Southern Health
NHS Foundation Trust

SH NCP 16

Policy for Managing Incidents and Serious Incidents (SI)

Version: 5

Summary:	This document sets out the requirements for the reporting and management of incidents across the Southern Health NHS Foundation Trust	
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Target Audience:	All staff employed by Southern Health NHS Foundation Trust	
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Version Control

Change Record

Date	Author	Version	Page	Reason for Change
07.03.14	Risk and Business Continuity Officer	2	All	Complete Re-write of Policy in line with updated National Guidance, merging process with Serious Incident Management Policy (now a Procedure) and amalgamating Procedure for reporting incidents to external Agencies.
21.07.14	Risk and Business Continuity Officer	2	8-9	Inclusion of Reporting Guidance adapted from guidance from Commissioners (July 14) on reporting with shared care arrangements for Pressure Ulcers – adapted to apply to all incidents.
21.03.16	Incident and Investigation Manager Kay Wilkinson	3	All	Review of Policy in line with changes to National SI reporting and implementation of Procedure for reporting and Investigating Deaths SH NCP 75
20.01.17	S Pearson	3	Appx 6 & 7	Job Roles for Investigating Officer & Commissioner Manager added in to appendices.
25.01.2017	Incident and Investigation Manager Kay Wilkinson	4	All	Review of Policy in line with changes to organisational change
30.01.2017	H Ludford	4	All	Re-ordering of contents following review by 'Family First' Involvement Group. Refreshing some sections to remove terminology.
11/4/17		4		Review date extended from April to May 17 - awaiting the new national framework document before review can be completed
21/7/17		4		As above – review date extended to January 2018
26/9/17		4		Families First Involvement Group added to reviewer list
22/3/18		4		Review date extended to June 2018
9/5/18	S Pearson	5	9 12	Additional reporting criteria Circulation to Board for catastrophic incidents

Reviewers/contributors

Name	Position	Version Reviewed & Date
Quality and Governance team		V2.0 07.03.14
Quality and Governance Team		V2.1 21.07.14
Information Governance Team		V2.1 21.07.14
Safeguarding Team		V2.1 21.07.14
Professional Leads		V2.1 21.07.14
Clinical and Divisional Directors		V2.1 21.07.14
Mental Health Act Team		V2.1 21.07.14
Infection Control Team		V2.1 21.07.14
Falls Team		V2.1 21.07.14
Tissue Viability Team		V2.1 21.07.14
Health and Safety Team		V2.1 21.07.14
Safer Forum Members		V2.1 21.07.14
Medicines Management Team		V2.1 21.07.14
Medical Device Advisor		V2.1 21.07.14
Local Counter Fraud Specialist		V2.1 21.07.14
Families First Involvement Group		V2

Contents

Policy for the Management of Incidents

1 Introduction

1.1 The National Health Service (NHS) provides effective health care to millions of people every year. Although the majority of these people are treated safe and effectively there is a risk associated with each treatment and evidence shows that things will and do go wrong leading to some people being harmed no matter how professional and dedicated staff are. It is recognised good practice for care providers to recognise and report incidents which occur in services to ensure that learning and improvement takes place.

1.2 Southern Health NHS Foundation Trust (hereafter known as the Trust) provides Health services across Hampshire. As a provider of NHS commissioned services the Trust has a duty to report, investigate and manage incidents through procedures aligned with the national requirements.

1.3 The aim of this policy and the procedures which sit alongside is to support staff to navigate the system of incident reporting, incident investigation and associated learning.

1.4 The document will be reviewed annually aligned with update documents provided by NHS England which set the national standards for incident management.

2 Purpose and Scope

2.1 Our overall purpose is to improve the health, wellbeing and independence of all service users, patients and the public. It is a priority of the Trust to deliver care in a safe environment to protect patients, visitors, staff and the organisation from harm.

2.2 All staff have a legal duty to ensure their own safety at work and the safety of others who can be affected by their acts or omissions whilst at work. All healthcare staff have a professional and ethical responsibility to ensure that service users in their care come to no harm. In order to ensure this the Trust has development of framework for incident report, management and learning which is coordinated by the central Quality Governance team but owned by the operational divisions.

2.3 The framework has been created to follow the best practice of the NHS England Serious Incident Framework published in March 2015 with the Serious Incident and Incident Management team base within the Quality Governance team providing facilitation, monitoring and communication with parties external to the Trust.

2.4 The policy provides a definition of an incident or near miss, and direction in reporting, and management of all incidents, including Serious Incident. This Policy is supported by the Trust's Risk Management Strategy and Policy.

2.5 The framework described within this policy and the associated procedures support an open an honest safety culture where employees are supported to report all incidents including those which have occurred due to human error. The Trust operates its incident management framework in an open and fair blame culture where action against individuals will be considered only if there has been reckless intent, failure to follow Trust Policy or Practice Guidance or have acted outside of their professional boundaries or responsibilities.

2.6 The Trust's approach to investigating and learning from incidents focuses on what went wrong and not who is wrong. However, if staff feel unable to report an incident via the incident reporting system, they should follow 'SH HR 12 Speak Up (Whistleblowing) Policy'

2.7 While the emphasis of investigating and learning from incidents focuses on identifying and addressing failures in systems and processes, in certain circumstances it may be necessary for Disciplinary Procedures to be initiated including occasions where:

- The incident has resulted in a police investigation or an investigation by the Trust's Local Counter Fraud Specialists (LCFS)
- There are repeated occurrences involving the same individual
- In the view of the Trust and/or any professional body, the action(s) causing the incident were far removed from acceptable practice
- There is evidence of an attempt to conceal the fact that the incident occurred or to tamper with any material evidence relating to the incident

2.8 This policy will be read in conjunction with these associated documents:

- SH NCP 17 Procedure for Reporting and Managing Incidents
- SH NCP 60 Procedure for the Management of Serious Incidents that Require Investigation
- SH NCP 75 Procedure for Reporting and Investigating Deaths
- SH HR 12 Speak Up (Whistleblowing) Policy
- SH HR 13 Speak Up (Whistleblowing) Procedure
- SH NCP 12 Duty of Candour Policy
- SH NCP 13 Being Open Procedure (incorporating Duty of Candour)
- SH FP 4 Counter Fraud Policy
- SH CP 145 Care of a Patient after their Death Policy
- SH CP 146 Care of a Patient after their Death Procedure
- SH NCP 61 Guidance for staff when preparing statements (court/police) and attending inquests and court hearings
- SH NCP 9 Inquest Management Protocol
- SH IG 47 Disclosure of Information to the Police Procedure
- SH CP 15.2 Safeguarding Adults Policy
- SH CP 56 Safeguarding Children Policy
- SH CP 10 Infection Prevention and Control Policy
- SH CP 121 Pressure Ulcer Prevention and Treatment Policy
- SH HS 04 Health and Safety Policy
- Local Safeguarding Children Board Procedures

3 Duties / Responsibilities

3.1 **ALL Staff (including agency, bank, students and contractors)** – are responsible and accountable for:

- Ensuring the immediate safety of persons and the environment, ensuring all incidents they are involved in, or witness are reported by the end of shift or within 24 hours.
- Taking appropriate action following an incident to prevent or reduce the chance of the incident re-occurring, escalating concerns where needed, and supporting improvements to work processes following incident investigations and recommendations.
- Raising concerns using Trust policies/procedures as appropriate.
- Completing the Trust organisational induction which includes an overview of incident reporting and keeping up to date with statutory/ mandatory/ essential training

3.2 **Managers of Teams or Services** – are responsible and accountable for:

- Ensuring this policy and associate procedures are applied within their sphere of responsibility; ensuring staff are aware and comply with their responsibilities outlined in this policy.

- Demonstrating that all staff (including temporary staff) have received appropriate training in these arrangements.
- Ensuring that they receive notification of all relevant incidents and complete the "Managers Form" section of the incident report within 10 days of the incident being reported; completing the investigation and recording accurately what has been done, by whom, the outcome, recording the learning to prevent reoccurrence and how this is to be shared with all involved including the individual to whom the incident pertains.
- Ensuring appropriate corrective actions are implemented following an incident, escalating concerns where management is outside of their area of control or where the incident or its impact may affect others.
- Providing staff, service users or other persons involved in the incident with appropriate professional or personal support or access to such support as appropriate.
- TQtwentyone Registered Managers also have a responsibility to report incidents which are covered by Regulation 18 of the Health and Social Care Act (2008) directly to the Care Quality Commission.
- Refer any incident where there is any suspicion of fraud, bribery, corruption or a similar offence to the Trust's security team.
- Ensure that incidents involving staff or patients that are RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences Regulations) reportable are additionally discussed with the Trust's Health and Safety Team.

3.3 **Divisional Directors and Senior Managers** – in addition to the above, are responsible and accountable for:

- Promoting the importance of this policy to all staff, including temporary staff.
- Developing and maintaining a robust governance framework which ensures:
  - All incidents are reported and investigated in accordance with this policy and supporting procedures, all actions required are fully implemented, evidenced and lessons learned are shared.
  - Incident trends are monitored, identifying any trends and outlying events - using this information to support the identification of risks; and taking additional scrutiny and action as required, addressing any concerns.
- Ensuring the Quality Governance team are notified of any service or organisational changes in a timely way to enable maintenance of reporting structures embedded in the Risk Management System supporting electronic reporting: Ulysses Safeguard.
- On-Call Managers and Directors are responsible for informing NHS England of any Major Incident within the Trust, as per the Trust Incident Response Plan

3.4 **The Accountable Officer for Controlled Drugs and Counter-fraud** – is responsible and accountable for:

- Sharing information within Local Intelligence Networks (LIN) in relation to controlled drug incidents and/or fraudulent behaviour of relevant people: in this context a relevant person is anyone who prescribes, dispenses, administers or transports drugs and information will only be shared about those individuals where there are well founded concerns in relation to patient safety. This is in-line with the Statutory Instrument 3148 of the Health Bill in relation to the Accountable Officers Responsibilities.

3.5 **Chief Nurse** – is Executive Lead for Quality and Safety and is responsible and accountable for:

- All aspects of Incident Management within the Trust and ensuring that management arrangements / frameworks are in place to comply with this policy.
- Ensuing that there is a robust reporting structure in place via the Quality and Safety Committee and the Integrated Performance Report to the Board.
- Ensuring that all Executive Directors have sight of the completed investigation reports with a final impact grade of major or catastrophic.

This is monitored through: agendas and minutes from Trust Board, Audit, Assurance and Risk Committee, Quality and Safety Committee and Patient Safety Group.

3.6 **The Chief Executive Officer has**:

Overall accountability for Patient Safety and Risk Management, with the responsibility delegated to the Chief Nurse as the Trust Executive Lead. The Chief Executive is responsible for promoting an effective patient safety and reporting culture within the Trust.

3.7 **The Quality Governance Team will:**

- Act as custodians for the Trust's policies and procedures for the management of incidents and will support the monitoring processes in relation to compliance and implementation.
- Maintain the Safeguard Ulysses Risk Management System coordinating system updates aligned with either:

  Organisational changes – Trust sites and locations

  National policy change from NHS England
- Provide quality assurance review of all of the incidents reported onto the system.
- Provide advice and support to all staff and ensure training, resources and information is available to relating to reporting, managing and investigating incidents.
- Reporting to external agencies as required and listed in Appendix 3.
- Store all accident/incident information for a period of ten years in line with Department of Health guidance for record retention.
- Provide a whole range of reports to different levels within the organisation to enable scrutiny of data, identification of risks and the sharing of learning from all incidents.

This is monitored by the Quality and Safety Committee and Patient Safety Group.

4 Definitions of terms commonly used in incident management

4.1 ***'Incident'*** – an event or circumstance that could have, or did result, in unnecessary damage, loss or harm such as physical or mental injury to a patient, staff, visitors or members of the public: definition provide by the World Health Organisation.

4.2 ***'Near miss' or 'Prevented Incident'*** – Any incident that had the potential to cause harm but was prevented (by chance or appropriate intervention), and resulted in no harm.

4.3 ***'Serious Incident' (SI)*** – Some incidents are classified as Serious Incidents (SIs). This is a term used by the National Reporting and Learning Service (NRLS) for incidents which are critical in terms of impact and may also impact other organisations, the public and may give rise to media interest. The NRLS uses the following definition:

"An accident or incident when a patient, member of staff, or member of the public suffers serious injury, major permanent harm or unexpected death, (or the risk of death or injury), on hospital, other health service premises or other premises where health care is provided

and where actions of health service staff are likely to cause significant public/media concern".

4.4 ***'Never Events'*** – Some Serious Incidents may also be classified as Never Events. This is a term used by the National Reporting and Learning Service (NRLS) for serious events that are preventable by implementing national safe practice. A national list of Never Events are published and reviewed on a yearly basis. The most recent list can be viewed the Department of Health Website: https://www.gov.uk/government/organisations/department-of-health

4.5 ***'Patient Safety Incident'*** – Any incident that has involved or could have affected the safety of one or more service users. Patient safety incidents are reported anonymously to the National Reporting and Learning System (NRLS) database.

4.6 ***'Duty of Candour'*** – This is the legalistic term which describes being open and honest in communication of patient safety incidents that result in moderate harm or death with the patient, service user and family members.

4.7 **Strategic Executive Information System (StEIS)** – A reporting system 'hosted' by the Department of Health; all Serious Incidents are reported onto this system by the Quality Governance team.

4.8 **Initial Management Assessment (IMA)** – A short investigation report which is factual and used to assist decision making as to the level of further investigation required and immediate safety concerns which need to be addressed. The report can either be attached to the Safeguard Ulysses system or be embedded into the manager's incident form. The report in is compiled to support the 48 hour review panel.

4.9 **Root Cause Analysis (RCA)** – Is a formal analysis framework which should be used as part of the methodology when investigating incidents, claims and complaints.

4.10 **Degree of Harm from Incidents -** The severity of the incident is decided on the outcome to the individual due to an act or omission of care, impact on the service or the organisation. The levels are no harm, minor harm, moderate harm, major harm or catastrophic.

5 Standards for Immediate Management of Incidents

5.1 The member of staff who discovers or is informed about the near miss or incident is responsible for informing the most senior member of staff on duty and taking immediate necessary action to ensure the safety of those involved.

5.2 The most senior member of staff is responsible for assessing the situation and taking appropriate immediate action to:

- Ensure the wellbeing of all those involved and ensure the area is safe.
- Manage the incident and minimise potential adverse effects of the incident.
- Minimise the risk of the incident occurring again in the future.
- Inform the patient, service user and / or family about the incident and possible requirement to investigate.

5.3 It should be remembered that the potential exists for the location of the incident to be classified as a "scene of crime", if this is the case, or likely to be the case, the immediate location should not be disturbed more than is essential to provide first aid and should not be cleared or cleaned until authorised by police.

5.4 Where the incident involves a death, the body should not be moved other than for resuscitation attempts.

6 Standards for Reporting Incidents

6.1 The most senior person on duty is responsible for ensuring that the incident is reported by an appropriate member of staff.

6.2 The incident must be reported onto the Safeguard Ulysses Risk Management System, which is an electronic platform.

6.3 All safeguarding concerns must be reported as incidents and also referred to the relevant Adult or Child Services Safeguarding team.

6.4 All incidents where there is any suspicion of fraud, bribery, corruption or a similar offence must also be reported to the Trust's security office.

7 Multiple Providers of Care

7.1 Reporting can be confusing when the patient or service user is receiving care from one or more providers or one or more Southern Health teams. If there is doubt about reporting the Serious Incident and Incident Management team must be contacted for advice.

7.2 Incidents do not require reporting on the Southern Health Ulysses system if:

- The incident is caused by another provider.
- The service user/patient is resident in a care or nursing home which is not managed by Southern Health.
- The service user/patient is being seen at least 3 times a week for personal care not provided by Southern Health.

7.3 Incidents that must be reported:

- All child or adult safeguarding concern regardless of shared care arrangements.
- All pressure ulcers acquired in our care, or present on admission/referral to our care.
- Incidents where a Southern Health staff member was present; involved in or witness to an incident involving our service user/patient.
- The incident relates directly to treatment, care or support we are providing.
- An incident occurs on Southern Health managed premises to any person including visitors.
- The suicide or suspected suicide of a person who was a current service user/patient or who had been under our care.
- Where a death has occurred where an act or omission of Southern Health may have caused or contributed to the outcome.
- Any death of a current service user/patient that is reported to the Coroner.

8 Recording and Grading the severity and Impact of the Incident

8.1 The incident report is to contain factual information and clinical judgements only, statements of opinion or assumptions must not be included.

8.2 The Trust is required to report some incidents to external agencies and stakeholders. This depends on a variety of other criteria, detailed as Appendix 3.

8.3 The incident is graded to indicate both potential severity and the actual impact which indicates the level of investigation required. Impact influencing the grading must be directly related to the incident, not relating to a pre-existing condition.

8.4 Information Governance incidents follow specific potential severity grading based on Information Commissioner Guidelines.

8.5 The actual impact definitions are based on the National Reporting and Learning Service (NRLS) definitions.

8.6 The severity of the incident is decided on the outcome to the individual due to an act or omission of care, impact on the service or the organisation. The levels are no harm, minor harm, moderate harm, major harm or catastrophic. Incident procedure documents provide full explanation of the grading process.

9 Management and Investigation of Incidents

9.1 The "Manager's Form" investigation section of the electronic incident report must be completed by the manager of the service/team or their deputy within 10 working days of the incident. This is inclusive of the how, why, what, the outcome, the communication to the person harmed or their family, the learning and how this is shared.

9.2 It is especially important that the managers' workload is covered with a deputy during periods of leave to ensure there is delay to incident management.

9.3 An **Initial Management Assessment (IMA) is required for all with 24 hours** of reporting:

- incidents severity graded as red, and where requested within the service
- or the Serious Incident and Incident Management team believe the incident is severe or may fit into the Serious Incident Framework.

9.4 The IMA form should be reviewed within the Division at the **48 Hour Incident Assessment Panel** within the Division.

9.5 This panel will make a decision of whether the incident meets the Serious Incident Framework and requires reporting as a Serious Incident. The panel will also define the communication with the patient, family and loved ones.

9.6 The Serious Incident and Incident Management team will report the Serious Incident onto the national **StEIS within 48 hours of the incident being reported**.

9.7 For all Serious Incident a **72 hour report must be submitted to the relevant Clinical Commissioning Group (CCG)**. The IMA on the Ulysses Risk Management System will be used for this purpose.

9.8 The **completed investigation report** must be submitted to the relevant Clinical Commissioning Group (CCG) **within 60 working days***.

9.9 *The completed investigation report requires approval at the **Divisional Assurance Panel** and **Corporate Assurance Panel** prior to external submission, with any minor amendments being reviewed by the **Corporate Minor Amendments Panel**.

9.10 Should deadlines not be met, numbers and details of overdue incidents and Serious Incidents will be escalated on a weekly basis to the Quality Governance Business Partners, Associate Directors of Nursing, Divisional Directors and Clinical Directors, via Tableau governance reports and the Executive Flash Report.

10 Involvement of Patients, Service Users, Families and Loved Ones in incident investigation

10.1 The Trust is fully supportive of the involvement of patients, service users, families and loved ones in investigations, as appropriate[1], as they can provide a wealth of additional knowledge and information. It is the responsibility of the **48 hour incident assessment panel** to define the method and level of contact.

10.2 Through the incident investigation process the Trust is keen to involve patient and families to ensure that their questions are answered in an open and transparent manner and they are aware of the findings of any investigation in a timely manner, with a copy of the final report provided.

10.3 All Serious Incident investigations will be undertaken by Trust employees who have undergone investigation training but will not be from the specific location where the incident has taken place. In a small amount of very serious incidents an external investigator would be considered with approval from the Chief Executive Officer.

10.4 It must be remembered that in incidents that have not led to death or critical harm requiring intensive life support, the patient should be the first line of contact although other family members can be included.

10.5 Patients, service users, families and loved one who chose not to engage in the investigation process can chose to re-engage at any point in time and at any level, and their wishes should be clearly documented on Ulysses at each contact. Levels of involvement which can be individual decided:

- Ask questions
- Add Terms of Reference
- Review Terms of Reference
- Be interviewed
- Receive a draft copy of the investigation
- Receive a copy of the investigation.

10.6 In incidents that have resulted in serious life threatening harm or death there is never a right time to make the initial contact with the family. The initial contact should be made as soon as possible and should be followed up with contact details of the investigating officer in writing.

10.7 Where indicated, the Trust Family Liaison Officer (FLO) should become involved to ensure that the family is comprehensively supported and understands the investigation process. The FLO is able to work with all families no matter the circumstances and will signpost individuals for further support such as counselling.

10.8 Where the investigation has proven that there is an act or omission in the care provided by the Trust which has caused the patient safety incident a formal written apology must be provided and this process in detailed in the Being Open / Duty of Candour procedure.

11 Learning from Incidents

11.1 The purpose of reporting and investigating incidents is to ensure that the Trust learns and prevents similar incidents from occurring in the future. Sharing learning is crucial to the

[1] In some incidents there will be police investigations taking place. Permission must be obtained from the police to involve people who are also subject to the police interview process or have had associated criminal charges brought against them in relation to the incident before an approach is made.

Trust and the methods for learning are demonstrated with the Organisational Learning Strategy.

11.2 Learning from incidents should be widely shared with staff within their team involved via a variety of different methods:

- Circulation of the final approval investigation report
- Team meetings
- Clinical supervision / one-to-ones / reflective practice
- Learning from Incidents meetings

11.3 Learning across the organisation is all important and should be undertaken through a variety of methods:

- Hotspot and Learning Matters publications
- Quality and Safety meeting
- Immediate Learning from Serious Incident Panels – Alerts
- Weekly Bulletin
- Learning Network Meetings

11.4 All Serious Incident investigation which have had an final grade impact score of 4 major or 5 catastrophic with return to an **Evidence of Improvement Panel** four to six months after the incident being reported. Chaired by the Associated Medical Directors the panel will request assurance evidence form the team that the action plan has been completed and any changes made in practice.

11.5 The Clinical Commissioning Group (CCG) may also randomly select Serious Incident cases for an **Evidence of Improvement Panel** to provide commissioner level assurance.

11.6 All Serious Incident investigations which have had a final grade impact score of 5 catastrophic will be shared with the Company Secretary for onward dissemination to Trust Board for their oversight of such incidents. This will occur on a bi-monthly basis.

12 Standards for Supporting for Staff

12.1 The process of investigation and the procedural issues relating to an incident can occasionally be very time consuming for staff involved. The Trust acknowledges that staff may find the process stressful and recognises it is therefore important that staff are appropriately supported. This applies to all staff, including bank, agency and locum workers, volunteers and those on work experience.

12.2 The Director of Human Resources has a specific responsibility to ensure and provide assurance to the Board and Chief Executive that processes are in place for all staff who are involved in a traumatic or stressful event to be supported throughout and receive continued support after the event, if required.

12.3 Line managers are responsible for providing adequate and appropriate support for staff following an incident.

12.4 Staff must be informed if an investigation is being undertaken into an incident in which they were involved, kept up to date with the progress, the eventual outcome and learning to be implemented.

12.5 Where a case is to go to inquest or criminal trial support can be provided by the Legal Team who are part of the Quality Governance team who must be notified that this is taking place. Staff involved in a traumatic or stressful event must inform their manager if:

- They are experiencing difficulties associated with the situation or as a result of the requirement to act as a witness, in order to enable their line manager to support them directly
- Request referral to relevant support services if they are experiencing difficulties
- Time is required away from the workplace to attend any meetings associated with the claim or court proceedings, or, where required, to attend for counselling or support

13 Standards for Managing Media Interest in Incidents

13.1 Any incident may result in media or public attention. If a media request for any information is received, the Trust's Communications Team must be informed. It is important that only information is released to the media through the Communications Team to ensure that it is correct and shared in an appropriate format.

14 Integration with Complaints

14.1 It is important that the Trust moves to a status where Serious Incidents and associated Complaints are seen and investigated through one lens. The skills obtained through the training provide investigating officers with the ability to investigate both complaints and incidents.

14.2 Where a Serious Incident investigation already is underway and a complaint about the same aspect of service or care delivery is received, the situation must be discussed with the complainant to ascertain, with approval, whether it is appropriate for the questions to be added to the investigation? The complaint would then be closed and the complainant would receive a copy of the full investigation report.

14.3 Should a complaint highlight that a missed Serious Incident has occurred, the serious incident process would be triggered and the concerns from the complaint be added to the Terms of Reference for the investigation. The complaint would be closed at this point.

15 Training

15.1 All staff will receive incident reporting, management and risk training as part of the Trust's Induction Programme this is provided through the e learning system.

15.2 Investigating Officers who undertake investigations into Serious Incident must attend the two-day Southern Health training course which is bookable through the LEaD system and offered four times per years. This comprehensive course fulfills the requirements of the NHS England Frequently Asked Questions: Serious Incident Framework update April 2016.

15.3 A register of trained Investigating Officers is held by the Divisional Lead Investigating Officers. Each officer it expected to undertake a minimum of one investigation per annum or is retired from the active register. A refresher training day for Investigation Officers is available to meet the requirement of the bi-annual update.

15.4 Commissioning Manager training is offered to all commissioning managers although this is not mandatory. This is a half day course.

15.5 Role descriptions for investigation officers and commissioning managers can be found in full at appendices 6 & 7.

16 Monitoring Compliance

16.1 The Quality Governance team is responsible for monitoring compliance with this policy every 12 months to ensure that staff are meeting the policy requirements.

16.2 The following performance measures will be used:

Policy Requirement	Performance Indicator	Measure
Serious Incidents are reported onto StEIS within 2 working days of the incident being reported.	100% of Serious Incidents are reported onto StEIS within 2 working days of the incident being reported.	Dashboard - Reporting to the Patient Safety Group and Quality and Safety Committee
That all Serious Incidents final graded 4 & 5 return to an Evidence of Improvement Panel.	100% of Serious Incident final graded 4 & 5 return to an Evidence of Improvement Panel.	Percentage of incident graded 4 & 5 return to improvement panel
The involvement of patient, service users, families and loved ones in investigations.	100% ability to evidence that patient, service users, families and loved ones in investigations have been asked to participate in investigations.	Percentage achievement monitored a minimum of quarterly.

17 Financial Impact & Resource Implications

17.1 Financial impact is associated with staff attending the required training and the Quality Governance team providing the face-to-face courses however this will be mitigated against the financial impact of the occurrences' high harm patient safety incidents.

17.2 Continuous update, maintenance and licencing of the Ulysses Risk Management System require both resource and finance provided by the Quality & Governance Team.

18 Policy Review

18.1 This policy will be reviewed annually in April aligned with NHS England publications or when there are changes to internal processes.

19 Supporting References

- NHS England (2015), *Serious Incident Framework* https://www.england.nhs.uk/patientsafety/wp-content/uploads/sites/32/2015/04/serious-incidnt-framwrk-upd2.pdf
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APPENDIX ONE

LEAD (Leadership, Education & Development) Training Needs Analysis

If there are any training implications in your policy, please complete the form below and make an appointment with the LEAD department (Deputy Head of LEAD or LEAD Strategic Education Lead) before the policy goes through Policy Board.

Training Programme	Frequency	Course Length	Delivery Method	Trainer(s)	Recording Attendance	Strategic & Operational Responsibility
Investigating Officers to include Being Open/Duty of Candour, complaints, Human Factors, Inquests and Ulysses RCA Module	Once	The course will take 2 days	Face to face training in appropriate venues within the Trust	Associate Director of Governance, Incident and Investigation Manager and key subject specialists	Staff to provide training through LEAD so that attendance is recorded on the training database	Chief Nurse
Directorate	**Division**	**Target Audience**				
MH/LD	Adult Mental Health	Senior qualified clinical staff who have been identified to become Investigating Officers within their roles by the Divisional Director , have undertaken training				
	Learning Disabilities	Senior qualified clinical staff who have been identified to become Investigating Officers within their roles by the Divisional Director				
	Older Persons Mental Health	Senior qualified clinical staff who have been identified to become Investigating Officers within their roles by the Divisional Director				
	Specialised Services	Senior qualified clinical staff who have been identified to become Investigating Officers within their roles by the Divisional Director				
Integrated Services Division	Adults	Senior qualified clinical staff who have been identified to become Investigating Officers within their roles by the Divisional Director				
	Childrens & Wellbeing	Senior qualified clinical staff who have been identified to become Investigating Officers within their roles by the Divisional Director				
	Dental	Senior qualified clinical staff who have been identified to become Investigating Officers within their roles by the Divisional Director				
Corporate Services	All (HR, Finance, Governance, Estates etc.)	N/A				

APPENDIX TWO

Southern Health NHS Foundation Trust:

Equality Impact Assessment / Equality Analysis Screening Tool

Equality Impact Assessment (or 'Equality Analysis') is a process of systematically analysing a new or existing policy/practice or service to identify what impact or likely impact it will have on different groups within the community

For guidance and support in completing this form please contact a member of the Equality and Diversity team on 01256 376358

Name of policy/service/project/plan:	Policy for Managing Incidents
Policy Number:	SH NCP 16
Department:	Quality & Governance Team
Lead officer for assessment:	Sarah Pearson Head of Organisational Learning
Date Assessment Carried Out:	March 2016

1. Identify the aims of the policy and how it is implemented.	
Key questions	**Answers / Notes**
Briefly describe purpose of the policy including • How the policy is delivered and by whom • Intended outcomes	This policy sets out the requirements for the identification and management of incidents and near misses across the Southern Health NHS Foundation Trust. The policy is publically available on the Trust website. It is intended that all staff will report all incidents so that the Trust can learn from them to minimise risk and improve the health, safety and wellbeing of all who use services or enter Trust premises (including patients, service users, staff or visitors).
Provide brief details of the scope of the policy being reviewed, for example: • Is it a new service/policy or review of an existing one? • Is it a national requirement?	This policy is a review in light of changes to SHFT Organisational changes. There is a national requirement for the Trust to have this policy to enable it to meet various statutory and legislative requirements. It is applicable to all staff within the Trust (including contractors)

2. Consideration of available data, research and information
Monitoring data and other information involves using equality information, and the results of engagement with protected groups and others, to understand the actual effect or the potential effect of your functions, policies or decisions. It can help you to identify practical steps to tackle any negative effects or discrimination, to advance equality and to foster good relations. Please consider the availability of the following as potential sources: • **Demographic** data and other statistics, including census findings • Recent **research** findings (local and national) • Results from **consultation or engagement** you have undertaken • Service user **monitoring data** • Information from **relevant groups** or agencies, for example trade unions and voluntary/community organisations • Analysis of records of enquiries about your service, or **complaints** or **compliments** about

APPENDIX TWO

	them • Recommendations of **external inspections** or audit reports	
	Key questions	**Data, research and information that you can refer to**
2.1	What is the equalities profile of the team delivering the service/policy?	The policy is applicable to the whole Trust including all staff (clinical and non-clinical). The Equality and Diversity team collect data in relation to the equalities profile for all Trust staff and this is available as required.
2.2	What equalities training have staff received?	All staff within the Trust receive Equality and Diversity Training at induction. There is an E-learning package for staff to complete. If staff fail the e-learning package, support is provided to them through additional face to face contact.
2.3	What is the equalities profile of service users?	The policy is applicable to the whole Trust including all patients, service users and clients. The Equality and Diversity team collect data in relation to the equalities profile for patients, service users and clients and this is available as required.
2.4	What other data do you have in terms of service users or staff? (e.g results of customer satisfaction surveys, consultation findings). Are there any gaps?	The Ulysses database system which the Trust uses to record information from incidents includes the: date of birth, gender and ethnicity of all staff and patients or service users who have been involved in an incident. This information can be used in the analysis of incidents. For example, in relation to suicides, the annual report considers age, gender and ethnicity in relation to various aspects of suicide and compares these with national data.
2.5	What engagement or consultation has been undertaken as part of this EIA and with whom? What were the results?	This section needs to be completed once the Policy consultation has completed. The EIA should be sent out as part of the policy consultation and feedback on this requested. Where possible, patient, service user, carer should be involved in the consultation process
2.6	If you are planning to undertake any consultation in the future regarding this service or policy, how will you include equalities considerations within this?	When this policy is reviewed, the consultation will target specific equality considerations if particular trends in incidents are noted in relation to any of the protected groups

APPENDIX TWO

Southern Health NHS Foundation Trust:
Equality Impact Assessment Screening Tool

	Positive impact (including examples of what the policy/service has done to promote equality)	**Negative Impact**	**Action Plan to address negative impact**			
			Actions to overcome problem/barrier	**Resources required**	**Responsibility**	**Target date**
Age	In response to requirements of the Equality Act 2010 and Equality Duty, SHFT will: • produce and publish an equality impact assessment at the earliest opportunity • consult with those affected by the policy and procedure • scrutinise and monitor the equality impacts, post-implementation In doing so, the Trust can be satisfied that it has done, and will continue to do, everything that is reasonably possible to remove or mitigate adverse equality impacts; and to remove the potential for unlawful discrimination This Policy promotes and enables the reporting of any discriminatory abuse (verbal, physical or sexual in nature) to service users and/or staff and enables the Trust to monitor and act upon all incidents which					

	involve discrimination directly.					
Disability	See statement in the age equality profile	Patients and service users with disabilities in relation to communication may not be able to report incidents to staff. The Trust utilises a range of methods of communication appropriate to individual patient and service user's needs.	The Trust is already taking action to overcome the negative impact			
Gender Reassignment	See statement in the age equality profile	It has not been identified that this policy has any negative impacts at this stage of the screening process. However; should future analysis through audit from an equalities perspective, may provide further analysis in the policy's effectiveness.				
Marriage and Civil Partnership	See statement in the age equality profile	It has not been identified that this policy has any negative impacts at this stage of the screening process. However, should future analysis through audit from an equalities perspective, may provide further analysis in the policy's effectiveness.				
Pregnancy and Maternity	See statement in the age equality profile	It has not been identified that this policy has any negative impacts at this stage of the screening process. However, should future analysis through audit from an equalities perspective may provide further				

		analysis in the policy's effectiveness.				
Race	See statement in the age equality profile	Patients and service users whose first language is not English may not be able to report incidents to staff.	The Trust utilises interpreters to communicate with patients and service users. The Trust is already taking action to overcome the negative impact			
Religion or Belief	See statement in the age equality profile	It has not been identified that this policy has any negative impacts at this stage of the screening process. However, should future analysis through audit from an equalities perspective may provide further analysis in the policy's effectiveness.				
Sex	See statement in the age equality profile	It has not been identified that this policy has any negative impacts at this stage of the screening process. However, should future analysis through audit from an equalities perspective may provide further analysis in the policy's effectiveness.				

APPENDIX THREE - External Reporting Requirements for Incidents

Incident Type	Agency to notify	Person Responsible
Serious Incidents requiring investigation (SI)	Strategic Executive Information System (StEIS) Relevant Clinical Commissioning Group NHS England	Governance Team (SIRI Manager)
Information Governance Incidents graded as SIs	Information Commissioner	Information Governance Manager
Serious injuries to staff at work or incidents which result in 7 or more calendar days off work	Health and Safety Executive Reporting of Incidents, Diseases or Dangerous Occurrences Regulation (RIDDOR)	Health and Safety Team
RIDDOR reportable Serious Injuries to patients	Health and Safety Executive Reporting of Incidents, Diseases or Dangerous Occurrences Regulation (RIDDOR)	Health and Safety Team
Patient safety incidents	National Reporting and Learning Service (NRLS)	Governance Team (Head of Risk and Business Continuity)
Medical Device failures	Medicines & Healthcare Regulatory Authority (MHRA)	Health and Safety Team
Deaths of detained service users	Care Quality Commission (CQC)	Mental Health Act Team
AWOLs of detained service users	Care Quality Commission (CQC)	Corporate Incident and Investigation Team (SI Manager)
Incidents under Regulation 18 of the Health and Social Care Act (2008)	Care Quality Commission (CQC)	TQtwentyone Registered Managers
Additional information where a service user has been involved in a suicide or homicide	National Confidential Inquiry into Suicides and Homicides (NCI)	Consultant when request received from NCI
Medicine contra-indications or suspected adverse reactions to any therapeutic medication	MHRA	Chief Pharmacist
Incidents leading to legal and/or insurance claims	NHS Litigation Authority	Quality & Governance Team (Head of Legal Services)
Notifiable diseases	Centre for Communicable Disease Control HSE Incident Contact Centre for RIDDOR	Registered Medical Practitioner (attending)
Infection control outbreaks	Health Protection Agency (HPA)	Infection Control Team
Serious Physical Assault on staff	Security Incident Reporting System (NHS Protect)	Local Security Management Specialist (via Governance Team)
Any Suspicion of Fraud, Bribery, Corruption or a similar offence	NHS Protect's Fraud Monitoring Database	LCFS

There will be situations where Managers may need to notify the Police, Professional Bodies or other organisations dependent on what further support is needed or where stakeholders or partner organisations need to be informed.

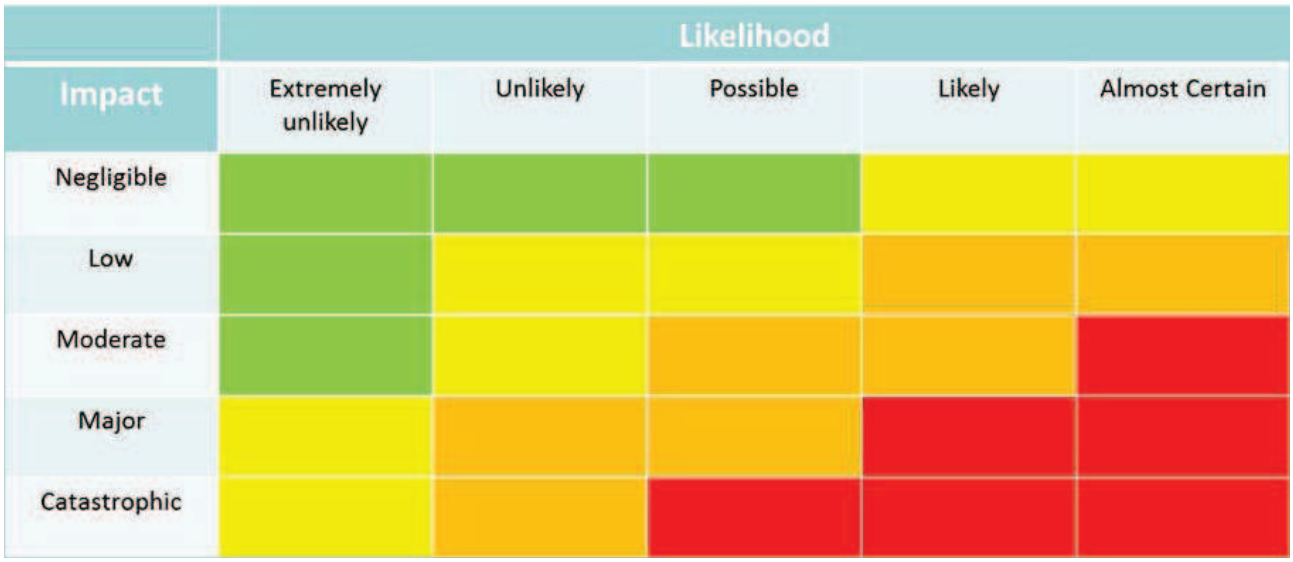
In addition to this there is a responsibility for the Trust's Accountable Officer to share information within Local Intelligence Networks in relation to controlled drugs incidents and/or fraudulent behaviour of relevant people. In this context a relevant person is anyone who prescribes, dispenses, administers or transports drugs and information will only be shared about those individuals where there are well founded concerns in relation to patient safety. This is in-line with the Statutory Instrument 3148 of the Health Bill in relation to the Accountable Officers Responsibilities.

APPENDIX FOUR - Grading an incident – Potential Severity

Potential Severity should be graded using a standard 5x5 Risk Matrix, definitions for Impact and Likelihood follow. Potential severity is subjective and is best graded by someone who knows the service user, staff, environment and specific circumstances of the incident.

The four potential severity gradings are Minor/Green, Moderate/Yellow, Major/Amber, and Catastrophic/Red

The colour appearing in the risk matrix corresponds to each of these 4 gradings. Guidance on choosing the impact and likelihood in the risk matrix can be found below.



Grading the Actual Impact of the Incident

The actual impact of the incident is designed to reflect all harm which occurs as a result of the incident. The definitions below are based on the NRLS definitions for harm, however they have been expanded to include harm which was financial and/or reputational, rather than just harm to people.

Actual Impact Grading	
Actual Impact	**Definition**
Near Miss	An event or circumstance which was prevented or did not occur due to luck or timely intervention
No Harm	An Incident which occurred but did not cause any harm, damage or loss
Low Harm	Minor injury to a person or people not requiring treatment beyond first aid or attendance at Minor Injuries Unit (MIU) or Emergency Department (where no MIU is available) Negligible financial impact with little or no service disruption.
Moderate Harm	Unexpected or unintended harm to a person or people that resulted in a moderate increase in treatment, possible surgical intervention, cancelling of treatment or transfer to another area and which caused significant but not permanent harm. Some financial impact on the service with short term implications for provision of non-essential aspects of the service
Major Harm	Harm to a person or people which is significant, long term or permanent to one or more people. Financial impact or disruption to the service which affected some or all essential services in the short term

Catastrophic Harm	Death of one or more people as a direct result of the incident. Financial impact or service disruption affecting essential services over the long-term or permanently.

APPENDIX FIVE – JOB DESCRIPTION FOR INVESTIGATING OFFICER

Investigating Officer Role.docx

APPENDIX SIX – JOB DESCRIPTION FOR COMMISSIONING MANAGER

Commissioning Manager Role.docx