Incident reporting and serious incident review policy

Ref CORP-0043-v8.2

Status: Ratified
Document type: Policy

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1 Introduction

Every day millions of people are treated safely and successfully in the NHS. However, when something does go wrong and incidents happen, it is important that lessons are learned to prevent/minimise the same incident occurring elsewhere. Patient Safety is about working to prevent incidents/harm in healthcare, which in this context means injury, suffering, disability or death. When something goes wrong in healthcare it is usually the result of problems in the systems staff work in rather than an individual themselves. We need to ensure NHS patients are treated in a safe environment and protected from avoidable harm and that we learn from each and every incident. As Tees Esk and Wear Valley NHS Foundation Trust (TEWV) employees we know we are all accountable and responsible for what we do or do not do.

TEWV is committed to embedding a patient safety culture supported by all its senior managers, who take patient safety very seriously and are willing to support staff involved in errors or incidents. When an incident occurs staff need to feel supported; their willingness to report errors and incidents and to learn from them as well as to challenge colleagues including those at a senior level over poor practice, is an essential part of patient safety and must be maintained. **The needs of staff, patients and the family affected are our primary concern, it is important that all parties are involved and supported** throughout the review process; and for our staff that this supports a Just Culture.

Additionally, a strong safety culture ensures that when there is a notifiable safety incident our statutory, professional and contractual role in Duty of Candour to be open, honest and transparent both within the Trust and with the patient and family is fulfilled.

Sign up to Safety helps NHS staff and organisations achieve their patient safety goals and care for their patients in the safest way possible.

The aim of a serious incident review is to find how and why an incident happened to minimize a reoccurrence and support a 'just culture'.

The Sign up to Safety Campaign says a Just Culture should:

- Make sure you are cared for and supported if you make an error
- If your behavior has been risky by not adhering to policies, be asked why first before being judged
- If you have behaved recklessly, been careless and intentionally putting your patients, staff or you at risk and not followed policy and procedures know you are accountable for your actions.

Serious incident reviews are led by the Patient Safety Team (PST) and are based in the Nursing and Governance Directorate; they are independent of clinical services. They prepare a report and take it through the Trust's Governance process where the focus is on learning lessons. This is shared with Clinical Commissioning Groups (CCG's), families, and Coroners to provide assurance and maintain the confidence of the public of our commitment to the safety of patients and staff. The PST reviewers aim to involve families and carers in their reviews if this is what the family and/or carers want.

Following the review any lessons to be learned are managed in the context of preventing a further patient safety incident reoccurring. Whenever learning lessons are mentioned in this policy it is in the context of preventing any further harm.

The PST's review of incidents is carried out according to the guidance and principles of the NHS England Serious Incident Framework (NHS England 2015).

2 Why we need this policy

2.1 Purpose

This policy informs staff of their roles and responsibilities in the process of reporting, managing and reviewing all incidents involving patients, staff and or visitors. This includes being open, honest and transparent with patients their family and or carers if something has gone wrong in the course of their care and treatment that we have provided. This gives an opportunity to review what has happened and ensure Duty of Candour has been applied in a notifiable safety incident and that staff, patients and family are treated fairly and with compassion. This policy also ensures that family and carers are supported and involved in any incident review in line with the patient wishes and where family wants to be involved.

See the Duty of Candour policy Being Open, Honest and Transparent CORP–0062.

2.2 Objectives

The core objectives of this policy are to:

- Establish the principles by which all incidents are openly reported within the Trust and where appropriate externally, and that they are systematically reviewed and analysed to prevent/minimise the incident being repeated
- Coordinate the process of incident reviews and ensure reporting timescales are achieved
- Involve patients and family from the beginning of the incident review process where appropriate
- Learn lessons, identify good practice and improve services as a consequence of an incident review
- To assure proactive learning from patients, family/carers and staff and demonstrate this in reports
- To apply the legal responsibility of Duty of Candour as part of the reporting policy
- To ensure Never Events are recognised and reported in line with Trust and national guidance

3 Scope

3.1 Who this policy applies to

This policy applies to all staff members who are involved with patients, staff, and or visitor incidents to support the reporting process and to ensure that lessons are being learned. It informs you of your role and responsibility in reporting, managing and supporting the process of incident review in an open, honest and transparent way.

When there is interagency working there will be a partnership agreement in place between the different organisations to inform on how serious incidences will be reported and reviewed in the respective organisations governance processes.

3.2 Roles and responsibilities

Role	Responsibility
Chief Executive and Trust Board	The Chief Executive has overall accountability for Trust wide legislative compliance and management of risk. The Trust Board of Directors has operational responsibility for the implementation and monitoring of patient safety and ensures the delivery of safe high quality care. The members of the Trust Board will be advised of all serious incidents, clusters themes and trends including where there is a high risk of recurrence and a high impact outcome, via the relevant committees or Executive Management Team, as described in the Integrated Governance Strategy
Quality Assurance Committee	**Quality Assurance Committee and Executive Management Team** The Quality Assurance Committee (QAC) has devolved responsibility from the Trust Board for monitoring clinical risk management and to receive patient safety incident reports, a regular report from the Patient Safety Group and an annual Patient Safety Report detailing trends and themes. The Trust Board has devolved to the QAC responsibility for monitoring clinical risk management and devolved responsibility for non-clinical risk to the Executive Management Team (EMT). The QAC receives reports about patient safety incidents, demonstrating any actions taken to mitigate the risks. This includes bi- monthly reports from Locality Management Governance Boards (LMGB) describing the patient safety information presented (as described above), a regular report from the Patient Safety Group and an Annual Patient Safety Report detailing trends and themes. The Executive Management Team (EMT) receives reports on the key performance indicators linked to completion of serious incident reviews (severe harm and unexpected death) and the completion of improvement action plan monitoring.
Executive Management	Has executive responsibility for the development and monitoring of this policy and associated guidelines (in cases of

Team	unexpected death, suspected suicide). The EMT ensures that the Incident Reporting Policy is fully implemented within their areas of responsibility in a timely manner, and that there is sufficient staff at the appropriate senior level involved. The EMT also receives reports on the key performance indicators linked to completion of serious incident reviews (severe harm and unexpected death) and the completion of improvement actions against planned timescales.
The Executive Director of Nursing and Governance and Director of Quality Governance and Head of Patient Safety, Complaints, Legal and Claims	Have responsibility for ensuring the systems for incident reporting, identification of patient safety issues and reporting appropriate incidents through correct procedures is in place. These responsibilities are carried out through the PST. The PST ensures all reportable serious incidents are reviewed within the agreed timescales following an internal governance process with Directors finalising and signing off reports and action plans. PST reviewers are trained in the principles of root cause analysis. A PDF version of the final report is dispatched to appropriate internal and external agencies.
Clinical Directors, Medical Staff, Heads of Service, Heads of Nursing, Locality Managers, Service Managers, **Modern Matrons, Ward/Unit Managers and Team Managers**	Have operational responsibility for the implementation of this policy and associated guidelines (in cases of unexpected death, suspected suicide) within their own area of management accountability. Have a responsibility to foster a culture of openness, honesty and transparency in reporting of incidents whether or not they have caused harm. When appropriate to take an active role in and or ensuring relevant staff members are proactive in supporting the service review process to identify the how and why of the incident and that lessons are learned, good practice is identified and that services are improved as a result of the review process. Data obtained from incident monitoring will be considered at the Directorate Quality Assurance Group (QuAG) (and Locality Management and Governance Boards (LMGB) on a monthly basis. Always assuring a Just Culture.
Clinical staff	Are responsible for implementing the guidance and procedures within this policy and associated guidelines (in cases of unexpected death, suspected suicide and Never Events).
Specialist Operational and Training Teams	All specialist teams will provide advice and guidance for incident reviews regarding incidents within their area of expertise including the provision of relevant information pertinent for action plans linked to previous complaints; CQC action plans; audits or patient experience reports.

⚠ Any member of staff who has concerns about patient and/or staff safety can contact the Freedom to Speak Up Guardian (Appendix 1) or use the Whistle Blowing policy (Available on Intouch).

3.3 The process by which this policy will be delivered

The processes by which this policy will be delivered are outlined in the associated processes and procedures including:

- Incident Process for Escalating Trust wide Actions
- Health and Safety Executive (HSE) RIDDOR Regulations
- Whistleblowing policy (December 2016)
- Duty of Candour policy Being Open, Honest and Transparent CORP – 0062 V1
- Never Events Framework (NHS Improvement 2016)
- LeDeR http://www.bristol.ac.uk/sps/leder/about/

The policy and associated processes and procedures include all incidents that:

- Occur in or on any Trust premises
- Occur off Trust premises but involves staff employed by the Trust whilst on Trust business
- Affects anyone in receipt of Trust services
- Affects anyone to whom the organisation owes a duty of care including visitors, the public and Trust employees, those seconded from other organisations (training placements and work experience) and any subcontracted staff or volunteers.
- Involves former patients involved in either a homicide or suicide, if they have been open to Trust services in the previous six months. Although each incident will be considered individually in line with the NHS England Serious Incident Framework, (NHS E 2015), where it may be more than 6 months since the patient was in receipt of services.
- Affects the delivery and business continuity of services

4 Policy

The commitment to patient, staff and visitor safety will be delivered through understanding of:

- The importance of timely incident reporting
- The significance of effective incident management
- The need to work collaboratively on the review of incidents in the given timescales
- The value of incident reviews to establish any root cause and or contributory factors for wider learning of lessons across the Trust
- **All lessons learned will be monitored by relevant service leads and through appropriate governance structures, to ensure the identified issues are addressed and remedial actions implemented**
- The high level of importance of involving patients and carers
- The need to implement any resulting action plans and retain evidence

- Use of the policy and data collection relating to safety incidences determine trends and themes for continuous improvement

4.1 Incident Reporting

The reporting and reviewing process in this policy is in line with the NHSE Serious Incident Framework and NHS Improvement FAQ's (April 2016). Responding appropriately when things go wrong in healthcare is a key part of the way we continually improve the safety of services we provide. The timely reporting and review of all incidents is essential to improving patient safety. This process begins with reporting all incidents on the Datix system whatever the level of harm. This will support the Trust being able to demonstrate it has robust processes in place to review how and why an incident has happened and implement actions and promote learning to reduce or prevent the recurrence of similar incidents (Appendix 2).

4.1.1 Incident Response and Management

Immediate Action

The immediate safety or well-being of the patient, staff member or visitor affected or involved in the incident is paramount. The response to managing an incident must be proportionate to the severity of impact or harm, the patient/person involved in the incident must be made safe and appropriate actions taken. This may involve first aid or emergency treatment; where appropriate the emergency paramedic ambulance must be called using the locally agreed route.

After the immediate actions needed to safely manage the incident are taken, a risk assessment of the situation to reduce the likelihood of the incident being repeated is required; if risk cannot be mitigated this must be escalated to a senior manager and their advice sought.

A Datix form must be completed and submitted within 24 hours of the incident identifying whether it is an actual or potential serious incident. The staff member responsible for completing the Datix is the one who is first aware or has first contact of the incident with the patient. If the patient is detained under the MHA (1983) the MH Legislation Office must be informed as soon as possible to inform the Care Quality Commission (CQC).

For specialist services their Form 1 must be completed and sent to their commissioner and the email copied to tewv.patientsafety@nhs.net

Incident Management

If the incident is an actual or suspected serious incident the reporter informs the Head of Service of the incident. If the incident has occurred Out of Hours the report will inform the Senior Manager first on call who will decide escalation to the Director on Call.

If the incident is an unexpected death or suspected suicide the appropriate senior manager (Locality Manager or equivalent) will ensure a staff debrief is carried out with the staff involved. It is important for senior managers to ensure staff are cared for and supported when an incident has occurred.

Where appropriate, staff will be asked to make a statement by the relevant senior manager.

The Ward/Team/Unit Manager will ensure the Duty of Candour / culture of candour processes are implemented in line with the Duty of Candour policy (see check list Appendix 2). Out of hours this may be delegated to the nurse in charge by the senior manager on call; the responsibility for this will be resumed by the Ward/Team manager the next working day. The incident and how it has been managed and the actions for Duty of Candour must be fully recorded on case notes in PARIS.

The completed Datix will be reviewed by the Central Approval Team (CAT) and where appropriate the PST daily Clinical Huddle. When a serious incident is confirmed the CAT report the incident on the Strategic Executive Information System (STEIS) and a request for a 72 hour report is made to the reporter or the service (whichever is most appropriate) for the CCG. **All sections of the 72 report must be immediately completed and returned to the PST.** TEWV.patientsafety@nhs.net

If the incident occurred in a **Specialist Service (Forensics, Eating Disorder and or CAMHS Tier 4)** the service will need to complete a **Form 1** sometimes referred to as a 24 hour report (Appendix 3) and send it directly to their specific Commissioner with a copy to the PST at TEWV.patientsafety@nhs.net

Learning Disabilities Mortality Review Programme

If a serious incident occurs in the Learning Disability Service the Learning Disability Mortality Review (LeDeR) process is in place, anyone can report an incident through the North East and Cumbria Learning Disability Network.

Notification of deaths for LeDer:

Website for more details is: http://www.bristol.ac.uk/sps/leder/about/

Who can notify LeDeR of a death?

Anyone can notify us including people with learning disabilities themselves, family members, friends and paid staff.

How do you notify LeDeR of a death? Click here to notify us of a death online

OR Call 0300 777 4774

4.1.2 Health and Safety Reportable Issues

If a member of staff has been harmed in an incident this is also reported on Datix; if RIDDOR applies (the member of staff is off work for 7 days due to the incident) the Health and Safety Team will contact the service to confirm any sickness and report to the Health and Safety Executive (H&SE) within 15 days of the incident occurring where required and appropriate. The Health and Safety Team will instigate a Root Cause Analyses session and include staff involved in the incident. This will include evidence of photographs, CCTV footage, patient care and intervention plans where relevant. A factual report will be completed and shared with individual concerned; including the Head of Service to ensure any actions identified have been completed and disseminated through QuAG to help prevent similar incidents occurring.

Any Health and Safety issues may require:

a. A review of all Health, Safety and Security issues by or with the H&S Team and
b. All intentional physical assaults to be reported to the Security Management Service
c. Repairs and remedial action to be taken to avoid further incident

Further information and guidance are on the Trust Intouch pages on:
http://intouch/Services/Corporate/HealthRiskandSafety/Pages/RIDDORReporting.aspx

Incidents involving patient's visitors, staff and or contractors will be reviewed by the Health and Safety Team to ensure that where issues fall under the criteria for reporting under RIDDOR the Health and Safety Team report these incidents to the H&SE. When a patient and or a patient visitor are involved in an incident the service where the incident occurred will ensure information is shared as appropriate.

The TEWV incident review process is the responsibility of the PST, who in the first instance work with the CAT on the Datix to confirm the level of harm and type of review required. The PST are trained in using a variety of tools including using Root Cause Analysis to identify root causes, contributory factors, lessons learned as well as good practice. They work in close collaboration with operational services, specifically with the Locality Manager or equivalent. The PST holds all reports and evidence from reviews in an electronic folder and will support the monitoring process of SI Action Plans.

PST Reviewers will, unless informed otherwise, make contact with families and carers at the beginning of the incident review process; they will need to clarify what actions the service has already taken. The purpose of this contact is to explain and offer involvement in the review process; they will also offer condolences and sympathy on behalf of the Trust. The Head of Service will already have sent a condolence letter, explained the process of review and that they will be offered the opportunity to be involved in the review process, the PST add to this contact with the family. When the review is complete the PST Reviewer will offer to meet up with family to consider the findings and any learning identified to be taken forward in an action plan, in conjunction with senior staff from the service involved.

The terms used throughout the Policy are described in Section 5, which may useful to consider first.

4.1.3 Reporting a moderate, low or no harm incident and near miss:

Once immediate actions have been taken to safely manage the incident and to conduct an interim risk assessment of the situation a Datix form must be completed and submitted within 24 hours identifying whether the incident is moderate, low or no harm incident or near miss.

Any incidents reported as moderate, low or no harm or near miss must be considered under the Duty of Candour policy and all decisions and actions fully recorded on case notes in PARIS. After which the CAT informed to update Datix as per the Duty of Candour Checklist (Appendix 2). For any patient involved in an incident graded as moderate harm or above and the Duty of Candour Policy applies after the face to face meeting to explain what happened a letter should be offered to explain the incident to the patient and or family/carer; all of which must be recorded on Paris; if a letter is sent to the patient, family or carer it will be saved in 'letters' on Paris and a record that it was sent made on PARIS.

A Moderate harm incident will result in a 'Head of Service Review' being requested through patient safety processes, the requirement is for this to be completed within 8 weeks and for assurance taken to the Locality Quality Assurance Group (QuAG) for local learning (for more information on the Head of Service Review process please see appendix 7). Low Harm incidents may result in the detail of the incident being sent to the Head of Service for information.

4.1.4 Never Event

A Never Event is defined as a serious, largely preventable patient safety incident that should not occur if the available preventative measures have been implemented by the healthcare providers. A never event would be reported on Datix and treated as a serious incident and managed in that way. The current list of never events applicable to mental health includes:

- Wrong route administration of medication
- Overdose of Insulin due to abbreviations or incorrect device
- Mis-selection of high strength midazolam during conscious sedation
- Failure to install functional collapsible shower or curtain rails
- Falls from poorly restricted windows
- Chest or neck entrapment in bedrails
- Misplaced naso or orogastric tubes
- Scalding of patients

For more details, please see the NHS England Never Events Framework.

4.1.5 Incidents involving children and vulnerable adults

Guidance for reporting incidents that involve the safeguarding of children and the safeguarding of vulnerable adults incidents are described in the relevant national documents Working Together and No Secrets. The procedures of Local Safeguarding Children's Boards and Local Safeguarding Adult's Boards include the incident management processes and the systems for determining whether an incident should have a Serious Case Review or Local Management Review (LMR). An incident may be classified as a serious incident requiring both STEIS reporting and Serious Case Review. Guidance should be sought from the Trust leads for safeguarding and the corporate safeguarding departments.

- Allegations of sexual abuse against children or vulnerable adults must be reported through Datix as a serious incident
- Allegations of serious abuse by children or vulnerable adults against healthcare staff must be reported on Datix as a serious incident

4.2 The Patient Safety Review Process

The patient safety review process ensures serious incidents are reviewed and taken through the Trust Governance process in a consistent way. The operational manager of the service involved in a serious incident (usually the Locality Manager) has a role in managing the incident ensuring appropriate follow up, supporting staff and that witness statements are taken. A serious incident can be reviewed at any time on the Integrated Information Centre (IIC) once it has been approved by the CAT.

All Datix forms are reviewed for accuracy and to ensure a full account of the incident has been recorded by the CAT; they will seek additional information from teams if required to assign level of harm as set out below:

- **Serious incidents** (unexpected death) including incidents involving severe harm (permanent or long term)
- **Moderate harm** (short term harm requiring additional treatment or a procedure)
- **Low harm** (minimal harm requiring additional observation or minor treatment)
- **No harm** incidents (No injury). Any patient safety incident that occurred but no harm was caused to the patient.
- **Near miss** incidents. Any patient safety incident that occurred but no harm was caused to the patient.

The head of patient safety, complaints, legal and claims and the CAT hold a daily Clinical Huddle to review Datix and confirm the appropriate level of review for the incident that has occurred. All Clinical Huddle decisions are recorded on a data base and shared with the senior corporate staff and directors.

Following the Clinical Huddle and a confirmation of a Serious Incident the CAT Team report the incident on the **STEIS** and submits the completed 72 hour report to the commissioners.

The serious incident data is inputted into the Patient Safety electronic system and the incident is allocated to a PST reviewer for a full review of the care and treatment provided. All staff involved and identified in the 72 report and those invited by the PST reviewer are expected to attend the Root Cause Analysis (RCA) and feedback meetings, which the PST reviewer leads on and organises with PST administrators.

On completion of the RCA meeting the PST Reviewer will write up their findings in a draft report and then hold a Feedback meeting with staff from the RCA to confirm their findings (if any) and to check for factual accuracy and learning of lessons. Attendance at the feedback meeting is critical for the Locality Manager (or equivalent) who will lead on any Action Plan, write the SMART objectives and be part of the learning lessons process.

The PST Reviewer then presents the report to the Service Panel made up of the Head of Service, Associate/Deputy Medical Director, Modern Matron and the Consultant Psychiatrist to ensure a full account of the incident and factual accuracy and confirm findings. Any Action Plan will be presented by the Locality Manager for the Service Panel to agree; this is also in preparation for the Director Panel as the Directors will not accept the report without the completed Action Plan. The PST Reviewer will amend the report with agreed points from the Service Panel and feed comments from the Service Panel into the Director Panel.

The Director Panel is the final stage to review and ‘sign off’ the report and confirm if Duty of Candour applies. The Director Panel is made up of a Medical Director, an Executive Director, a Non-Executive Director, and a Head of Nursing. The PST Reviewer and the Locality Manager present the report and Action Plan with the SMART objectives (the Directors will not accept the report without the Action Plan). The Head of Patient Safety, Complaints, Legal and Claims oversee the process.

If the Director Panel has an alternative view and or requests additional information or actions the PST Reviewer will carry out the additional work. Any additional work will be emailed to

the Director Panel where the report was discussed and they will respond by return of email and state whether the amendments mean the report can finally be 'signed off'.

When the Director Panel confirm they accept the report that is the final assurance to the organisation of the full governance process is complete. The report is then proof read by the PST and saved as a PDF version for distribution to the CCG within the time frame of 60 days, it is also at that point sent to the Head of Service, Locality Manager, Head of Nursing, the family where it has been requested, and or the Coroner. The PST upload the lessons learnt to STEIS and Datix. The service is responsible for ensuring the report is distributed to staff members in the service who were involved in the Serious Incident as they deem appropriate. Where families have chosen to be involved in the review process, arrangements are generally made for the PST reviewer and a senior member of the service involved to feedback the report and findings during a face to face meeting.

This review process must be completed within 60 days of the incident being reported on STEIS in line with the guidance in the NHS England Serious Incident Framework (NHS England 2015). The commissioners may in exceptional circumstances agree an extension to the 60 day deadline.

The Action Plan owner is responsible for ensuring the Action Plans are fully implemented in the agreed timeframes and that all documented evidence is forwarded to the PST on email to TEWVpatient.safety@nhs.net This ensures a central point for all evidence required. Any delays on completion of Action Plans need to be communicated to the Head of Service involved and the PST on the email address above; this is then included in the EMT report.

4.2.1 Moderate, Low to No Harm and Near Miss

When an incident involves Moderate, Low or no Harm or a Near Miss, the decision of the Clinical Huddle will be to request a Head of Service Review from the appropriate Locality Head of Service. The Head of Service Review template (Appendix 5) will be provided by the CAT with an 8 week deadline for completion. The Locality will take this report through their QuAG within 12 weeks of the request being made; the Locality will disseminate their learning across specialty via LMGB.

4.3 Near miss incidents

The Serious Incident Framework (NHS England 2015) suggests that it may be appropriate for 'Near Miss' incidents to be classed as serious incidents, as the outcome does not necessarily reflect the potential severity of harm that could be caused should the incident (or a similar incident) occur again. The NPSA guidance states that a 'Near Miss' is classified as: "Any patient safety incident that had the potential to cause harm but was prevented and so no harm was caused to the patient". Whereas a 'No Harm' is classified as: "Any patient safety incident that occurred but no harm was caused to the patient".

This decision would be based on an assessment of risk that considers the likelihood of recurrence of the incident if current systems/processes remain unchanged and the potential for harm to staff, patients and the organization if the incident occurred again.

4.4 Deaths in prison/police custody: Incident Reporting and Investigating process

The Serious Incident Framework (NHS England 2015) states that any death in prison and police custody, will be referred (by the relevant organisation) to the Prison and Probation Ombudsman (PPO) or the Independent Police Complaints Commission (IPCC) who are responsible for carrying out the relevant investigations. Healthcare providers must fully support these investigations where required to do so. The PPO has clear expectations in relation to health involvement in PPO investigations into deaths in custody.

Any death of a detained patient (MHA 1983) must be reported to the CQC as soon as possible, the MHA office must be notified and will support the clinical teams with completion of the necessary documentation.

The Integrated Clinical Governance Board is attended by all the providers working within prisons including Spectrum, TEWV, G4 and G4S. When a death in custody (DIC) or serious incident occurs, Prison staff complete the STEIS Report to the commissioner. If the prisoner is involved with the Mental Health In-Reach Team provided by TEWV a Datix form will be completed.

Each provider (TEWV, G4S and Spectrum) are included in a 'rolling rota' for accepting lead responsibility in the event of a Death in Custody; the aim is to review the healthcare and treatment that was provided. The process for this review is in the form of a multi-disciplinary type meeting. The report generate from this is sent to NHSE and is considered alongside the Ombudsman's report. The lead reviewer (decided by the rolling rota) will ensure that the following documents are completed:

1. A DIC Serious Incident 24 hour report; this requests details of the SI

2. A DIC Serious Incident 72 hour report: this requests details about the prisoner, how the incident was managed and asks for a chronology of events leading up to the incident, a pre investigation assessment, terms of reference and details of the Investigation Team.

During the MDT meeting there is an opportunity to identify good practice, lessons to be learned and to ensure that an appropriate action plan is developed. This process will look to review the deaths of all prisoners in custody and is not restricted to unexpected deaths.

Completed MDT reports are reported back through the Integrated Clinical Governing Board; they are then submitted to NHSE. Action plans are the responsibility of the relevant provider and will be written by that provider in conjunction with the lead person responsible for the taking the MDT report forward.

4.5 Homicide Incident investigation and reporting in mental health

Homicides committed by those in receipt of mental health care have devastating consequences for the family of the victim(s), patients and their families and can have a profound impact on all parties involved. These incidents often require complex multi-agency investigation involving internal and external stakeholders across geographical and organisational boundaries. There is a regionally led standardised approach to investigating such incidents (Delivering a Single Operating Model for Investigating Mental Health

Homicides for the NHS in England (2013) and the 'Serious Incident Framework' (2015) Appendix 1). The main purpose of which is to:

- Ensure mental health care related homicides are investigated in a way that lessons can be learned effectively to prevent recurrence;
- Consider if a wider investigation is needed into the commissioning and configuration of services that may have contributed to the homicide incident;
- Review the care and treatment and establish if the incident could have been predicted or prevented and what lessons can be learned
- Provide additional objectivity for the family and wider public;
- Ensure any recommendations made are implemented through effective action planning and are then monitored by providers and commissioners;
- Ensure there is early consideration for joint investigations where other agencies are carrying out investigation into the same event/s, for example in cases of the death of a child and that where possible a single investigation is commissioned and together they agree the approach to the timing, sharing of information and confidentiality issues as well as communications with families, carers, staff and the media

The regional investigation team will ensure that consent to access information and to share information with the victim's family is sought at the earliest opportunity.

4.5.1 The Standard Operating Model

This has three defined stages:

Stage 1 – Incident reporting on STEIS and the initial 72 hour report/review

a. In the event of an incident all relevant and known details should be Datixed and then reported on STEIS and a 72 hour report requested and then submitted to the CCG who will share with the quality lead
b. The PST inform NHS England and the relevant CCG incident/quality lead
c. NHS England quality lead will alert the Regional Investigations Team and ensure with the provider that the 72 hour report/review is completed by the provider
d. The 72 hour report informs of the immediate actions relating to:
    - Providing assurance that the safety of staff patients and the public is protected
    - Assessing the incident in more detail to confirm if a full investigation is required
    - Proposing the appropriate level of investigation
    - Communicating with relevant individuals and organisations including the families of victims and perpetrators and CQC, Police, HSE, NHS Improvement as required
e. The provider should actively seek the details of the victim/s and families at an early stage

Stage 2 – Provider focussed internal investigation and 60 day investigation

a. The internal report should be complete within 60 days from the day it is reported (this will be shared with CCG lead, sub-region quality lead, families and the Investigation Team;
b. The relevant commissioner (usually the CCG quality lead) ensure the provider undertakes a robust internal investigation, the Regional Team will assist with Terms of reference and where possible with family involvement of the victim and perpetrator with their concerns being noted

Stage 3 – Independent Investigations Review Group (IIRG)

There is an IIRG in each NHS England Regional Investigations Team to review and determine cases that require independent investigations. They have representation from experts in mental health, investigation as well as lay members. NHS England will, on receiving the 60 day report, make arrangements for a review by the IIRG to take place to consider scope and quality of the internal investigation, provide feedback and determine if an independent investigation is required.

There is no automatic bar on conducting independent investigations whilst criminal investigations are underway and there should be an early discussion with relevant partners (Police and Coroner) to ensure investigations can commence at the earliest opportunity. The Regional Team then informs the provider of the IIRG decision and what level of investigation is needed.

The regional investigations team will ensure families of the both the perpetrator and the victim are fully informed about the investigation, what they can expect from it and how they can contribute to it and seek their consent for access to medical records. They draw up the terms of reference for the independent investigation following liaison with all appropriate stakeholders and a tender process takes place for the most suitable investigator.

4.5.2 Conducting the Independent Investigation

The regional investigation team will arrange a start-up meeting with the key stakeholders to:

- Introduce the stakeholders to the Independent investigators
- Establish links with each of the stakeholders
- Refine the terms of reference
- Discuss issues of concern

The Independent investigation should be complete in 6 months from the date it is commissioned and monthly reports will be provided to the NHS England Regional Investigation Team with bi monthly reports to the stakeholders. The first draft report is shared with stakeholders to check factual accuracy and commissioners and providers consider the recommendations. The final draft is submitted to the Regional Investigations team to agree sign off, publication and closure of the investigation.

A thematic analysis of previous Independent Investigations (within specified time period) will be undertaken to consider and report on findings and recommendations from previous Independent Investigations and current progress of implementation against action plans specifically in relation to:

- Risk assessment – contingency planning and responding to crisis; staff understanding of key responsibilities and role of care co-ordinators, specifically in relation to continuity of care;
- Compliance with Care Co-ordination policy;
- Communication electronic records / quality of clinical record keeping;
- Interagency interface / liaison
- Understanding of Section 117 entitlement and what process it invokes;
- Carers' assessment.

This will assist/support us in developing an outcome based implementation plan and support commissioners in developing a structured plan for review of implementation of recommendations.

4.5.3 Contact with families of victims and perpetrators

Where appropriate the PST Reviewers will make contact with families of victim and perpetrator in conjunction with NHS England and the police, in line with 'Being Open' and statutory duty of candour best practice. The purpose of this contact is to offer condolences / sympathies on behalf of the trust and to explain the internal investigation process to relatives. The reviewer should offer to meet up with families on conclusion of the internal investigation to highlight the findings and any learning identified to be taken forward in the action plan.

4.6 Information Governance Incidents

Information incidents are logged using DATIX, from which Information Governance receives alerts and this instigates an investigation led by Information Governance and involving the service as appropriate. Information investigations are carried out by the Information Governance Team, as required by the IG Toolkit.

Where a personal data breach is assessed as being likely to result in a risk to the rights and freedoms of natural persons, a notification to the Information Commissioner's Office (ICO) will be made within 72 hours by the Information Security Officer or Privacy Officer.

A log of all personal data security breaches is kept via Datix recording the facts relating to the personal data breach, its effects and the remedial action taken.

4.7 Communication with and Support for Staff

The Trust is committed to developing a culture which allows staff to raise concerns through appropriate channels, particularly in relation to patient safety. Staff will be proactively encouraged and supported to raise concerns by operational senior managers and or use of the Raising Concerns/Whistle blowing Policy, and the Freedom to Speak Up Champion, the latter who along with senior managers will be responsible for raising and escalating concerns.

Following a reported incident, regardless of severity level it is essential that the staff are appropriately supported by operational senior managers in any subsequent investigation and advised of the investigation outcomes and recommended changes to practice. There is a Process for Support for Staff affected by incidents and staff leaflets can assist with this.

4.8 Sharing Learning Lessons

Every day millions of people are treated safely and successfully in the NHS. However, when incidents do happen, it is important that lessons are learned to prevent/minimise the same incident occurring elsewhere. The RCA is a well-recognised way of doing this. Investigations identify how and why patient safety incidents happen the analysis identifies areas for change and make recommendations which deliver safer care for our patients. To

support this further the National Patient Safety Agency (NPSA) RCA Investigation resources provides or links to all of the good practice tools and templates and we have the NHS England Serious Incident framework (2015); the National Framework for Reporting and Learning from Serious Incidents Requiring Investigations.

To ensure the Trust learns lessons from reported incidents the following will be undertaken:

- Analysis of trends emerging from high numbers of incidents involving either a specific type of incident, an individual member of staff, an individual patient or particular service.
- Serious incident reviews will involve a root cause analysis
- A quarterly review of incidents will be carried out
- Lessons learnt from incidents will be shared by Action Plan Owners via the Quality Assurance Committee (QuAC) and QUAG's
- Lessons requiring instant dissemination will be cascaded through the Trusts Safety Alert Broadcast System
- Locality Service Development Leads, critical incident review meetings and patient safety sub groups

As part of the incident review process operational services will seek to identify lessons learned in addition to those arising from the serious incident investigation.

The reporting of incident analysis and lessons learned to Trust Board will be through the QuAC from the relevant working or assurance groups. For non-clinical incidents the reporting of incident analysis and lessons learned to Trust Board will be through the EMT following analysis by the various relevant working groups.

5 Definitions

5.1 Classification of Incidents/Grading

Level of Harm	Description
Never Events	Please see NHS England Never Events Framework.
Serious Incident (SI)	Incidents involving an unexpected death or severe harm or permanent or long term harm that are STEIS reportable.
Moderate Harm	Short term harm requiring additional treatment or procedure.
Low Harm	Minimal harm – patient(s) required extra observation or minor treatment
No Harm	Incidents that result in a minor unintended or undesirable outcome or have no serious consequence.
Near Miss	Any patient safety incident that had the potential to cause harm but was prevented and so no harm was caused to the patient.

Some incidents, handling procedures such as Clinical incident handling procedure; IG incident handling procedure; Environmental, health and safety incident procedure, Security incident handling procedure; should be established so as to be able to meet the respective legal requirements.

Where incidents fall under RIDDOR, the investigation will be undertaken by the Health and Safety team or in conjunction with the PST so as not to duplicate investigations.

5.2 Terms

Term	Definition
Accountability	Responsibility to someone for some activity with an obligation to demonstrate and take responsibility for performance of agreed expectation
Contributory Factors	The contributory factors are those things that contributed to or had an influence on the incident occurring.
DATIX	DATIX is the Trust's electronic Risk Management Software System implemented to collate incidents completed by staff following an incident.
Incident	An incident is defined as an event or circumstance that resulted, or could have resulted, in unnecessary harm, loss or damage - such as physical or mental injury to a patient, staff, visitors or members of the public, environmental or reputational damage to the Trust.
Mistake	A wrong action attributable to poor judgement, ignorance or inattention. To misunderstand or do something wrongly, improperly or faultily, to err in opinion or judgement.
Patient	As a guide, this is anyone on a current caseload or discharged from a caseload in the previous 6 months. The Serious Incident Framework, NHS England 2015 advises that each case should be considered individually – it may be appropriate to declare a serious incident for a homicide by a person discharged from mental health care more than 6 months previously.
Responsibility	Being responsible for something with a liability to be called to account by someone for conduct or actions.
Learning Lessons	As a Trust we strive to learn from each incident, key ways in which learning takes place is through supervision, debriefings and the Root Cause Analyses. The agreed approach will be influenced be a range of factors specific to what needs to be addressed and may include: • **Team/peer group review** culminating in the development of a plan identifying specific actions to take place. • **Coaching or mentoring** – this would generally be conducted on an individual one to one basis. • **Managerial/clinical supervision** linking to the development of agreed objective(s) supported by a Personal Development Plan. • **Mediation** – where it is identified that working relationship issues may need to be addressed.

Serious Incident	Serious Incidents in the NHS are defined in the Serious Incident Framework (NHS England 2015) as including: • Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in: ➢ The unexpected or avoidable death of one or more people. This includes - suicide/self-inflicted death; and - homicide by a person in receipt of mental health care within the recent past *(it may be appropriate to declare a serious incident for a homicide by a person discharged from mental health care more than 6 months previously)* ➢ Unexpected or avoidable injury to one or more people that has resulted in serious harm; ➢ Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent: - the death of the service user; or - serious harm; ➢ Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where: - healthcare did not take appropriate action/intervention to safeguard against such abuse occurring or - Where abuse occurred during the provision of NHS-funded care. This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS funded care caused/contributed towards the incident A Never Event - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death. See Never Events Policy and Framework for the national definition and further information.
Systems-based Review	This is defined as a structured and systematic review of an incident to establish a chronology of all the events leading up to the incident, identifying any root and/or other causal factors that may have contributed to the incident. The aim of which is to understand what happened, identify how future incidents may be prevented

	and provide a set of conclusions in the final report that are fair, evidenced and reasoned.
	Root Cause Analysis The investigation must be conducted using a recognised systems-based investigation methodology that identifies: ➢ The problems (the what?); ➢ The contributory factors that led to the problems (the how?) taking into account the environmental and human factors; and ➢ The fundamental issues/root cause (the why?) that need to be addressed. Within the NHS, the recognised approach is commonly termed Root Cause Analysis (RCA) investigation. The investigation must be undertaken by those with appropriate skills, training and capacity, which in TEWV is the PST reviewers.

6 Related documents

This policy is to be read in conjunction with TEWV:

- Harm Minimisation Policy
- Safety Policy
- RIDDOR guidance
- Safeguarding Adults Protocol
- Safeguarding Children Policy
- Protocol for the Distribution of Safety Alert Broadcasts and Trust Safety Notices
- Whistle blowing Policy
- Sickness Absence Management Procedure
- Integrated Governance Strategy
- Duty of Candour Policy / Procedure

7 How this policy will be implemented

- Mandatory policy briefing and training on incident reporting is available at corporate induction.
- Operational Managers should ensure their staff are aware of this policy and associated processes and procedures and arrange any update training or briefing as required.
- Training on the use of DATIX is available for all staff.
- This policy will be published on the Trust's intranet and external website.

8 How this policy will be audited

The Head of Patient Safety, Complaints, Legal and Claims will be responsible for ensuring

monitoring of the policy and associated processes and procedures. The policy and processes and procedures will be audited before the proposed review date.

In addition key performance indicators and reports will be employed to monitor the effectiveness of the policy:

- National staff survey questions pertaining to Incident reporting and support following an incident will be reviewed and subsequent actions monitored by the Patient Safety Group.
- NRLS benchmark reports will be reviewed and subsequent actions monitored by the Patient Safety Group.
- Weekly and monthly EMT performance reports monitoring the completion of SI's.
- Monthly performance reports monitoring the completion of SI action plans.
- Annual performance report at the end of Q4 identifying numbers SI progress against completion and thematic analysis of any root causal or contributory factors**.** Monthly reports from Locality Management and Governance Boards that monitor the aggregation of incidents, complaints, claims and present trend analysis.
- Suicide Prevention Audit will be reviewed and subsequent actions monitored by the Patient Safety Group.
- Unannounced audits will be conducted by the Clinical Audit team to assess compliance with the Serious Incident Reporting and Management processes and procedures. The outcomes of these checks will be reported through the Patient Safety Group.
- An annual audit will be completed of the key themes from lessons learnt to demonstrate sustainability of their implementation within the organisation. The outcome of this report will in the first instance be reported to the Patient Safety Group.

9 References

- NHS England (2015) Serious Incident Framework
- NHS England (2015) Revised Never Events Policy and Framework
- NHS England (2013) Developing a Single Operating Model for Investigating Mental health Homicides
- Care Quality Commission (2014) Fundamental Standards Regulation 20: Duty of Candour
- NHS Litigation Authority (2013) Clinical Negligence Scheme for Trusts, Mental Health and Learning Disability Clinical Risk Management Standards (ceased to exist 31/03/2014 still available on NHSLA website)
- Reporting of Injuries, Diseases, and Dangerous Occurrences Regulations
- (RIDDOR) 1995 amended 2013
- National Patient Safety Agencies (2005) Being Open.
- North East SHA Additional Guidance for reporting safeguarding children incidents to the NE SHA.
- Learning Disability Mortality Review (LeDeR)http://www.bristol.ac.uk/sps/leder/about/

10 Appendices

Appendix 1 Freedom to Speak up Guardian
Appendix 2 Incident Reporting Process flow
Appendix 3 Duty of Candour Check list
Appendix 4 Specialist Commissioned Services and Form 1
Appendix 5 Moderate Harm and Near Miss Incident Review Process
Appendix 6 Head of Service Moderate Harm Incident Review Form
Appendix 7 Head of Service Review Flow Chart
Appendix 8 Incident Management Flow Chart

Appendix 1 - National Guardian Freedom to Speak Up

Role specification for the Freedom to Speak Up Guardian

Acting in a genuinely independent capacity, the Freedom to Speak Up Guardian will be appointed by the Board, working alongside them and members of the executive team to help support the organisation to become a more open, transparent place to work.

In particular the Freedom to Speak Up Guardian will:

- Work with the chief executive and Board to help create an open culture which is based on listening and learning and not blaming.
- Develop, alongside the Board, chief executive and executive team a range of mechanisms, in addition to the formal processes, which empower and encourage staff to speak up safely.
- Ensure that staff with disabilities and those from black and other minority ethnic backgrounds are encouraged to speak out and are not disadvantaged by doing so.
- Participate in the organisation's educational programme for all staff so that they understand how they can raise concerns and for managers about how they respond to concerns and supporting the member of staff appropriately.
- Be entirely independent of the executive team, so they are able to challenge senior members of staff, reporting to the Board or externally as required.
- Be a highly visible individual, who spends the majority of their time with 'front line' staff, providing expertise in developing a safe culture which supports and encourages staff to speak up using the local procedures and if necessary advising them on how to raise concerns, including externally.
- Act in an independent and impartial capacity, listening to staff and supporting them to raise concerns they may have by using the available structures and policies, both within the organisation and outside.
- Independently review any complaints from members of staff about the way they have been treated as a result of raising a concern and report back to the individual and, with their agreement, to their manager, the chief executive and the director of human resources.
- Ensure members of staff who speak up are treated fairly through the investigation, inquiry and or review and that there is effective and open communication during this time.
- Ensure that information about those who speak up is kept confidential at all times, subject to requirements around safeguarding and illegality.
- Meet quarterly with the chief executive to feedback themes from the concerns raised and to share positive and negative experiences and outcomes.
- Report at least every six months to the Board and the organisation as a whole.
- Participate in the national network for the guardians, sharing and helping to develop excellent practice in supporting members of staff who speak up.

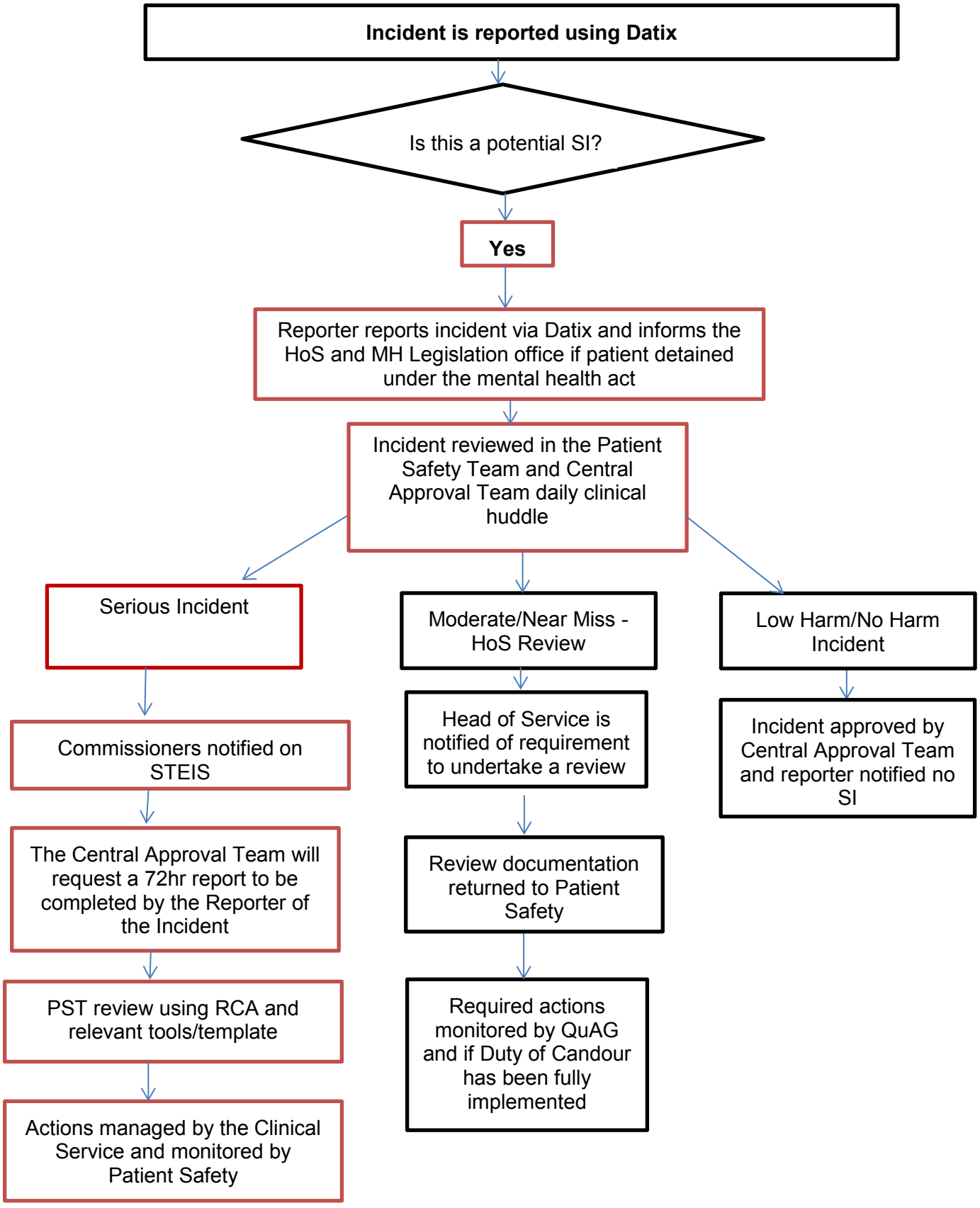
Those appointed as Freedom to Speak Up Guardian should have these characteristics:

- Understand the trust, its values and key priorities and challenges.
- Have a track record of supporting and listening to staff and in demonstrating the values of the trust and the NHS constitution in their daily working lives.
- Be able to facilitate a conversation between members of staff and their managers.

- Have a good understanding of how to raise concerns and the barriers that can exist for those who speak up.
- Be an approachable, trusted, non-judgemental individual, who is comfortable with talking with 'front line' staff from all disciplines and all grades and can build a rapport which demonstrates compassion and understanding.
- Have the ability to set boundaries, be concise, synthesise and present information and be able to write reports for the chief executive and the Board.
- Have an understanding of mediation and managing confidential matters; this includes an understanding of managing and keeping confidential records of cases.
- Be responsive and resilient.
- Have an ability to work with a range of stakeholders, especially those responsible for patient safety and patient and staff experience, to ensure that lessons are learnt, themes identified and necessary changes are made.
- Confident in speaking at internal and external events.

March 2016

Appendix 2 - Incident reporting process flow



Appendix 3 - Duty of Candour Check List

Look at the incident and consider whether the harm has been caused during a regulated activity and ask yourself:

As a Healthcare Professional do I believe this harm may have resulted from actions, omissions or mistakes made in the course of this persons care and treatment (regulated activity)?

Was it an unintended OR unexpected incident (it can be either or and you don't need for both to apply) that occurred during the provision of the patient's care and treatment (regulated activity) that could result in or appears to have resulted in:

- **Death of the patient** (the death must directly to the relate to the incident and not the natural course of the service users illness or underlying condition)
- **Severe Harm**
- **Moderate Harm** means a moderate increase in treatment AND significant harm
- **Prolonged psychological harm** **(more than 28 days)**

FOR DUTY OF CANDOUR TO APPLY THE INCIDENT MUST OCCUR IN THE PROVISION OF REGULATED ACTIVITY AND AT THE TIME IT ONLY NEEDS TO BE THE REASONABLE OPINION OF THE HEALTHCARE PROFESSIONAL AS TO WHETHER DUTY OF CANDOUR APPLIES.

The relevant person (the patient where appropriate or family/carer must be NOTIFED for each incident.

It is recognised that serious incidents can have a significant impact on staff involved or witness to the incident. They will want to know what happened and why and what can be done to prevent it happening again. Staff should have the opportunity to access professional advice from their relevant professional body or union, staff counselling and or Occupational Health services.

An early meeting must be held with the relevant person to explain what happened, why it happened, how it happened and what can be done to minimise it happening again to someone else i.e. action is being taken. Appropriate treatment and support should be provided for the patient, family and or carer; signposting to a suitable organisation, such as Healthwatch, PALS, AvMA or an independent advocate, and support them. An example of additional help may include organising transport for them.

In line with the Duty of Candour where possible the relevant person needs to be made aware as soon as possible in person and in writing of the process of review, a meeting to express concerns, an opportunity to inform the Terms of Reference and how they will be able to contribute to the review process and be given access to the findings. Where appropriate in incidents of death or severe harm this will involve the PST Reviewer.

Death of a patient - Duty of Candour

Where appropriate and in line with the patient's wishes when alive:	Y/N
A registered Healthcare Professional immediately notifies the relevant person and offers condolences ('I am very sorry for your loss and or I am sorry about what has happened')	
If the relevant person cannot be contacted or doesn't want to be involved this must be recorded in the case notes on Paris	
Offer the relevant person a face to face meeting to explain facts known at the time and what will happen next i.e. a review of the care and treatment and that they can be involved in the review	
Complete a DATIX as soon as practicable and inform the Head of Service	
Record the incident as well as actions taken for Duty of Candour in case notes on Paris, you must include the date the apology is given (this is classed a permanent record for Duty of Candour)	
The Head of Service will formalise this and write to relevant person and formally offer condolences and offering a face to face meeting to explain facts and inform what happens next, as well as to offer an apology and the opportunity to be involved in review process of what happened	
Save all Duty of Candour letters on PARIS in letters and record in case notes on PARIS the letter has been sent and to and by whom; and a copy of the letter to Patient Safety Inbox Tewv.patientsafety@nhs.net	

Severe Harm

A registered Healthcare Professional immediately notifies relevant person about the incident informing them of any short or long term effects and all facts known to that point, any remedy and what happens next i.e. a review of the care and treatment and that they can be involved	Y/N
Offer a verbal apology ('I am really sorry') and offer reasonable support and stay with the patient where this is what the patient wants and it is appropriate	
Offer a written apology; record in case notes on PARIS when it is sent and in letters	
Record full details of incident and Duty of Candour actions taken on PARIS, you must record the date the apology is given (classed as a permanent record)	
Complete DATIX as soon as practicable.	

Moderate level of harm

A registered Healthcare Professional immediately notifies the relevant person in a face to face meeting what has happened explaining any long and short term effects known and any remedy: with all facts known to that point, and what happens next i.e. a review of the care and treatment and that they can be involved	Y/N
Offer a verbal apology ('I am really sorry') and offer to follow this up in writing, record on PARIS when it is sent and also offer reasonable support from the team	
Record all Duty of Candour actions in case notes on PARIS, you must record the date the apology is given (classed as a permanent record) include Incident details, names of those present, who explained what happened and that an apology was offered.	
Complete a DATIX as soon as practicable	

Appendix 4 - Specialist Commissioned Services and Form 1

Process for Reporting and Monitoring of Specialist Commissioning Incidents ONLY

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Clinical Services Report incident on Datix

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Identified staff from the specialist clinical service completes Form 1 (only held by services) for relevant incidences and send this by email to their Commissioner

With a copy to:

tewv.patientsafety@nhs.net

↓

Patient Safety Administrators will immediately send the Specialist Commissioning (SC) 72hr report template to Clinical Services for them to populate to then forward on to their Commissioner with a copy to the tewv.patientsafety@nhs.net

ALL SC 72 HOUR REPORTS MUST BE RETURNED TO COMMISSIONERS WITHIN 72 HOURS

MONITORING

Patient Safety Administrator will monitor all returns from the specialist clinical services and send a reminder 24 hours before it is due to be completed; the Head of Service will be copied in to ensure returns are within the timeframe

↓

TEWV Monitoring spreadsheet is sent to Clinical Services to update on status of incident i.e. closed/open/requires further actions and returned to Patient safety

Appendix 5 - Moderate harm and near miss incident review process

	RESPONSIBILITIES FOR MODERATE HARM AND NEAR MISS INCIDENTS
REPORTING	A Datix report is submitted by the service. The Datix is approved and graded as moderate or near miss by the Central Approval Team.
NOTIFICATION	For Moderate Harm and Near Miss Incidents the Patient Safety Team requests a Head of Service (HoS) review on the form in Appendix 6.
TIMESCALES	When a Head of Service Review is requested it needs completed within 8 weeks of the request.
ACTIONS	The Head of Service retains the role and responsibility of overseeing any action plan and ongoing monitoring from the review. The Head of Service review process also assures that where the Duty of Candour and or the culture of candour policy applies that all necessary actions have been followed through and recorded on PARIS. The person carrying out the Head of Service review has the responsibility to give the assurance in the report that the Duty of Candour Policy has been fully implemented.
LEARNING LESSONS AND GOOD PRACTICE	All completed reviews will be shared with relevant Locality Governance Groups and reported to their local QuAG within 12 weeks of the request. It is the role of QuAG to give final reassurance that all Duty of Candour / culture of candour actions have been implemented in line with Duty of Candour policy.
STORAGE	All Head of Service reviews will require a mechanism to be in place within their Directorate to centrally store the incident review forms and associated completed actions (including evidence). This must be up to date and accessible for audit/assurance purposes.

Appendix 6 - Head of Service Incident Review Form

Datix ID Number

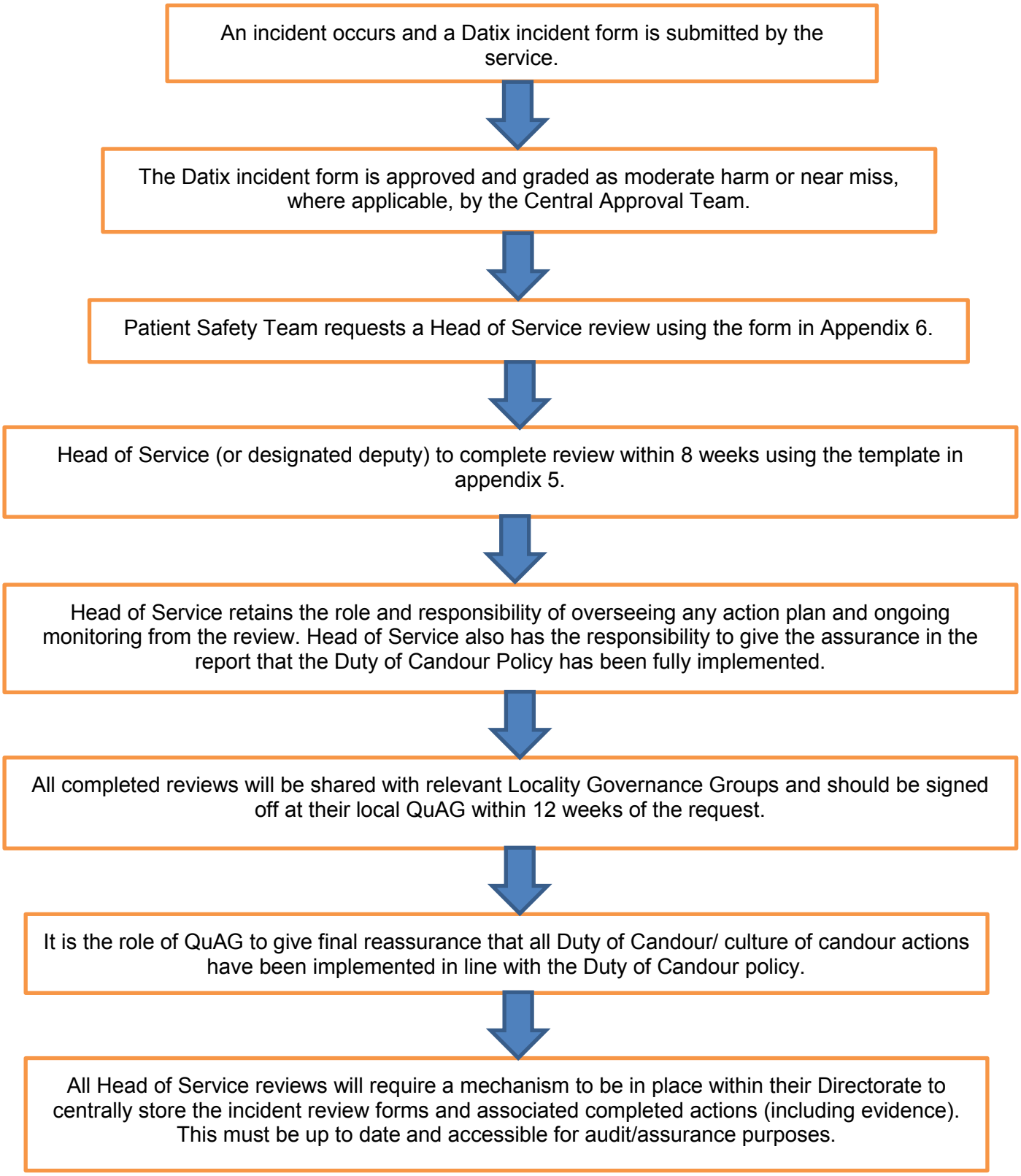
Name of Head of Service request sent to:	
Locality:	**Team:**
Type of Incident: (e.g. unexpected death, fall)	**Staff involved (if staff incident)**
PARIS ID:	**Incident Date:**
Significant Details (i.e. patient demographics, current risk assessment status, i.e. is it up to date.	
Actual Incident (what happened)	
What could have prevented the incident (if anything)	

DUTY OF CANDOUR SECTION MUST BE COMPLETED	
Confirm Statutory Duty Of Candour Applies and has been Implemented	**Y / N**
Confirm Culture Of Candour Process Has Been Implemented	
If yes to enable Datix to be updated please confirm the following has been implemented: a) A registered Healthcare Professional immediately notified the patient (relevant person) in a face to face meeting what has happened explaining any long and short term effects known and any remedy: with all facts known to that point, and what happens next i.e. a review of the care and treatment and that they can be involved.	
b) A verbal apology was given ('I am really sorry') and an offer to follow the apology in writing, both of which were recorded and whether it was sent.	
c) All reasonable support was offered to the patient from the team.	
d) Please provide date apology provided and recorded on case notes in PARIS.	
e) All Duty of Candour actions have been recorded in case notes on PARIS, include Incident details, names of those present, who explained what happened and the apology provided.	

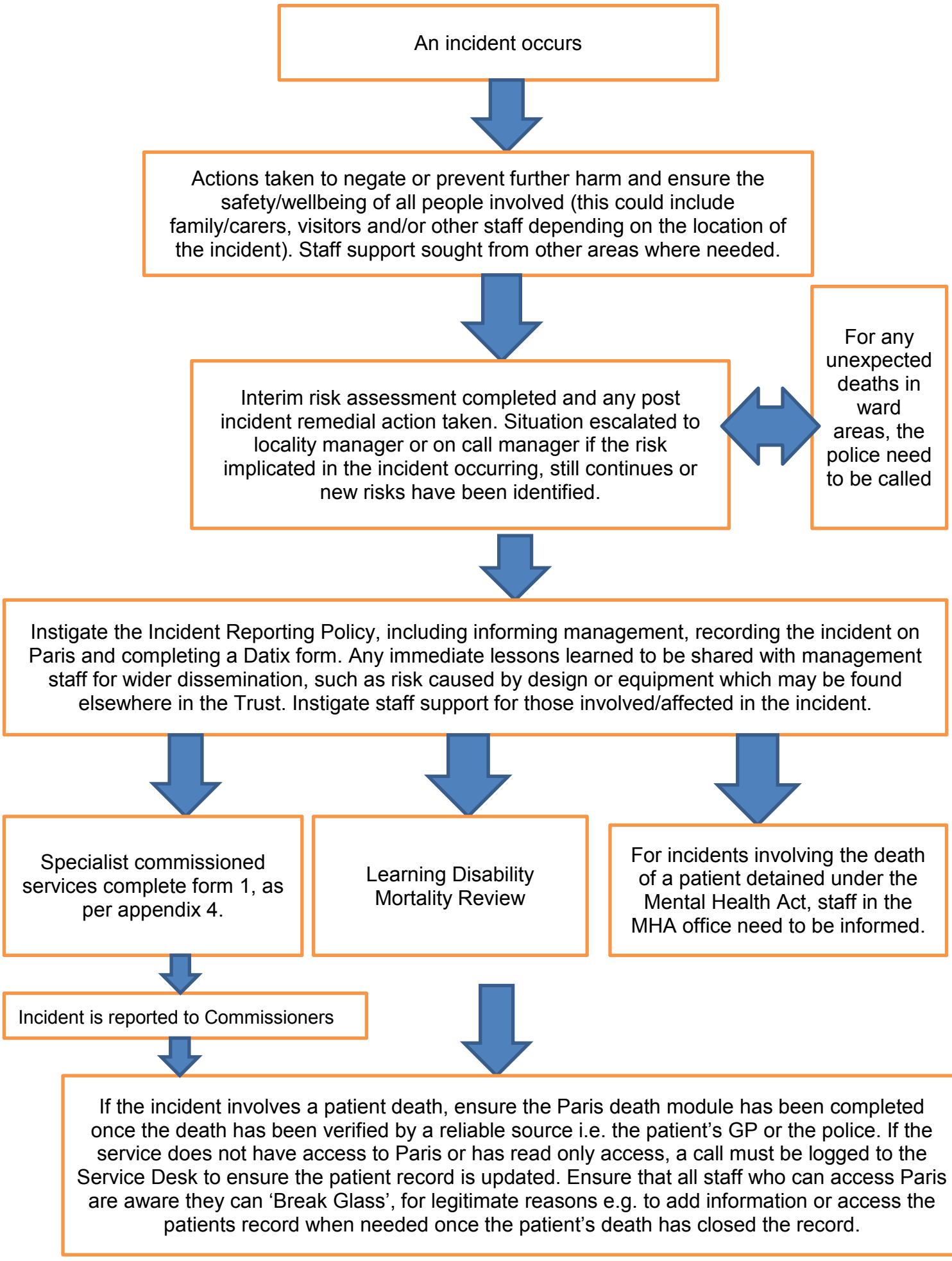
What can we learn and/or good practice identified	
What needs to change (action plan)?	
Author (reviewer)	**Printed:**
Date review completed:	**Signed:**

Date discussed at QUAG: _____

Appendix 7 - Head of Service Review Flow Chart



Appendix 8 - Incident Management Flow Chart



11 Equality Analysis Screening Form

Please note; The Equality Analysis Policy and Equality Analysis Guidance can be found on InTouch on the policies page

Name of Service area, Directorate/Department i.e. substance misuse, corporate, finance etc.	Patient Safety					
Name of responsible person and job title	Anne Lowery Head of Patient Safety, Complaints, Legal and Claims					
Name of working party, to include any other individuals, agencies or groups involved in this analysis	Patient Safety, Central Approval Team					
Policy (document/service) name	Incident Reporting and Serious Incident Review Policy					
Is the area being assessed a;	Policy/Strategy	x	Service/Business plan		Project	
	Procedure/Guidance			x	Code of practice	
	Other – Please state					
Geographical area	Trustwide					
Aims and objectives						
Start date of Equality Analysis Screening (This is the date you are asked to write or review the document/service etc.)	September 2016					
End date of Equality Analysis Screening (This is when you have completed the analysis and it is ready to go to EMT to be approved)	**January 2017**					

1. Who does the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan benefit?

All staff, patients, their family or carers and visitors to the Trust involved in a patient safety incident.

2. Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups below?

Race (including Gypsy and Traveller)	**No**	**Disability** (includes physical, learning, mental health, sensory and medical disabilities)	**No**	**Gender** (Men, women and gender neutral etc.)	**No**
Gender reassignment (Transgender and gender identity)	**No**	**Sexual Orientation** (Lesbian, Gay, Bisexual and Heterosexual etc.)	**No**	**Age** (includes, young people, older people – people of all ages)	**No**
Religion or Belief (includes faith groups, atheism and philosophical belief's)	**No**	**Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave)	**No**	**Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners)	**No**

No – Please describe positive impacts/s

The policy applies to all people involved in patient safety incidents that are or have been patients receiving services, their family or a visitor equally and without exception.

3. Have you considered other sources of information such as; legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.? **If 'No', why not?**	**Yes**			

Sources of Information may include: • Feedback from equality bodies, Care Quality Commission, Equality and Human Rights Commission, etc. • Investigation findings • Trust Strategic Direction • Data collection/analysis • National Guidance/Reports		• Staff grievances • Media • Community Consultation/Consultation Groups • Internal Consultation • Research • Other (Please state below)

4. Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the following protected groups?: Race, Disability, Gender, Gender reassignment (Trans), Sexual Orientation (LGB), Religion or Belief, Age, Pregnancy and Maternity or Marriage and Civil Partnership

Yes – Please describe the engagement and involvement that has taken place

No – Please describe future plans that you may have to engage and involve people from different groups

Briefings are being prepared for staff and will be taken to the Fundamental Standards Group and Triangle of Care Groups.

5. As part of this equality analysis have any training needs/service needs been identified?

~~Yes/No~~	~~Please describe the identified training needs/service needs below~~

A training need has been identified for;

Trust staff	**Yes**	Service users	No	Contractors or other outside agencies	No

Make sure that you have checked the information and that you are comfortable that additional evidence can provided if you are required to do so

The completed EA has been signed off by: You the Policy owner/manager: Type name: Anne Lowery	Date: **10/1/17**
Your reporting (line) manager: Type name: Jennifer Illingworth	Date: 10/1/17

If you need further advice or information on equality analysis, the EDHR team host surgeries to support you in this process, to book on and find out more please call: 0191 3336267/6542 or email: traceymarston@nhs.net

12 Document control

Date of approval:	18 January 2017	
Next review date:	18 January 2020	
This document replaces:	CORP-0043-v8 Incident reporting and serious incident review policy	
Lead:	Name	Title
	Anne Lowery	Head of Patient Safety, Complaints, Legal and Claims
Members of working party:	Name	Title
	Anne Lowery Emma Haimes Jan Bartlett Lesley Munshi Paul Stephenson Brenda Wilson Alison McGrath Elaine Radford Helen Cunningham	Head of Patient Safety Head of Quality Data Serious Incident Investigator Serious Incident Investigator Serious Incident Investigator Serious Incident Investigator Serious Incident Investigator Claims and Legal Services Manager Health and Safety Manager
This document has been agreed and accepted by: (Director)	Name	Title
	Jennifer Illingworth	Director of Quality Governance
This document was ratified by:	Name of committee/group	Date
	Executive Management Team	18 January 2017
An equality analysis was completed on this document on:	10 January 2017	

Change record

Version	Date	Amendment details	Status
V8.1	28 April 2017	Duty of Candour Checklist updated re outcome of Audit One report. Added flow charts for incident management and Head of Service review (as requested by staff). Head of Service review deadlines updated in line with service need. Added the link for Never Events.	Withdrawn
V8.2	10 May 2018	Revision of section 4.6 re reporting of information security incidents and breaches	Published