Nottinghamshire Healthcare
NHS Foundation Trust

SECTION:	**15 - RISK MANAGEMENT**
POLICY NO:	**15.03**
NATURE AND SCOPE:	**POLICY – TRUST WIDE**
SUBJECT:	**MANAGING SERIOUS INCIDENTS (SI) AND REPORTING AND LEARNING FROM DEATHS**

This procedure determines the responsibility of all staff with regard to the reporting and investigation of all Serious Incidents (SIs).

It defines the requirements for reporting serious incidents to external stakeholders e.g. NHS England, Commissioning Bodies, CQC etc.

It also defines the requirements for reporting and review of known deaths of service user whether or not they are identified as meeting the requirements or reporting as a serious incident.

DATE OF LATEST RATIFICATION:	**SEPTEMBER 2017**
RATIFIED BY:	**EXECUTIVE LEADERSHIP TEAM (ELT)**
IMPLEMENTATION DATE:	**SEPTEMBER 2017**
REVIEW DATE:	**AUGUST 2018 (Extended to December 2018)**
ASSOCIATED TRUST POLICIES & PROCEDURES:	Trust Risk Management Strategy. Reporting of Accidents, Incidents & Near Miss Situations – 15.01. Reporting & Managing Legal Claims against the Trust - 15.04 Complaints -15.05 Public Interest Disclosure (Whistle Blowing) - 11.09 Being Open and Duty of Candour - 15.11 Health & Safety Risk Assessment – 16.20 Dealing with Multiple Enquiries 2.03 Domestic Violence and Abuse17.06 Safeguarding Children - 17.01 Safeguarding Vulnerable Adults -17.04 Prevention & Management of Pressure Ulcers – 1.28 Safe & Secure Handling of Confidential Information – 7.04 Allegations of Abuse Made Against an Employee, Agency Worker, Volunteer, Student or Bank Worker - 17.05

NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST

MANAGING SERIOUS INCIDENTS (SI) AND REPORTING AND REVIEWING DEATHS

CONTENTS

NOTTINGHAMSHIRE HEALTHCARE NHS FOUNDATION TRUST

MANAGING SERIOUS INCIDENTS (SI) AND REPORTING AND LEARNING FROM DEATHS

1.0 PURPOSE

1.1 The purpose of this policy is to provide a consistent interpretation of the 2015 NHS England Serious Incident Framework (SIF), ensuring the management of Serious Incidents (SIs) is clearly defined, embedded and understood across the organisation. https://www.england.nhs.uk/patientsafety/serious-incident/

1.2 This policy outlines the processes and procedures to ensure that SIs are identified correctly, investigated appropriately and, most importantly, learned from to prevent the likelihood of similar incidents happening again.

1.3 This policy sets out the reporting arrangements, actions to be taken, and by whom, in the event of SIs. It will ensure that there is a consistent approach to the management of SIs and that staff at all levels are aware of their roles and responsibilities in the reporting and management of such events.

1.4 This policy also sets out the process for reviewing all known deaths of service users, whether or not they meet the definition of an SI in accordance with the National Quality Board's National Guidance on Reporting and Learning from Deaths. https://www.england.nhs.uk/publication/national-guidance-on-learning-from-deaths/

1.5 It describes the arrangements for undertaking a systematic investigation that looks beyond the actions of individual staff to the circumstances, both local workplace & organisational, in which they were working. This may include using a human factors approach.

1.6 This policy is separate from the 15.01 Incident Policy, which focuses on effective reporting and management of all incidents, accidents and near misses. However, this policy will need to be read in conjunction with 15.01.

2.0 DEFINITIONS

2.1 **Serious Incident (SI)**

A **Serious Incident** (SI) is defined in the NHS England Serious Incident Framework. In broad terms, serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. See section 6.1.1 for the full definition.

Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare.

Serious Incidents occurring within Rampton Hospital are subject to the National High Secure Hospital Services Serious Incident Reporting Policy and Serious Incident Definition Set (2013) which outlines additional reporting criteria. See Section 6.4.1

2.2 **Never Event**

Never Event Incidents are serious, preventable patient safety incidents that should not occur if the available preventative measures have been implemented by the healthcare provider. These are reviewed on an annual basis and are available on the Department of Health website. https://www.england.nhs.uk/patientsafety/never-events/

2.3 **Investigation**

The act or process of investigating; a systematic analysis of what happened, how it happened and why. This draws on evidence including physical evidence, witness accounts, policies, procedure, guidance, good practice and observation – in order to identify the problems in care or service delivery that preceded an incident to understand why it occurred. The process aims to identify what may need to change in service provision in order to reduce the risk of future occurrence of similar events. These will be either a Level 1 (concise) or Level 2 (comprehensive) investigation (see section 7).

2.4 **Case Note Review**

The application of a review of case notes/ clinical records to determine whether there were any problems in the care provided to a patient in order to learn from what happened.
NB: The Trust is currently developing the process which will be rolled out incrementally.

2.5 **The Strategic Executive Information System (STEIS)**

STEIS is the national database for reporting and learning from the most serious incidents in the NHS. The divisions are responsible for recording serious incidents onto STEIS. This is how our commissioners and the CQC are informed of all serious incidents that are reported in accordance with the NHS England Serious Incident Framework.

2.6 **Non STEIS Serious Incidents**

There are some incidents that will be considered as serious internally but do not meet the definition of a reportable incident in accordance with the NHS England Serious Incident Framework. These are reportable internally on Ulysses and to the weekly Serious Incident Review/Issues Group. They are likely to require a Level 1 (concise) investigation.

2.7 **Regulation 28**

The Coroner has a legal power and duty to write a report following an inquest if it appears there is a risk of other deaths occurring in similar circumstances. This is known as a 'report under regulation 28' or a Preventing Future Deaths Report (PFD) because the power comes from regulation 28 of the Coroners (Inquests) Regulations 2013. The Executive Medical Director is responsible for liaison with the Coroner and the Trust must reply within 56 days to say what action we plan to take or have taken already.

2.8 **National Reporting and Learning System (NRLS)**

The National Reporting and Learning System (NRLS) is the central database of all patient safety incident reports. The Trust regularly submits data to this national database which is analysed nationally to identify hazards, risks and opportunities to continuously improve the safety of patient care on a national basis. Reports are produced every six months by NHS Improvement. The NRLS also shares information on incidents to the Care Quality Commission.

3.0 DUTIES AND RESPONSIBILITIES

3.1 **Executive Medical Director**

The Executive Medical Director has responsibility for the development and strategic implementation of this policy. Ensuring the processes are in place so that meaningful information about incident reporting and management is presented to and reviewed by the Trust Board or designated sub-committees.

3.2 Executive Directors

All Executive Directors are responsible for ensuring this policy is implemented across the Trust. They are also responsible for ensuring staff have the capacity and capability to implement the policy, have appropriate structures and processes in place to manage serious incidents and reviews of deaths, reporting confirmed SIs to Clinical Commissioning Groups (CCGs) and onto STEIS and for ensuring external agencies, e.g. CQC or HSE are informed, if required. This will be assigned to Division Governance Teams who will also respond to any queries made by CCGs on the outcome and reports of SIs. The Divisional Heads of Governance will be responsible for ensuring that all adverse incidents and near misses are reported and managed in line with this policy; are discussed at Trust/Divisional Clinical Incident Review Creating a Learning Environment (CIRCLE)/Governance meetings and shared with staff.

3.3 Information Governance Manager

The Information Governance Manager is responsible for reporting relevant incidents to the Information Commissioner, in accordance with the Commissioners' guidance.

3.4 Controlled Drugs Accountable Officer and Medicines Safety Officer

The Controlled Drugs Accountable Officer (CDAO) and Medication Safety Officer (MSO) have statutory responsibilities for ensuring that the Trust handles investigations into incidents pertaining to Controlled Drugs and Medication Safety, respectively.

3.5 All Managers

Managers are responsible for ensuring their staff are released for training, are fully assisted and supported throughout the reporting and handling of an SI, serious near miss or other death and receive feedback on the outcome of any investigation. Where staff experience particular difficulties associated with an SI, serious near miss or other death, managers should consider referring the staff member or members to the Occupational Health Department or the Counselling Service.

Managers are responsible for identifying the need for a change in policy as a result of becoming aware of changes in practice, changes to statutory requirements, revised professional or clinical standards and local/national directives, and advising their line manager accordingly.

3.6 All Staff

All staff are responsible for:

- adherence to this policy
- ensuring any training required is attended and kept up to date
- ensuring any competencies required are maintained co-operating with the development and implementation of policies as part of their normal duties and responsibilities

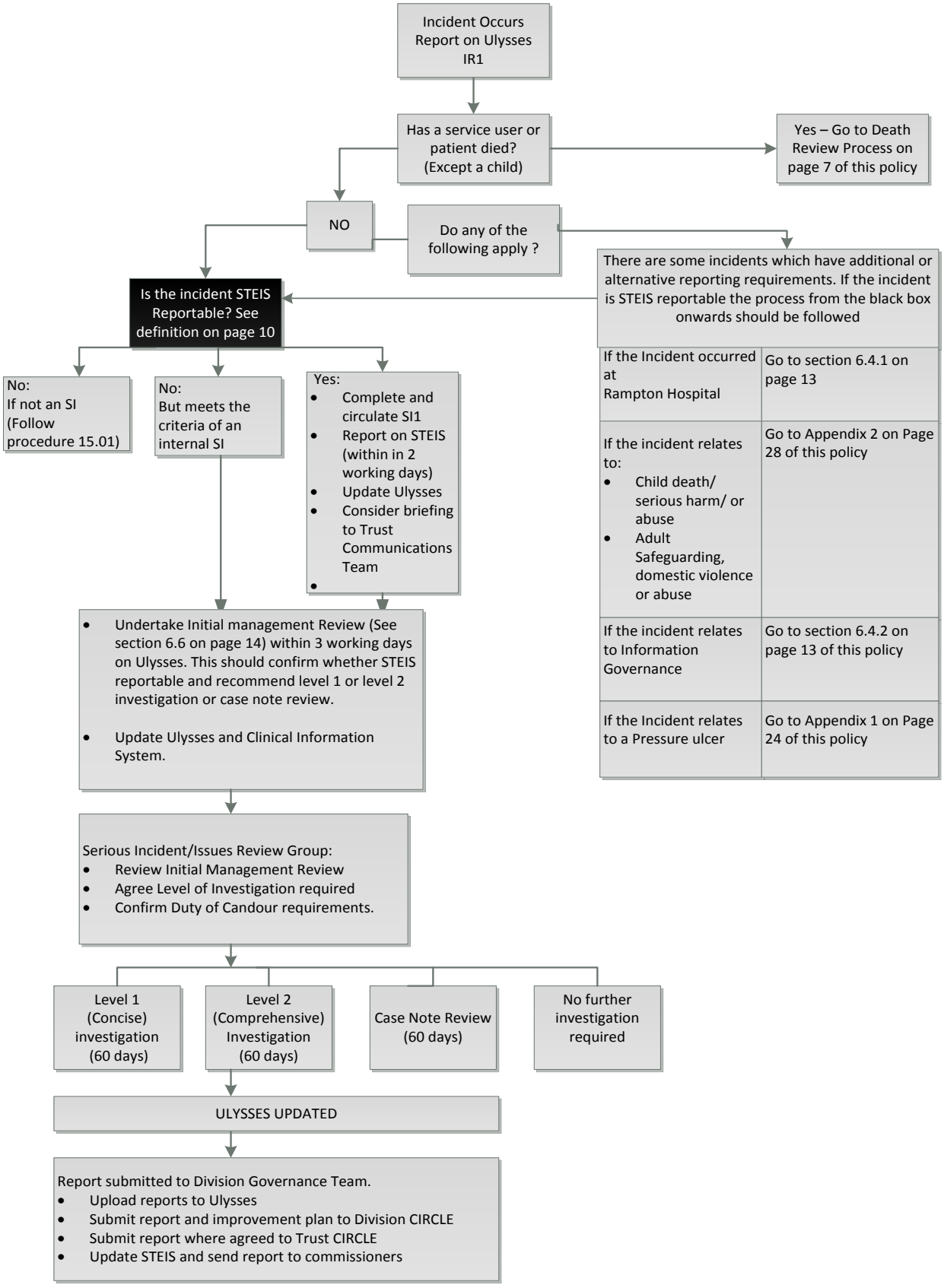
3.7 Trust Serious Incident/Issues Review Group

This Group meets weekly to review all new serious incidents. It provides Trustwide oversight of the reporting and management of serious incidents and ensures: immediate risks are managed, the appropriate level of investigation is commissioned, the Duty of Candour is applied when required, that staff are supported and incidents are communicated in an appropriate and timely manner.

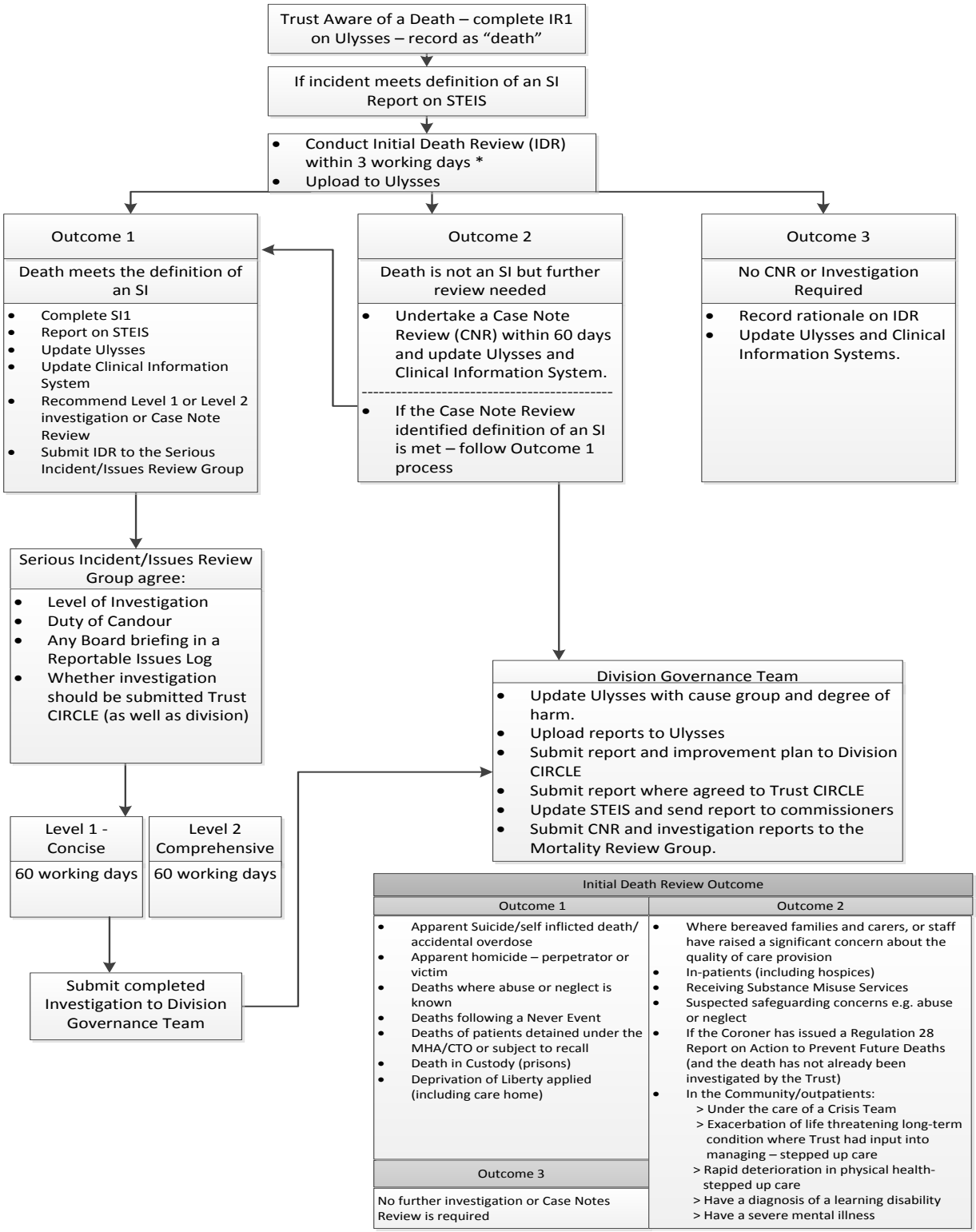
3.8 **Trust Clinical Incident Review Creating a Learning Environment (CIRCLE)**

The Trust CIRCLE Group provides a high level forum in which to oversee and monitor the reporting and review of SIs, ensuring that recommendations arising from SIs investigations are implemented as required and that organisational learning has taken place. In addition CIRCLE will escalate any appropriate risks to the Quality Committee for inclusion on either the Board Assurance Framework (BAF) or the Trust Risk Register. Each Division's own CIRCLE reports to Trust CIRCLE.

4.0 SERIOUS INCIDENTS REQUIRING INVESTIGATION PROCESS



5.0 PROCESS FOR REPORTING AND REVIEWING ALL DEATHS



NB – Outcome 2 – The Trust is adopting the Humber model for Case Note Review, which is a Structured Judgement Review. Until this is fully rolled out, a Level 1 concise investigation will be always be conducted for deaths of services users where families, carers or staff have raised a concern, the service user was an in-patient or had a severe mental illness or learning disability.

If following the Initial Death Review in 3 working days, any of the Outcome 1 or 2 criteria are found to have been met, the process will start from that date.

6.0 PROCESS FOR MANAGING SERIOUS INCIDENTS (INCLUDING DEATHS)

All incidents, including serious incidents are reported on Ulysses in line with the Trust Reporting of Accidents, Incidents & Near Miss Situations – 15.01.

6.1 Serious Incident Definitions

6.1.1 Serious Incidents are unintended and unexpected incidents that occur as part of NHS funded healthcare (including in the community) and include:

- The following deaths:
  - Apparent suicide, self-inflicted death or accidental overdose
  - Apparent homicide – perpetrator or victim
  - Where abuse or neglect is known/suspected
  - Patients detained under the Mental Health Act (1983), Community Treatment Order or subject to recall
  - Death in Custody (Offender Health)
  - Deprivation of Liberty applied (including care homes)

NB: ALL DEATHS SHOULD BE REPORTED AND REVIEWED FOLLOWING THE PROCESS OUTLINED IN THE FLOWCHART ON PAGE 9

- Incidents that result in **severe/serious harm** to one or more people. This is a permanent lessening of bodily, sensory, motor, physiological or intellectual functions related directly to the incident rather than the natural course of the service user's illness or underlying condition. NB – there may be some non STEIS SIs that have only caused low or moderate harm.

- Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent:—
  - the death of the service user; or
  - serious harm;

- Stage 3 or 4 pressure ulcers (These follows a different process, refer to **Appendix 1**)

- Never Events – as defined by the NHS England Framework

- Incidents that prevent (or threaten to prevent) an organisation's ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in a loss of confidence in healthcare services, including prolonged adverse media coverage;

- 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
  - 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 (Refer to **Appendix 2)**

The above is not an exhaustive list of serious incidents and professional judgement will always need to be made. This includes incidents that are considered serious because of their potential risk rather than actual harm caused.

6.2 Immediately Following the Serious Incident

The General or Area Manager/Heads of Services or equivalent will take such steps as necessary to ensure the safety of all persons in the clinical area and that staff are able to continue to operate the service and provide additional support or resources where required.

6.2.1 It is important that the staff on duty are advised to begin to prepare their statements and attempts are made to contact staff not on duty who may be involved in any subsequent investigation. If the Trust is notified of the event sometime after it has occurred it is also important to advise staff to record what they can remember at the earliest opportunity. This is necessary to reduce the risk of important information being lost.

6.2.2 Support for patients, families and staff should be considered, see section 6.7.6 below.

6.3 Reporting Arrangements for Serious Incidents

6.3.1 The General or Area Manager/Heads of Services or Equivalent of the area concerned is responsible for the overall management of the incident and for agreeing in consultation with the relevant Executive Director (or their deputy[1]) whether this should be recorded as a serious incident or not. If there is any doubt, advice can be sought from the Executive Medical Director, Executive Director of Nursing or Associate Director Quality Governance.

6.3.2 Incidents occurring during the out of hours period will be initially responded to by the Senior Manager/Senior Practitioner/Bronze or Silver Command on-call, in liaison with the Executive Director on-call as necessary. Responsibility for the management of the incident will transfer to the appropriate General or Area Manager/Heads of Services or Equivalent at the earliest possible opportunity. The Senior Manager/Senior Practitioner /Bronze or Silver Command on-call who has been dealing with the incident until this time will be responsible for initiating the handover of responsibility.

6.3.3 All incidents – whether SIs or not – must be recorded on the Trust Incident Report Form (Ulysses IR1). Serious Incident (SI1) forms are also required to be completed for all STEIS reportable serious incidents except pressure ulcers.

6.3.4 As soon as the initial SI1 form has been completed it should be electronically forwarded to the individuals identified on the form.
Note: There are different SI forms for each Division and these can be found in the guidance pack on Connect. Please follow: http://connect/incident-and-serious-incident-guidance-pack

[1] Deputy would include Division Deputy Director, Associate Director of Nursing or Head of Governance

6.3.5 SI forms will be circulated through the relevant administration processes as soon as possible once a SI has been authorised. (Distribution lists relevant to the Commissioners are held within the Divisions).

6.3.6 Common to all SI distribution lists must be the following posts:

- Chief Executive
- Executive Medical Director
- Executive Director of Nursing
- Associate Director Quality Governance
- Associate Director Safeguarding
- Head of Communications & Deputy Head of Communications
- Head of Compliance
- Chief Pharmacist
- Others may be included as determined by the Divisions.

6.3.7 Division Governance Teams are responsible for ensuring the reporting of the incident on to STEIS when relevant (the national Department of Health Incident System) in accordance with the relevant Commissioners' SI policies.

6.3.8 All identified serious incidents must be notified to the relevant bodies where appropriate without delay and within **two working days** (excluding weekends and bank holidays). This is when it has been identified that the incident meets the definition of an SI, not necessarily from the date of the incident occurring or reported on Ulysses on an IR1. If there is a delay in reporting the incident as an SI, an explanation will be required to understand the reasons for the delay.

6.3.9 The IR1 form on Ulysses must be updated to reflect any reporting of the incident on STEIS.

6.3.10 In instances where responsibility for part of the agreed care is being delivered by another organisation a decision is to be made with the other provider, in conjunction with the Commissioners as to the most appropriate organisation to complete the SI form. It is essential that the SI should not be recorded by both providers ensuring that any duplication is minimised.

6.3.11 There are a number of Commissioners of the Trust services and these Commissioners have individual requirements for the briefing/communication of SIs. These requirements are contained within the Commissioners own SI policies. The Executive Director or their deputy are responsible for ensuring that the particular needs of their service commissioners are met with regard to the reporting of SIs. These requirements will also include the Commissioners' On Call arrangements for the initial reporting of SIs out of hours.

6.3.12 The responsibility to inform the Chief Executive of an SI will rest with the appropriate Executive Director or their deputy.

6.3.13 The Communications Department has a pivotal role in both "real time" reporting to NHS England and advising on/co-coordinating medium and longer term communications with a range of stakeholders likely to have an interest, including the media. The General or Area Manager/or the nominated deputy (or the Senior Practitioner on-call out of hours) will be responsible for informing the

Communications Department of specific SIs and working closely with them thereafter.

6.4 Specific Serious Incident Reporting Requirements

Some incidents have supplementary or alternative reporting and management arrangements. In addition to any additional processes, the process for serious incidents described above should still be followed.

6.4.1 Rampton Hospital

Serious Incidents occurring within the High Security Services (Rampton Hospital) are also subject to the National High Secure Hospital Services Serious Incident Reporting Policy and Serious Incident Definition Set (2013) which outlines additional reporting criteria. Rampton Hospital has a local procedure covering these requirements – FO/R/35.

6.4.2 Serious Information Governance Incidents

For all incidents involving the loss of personal identifiable data the checklist and risk assessment matrix described in Information Governance Breaches - Appendix 3 within the 15.01 Incident Policy must be used. The use of this matrix will determine whether the incident is reportable as a Serious Incident. A member of the Information Governance Team must form part of the investigation team for all these incidents. Other exceptions or variations to the reporting of SIs may be introduced from time to time. These will be communicated as and when they become apparent.

6.4.3 Pressure Ulcers

See Appendix 1 on page 24

6.4.4 Adult and Child Safeguarding, Including Child Deaths

See Appendix 2 on page 28

6.4.5 Controlled Drugs

Inform the Controlled Drugs Accountable Officer as soon as the incident is reported and seek advice on:

- Investigation requirements
- Requirements with respect to informing the Controlled Drugs Liaison Officer
- Ongoing vigilance and arrangements with respect to Controlled Drugs

6.5 Initial Review of Serious Incidents (excluding deaths)

Following the reporting of the incident on Ulysses using the IR1 form within **1 working day** and the completion of an SI1 form, the appropriate General/Area Manager is responsible for ensuring the completion of the Initial Management Review within **3 working days.** This should:

- Identify and provide assurance that any necessary immediate action to ensure the safety of staff, patients and the public is in place;

- Assess the incident in more detail (and to confirm if the incident does still meet the criteria for a serious incident and does therefore require a full investigation); and

- Propose the appropriate level of investigation – Level 1 Concise or Level 2 Comprehensive or case note review (See section 7.1 below).

- The Initial Management Review Report should be uploaded to Ulysses.

- The Initial Management Review Report will be presented to the weekly Serious Incident Review/Issues Group. This Group will also approve the terms of reference for Level 2 Comprehensive Investigations.

6.6 Reporting and Initial Review of Deaths

6.6.1 Compliance with this section of the policy will ensure the Trust follows the National Quality Board's Guidance on Learning from Deaths.

6.6.2 Reporting Deaths on Ulysses

All known deaths will be reported on an IR1 on Ulysses and recorded as 'Death' with no degree of harm assigned. Staff reporting deaths will not be able to assign any causes/ categories. Following completion of any investigation or review, Ulysses will be updated by Division Governance Teams with the category of death and degree of harm. **See Appendix 3.**

6.6.3 Initial Death Review

The appropriate General or Area Manager is responsible for ensuring the completion of the Initial Death Review **within three working days** of the Trust becoming aware of the death. This should:

- Identify and provide assurance that any necessary immediate action to ensure the safety of staff, patients and the public is in place

- Assess the death according to the criteria below and determine whether Outcome 1, 2 or 3 apply and propose the level of investigation or case note review required

- If at any point it is known that the definition of an SI has been met the death must be reported on STEIS

- Provide details of communication with the family and any information regarding the application of the Duty of Candour

- The Initial Death Review Report should be uploaded to Ulysses.

This review also acts as a triage to determine whether the death should be reported on STEIS as a serious incident and the level of investigation required. The outcome of the Initial Death Review will be either:

Outcome 1 - With the facts known it meets the definition of an SI - this would require reporting on Ulysses & STEIS. An SI 1 should be completed

Or

Outcome 2 - The death does not appear to meet the definition of an SI but does need to be looked at in more detail.

Or

Outcome 3 - There are no apparent issues that need to be explored.

NB: If following the Initial Death Review in 3 working days, any of the Outcome 1 or 2 criteria are found to have been met, the process will start from that date.

6.6.4 Initial Death Review Outcome Criteria Investigation Requirements

Outcome 1 - The definition of an SI is met (see Section 6.1.1), as a minimum this relates to the following deaths:

- Apparent suicide/ self-inflicted death/ accidental overdose
- Apparent homicide – perpetrator or victim
- Deaths where abuse or neglect is known
- Deaths following a Never Event
- Deaths of patients detained under the MHA/CTO or subject to recall
- Death in custody (prisons)
- Deprivation of Liberty applied (including care home)

The Review will propose whether a Level 1 (concise) or Level 2 (comprehensive) investigation is required as per NHS England SI Framework or a case note review and provide rationale for this.

Outcome 2 – The definition of an SI has not been met, however the following apply:

- Bereaved families and carers, or staff have raised a significant concern about the quality of care provision
- Any clinical area where Trust mortality surveillance has identified a concern
- In-patient (including hospices)
- Receiving Substance Misuse Services
- Suspected safeguarding concerns e.g. abuse or neglect
- The Coroner has issued a Regulation 28 Report on Action to Prevent Future Deaths (and the death has not already been investigated or reviewed by the Trust)
- In the community/outpatients:
    - Under the care of a Crisis Team
    - Exacerbation of life threatening long-term condition where Trust had input into managing – stepped up care
    - Rapid deterioration in physical health – stepped up care
    - Have a diagnosis of a learning disability (see Appendix 3 on LeDeR)
    - Have a severe mental illness (On CPA)

If the above apply, a Case Notes Review should be conducted.
NB – The Trust is adopting the Humber model for Case Note Review, which is a Structured Judgement Review. Until this is fully rolled out, a Level 1 concise investigation will be always be conducted for deaths of services users where families, carers or staff have raised a concern, the service user was an in-patient or had a severe mental illness or learning disability

Outcome 3 – The criteria for Outcome 1 and 2 have not been met, therefore no further investigation or Case Notes Review is required. Rationale for this will be

provided. In these cases the final stage will be the completion of the IR2 Form on Ulysses.

The template for Initial Management and Death Review Reports are available in the SI guidance pack; http://connect/incident-and-serious-incident-guidance-pack

6.6.5 Review of Initial Death Review Reports

All Initial Death Review Reports which meet outcome 1 will be reviewed by the Serious Incident/Issues Review Group who will agree the level of investigation to be conducted. In addition the outcomes of all Initial Death Review Reports will be analysed by the Mortality Surveillance Group on behalf of Trust CIRCLE.

6.7 General Management Arrangements for Serious Incidents

6.7.1 Ulysses IR2 Forms

There is a requirement in Policy 15.01 Trust Reporting of Accidents, Incidents & Near Miss Situations for an IR2 Form to be completed. This form still needs to be completed for serious incidents and deaths to record that the Initial Management/Death Review Report has been completed and the plans for any ongoing investigation or case note review. The incident or death should not be closed on Ulysses until the investigation or case note review has been completed and any required Quality Improvement Plan developed.

6.7.2 Communications

Responsibility for developing and managing communications with the media lies with the Communication Department. A Communication Plan will be developed jointly by the Investigation Lead and Communications Manager and approved by the relevant General Manager / equivalent which covers all aspects of communication including the media, MPs, victims, perpetrators, family, legal representatives, staff, pressure groups and other stakeholders where this is appropriate. For incidents involving staff working in an integrated service, the respective communication teams will confirm which organisation is leading the response and for ensuring that robust processes are in place to ensure clear and timely communication between organisations throughout the investigation. The Communication Team will work closely with organisational staff to determine the precise nature, frequency and content of such communication. See Policy: Dealing with Multiple Enquires - Policy Ref: 2.03.

The management of the publication of the investigation report and subsequent media relations will be carried out in line with the existing protocols for communications operating within NHS England.

6.7.3 Briefing the Board

The Executive Medical Director will be responsible for briefing the Trust Board in relation to the most Serious Incidents, including homicide and for providing copies of reports as requested. The most serious incidents will be included on the Trust Board Reportable Issues Log.

6.7.4 Confidentiality of Reports

In the interest of confidentiality, **all reports must be anonymised** so that no individual involved in the incident can be identified from it and password protected (Please refer to the Policy for the Safe and Secure Handling of Confidential Information 7.04).

All information passed between organisations must be password protected to maintain confidentiality (see policy 9.05 Email/Internet General Policy) and sent where possible via nhs.net accounts in line with Trust Information Governance Policies and Procedures. Anyone receiving a password protected document should call the originator for the password.

6.7.5 Incident Co-Ordination Group

This is most likely but not restricted to homicide or inpatient deaths. As incidents of this type are also likely to require the involvement of the police an early decision by the relevant Executive Director or their deputy on their involvement and whether there may be a need to establish an Incident Co-ordination Group as set out in the Memorandum of Agreement between the Police and the NHS (information Sharing) see section 13.4. This should be noted in the Initial Management Review Report.

The purpose of the Incident Co-ordination Group is to provide strategic oversight of the incident and is the forum for communicating, exchanging information and coordinating multiple investigations. This will ensure that the actions of the organisation do not prejudice the work of other organisations involved in the investigation. In instances which it is agreed that an Incident Co-ordination Group is required, the Trust will deal with concerns about patient safety, but not undertake any activity that may compromise subsequent investigations by the police in instances where there is a joint investigation, involving the police. The relevant Executive Director or their deputy will ensure that immediate contact will be made with the Local Security Management Service (LSMS).

6.7.6 Support – Victims, Perpetrators, Families, Carers & Friends

When an incident leading to death or serious harm occurs, the needs of those affected must be a primary concern to the Trust. Any contact should be undertaken in a respectful, non-judgemental, dignified and compassionate manner and in the spirit of openness. The person best placed within the Trust will agree with the patient or families concerned who will be the main contact in accordance with the Trust's Being Open and Duty of Candour Policy (Policy Ref: 15.11).

The victim and family may be offered a meeting by the Trust to inform the investigation process and signpost them to the appropriate support. This should be done in writing should the family not wish to participate in this process this should also be noted.

This may include acknowledging the incident, offering an apology, setting out how the trust proposes to investigate, update reports on progress/delays, providing the next of kin / principal carer with a full copy of the final report (excluding the timeline) and an invitation to discuss the findings of the investigation. The Chair of the Panel will ensure that these communications are fully documented

There may be occasions when Police or Prison Liaison Officers are involved in the support of the family, in these incidents the Trust will be guided by the Police or Prison authorities on when and how to communicate with the family. Communication with prisoner families is included within the Being Open and Duty of Candour Policy.

6.7.7 Supporting Staff

All staff involved in an incident or serious incident must be offered access to the appropriate debriefing process if applicable. Consideration must be given to extending this to other staff that may have left the organisation since the incident occurred. Refer to Preventing Work Related Stress and Ensuring Staff Well Being Policy & Procedure (Policy Ref: 11.15)

Staff involved will also be provided with information about the stages of the investigation and how they will be expected to contribute to the process.

It is the responsibility of the General or Area Manager or their deputy to ensure that all staff involved in an SI are signposted to relevant support.

7.0 INVESTIGATION AND REVIEW OF SERIOUS INCIDENTS AND DEATHS

7.1 Level of Investigation or Review

The proposed level of investigation will be recorded in the Initial Management/Death Review Report in accordance with the grading criteria provided by NHS England and the National Guidance from Learning from Deaths. This will be either a:

- **Level 1 Concise Investigation** – Less complex incidents which can be managed by individuals or a small group at local level

- **Level 2 Comprehensive Investigation** – Complex issues which should be managed by a multidisciplinary team involving experts and/or specialist investigators where applicable

- **Case Note Review** – Completed for deaths that do not meet the definition of an SI but would benefit from a further review. This process is currently being developed

NB – if at any point during the undertaking of a Case Note Review it becomes apparent that the definition of an SI has been met, this must be reported to the Division Governance Team who will report the death on STEIS.

NB –The Trust is adopting the Humber process for Case Note Review, a Structured Judgement Review. This will be implemented through a phased approach prioritising in-patients, severe mental illness in the community, learning disability and where bereaved families of staff have raised concerns. Until this is fully rolled out, a Level 1 concise investigation will be always be conducted for these deaths to ensure they are subject to a review.

The relevant Executive Director or their deputy in conjunction with the General Manager/ Equivalent will develop Terms of Reference for the investigation.

The level of investigation to be conducted will be agreed by the Serious Incident/Issues Review Group. The Terms of Reference, agreed by Division Associate Medical Directors or Associate Directors of Nursing will be forwarded to the investigation panel which will be nominated by the relevant division.

7.2 Incidents Involving Use of Medicines

Any serious incident or death where there are themes with respect to the use of medicines must include a senior pharmacist, nominated by the Chief Pharmacist in the investigation team.

7.3 Investigation Process

The investigation will comprise of a number of distinct phases, some of which will be undertaken concurrently. Systematic investigations should have at least one person on the team who has received training or at the very least have done a number of similar

investigations with an investigation trained person in the past. Guidance on investigations can be found on Connect. http://connect/incident-and-serious-incident-guidance-pack. However the Trust is moving towards a human factors approach to investigations. The Divisions will manage the investigation process through to the completion of the report

Where there are clear issues relating to staff conduct it is acknowledged that the format of a conduct investigation may differ from that of an incident investigation. It is also acknowledged that there may be staff conduct investigations carried out in parallel with the incident investigation in which case there may be a requirement for two separate investigation reports.

It is possible that an incident investigation may also have involvement of the police. In these cases the Police will advise on whether the investigation can continue and in what format so as not to compromise any potential criminal investigation.

7.4 Investigation and Case Note Review Timescales

Investigations into STEIS reported serious incidents are required by commissioners to be completed within **60 working days**. In exceptional circumstances an extension to this time frame can be applied for to the Commissioners by the Divisions on request from Division Governance Teams.

Internal SIs and case note reviews should also be completed with **60 working days.**

There may be occasions where an internal investigation cannot start until an external agency has given the go-ahead i.e. Police, Coroner, Fire Service, Health and Safety Executive, etc. In such cases it may also be possible to coordinate or combine the investigation with the external body.

The Chair of the Investigation Panel will be responsible for ensuring that required timescales are met and that the investigation is carried out in accordance using systematic investigation techniques.

7.5 Consent

In circumstances where the investigation involves a patient their consent must be obtained before any information is shared with family members or carers in line with the Consent to Examination or Treatment – 1.03 policy. If their competence to do so is in doubt or the patient is deceased this must be raised with the Responsible Clinician with reference to the Mental Capacity Act Policy and Procedure (Policy Ref: 8:12).

7.6 Independent Investigations

Some SIs may trigger an independent investigation which will be commissioned by the commissioning body. This is usually after the completion of the Trusts internal investigation and the process will follow the guidance within the NHS England SI Framework.

There may also be occasions when the Trust considers an incident to be serious enough to commission an independent investigation.

8.0 LEARNING FROM SERIOUS INCIDENT INVESTIGATIONS AND REVIEWS OF DEATHS

8.1 The Chair of the Investigation Panel will convene a meeting of the panel to analyse the information that has been collected for the purpose of identifying the underlying causes and any improvements to services required. These will be compiled into a written report which will clearly identify the issues raised and make recommendations for action. This will be forwarded to the relevant Executive Director for sign off.

8.2 Improvement Plan

The General Manager or Equivalent (or their deputies) working in conjunction with the Clinical Director and Executive Director as necessary will agree an Improvement Plan (Appendix 5).

The Improvement Plan will clearly state:

- What issues have been identified
- What outcome any improvements are intended to achieve
- What action is required to achieve the outcome and resolve the identified issue
- Who is leading the improvements
- Timescale for completion

As implementation of the Improvement Plan continues, this will be updated to:

- Provide a RAG rated progress rating
- Progress comments
- Evidence that the desired outcome has been achieved and on-going monitoring arrangements

8.3 Division Review of Serious Investigation Reports, Improvement Plans and Case Note Reviews

Respective Division CIRCLEs (Critical Incident Review Creating a Learning Environment) will be responsible for reviewing completed serious incident investigation reports, approving the Improvement Plan, ensuring adequate arrangements are in place to monitor improvement plans through to completion and receive the completed Plan for sign off. Divisions will ensure they review the outcome of Case Note Reviews and provide learning outcomes to Division CIRCLEs.

8.4 Trust Review of Serious Investigation Reports, Improvement Plans and Case Note Reviews

Divisional CIRCLE will provide learning outcomes from serious incidents to the Trust CIRCLE, who will also receive the investigation reports and improvement plans for the most serious incidents. Trust CIRCLE will develop a Trust Quality Improvement Plan to ensure issues identified through serious incidents and death reviews are captured and track improvement across the Trust.

The Trust Mortality Review Group will receive all Case Note Reviews and provide learning outcomes to Trust CIRCLE.

8.5 Involvement of Other Providers

If recommendations have implications for the practice of staff employed by other provider organisations consideration will be given to providing a copy of the final report. This will first be agreed by the relevant Executive Director.

Where another agency is requested to engage and cooperate in processes to share learning as required following serious incidents but fails to engage this must be escalated to the relevant Divisional Executive Director for information and appropriate action.

8.6 Sharing Learning

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 organisation or the NHS. The timely and appropriate dissemination of learning following a serious incident is core to achieving this and to ensure that these lessons are embedded in practice.

Divisions must have processes in place to identify lessons and disseminate them and ensure where appropriate these are embedded in practice. Some lessons will be appropriate for dissemination to a wider audience and this may be done in the form of, for example, a Learning the Lessons Bulletin.

The Trust CIRCLE Group reporting to the Quality Committee will be the forum for cross-organisational learning.

8.7 Completed Investigation Reports

The reports relating to serious incidents may be shared with the following:

- Relevant Commissioning Body
- Coroner
- Family
- Police
- Safeguarding Team
- Local Safeguarding Children's and Adults Board
- Local Authority
- Health and Safety Executive

The reports may only be shared with those above with the after appropriate sign off of the General or Area Manager/Clinical Director/Associate Director/Executive Director.

9.0 IMPLEMENTATION

This policy has some significant changes to previous policy, particularly the introduction of Initial Death/Management Reviews, Case Note Reviews and the recording of deaths on Ulysses. Full implementation of this policy will not be immediate and therefore implementation will be incremental and subject to evaluation. The plan below identifies the high level actions required and timescales.

Required Action to Support Implementation	**Timescale**
Communicate key changes to the policy in an easy to understand format to teams who are more frequent users.	31/10/17
Develop templates for Initial Management and Initial Death Reviews and publish on Connect	31/10/17
Update current templates for Level 1 (concise) and Level 2 (comprehensive) investigations and publish on Connect	30/11/17
Make required changes to Ulysses relating to: • Ability to record level of investigation being undertaken • Ability to record STEIS information	31/10/17
Adopt Humber model for Case Note Review (Structured Judgement Review) and deliver initial training	31/12/17

10.0 STAFF TRAINING

10.1 Training regarding the incident reporting and investigation procedures will be delivered in various forms for all staff and will be covered in:

- Staff Induction (local)
- Training Needs Analysis
- Essential Skills and Training
- Guidance (available on the Intranet/Ulysses)

10.2 Training for undertaking case note reviews will be developed

10.3 Where managers identify the need for some specific training in this policy and procedure such as investigation training they should contact the Organisational Development Department.

10.4 Training will be provided via the Learning and Development Department for key staff that would be required to participate in Serious Incident Investigation and will include systematic tools and techniques, formal records of attendance will be retained.

11.0 MONITORING COMPLIANCE & ASSURANCE

11.1 Systems must be in place to monitor the implementation and use of this policy at Trust, Divisional and Departmental levels.

11.2 The monthly Board Quality and Performance report monitors the following:

- Number of incidents, STEIS reportable Serious Incidents, Never Events, Patient Safety Incidents and incidents relating to Trust Quality Priorities that occur each month at Division and Trust level. An exception report is provided for any significant variation
- Degree of harm caused by incidents
- Number of incidents occurring in high reporting incident categories, e.g. assaults and self-harm and pressure ulcers.

11.3 The Quality Committee is the committee with responsibility for monitoring and receiving assurance on the implementation of this policy. It receives assurance from Trust CIRCLE.

Quantitative indicators monitored by the Trust CIRCLE Group quarterly at Divisional and Directorate level:

Assurance that managers are reviewing incidents by -

1. Number of SIs reported across the organization (STEIS and Non-STEIS)

2. Assurance that Initial Management/Death Reviews and SI investigations are completed within defined timescales and entered onto STEIS if applicable.

3. Assurance that all improvement plans and recommendations from Regulation 28 letters are implemented and monitored through appropriate divisional governance arrangements e.g. CIRCLE and Divisional governance arrangements.

4. Assurance that potential Duty of Candour incidents are being assessed and where the duty applies that this is being actioned.

Qualitative indicators monitored by Trust CIRCLE

Assurances will be received from Trust and Divisional Governance Groups e.g. CIRCLE Groups, to test the effectiveness of this policy. Trust CIRCLE will also agree with Divisions what audits are to be conducted each year. This may include:

- audit of evidence supporting sustained change against investigation improvement plans
- audit of data quality against the degree of harm reported

11.4 Any improvement plans resulting from investigations following Serious Incidents will be monitored and tracked through the processes relevant within each Division and Trust CIRCLE.

12.0 TARGET AUDIENCE

12.1 All Trust staff including bank and temporary staff, students, trainees, contractors, visitors and volunteers.

13.0 CONSULTATION

- Leadership Council (LC)
- Trust CIRCLE Group

14.0 LEGISLATION COMPLIANCE & EXTERNAL REFERENCES

14.1 This policy ensures compliance with the NHS England Serious Incidents Framework, supporting learning to prevent recurrence, March 2015.

14.2 The Coroners (Investigations) Regulations 2013

14.3 Health and Social Care Act 2014 (Duty of Candour)

14.4 Health and Social Care Information Centre guidance HSCIC Checklist Guidance for Reporting, Managing and Investigating Information Governance Serious Incidents Requiring Investigation (February 2015).

14.5 National Guidance on Learning from Deaths, National Quality Board (2017)

15.0 EQUALITY IMPACT ASSESSMENT

15.1 This policy has been assessed using the Equality Impact Assessment Screening Tool (attached at Appendix 6). Nottinghamshire Healthcare NHS Foundation Trust is committed to ensuring that, as far as is reasonably practicable, the way we provide services to the public and the way we treat our staff reflects their individual needs and does not discriminate against individuals or groups on any grounds.

16.0 CHAMPION AND EXPERT WRITER

16.1 The Champion of this policy and procedure is Dr Julie Hankin, Executive Medical Director; The Expert Writer is Fiona Illingsworth, Associate Director of Quality Governance.

17.0 REVIEW DATE

17.1 This policy will be reviewed and updated as necessary and in any case within a maximum of 3 years to meet the changing demands of the Trust and other external organisations.

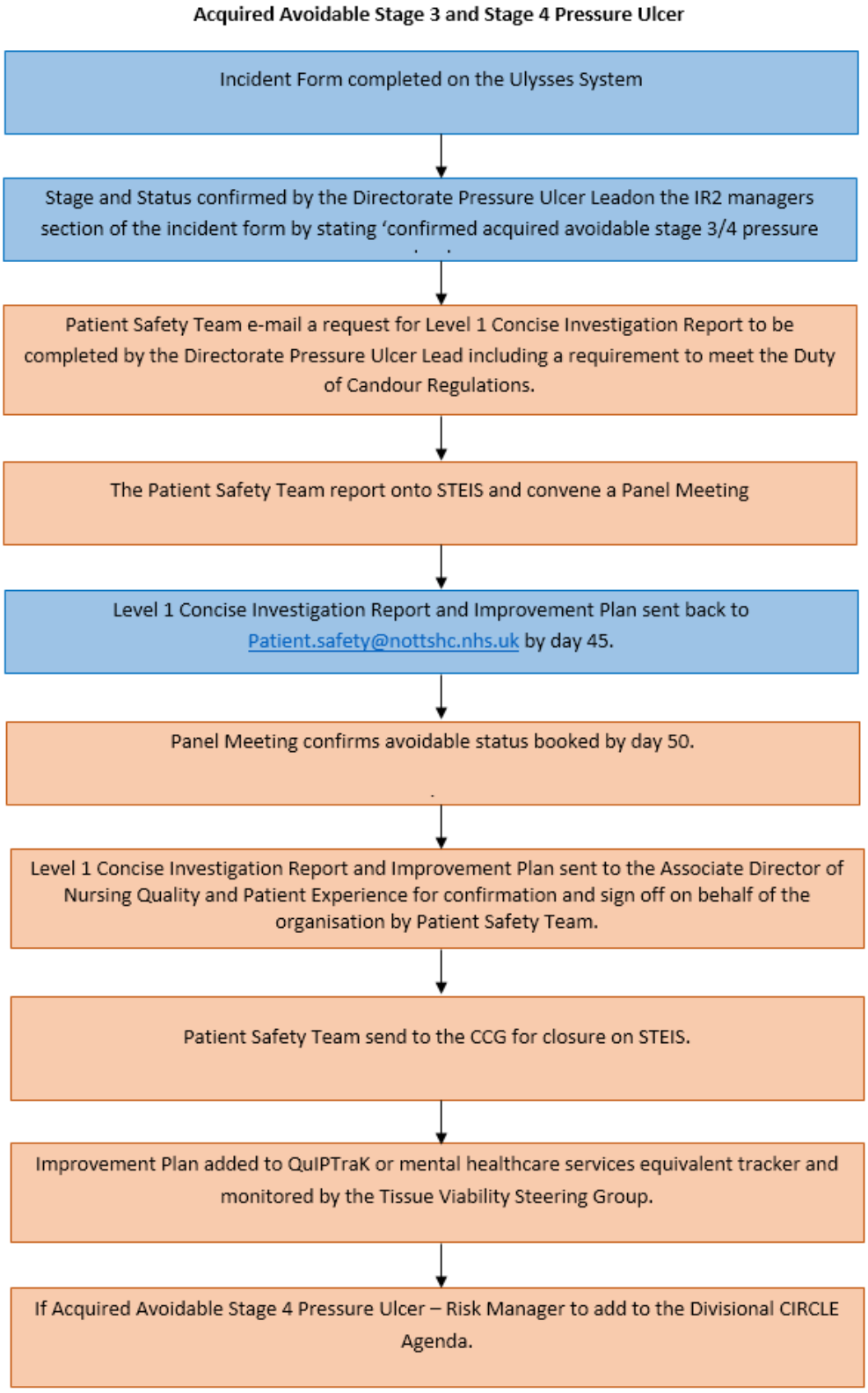
18.0 RELEVANT TRUST STRATEGIES, POLICIES AND PROCEDURES

- Trust Risk Management Strategy.
- Reporting of Accidents, Incidents & Near Miss Situations – 15.01.
- Reporting & Managing Legal Claims against the Trust - 15.04
- Complaints -15.05
- Public Interest Disclosure (Whistle Blowing) - 11.09
- Being Open and Duty of Candour - 15.11
- Health & Safety Risk Assessment – 16.20
- Dealing with Multiple Enquiries 2.03
- Domestic Violence and Abuse17.06
- Safeguarding Children - 17.01
- Safeguarding Vulnerable Adults -17.04
- Prevention & Management of Pressure Ulcers – 1.28
- Safe & Secure Handling of Confidential Information – 7.04
- Allegations of Abuse Made Against an Employee, Agency Worker, Volunteer, Student or Bank Worker - 17.05

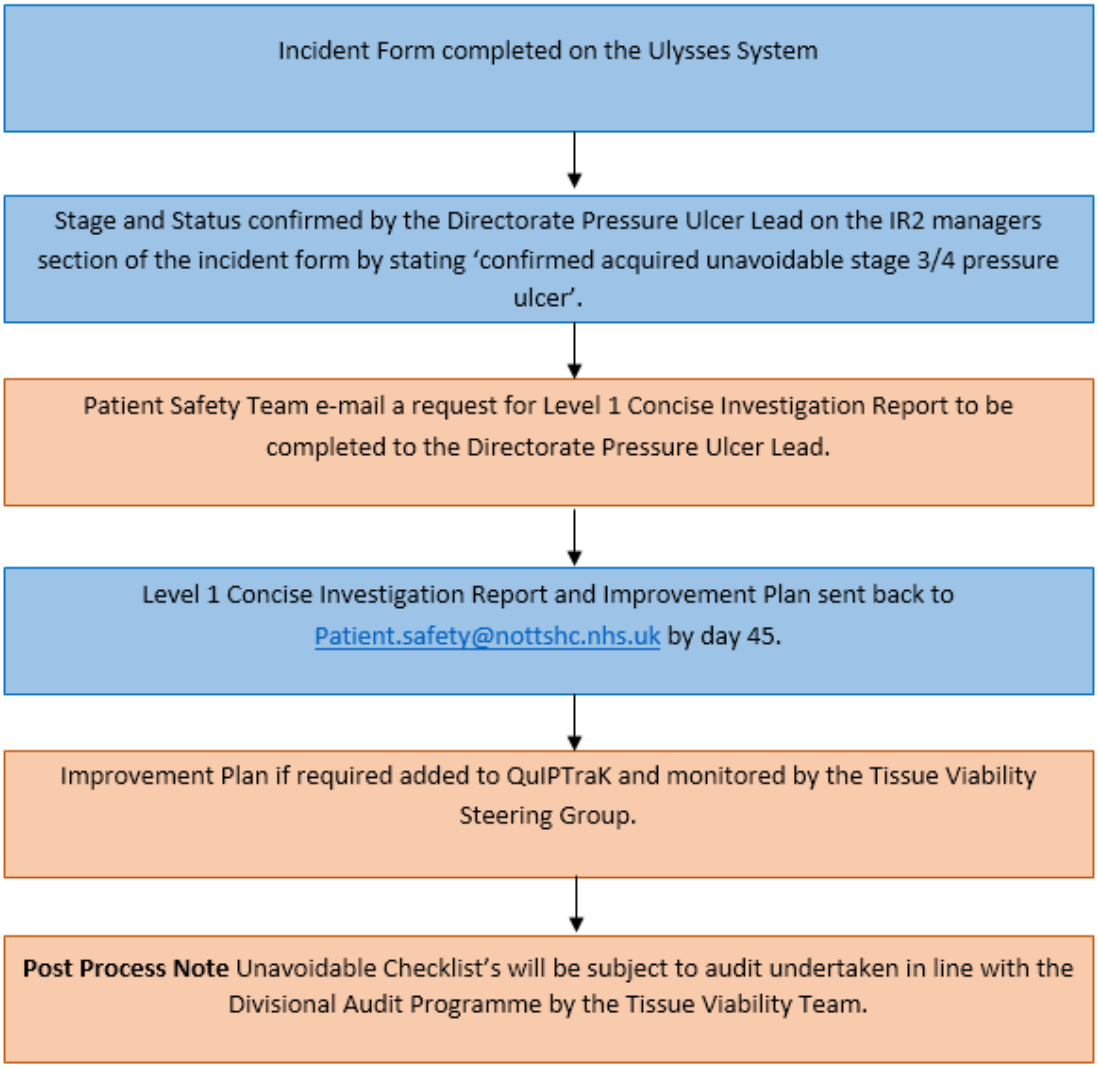
APPENDIX 1

INCIDENT REPORTING AND SERIOUS INCIDENT REPORTING OF PRESSURE ULCERS

Please note that the procedure for the management of pressure ulcer serious incidents is different to the procedure of other types of NHCT organisational serious incidents.



Acquired Unavoidable Stage 3 and Stage 4 Pressure Ulcer



PRESSURE ULCER INCIDENT REPORTING PROCESS

Please refer to the

- Prevention and Management of Pressure Ulcers Policy (01.28)
- Pressure Ulcer Reference Guide 2013

All stages of pressure ulcers whether acquired or inherited stages 1 to 4 (and including Suspected Deep Tissue Injury (SDTI's) will be reported via the organisation's incident and serious untoward incident reporting policy and procedure.

- All stage SDTI, 1 and 2 acquired/avoidable/unavoidable pressure ulcers are to be reported as a Patient Safety Incident.
- All stages of inherited pressure ulcers are by default unavoidable as per SHA definition guidance and are to be reported as a third party incident.
- All acquired avoidable stage 3 and 4 pressure ulcers are required to be reported as a serious incident on STEIS in order to comply with Trust policy and procedure and the NHS East Midlands and East Policy for the Reporting and Management of Serious Incidents.

Please note that acquired avoidable SDTI's are not STEIS reportable until staged as an acquired avoidable stage 3 or 4. Once a staging is completed of an SDTI the original incident form will be amended to record this status. Any SDTI's then staged as a 3 or 4 acquired avoidable at this point will be STEIS reported within 2 working days of this confirmation.

Pressure Ulcer Incident Reporting Requirements

Pressure Ulcer Stage	Inherited	Acquired Avoidable	Acquired Unavoidable
SDTI	Third Party Incident	Patient Safety Incident	Patient Safety Incident
Stage 1	Third Party Incident	Patient Safety Incident	Patient Safety Incident
Stage 2	Third Party Incident	Patient Safety Incident	Patient Safety Incident
Stage 3	Third Party Incident	**Serious Incident/STEIS with Concise Investigation/Duty of Candour applies**	**Patient Safety Incident with Concise Investigation required**
Stage 4	Third Party Incident	**Serious Incident/STEIS with Concise Investigation /Duty of Candour applies**	**Patient Safety Incident with Concise Investigation requirement**

The Procedure for the Reporting of Stage 3 or 4 Acquired Avoidable and Acquired Unavoidable Pressure Ulcers (Serious Incident/STEIS)

- Within one working day member of staff will need to complete an incident form and upload a photograph of the pressure damage to system one.
- The staging and status of the pressure ulcer will be confirmed with the appropriate Divisional Risk Manager in line with STEIS requirements of 2 working days.

- If the staging and status confirms that it is not an acquired stage 3 or 4 pressure ulcer the incident can be resolved within the service as a Patient Safety Incident
- If the staging and status confirms that it is an acquired unavoidable stage 3 or 4 pressure ulcer a concise investigation commences with a 45 working day deadline for completion given to the Investigation Lead.
- The Improvement Plan from the investigation will be monitored via QuIPTraK as per Divisional Procedure.

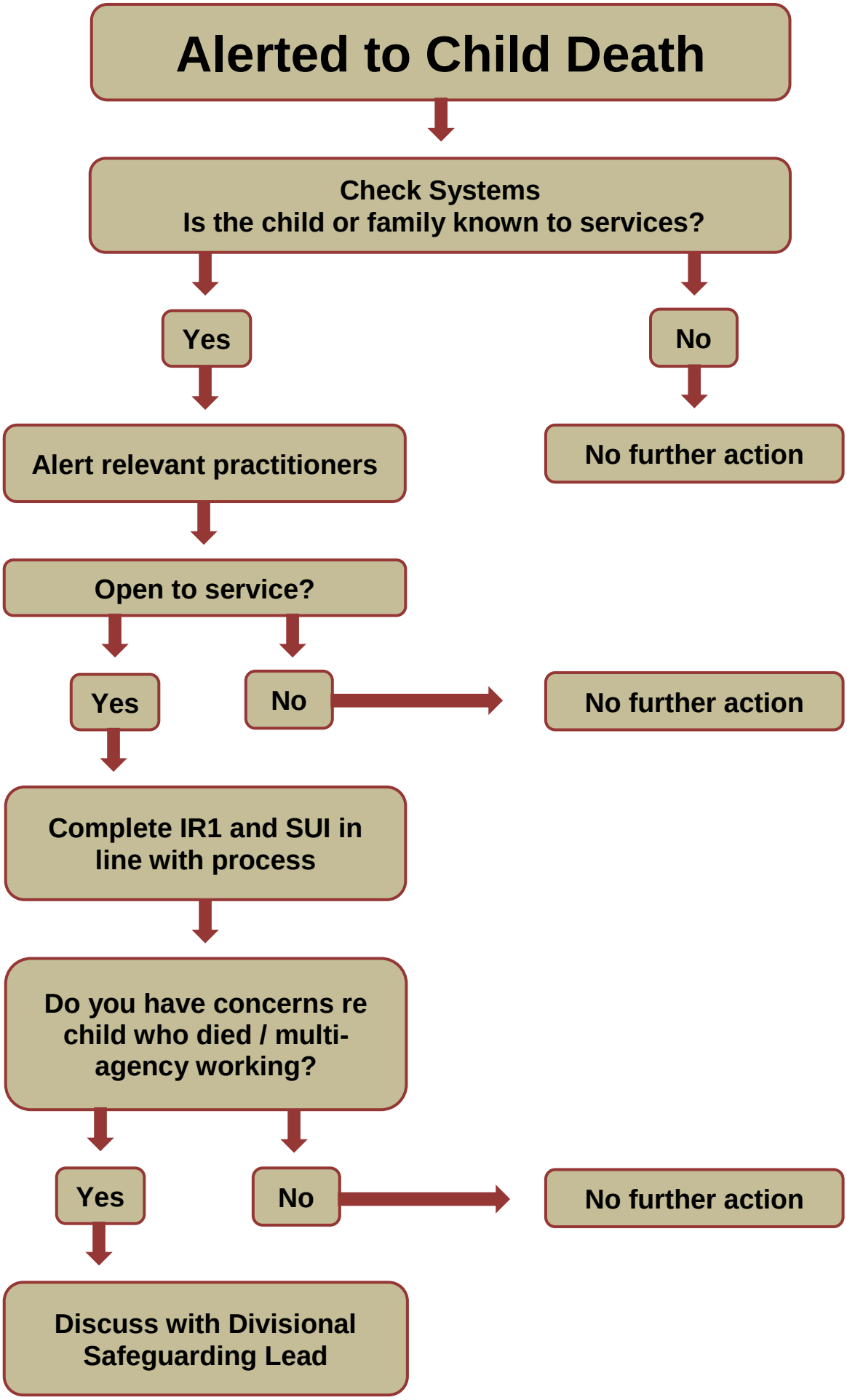
If the Locality Pressure Ulcer Lead confirms

- The staging is an acquired avoidable stage 3 or 4 pressure ulcer the incident is logged onto STEIS as per Trust Policy within two working days of the incident confirmation.
- A concise investigation commences with a 45 working day deadline for completion given to the Investigation Lead.
- The Duty of Candour (DoC) threshold will apply to all acquired avoidable stage 3 and 4 pressure ulcers and the DoC procedure will be required to be actioned.
- A concise investigation report is produced within 45 working days for the Associate Director of Nursing to sign off on behalf of the organisation.
- The concise investigation report is then sent to the Care Commissioning Group (CCG) within 60 working days.
- The Improvement Plan from the concise investigation report will be monitored via QuIPTraK as per Divisional Procedure.

QuIPTraK Improvement Plans including learning themes and trends will be monitored at each meeting by the Physical Healthcare Steering Group with all acquired avoidable investigations submitted to the Divisional CIRCLE Meeting.

APPENDIX 2

CHILD DEATHS AND SAFEGUARDING ADULTS AND CHILDREN



Child Deaths and Children's Safeguarding

1. When a child dies there are two interrelated processes for reviewing child deaths (either of which can trigger a Serious Case Review (Chapter 5 in Working Together):

   - Rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child;

   - An overview of all child deaths up to the age of 18 years (excluding both those babies who are stillborn and planned terminations of pregnancy carried out within the law) in the LSCB area(s) undertaken by a panel.

2. This process is highlighted within the Interagency Safeguarding Children Procedures of the Nottinghamshire Safeguarding Children Board (NSCB) and the Nottingham City Safeguarding Children Board (NCSCB) Procedure, September 2014. It retains references to Working Together 2015 and the Safeguarding Authority (ISA).

3. All child deaths are overseen by the local area Child Death Overview Panel (CDOP) which are aligned to The respective area Child Safeguarding Boards.

4. The CDOPs will receive notification of the deaths of all children from birth to 18 years in their respective areas. Foetal deaths in utero will not be considered by the CDOP nor will planned terminations of pregnancy carried out under the Abortion Act 1967. The death of any child whose birth has been registered should be notified to the CDOP. This should be done via the corporate safeguarding team.

5. Staff across all health communities will report the fact of all child deaths to their respective Designated Paediatrician of Unexpected Deaths (DPUD) or nominee. The Nottingham University Hospitals Trust and Sherwood Forest Hospitals Trust have child death review teams that receive notifications on behalf of the DPUD. The DPUD will ensure that Appendix 1: Form A – Notification of a Child death, is completed and forwarded to the relevant CDOP administrator as soon as possible and in any case within two working days of the child's death. (For children dying outside of Nottinghamshire and Nottingham City, within two working days of being made aware of the child's death. Each CDOP will have a Child Death Function administrator by whom all notifications will be received

6. It is essential that the DPUD or nominee makes clear in this notification whether the case is being treated as an expected or unexpected death.

7. An unexpected death is defined as the death of an infant or child which was not anticipated as a significant possibility for example, 24 hours before the death; or where there was an unexpected collapse or incident leading to or precipitating the events which lead to the death.

8. Where a child dies unexpectedly and healthcare management failures are suspected a Serious Incident Investigation (SI) is undertaken by the registered providers of Healthcare Services. The investigation is notified to, and monitored by, both the Lead Commissioners and the Care Quality Commission as set out in Regulation 6 of the Care Quality Commission (registration) Regulations 2009. The National Framework for Reporting and Learning from Serious Incidents requiring investigation provides further guidance about this process. The Serious Incident Investigation Report should be made available to the CDOP in order to allow the information to be included in the Panel's discussions. These should be also highlighted to the corporate safeguarding team for co-ordination and consideration regarding any staff involved will be required using the Allegations Against Staff policy ref 17.05.

9. Where a child has suffered harm but not died - If at any time it is considered that the child may be a child in need as defined in the Children Act 1989, or that the child has suffered significant harm or is likely to do so, a referral should be made immediately to local authority

children's social care. This referral can be made by any professional, and must be supported by an IR1.

10. As a Trust we also need to consider the following criteria:

    - Did the harm occur on NHS premises
    - Was the harm as a result of NHS funded care
    - Caused by the direct actions of healthcare staff
    - Been in receipt of healthcare services within the last 12 months
    - If any of these criteria has been met a SIS as was as a referral to the local authority will be needed. Additionally where healthcare professional are involved the Allegations Against Staff guidance (policy 17.05) should also be consulted.

11. If a young person under 18 years is admitted to an adult mental health ward or the 136 suite please also refer to the respective policies for guidance. Policy 1703 and 17.05 respectively.

Adult Safeguarding

12. Safeguarding means protecting an adult's right to live in safety, free from abuse and neglect. Organisations have a duty to promote the adult's wellbeing in their safeguarding arrangements. In addition, there is a duty to make safeguarding personal: adult safeguarding arrangements are there to protect individuals and safeguarding action should be person-led and outcome-focused (Care Act 2014).

13. In addition to the responses required where there are concerns around adult safeguarding the Trust should also consider:

    - Did the harm occur on NHS premises
    - Was the harm as a result of NHS funded care
    - Caused by the direct actions of healthcare staff
    - Been in receipt of healthcare services within the last 12 months

14. If any of these criteria has been met a SIS as was as a referral to the local authority will be needed. Additionally where healthcare professional are involved the Allegations Against Staff guidance (policy 17.05) should also be consulted.

15. If concern arise consideration maybe given as to whether the case fulfils the criteria for a Safeguarding Adults Review (SAR). Any referral should be made via the corporate safeguarding team.

Domestic Violence and Abuse

16. Any incident or pattern of incidents of controlling, coercive or threatening behaviour, violence or abuse between those aged 16 or over who are or have been intimate partners or family members regardless of gender or sexuality. This can encompass but is not limited to the following types of abuse: psychological, physical, sexual, financial, and emotional.

17. This definition includes so called 'honour' based violence, female genital mutilation (FGM) and forced marriage, and is clear that victims are not confined to one gender or ethnic group. Please refer to the Domestic Violence and Abuse Policy 17.06

18. Where a homicide occurs that involves the death of a person aged 16 years or over has or appears to have resulted from violence, abuse or neglect by:

- A person to whom s/he was related or with who s/he was, or had been in an intimate relationship, or

- A member of the same household as her/himself, held with a view to identifying the lessons learnt from the death.

19. A domestic homicide review will be commissioned if a service user is involved and consideration as to whether an internal homicide review is also required will be needed. The SI1 and Level 1 Concise and Level 2 Comprehensive Investigation should be followed.

SAFEGUARDING REFERRAL PROCESS

APPENDIX 3

LEARNING DISABILITIES MORTALITY REVIEW (LeDeR) PROGRAMME

The LeDeR Programme is included in the National Quality Board's National Guidance on Learning from Deaths.

Since the 1990s, there have been a number of reports and case studies which have consistently highlighted, that in England, people with learning disabilities die younger than people without learning disabilities. The Confidential Inquiry of 2010-2013 into premature deaths of people with learning disabilities (CIPOLD) found that assumptions were sometimes made that the death of a person with learning disabilities was 'expected' or even inevitable, because that person had learning disabilities. As with the CQC report of 2016[11], CIPOLD also identified deaths that should have been, but were not, reported to mandatory review processes, including safeguarding reviews and to the coroner.

Additional scrutiny should be placed on the deaths of people with learning disabilities and this work has already been started by the LeDeR programme, commissioned by Healthcare Quality Improvement Partnership (HQUIP) for NHS England. Once fully rolled out, the programme will receive notification of all deaths of people with learning disabilities, and support local areas to conduct standardised, independent reviews following the deaths of people with learning disabilities aged 4 to 74 years of age. These will be conducted by trained reviewers.

The purpose of the local reviews of death is to identify any potentially avoidable factors that may have contributed to the person's death and to develop plans of action that individually or in combination, will guide necessary changes in health and social care services in order to reduce premature deaths of people with learning disabilities.

The LeDeR programme has an established and well-tested methodology for reviewing the deaths of people with learning disabilities. All deaths of people with learning disabilities are notified to the programme. Those meeting the inclusion criteria for mortality review receive an initial review of their death by an independent, trained reviewer. The LeDeR programme currently operates independently of, but communicates and cooperates with, other review and investigatory processes. This enables an integrated approach to initial reviews of deaths of people with learning disabilities to be taken whenever possible, so as to avoid unnecessary duplication but ensure that the specific focus of the different review or investigation processes is maintained.

The LeDeR programme is currently being rolled out across England. Full coverage is anticipated in all Regions by the end of 2017. If a Trust wishes to complete its own internal mortality review, it is recommended that it uses the LeDeR initial review process and documentation available at:

http://www.bristol.ac.uk/media-library/sites/sps/leder/Initial%20Review%20Template%20version%201.2.pdf

The provider can then submit that as an attachment to the LeDeR notification web-based platform once their internal review is completed. Once the LeDeR review has been completed, a copy will be sent to the relevant governance body at the Trust where the death occurred.

Trusts are encouraged to identify appropriate personnel to undertake LeDeR training and review processes. Reviewers would be expected to conduct reviews independent of the Trust in which they work.

APPENDIX 4

RECORDING DEATHS ON ULYSSES

Initial Reporting

- Recorded as 'Death' and no degree of harm assigned. Staff reporting deaths will not be able to assign any causes/categories

Death Cause Groups

- These will not be recorded on Ulysses until the cause of death is known and any investigation/review/post-mortem/inquest has confirmed.
- Categorising will be done by governance/risk teams

Cause Group	Cause 1	Mazar's Code
Natural Cause -Expected	End of Life Care – on declared pathway	EN1
	Exacerbation of a life threatening Long Term Condition	EN2 or UN1
Natural Cause - Unexpected	Sudden Death – Cardiac Arrest	EN2 or UN1
	Sudden Death – Other Cause	EN2 or UN1
	Rapid deterioration in physical health	EN2 or UN1
	Rapid deterioration in physical health (Drug/ alcohol related)	EN2 or UN2
	Self-Neglect	UN2
Unnatural Cause	Suicide - Apparent	UU
	Suicide - Confirmed	UU
	Homicide - Victim	UU
	Homicide – Perpetrator	UU
	Accident/ Misadventure	UU
	Accidental Overdose	UU or EU
	Abuse/Neglect/ Self-Neglect *(could also be natural cause)*	UU or UN2
Undetermined	Undetermined	

Degree of Harm

- These will not be recorded on Ulysses until the cause of death and the outcome of any investigation/review is known
- Categorising will be done by governance/risk teams to ensure greater consistency
- DoH 5 (death) equates to 'potentially preventable death' –This will only be using this category when investigation/review identifies causal or contributory factors
- DoH 1 (no harm) – This will be used where the investigation/review has identified no causal or contributory factors.

Mazar's Codes

The investigation by Mazar's into deaths at Southern Healthcare identified codes for categorising deaths which may be required for external benchmarking. Categorising will be done by governance/risk teams to ensure greater consistency

APPENDIX 5

QUALITY IMPROVEMENT PLAN

Title:
Quality Improvement Plan for:

Lead:	**Date Plan Approved:**	**Date Plan Signed off Complete:**
Background/Gap:		

Progress Key

- Positive impact of improvement found. It is embedded into practice and has been signed off by the appropriate forum.
- Improvement considered complete by action plan lead. Evidence of compliance and embeddedness is available.
- Progressing to time, evidence of progress.
- Delayed, with evidence of improvement and agreed actions to get back on track.
- Cause for concern. No progress towards improvement completion. Needs evidence of action being taken to improve.

Issue/Gap Identified	Outcome Required (what do you want to achieve)	Improvements Required to Address Gap and Achieve Outcome	Lead	Timescales			Progress Rating	Progress / Resources Required / Evidence	Ongoing Monitoring and Evidence Outcome Required Achieved	Date Improvement Considered Embedded
				Planed Start Date (--/--/--)	Planned End Date (--/--/--)	Completion Date (--/--/--)				
Record here the actual issue or gap identified. This may be taken from the recommendations section of a report.	The outcome required is what we actually want to achieve. This must be measurable	This is the action we plan to take. There may be more than one action required to achieve the outcome.	Name of one person wo will have ultimate responsibility for leading on the action.	Planned Start Date	Planned End Date	Date Action was completed	Based on progress key (R, A, Y, B)	Use to record: • Progress towards completing required actions • Resources required to achieve outcome • Evidence available to demonstrate actions complete • Issues that are preventing completion of the required actions	When action complete record: • Ongoing monitoring arrangements (to assess effectiveness of the improvements to address the issues) – include what will be monitored and where this will happen. • Outcome of monitoring (e.g. routine reporting or audit)	When evidence by the relevant committee/group and practice is considered to be embedded – RAG rate GREEN

APPENDIX 6

EQUALITY IMPACT ASSESSMENT (EIA) SCREENING TOOL
(Towards an Equality and Recovery Focused Organisation)

A. Name of policy/procedure/strategy/plan/function etc. being assessed:	15.03 Managing Serious Incident and Reporting and Reviewing Deaths
B. Brief description of policy/procedure/strategy/ plan/function etc. and reason for EIA:	This policy defines the requirements for reporting and investigating serious and reviewing all deaths, including those which do not met the requirements of a serious incident. It ensures the requirements of the NHS England Serious Incident Framework are met and how the Trust is working towards the implementation of National Guidance on Learning from Deaths.
C. Names and designations of EIA group members:	Fiona Illingsworth – Associate Director Quality Governance Robert Mooken – Head of Risk and Assurance
D. List of key groups/organisations consulted:	Trust CIRCLE
E. Data, Intelligence and Evidence used to conduct the screening exercise:	Regular reports submitted to the Trust Board of Directors, Trust CIRCLE and Division CIRCLEs will demonstrate that investigations have been undertaken where relevant, that learning points have been identified as part of incident reporting process. A good reporting culture provides the Trust with trends and analysis of incidents which can then focus on areas for further improvements.

F. Equality Strand	Does the proposed policy/procedure/ strategy/ plan/ function etc. have a positive or negative (adverse) impact on people from these key equality groups? Please describe	Are there any changes which could be made to the proposals which would minimise any adverse impact identified? What changes can be made to the proposals to ensure that a positive impact is achieved? Please describe	Have any mitigating circumstances been identified? Please describe	Areas for Review/Actions Taken (with timescales and name of responsible officer)
Race	Yes – positive. This policy will have potential benefits across all of the diversity strands through the identification of learning points and where necessary changes to service models made. It will also ensure that the policy is applied equally across all diversity strands	N/A	N/A	Regular reports submitted to the Trust Board of Directors and Patient Safety Sub Committee. Policy to be reviewed in 3 years by author but may be sooner due to national influences.
Gender **Inclu. Transgender and Pregnancy & Maternity**	As race	N/A	N/A	As race
Disability	As race	N/A	N/A	As race
Religion/Belief	As race	N/A	N/A	As race
Sexual Orientation **Incl. Marriage & Civil Partnership**	As race	N/A	N/A	As race
Age	As race	N/A	N/A	As race
Social Inclusion*[1]	As race	N/A	N/A	As race
Community Cohesion*[2]	As race	N/A	N/A	As race
Human Rights*[3]	As race	N/A	N/A	As race

*[1] for **Social Inclusion** please consider any issues which contribute to or act as barriers, resulting in people being excluded from society e.g. homelessness, unemployment, poor educational outcomes, health inequalities, poverty etc.

*[2] **Community Cohesion** essentially means ensuring that people from different groups and communities interact with each other and do not exclusively live parallel lives. Actions which you may consider, where appropriate, could include ensuring that people with disabilities and non-disabled people interact, or that people from different areas of the City or County have the chance to meet, discuss issues and are given the opportunity to learn from and understand each other.

***[3] The Human Rights Act 1998** prevents discrimination in the enjoyment of a set of fundamental human rights including: The Right to a Fair Trial; Freedom of Thought, Conscience and Religion; Freedom of Expression; Freedom of Assembly and Association; and the Right to Education.

G. Conclusions and Further Action (including whether a full EIA is deemed necessary and agreed date for completion)	Following the completion of an equality impact screening exercise it has been concluded that a full impact assessment is not required. The purpose of this policy is to encourage a positive reporting culture, ensure serious incidents and deaths are investigated or reviewed appropriately and that lessons are identified from trends and analysis which is then shared across the Trust and external stakeholders, where necessary changes to services made.
H. Screening Tool Consultation End Date	5:00pm on Thursday 4 May 2017
I. Name and Contact Details of Person Responsible for EIA (tel. e-mail, postal)	Fiona Illingsworth – Associate Director Quality Governance – 0115 9691300 ext 10126 Fiona.illingsworth@nottshc.nhs.uk
J. Name of Group Approving EIA (i.e. Directorate E&D Group; Divisional Workforce, Equality & Diversity Group; Trustwide E&D Subcommittee; or Divisional Policy & Procedures Group)	Equality and Diversity Subcommittee of the Board of Directors

APPENDIX 7

Title of Procedure:	**Managing Serious Incidents and Reporting and Learning from Deaths**
Issue:	**03**
Status:	**APPROVED**
Authors Name and Title:	**Fiona Illingsworth – Associate Director of Quality Governance**
Issue Date	**27 SEPTEMBER 2017**
Review Date:	**AUGUST 2018 (Extended to December 2018)**
Approved by:	**EXECUTIVE LEADERSHIP TEAM (20/09/2017)**
Distribution /Access:	**Normal**

RECORD OF CHANGES

DATE	AUTHOR	POLICY	DETAILS OF CHANGE
19/9/17	Fiona Illingsworth	15.03	Minor amendments to refer to adoption of Humber model for Case Note Reviews
23/8/18	*Becky Cassidy*	15.03 (issue 2)	Extension of review date from August 2018 to December 2018