Safety and Security Committee
- The Clinical Quality Sub Committee
- Annual reports
- Performance reports

15.12 The Head of Serious Incidents will be responsible for ongoing analysis of trends and themes arising from Serious Incidents and will share any areas identified with the Executive Director of Mental Health/Executive Nurse, the Executive Medical Director and the relevant Operational Director. The Head of Serious Incidents will produce regular reports about Serious Incident reporting and management for Trust governance groups and committees.
15.13 Key tools in the identification and sharing of lessons will be:

- Reports and analyses of incidents, complaints, and claims
- The analysis of trends and themes from Serious Incidents
- Serious Incident Learning Summaries
- Trust publications such as Trust Today, Weekly Brief,
- “Skin Matters” for learning on pressure ulcers
- Intranet (InPut) resources
- Annual reports
- External reporting channels
- External information channels
- SMTs / Local Governance Meetings

### 16.0 COMPLAINTS AND CLAIMS

16.1 Links between the complaints, claims and incident systems are essential to ensure that organisational learning takes place.

16.2 Complaints

16.2.1 Any complaint received by the Complaints Department that could be connected to an Adverse Incident or Serious Incident will be identified and sent to the Risk Management Team and Head of Serious Incidents & Quality for cross referencing.

16.2.2 If a complaint arises as part of the Serious Incident process the appointed Complaint Investigator will liaise with the investigator of the Serious Incident as the serious incident report must be used as the basis of the response to the complainant. All complaint responses must be checked to ensure that there is no contradiction. The complainant will be kept informed of progress by the appointed Complaint Investigator.

16.3 Claims

16.3.1 Any incident received by the Risk Management Team that could potentially lead to a claim will be sent to the Legal Department for information. The Head of Serious Incidents & Quality will also alert the Legal Department of any Serious Incident that may lead to a claim.

16.3.2 When a claim is received by the Legal Department it will be linked on Datix to the appropriate incident record enabling the Legal Department to access or request any relevant investigation reports or supporting information from the Risk Management Team or the Head of Serious Incidents and Quality.
17.0 TRAINING

17.1 Following the Trust analysis of training needs Investigation of Incidents and Clinical Risk Training are mandatory/core practice training for staff. All mandatory/core practice training is provided by Workforce and Development. Please see analysis below for staff groups:

<table>
<thead>
<tr>
<th>Statutory / Mandatory Training</th>
<th>Update Interval</th>
<th>Staff Category</th>
<th>Delivery Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Induction Pathway</td>
<td>Once only – no update required</td>
<td>All new starters to the organisation</td>
<td>Direct (to be completed within 4 weeks of start date)</td>
</tr>
<tr>
<td>Core Practice</td>
<td>UPDATE INTERVAL</td>
<td>STAFF CATEGORY</td>
<td>DELIVERY METHOD</td>
</tr>
<tr>
<td>Incident, complaint and claim investigation training</td>
<td>Once only – no update required</td>
<td>All staff</td>
<td>E-learning</td>
</tr>
</tbody>
</table>

17.2 The Workforce Development and Training Department will report monthly on compliance levels for mandatory training for the Executive Team, Workforce and Business Support Service Board and Health, Safety and Security Committees.

17.3 Mandatory Training compliance reports are available on the Trust's intranet site (InPut) identifying which of their staff are up-to-date, when they are approaching update deadlines and those that are out of date. Managers are responsible for ensuring that all gaps are addressed and that staff are trained as required as a matter of urgency.

17.4 Staff who are booked onto mandatory training and are, for whatever reason, unable to attend, MUST inform their relevant Director of their reasons.

17.5 Staff who do not attend a Mandatory course will receive notification from the Mandatory Training Team informing them of their non-attendance.

17.6 Managers will receive a copy of this. Non-attendance will be recorded in the GAP report that managers receive monthly, from this information non-attendees will be automatically re-booked onto another course by the Mandatory Training Team.

17.7 If an individual fails to attend on the second occasion, the service Director will be notified and conduct procedures considered.

17.8 Root Cause Analysis Training will be available for staff Band 6 and above who are required to undertake investigations as part of their role.
18.0 MORTALITY REVIEW PROCESS

18.1 The Trust has an agreed Mortality Review Policy (CP64) which is designed to provide a robust governance framework for the effective delivery of mortality review across the Trust for all deaths that have occurred within Trust provided services or of individuals who have received services in the last 2 years.

18.2 The Policy details the processes to be followed by staff to deliver the requirements of the Mortality Review Framework. This includes a Protocol for the Notification and Recording of Deaths.

18.3 The processes contained within The Policy must therefore be referred to and followed appropriately for any death reported in the Trust. Various requirements in terms of specific action relating to in-patient deaths are also detailed throughout this Procedural Guideline.

18.4 The mortality review processes detailed in the policy are designed to:

- Provide a consistent and coordinated approach for the **review of deaths on an individual basis** to identify any area of practice both specific to the individual case and beyond that could potentially be improved as well as good practice. This enables the Trust to implement and share lessons learned and ultimately ensure that services are as safe and effective as possible.
- Provide a process for the Trust to be able to undertake “**mortality surveillance**” across the Trust – i.e. analysing and understanding the position in terms of overall numbers of deaths and any thematic issues arising and taking action accordingly.

END