Learning from Incidents

Reporting, Managing and Investigating

Policy and Guidance

Version: 7

Executive Lead: Executive Director for Quality and Safety
Lead Author: Patient Safety Manager

Approved Date: 31st January 2013
Approved By: Clinical Risk & Learning Lessons Group

Ratified Date: 12th February 2013
Ratified By: Policy Panel

Issue Date: 5th March 2013
Review Date: 5th March 2016

Target Audience:
❖ This Policy must be understood by all staff.
Preface - concerning the Trust Policy Management System (PMS)

P1 - Version Control History:
Below notes the current and previous Version details

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<th>Author</th>
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<td>19th August 2010</td>
<td>Patient Safety Manager</td>
<td>Superseded</td>
<td>Updated with new appendices</td>
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<td>V7</td>
<td>5th March 2013</td>
<td>Patient Safety Manager</td>
<td>Current</td>
<td>Fully reviewed and re-written – Name change of Policy</td>
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P2 - Relevant Standards:

a) **NHSLA Risk Management Standards Mental Health & Learning Disability Standard 2 Learning from Experience**, for full details please click here.
   - Criterion 2 - Incident Reporting
   - Criterion 5 - Investigations
   - Criterion 6 - Analysis Improvement
   - Criterion 7 – Learning Lessons from Claims

b) **Equality and RESPECT**: The Trust operates a policy of fairness and RESPECT in relation to the treatment and care of service users and carers; and support for staff.

P3 - The 2012 Policy Management System and the Policy Format:

- **Policy Template** is the essential format for most Policies. It contains all that staff need to know to carry out their duties in the area covered by the Policy.
- **Operational Policies Template** provides the format to describe our services, how they work and who can access them
- **Care Pathways Template** is at the moment in draft and only for the use of the Pathways Team as they are adapting the design on a working basis.

Symbols used in Full Policies:

- **RULE** = internally agreed, that this is a rule & must be done the way described
- **STANDARD** = a national standard which we must comply with, so must be followed

**Managers** must bring all relevant policies to the attention of their staff, where possible, viewing and discussing the contents so that the team is aware of what they need to do.

**Individual staff/students/learners** are responsible for implementing the requirements appropriate to their role, through reading the Policy and demonstrating to their manager that they understand the key points.

All Trust Policies will change to these formats as Policies are reviewed every 3 years, or when national Policy or legislation or other change prompts a review. All expired & superseded documents are retained & archived and are accessible through the Compliance and Risk Facilitator Policies@hertspartsft.nhs.uk

All current Policies can be found on the Trust Policy Website via the Green Button or http://trustspace/InformationCentre/TrustPolicies/default.aspx
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PART 1 – Learning from Incidents Policy

Flow Chart – Overview of Incident Reporting & Investigation Procedure

**Who is responsible?**

- Team
- Patient Safety Department
- Patient Safety Department
- Managing & Clinical Directors
- Managing & Clinical Directors
- Managing & Clinical Directors

**INCIDENT**

- Complete electronic Incident Form via Datix
- Confirm Level (1 to 4)

**Level 1**
- No further Action

**Level 2**
- 7 Day Report

**Level 3 & 4**
- 7 Day Report

**Timescale**

- 2 working days
- Within 7 working days
- 3 days from incident
- 45 Days
- 28 Days
- Max 4 Months

**PCT Scrutiny Process determines NHS Hertfordshire policy level**

- No further action (unless exceptional circumstances e.g. cluster)
- Full RCA Investigation
- No further action (unless exceptional circumstances e.g. cluster)

**Panel Review**

- Set TOR and Commission
- Report Completed
- Decision re: external enquiry
- Action Plan
- Implementation of Action Plan
- Monitoring at Clinical Risk and Learning Lessons

**Managing & Clinical Directors**

- Aggregated reports to Q&RMC and IGC
- Set TOR and Commission
- Report Completed
- Action Plan
- Implementation of Action Plan
- Monitoring at Clinical Risk and Learning Lessons

**Managing & Clinical Directors**
Introduction

Hertfordshire Partnership NHS Foundation Trust (the Trust) is committed to providing the best possible service to its service users and staff. This policy and guidance covers the reporting, management and review of incidents and serious incidents (including near misses) within the Trust both clinical and non-clinical.

The Trust aims to ensure that all incidents are reported by staff in a timely manner, and are managed and investigated appropriately based on their severity to minimise and contain the impact and prevent the recurrence of harm to staff, service users, visitors and contractors.

The Trust will learn and make changes as a result of incidents to improve the safety and quality of health services for service users and the working environment for staff, visitors and contractors.

Priority is given to ensuring that service users, their relatives and carers are kept informed of an incident and progress and outcome of the investigation. The Trust works within an open culture, sharing knowledge, good practice and experience and learning from issues where we find poor practice or where systems and procedures do not help the delivery of high quality care.

The policy incorporates the East of England policy documents, “Serious Incidents requiring investigation Policy” (July 2010) and “Serious Incident Procedure” (November 1999) and the National Patient Safety Agency’s “National Framework for Reporting and Learning From Serious Incidents Requiring Investigation”.

It also outlines the actions for the management and rapid follow-up of major clinical incidents at the Trust. It is related to the Major Incidents & Emergencies Policy and Procedure & Business Continuity Plan and links with the “Planning for Major Incidents” NHS Guidance document. In addition, it incorporates guidance from ‘Seven Steps to Patient Safety in Mental Health’ (November 2008), ‘Seven Steps to Patient Safety: Guide for NHS Staff’ (National Patient Safety Agency 2003) and NPSA Guidance document ‘Being Open’ 2005.

1.1 Purpose

1.1.1 The purpose of this policy and guidance is to reflect the National Patient Safety Agency National framework for Reporting and Learning from Serious Incidents Requiring Investigation.

This includes:

- a consistent definition of incidents to enable a prompt and speedy response to serious incidents that require investigation
- clarity of roles and responsibilities
- information on requirements and timescales
- the legal and regulatory requirements associated with the management of serious incidents
- process and procedures to ensure the implementation and support for good practice
- the reporting of serious incidents to the relevant bodies for a full investigation
• provision of a framework for learning from the incident
• an open and non-judgemental approach to adverse incidents and other incidents. This ensures that everyone within the organisation contributes to the reporting and learning process and is confident to do so without the fear of recrimination.

1.1.2 To enable the Trust to identify in relation to individual incidents, when the Disciplinary Procedure should appropriately be used and when it should not, the NPSA tool and guidance, known as the ‘Incident Decision Tree’, has been adapted by the Trust to assist the process;

➢ Appendix A: NPSA Incident Decision Tree

1.2 Definitions

STANDARD

1.2.1 Terms

Incident (Incident)
The term incident can broadly be defined as:
‘any event or circumstance that could have resulted (near miss) or did result in unnecessary damage, loss or harm such as physical or mental injury to a service users, staff, visitors, contractors, members of the public or to property, records or equipment on Trust premises or belonging to the Trust’.

A near miss is an incident (clinical or non-clinical) that could have caused harm but on this occasion did not.

A serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care resulting in one of the following:

(i) Unexpected or avoidable death of one or more service users, staff, visitors or members of the public.
(ii) Serious harm to one or more service users, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm (this includes incidents graded under the NPSA definition of severe harm).
(iii) A scenario that prevents or threatens to prevent a provider organisation’s ability to continue to deliver healthcare services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment, or IT failure;
(iv) Allegations of abuse - refer to the HPFT safeguarding adults and safeguarding children policies for the definition of abuse.
(v) Potential or actual adverse media coverage or public concern about the organisation or the wider NHS;
(vi) One of the core set of ‘Never Events’ as updated on an annual basis and currently including (as relevant to the Trust):
— misplaced naso-gastric or orogastric tube not detected prior to use
— inpatient suicide using non-collapsible rails
— escape from within the secure perimeter of medium or high security mental health services by patients who are transferred prisoners
As a minimum, patient safety incidents leading to unexpected death or severe harm should be investigated to identify root causes and enable ameliorating action to be taken to prevent recurrence.

The definition of serious incidents requiring investigation extends beyond those which affect patients directly, and includes incidents which may indirectly impact patient safety or an organisation’s ability to deliver ongoing healthcare. All serious patient safety incidents should be reported to the NRLS, and to notifiable partner organisations, as detailed in the information resource that supports this policy (found on the NPSA website at www.nrls.npsa.nhs.uk/patientsafetydirect).

Organisations are advised to err on the side of caution. Advice can be sought from the PCT commissioner of the service and or the Clinical Quality and Patient Safety Directorate at NHS East of England (01223 597567).

Excluded from this definition are adverse outcomes reasonably associated with routine NHS activity such as major surgical procedures or radiotherapy treatment.

A no harm event in relation to any of the above should also be recorded by NHS provider organisations and potential aggregated trends and clusters analysed using root cause analysis. Any emerging trends, which constitute a significant risk in any of the above categories, should be reported using this policy.

All incidents should be graded by the provider in line with the national framework subject to local arrangements.

1.2.2 Grading of Incidents

Incidents will be classified by the staff involved, into one of four levels. Higher levels of incident require more complex immediate responses, investigation and review. General guidance as to how staff should grade incidents is given below and examples are given in Appendix B.

- Appendix B: Incident Types

**LEVEL 1**

Level 1 incidents are untoward occurrences that can generally be managed adequately and promptly on the spot. Taken individually the incident does not have serious on going consequences, implications or repercussions for the individual or the service. Level 1 incidents will not normally require investigation on a case by case basis. However, trend data will be collected and analysed to assist the organisation in identifying areas for further work/learning.

**LEVEL 2**

Level 2 incidents may still be managed locally. However the nature of the incident and its possible implications requires that a manager be immediately informed. The incident may have consequences, in terms of the potential to cause a seriously adverse outcome or injury, or interruption to services which require on-going management action.

**LEVEL 3**

Level 3 incidents are of a degree of seriousness that requires an external element to any review. Such incidents typically relate to:
- Serious injury/unexpected death of a service user or member of staff or public,
- Serious criminal activity,
- A series of incidents which taken together could have serious implications.

**LEVEL 4**
Level 4 incidents are extremely serious incidents that automatically require an inquiry led by agencies external to the Trust, as specified by the Regional Office of the National Health Service Executive (NHSE). This would include:
- Local Safeguarding Children Board Child Protection Procedures
- Alleged and attempted homicide
- Series of Suicides in inpatient service
- Very serious criminal activity by staff
- Exceptional public interest

**Review of Grading/Classification**
The grading of the incident should be kept under review as it may emerge that the incident is actually more or less serious. The Patient Safety Team should be informed of any proposed change of grade, and the rationale for the change should be recorded formally and submitted to the Patient Safety Team.

The Patient Safety team will grade incidents as required by the National Patient Safety Agency, *National framework for Reporting and Learning from Serious Incidents Requiring Investigation, Grading of serious incidents, page 17.*

### 1.3 Duties and Responsibilities

**RULE**
The Trust has a responsibility to ensure that when an incident does happen, there are systematic measures in place for:
- safeguarding people, property, the service’s resources and its reputation
- understanding why the event occurred,
- ensuring that steps are taken to reduce the chance of a similar incident happening again,
- reporting to other bodies where necessary, and
- sharing the learning with other NHS organisations and providers of NHS-funded care.

This Policy applies to all staff employed within the Trust either permanently or on a temporary basis or contractor, and to volunteers. All are expected to know and use the procedure.

**1.3.1 Chief Executive**

Overall responsibility for the implementation of the policy rests with the Board through the Chief Executive.

**1.3.2**
The Executive Director for Quality and Safety is to be responsible for overseeing implementation of the policy.
1.3.3 Managing and Clinical Directors (on behalf of the Chief Operating Officer)

Managing and Clinical Directors are responsible for:

- ensuring that this policy and related procedures are notified to staff
- monitoring compliance
- ensuring that any remedial action required is actioned, or planned for action, and reported to the Patient Safety Department
- ensuring that the Governance structures are in place and operating effectively in identifying and implementing learning throughout the services.

1.3.4 Senior Information Risk Owner (SIRO)

The Trust’s SIRO is a nominated Executive Director on the Board who is familiar with information risks and the Trust’s response to risk. The role of the SIRO is to take ownership of the Trust’s Information Risk Policy, act as an advocate for information risk on the board and provide written advice to the accounting officer on the content of the statement of internal control in regard to information risk.

1.3.5 Members of the Senior Management Team/Service Line Leaders

The Senior Management Team in each Strategic Business Unit are primarily responsible for:

- ensuring that all incidents are reported
- ensuring that investigations into incidents (clinical and non-clinical) are undertaken in accordance with this policy in relation to the severity of the incident and its possible implications.

Service Line Leaders must ensure that investigations are comprehensive and action is taken to learn lessons and implement improvements to minimise the risk of recurrence.

Service Line Leaders are responsible for ensuring that all staff (including temporary staff) are trained in these procedures and supported if they are affected by an incident.

Service Line Leaders must liaise with their Managers, Senior Medical staff, Senior Clinical Professionals, Professional Leads and other advisors (such as the Health, Safety and Security Manager and the Patient Safety Manager) to make decisions on the management of Serious Incidents, including considering who is the best person to inform the service user and/or the relatives of the outcome of the incident and to liaise with them throughout the procedure.

1.3.6 Practice Governance Leads

Practice Governance Leads have a key role in ensuring the effective investigation of serious incidents, ensuring that recommendations and learning are implemented and shared across the Strategic Business Unit.

They also have a key role in ensuring that learning from incidents is communicated both within and across Strategic Business Units. This includes analysis of trends with regard to incidents as a whole, as well as learning to be taken from investigation reports into more serious incidents. Patient Safety Meetings are held within each
Strategic Business Unit where it is the role of the Practice Governance Lead to ensure all incident data is supplied to be considered on a bi monthly basis.

1.3.7 Department/Team Leaders

Departmental/Team Leaders are responsible for ensuring that all their staff are aware of and are trained in the procedures, so that the policy and procedures are appropriately applied within their sphere of management.

1.3.8 Consultants and Senior Professional Staff

Following an incident, the responsibility for ensuring continuity of patient care, rests with the respective Consultant and senior professional staff depending on the way the team operates.

Consultants and senior professional staff are also responsible for ensuring that all staff under their supervision are fully aware of this policy and organisational arrangements and comply with it at all times.

1.3.9 All Staff

All staff are responsible for:
- following this procedure by reporting incidents promptly and openly
- where appropriate being involved in an investigation
- learning from the incident/changing practice

Importantly all staff are expected to reflect on their own practice and participate in implementing actions and recommendations following incidents and to ensure lessons are learned to improve services and minimise risk of reoccurrence.

1.3.10 Patient Safety Department

The Patient Safety Department (primarily through the Patient Safety Manager) is responsible for co-ordinating the Reporting and Investigation Procedures and for gathering the necessary information to report and facilitate learning at all levels in the organisation.

1.3.11 Committees with overarching responsibility for Patient Safety

The Integrated Governance Committee (IGC) has overarching responsibility for Patient Safety on behalf of the Trust Board, leading on how all clinical and non-clinical incidents are identified and reported in the Trust, ensuring that actions are taken as a result of trend analysis, and for the cascading of information throughout the organisation. Monitoring is carried out by the Clinical Risk and Learning Lessons Group on behalf of the Quality & Risk Management Committee and the IGC.

These committees are responsible for the monitoring of the completion of action plans and the subsequent effectiveness of any risk reduction measures introduced.

1.3.12 Other committees/groups with responsibility for incident management

Other committees/group with a responsibility for the reporting and management of incidents are the Practice Governance Groups, Health Safety & Security Strategy Group, Learning & Development, local Incident and Patient Safety Groups, this is
reflected in the Terms of Reference of each group. They are collectively responsible for ensuring that the lessons are learnt organisationally and are introduced in other business groups, service areas and departments. These groups report into the Quality and Risk Management Committee, a sub committee of the Integrated Governance Committee, which includes the Clinical Risk and Learning Lessons Group.

1.4 Reporting, Managing and Investigating Incidents

1.4.1 A safe environment should be re-established and secured, all equipment or medication retained and isolated, and relevant documentation copied and secured to preserve evidence and facilitate investigation and learning. If there is a suggestion that a criminal offence has been committed or an unexpected death has occurred, the provider organisation should contact the police. Refer to Part 2 for the process and procedure for reporting all incidents/near misses involving staff, service users and others.

1.4.2 Priority must be given to communication, information and support for those affected by the incident.

In all instances, the first priority for the Trust is to ensure the needs of individuals affected by the incident are attended to, including any urgent clinical care which may reduce the harmful impact. (See the useful checklist of actions at Appendix J)

Early consideration will be given to the provision of information and support to members of staff, service users, relatives and carers involved in the incident, including information regarding support systems which are available to members of staff, service users/relatives/visitors/contractors. The guidance provided in the Trust’s Being Open policy should be followed.

1.4.3 Each Strategic Business Unit is allocated a Practice Governance Lead. Practice Governance Leads have a key role in ensuring that learning from incidents is communicated both within and across Strategic Business Units. This includes analysis of trends with regard to incidents as a whole, as well as learning to be taken from investigation reports into more serious incidents.

The principal route for this is the Quality & Risk Management groups, chaired by Clinical Directors (one per Strategic Business Unit), then Practice Governance groups, including Patient Safety Groups, within each Strategic Business Unit. Staff who attend these meetings are responsible for ensuring the lessons from these cases are considered at team level.

It is important that all recommendations from incident investigations are carried out, and the Trust Clinical Risk & Learning Lessons Group chaired by the Executive Director for Quality and Safety, makes sure this takes place. It tracks the themes of recommendations from such reports which are captured through the database held by the Risk Department. It also focuses on making sure Trust-wide recommendations (which may stem from one local incident), are implemented.

The Quality & Risk Management groups within each Strategic Business Unit report to the Clinical Risk & Learning Lessons Group. Practice Governance Leads are members of both groups and are in key positions to ensure that learning is disseminated to all levels of the organisation.
1.5 Learning from Incidents

Analysis of the root causes of individual Incidents and near misses will result in the identification of issues from which the service can learn. These must be translated into recommendations for change and action plans. They must then be monitored and reviewed to ensure that the service does learn the lessons and make improvements for the future via the Learning Database. Refer to Part 3 for the process for learning from incidents.

1.6 Training

The organisation’s expectations in relation to which staff need this training is identified in the Patient Safety Training Prospectus. The relevant section from Appendix 1 is included below:

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<th>Renewal Period</th>
<th>Delivery Mode</th>
<th>Contact Information</th>
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<tr>
<td>Seven Day Report Writing</td>
<td>Team Leaders, Managers</td>
<td>Once</td>
<td>Taught course</td>
<td>For taught courses, contact the Learning &amp; Development Team: <a href="mailto:Learning@hertspartsft.nhs.uk">Learning@hertspartsft.nhs.uk</a></td>
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<td>Writing Training</td>
<td>and staff above Band 5</td>
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<td>(2 hours)</td>
<td>You can check for future dates here, and request a specific date.</td>
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The Patient Safety Training Prospectus, also describes the process for checking that all relevant staff groups complete the training they need, and the process for following up those who fail to attend this, or any such training.

Basic awareness training is provided at Corporate Induction for Managers. Team Leaders and other managers responsible for all our frontline services need to have initial training in the generic level of investigation and report writing, and then to build up experience. ‘7 Day Report Writing Training’ is in effect mandatory ‘one-off’ training for all Team Leaders and other managers responsible for all our frontline services, as they will need to be able to carry out objective investigations of incidents, complaints and claims within their own service and potentially within other services too.

The organisation needs a pool of well trained, experienced people to carry out Root Cause Analysis investigations on some of the most serious incidents. This is not mandatory training for any group of staff, but the candidates are carefully selected and nominated according to their pre-existing skills and attitude to learning and development etc. General awareness raising sessions concerning the whole Learning from Incidents Policy, and the Datix system, and the Risk Management Policy are available when significant changes occur or as needed.

<table>
<thead>
<tr>
<th>Level of Training</th>
<th>Service</th>
<th>Staff Group</th>
<th>Training Package and/or Provider</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Root Cause Analysis</td>
<td>All</td>
<td>Nominated Staff</td>
<td>Private Provider</td>
<td>Once with refresher training bi-annually</td>
</tr>
<tr>
<td>Training</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Learning From Incidents</td>
<td>All</td>
<td>All</td>
<td>Patient Safety Department</td>
<td>As significant changes occur to the</td>
</tr>
</tbody>
</table>
1.7 Embedding a culture of Equality & RESPECT

The Trust promotes fairness and RESPECT in relation to the treatment, care & support of service users, carers and staff.

RESPECT means ensuring that the particular needs of ‘protected groups’ are upheld at all times and individually assessed on entry to the service. This includes the needs of people based on their age, disability, ethnicity, gender, gender reassignment status, relationship status, religion or belief, sexual orientation and in some instances, pregnancy and maternity.

Working in this way builds a culture where service users can flourish and be fully involved in their care and where staff and carers receive appropriate support. Where discrimination, inappropriate behaviour or some other barrier occurs, the Trust expects the full cooperation of staff in addressing and recording these issues through appropriate Trust processes.

**RULE:** Access to and provision of services must therefore take full account of needs relating to all protected groups listed above and care and support for service users, carers and staff should be planned that takes into account individual needs. Where staff need further information regarding these groups, they should speak to their manager or a member of the Trust Inclusion & Engagement team.

Where service users and carers experience barriers to accessing services, the Trust is required to take appropriate remedial action.

<table>
<thead>
<tr>
<th>Service user, carer and/or staff access needs (including disability)</th>
<th>All staff within the Patient Safety Department undergo needs assessments, and any necessary adjustments or access needs are facilitated. The process for reporting, investigating and learning from incidents will not be affected by the access needs or disabilities of staff, service users, carers or relatives. Any specific needs relating to staff, service users, carers or relatives will be considered and met by operational teams.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Involvement</td>
<td>Service users, carers and relatives are invited to contribute to Root Cause Analysis and Panel Review investigations following Serious Incidents. Any specific needs will be considered and reasonably met, e.g. access needs, interpreter, etc.</td>
</tr>
<tr>
<td>Relationships &amp; Sexual Orientation</td>
<td>The process for reporting, investigating and learning from incidents will not be affected by the relationship status or sexual orientation of staff, service users, carers or relatives. Any specific needs relating to staff, service users, carers or relatives will be considered and met by operational teams.</td>
</tr>
<tr>
<td>Culture &amp; Ethnicity</td>
<td>All staff within the Patient Safety Department are able to work according to their individual beliefs. The process for reporting, investigating and learning from incidents will not be affected by the culture &amp; ethnicity of staff, service users, carers or relatives. Any specific needs relating to staff, service users, carers or relatives will be considered and met by operational teams.</td>
</tr>
<tr>
<td>Spirituality</td>
<td>This should be considered as part of the support given to staff, service users, relatives and carers following an incident.</td>
</tr>
</tbody>
</table>
The process for reporting, investigating and learning from incidents will not be affected by the spirituality of staff, service users, carers or relatives. Any specific needs relating to staff, service users, carers or relatives will be considered and met by operational teams.

**Age**
The process for reporting, investigating and learning from incidents will not be affected by the age of staff, service users, carers or relatives. Any specific needs relating to staff, service users, carers or relatives will be considered and met by operational teams.

**Gender & Gender Reassignment**
The process for reporting, investigating and learning from incidents will not be affected by the gender of staff, service users, carers or relatives. Any specific needs relating to staff, service users, carers or relatives will be considered and met by operational teams.

**Advancing equality of opportunity**
Feedback received from staff, service users, carers and relatives as part of the investigation of Serious Incidents will be used to promote learning across the Trust and will be considered in future reviews of this Policy.

### 1.8 Process for monitoring compliance with the Learning from Incidents policy and guidance

<table>
<thead>
<tr>
<th>Action:</th>
<th>Lead</th>
<th>Method</th>
<th>Frequency</th>
<th>Report to:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of compliance with NHSLA Standard 5 Learning From Incidents at Level 2 &amp; 3</td>
<td>Compliance and Risk Manager</td>
<td>Review policy against NHSLA standards</td>
<td>Policy checked annually</td>
<td>Clinical Risk &amp; Learning Lessons Group Q&amp;RMC IGC</td>
</tr>
<tr>
<td>Ensure compliance with annual policy update</td>
<td>Patient Safety Manager</td>
<td>Policy review and ratification at internal committees</td>
<td>Annually</td>
<td>Clinical Risk &amp; Learning Lessons Group Q&amp;RMC IGC</td>
</tr>
<tr>
<td>Monitor compliance with key objectives regarding Serious Incidents</td>
<td>Patient Safety Manager</td>
<td>Provide the Executive Team with regular reports on Serious Incidents</td>
<td>Monthly</td>
<td>Executive Team Clinical Risk &amp; Learning Lessons Group Q&amp;RMC IGC</td>
</tr>
<tr>
<td>Ensure compliance with reporting of quantitative and qualitative data</td>
<td>Patient Safety Manager</td>
<td>Provide reports on incident and Serious Incident data trends</td>
<td>Quarterly</td>
<td>Clinical Risk &amp; Learning Lessons Group Q&amp;RMC IGC</td>
</tr>
<tr>
<td>Monitor the investigation process for Serious Incidents, by investigation timeliness, recommendation and action plans and lessons learned and</td>
<td>Patient Safety Manager</td>
<td>Provide reports to internal committees</td>
<td>Quarterly</td>
<td>Clinical Risk &amp; Learning Lessons Group Q&amp;RMC IGC</td>
</tr>
<tr>
<td>Implementation</td>
<td>Implement the key objectives of the policy.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>----------------</td>
<td>---------------------------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Monitor compliance with Training identified in the Policy</td>
<td>Patient Safety Manager</td>
<td>Review of training plan and investment in further training for staff and managers at Quality &amp; Risk Management Committee meetings.</td>
<td>Quarterly</td>
<td>Clinical Risk &amp; Learning Lessons Group Q&amp;RMC IGC</td>
</tr>
<tr>
<td>Ensure compliance with contract arrangements</td>
<td>Patient Safety Manager</td>
<td>Provide contract monitoring reports</td>
<td>Quarterly</td>
<td>Joint Commissioning Team</td>
</tr>
<tr>
<td>Ensure compliance with practice and corporate governance requirements as part of the risk reduction programme</td>
<td>Patient Safety Manager</td>
<td>Assessment of improvements in practice and/or systems and policies</td>
<td>Annually</td>
<td>Clinical Risk &amp; Learning Lessons Group Q&amp;RMC IGC</td>
</tr>
<tr>
<td>Monitor counselling/support offered to service users and families, carers and staff involved</td>
<td>Patient Safety Manager</td>
<td>Review the services we offer</td>
<td>Annually</td>
<td>Clinical Risk &amp; Learning Lessons Group Q&amp;RMC IGC</td>
</tr>
<tr>
<td>Monitor effectiveness of the policy processes for reporting and management of incidents and implementation of Action Plans</td>
<td>PACE</td>
<td>Internal audit, External audit, Service Line Leaders and clinical staff have responsibility for Patient Safety included in their job descriptions.</td>
<td>Annually</td>
<td>Clinical Risk &amp; Learning Lessons Group Q&amp;RMC IGC</td>
</tr>
<tr>
<td>Monitor compliance with the policy processes for reporting to external agencies, communication and support for staff and relatives</td>
<td>Patient Safety Team/PACE</td>
<td>Internal audit</td>
<td>Annually</td>
<td>Clinical Risk &amp; Learning Lessons Group Q&amp;RMC IGC</td>
</tr>
</tbody>
</table>
1.8.1 The Trust is registered with the Care Quality Commission (CQC). The information obtained from the notification system set out in section 2 will be used as part of the monitoring system of serious incidents.

1.9 Definition of terms used

1. **Incident** – an event or circumstance that could have resulted, or did result, in unnecessary damage, loss or harm such as physical or mental injury to a service user, staff, visitors or members of the public.

2. **Near miss** – an incident (clinical or non-clinical) that could have caused harm but on this occasion did not.

3. **NHS-funded services and care** – healthcare that is partially or fully funded by the NHS, regardless of the location.

4. **Unexpected death** – where natural causes are not suspected. Local organisations should investigate these to determine if the incident contributed to the unexpected death.

5. **Permanent harm** – directly related to the incident and not to the natural course of the service user’s/staff’s illness or underlying conditions, defined as permanent lessening of bodily functions, including sensory, motor, physiological or intellectual.

6. **Prolonged pain and/or prolonged psychological harm** – pain or harm that a service user or staff has experienced, or is likely to experience, for a continuous period of 28 days.

7. **Severe harm** – a service user or staff safety incident that appears to have resulted in permanent harm to one or more persons receiving NHS-funded care.

8. **Major surgery** – a surgical operation within or upon the contents of the abdominal or pelvic, cranial or thoracic cavities or a procedure which, given the locality, condition of patient, level of difficulty, or length of time to perform, constitutes a hazard to life or function of an organ, or tissue (if an extensive orthopaedic procedure is involved, the surgery is considered ‘major’).
Introduction

The purpose of this section is to ensure that all Trust staff follow a standard, consistent incident management procedure when reporting incidents.

2.1 In Office Hours

All incidents should be reported immediately using an electronic incident form which can be found via the “Incident Reporting System (Datix)” link on Trustspace or at the following address: https://wavy-db01/Datix/live/index.php

If the incident is Level 2 or above the Service Line Leader should be informed immediately through the relevant on-call systems. If necessary they will take responsibility for the management of the incident.

The staff members involved in the incident are responsible for reporting it to the appropriate manager and immediate, accurate completion of an incident form for every adverse incident, accident or ‘near miss’.

It is only necessary to fill out one electronic form per incident, as long as all persons involved in the incident are identified in the Persons affected section (you can add multiple people by selecting the “add another” button at the bottom of the persons affected section).

The incident form should be attached to CareNotes and titled correctly. If an incident occurs and is being investigated, a brief and objective summary of the event should also be recorded in a clinical note on the Electronic Patient Record, and followed up with the outcome of the investigation. If the incident has involved two service users, anonymised details should be recorded in both service users’ records.

For any queries relating to the above information please contact the Patient Safety Department at incidents@hertspartsft.nhs.uk

Key staff should also be asked to write statements immediately following serious incidents so that their recollections are immediately captured.

➤ Appendix C: Making a Witness Statement, Guidelines for Staff

2.2 Out of Hours (including weekends and bank holidays)

Level 2 incidents and above require immediate reporting to the Service Line Leader or manager on call as per local out of hours arrangements in each Service.

If a Level 3 or 4 incident occurs out of hours the Service Line Leader should report to the Executive Director on call via Oak/Beech reception. If necessary they will take responsibility for management of the incident.

➤ Appendix D: Internal Contact Details

The Patient Safety Department must be informed of this the next working day either via a personal telephone call or an e-mail (see paragraph 2.11). There are also specific requirements for Out of Hours reporting to the Health & Safety Executive for relevant
incidents (see paragraph 2.11.5) and to the PCT and East of England Strategic Health Authority for Serious Incidents (see paragraph 2.11.1).

2.3 Reporting Data Loss

Incidents relating to breaches of confidentiality involving person identifiable data and data losses should be reported to the Patient Safety Department and the Information Governance Officer. The Information Governance Officer or the Information Governance Lead will be responsible for ensuring that the SIRO and appropriate members of the Executive Team are informed.

- Information Security Policy
- Information Risk Policy

2.4 Reporting Medication Errors

Any incidents relating to the administration, dispensing or prescribing of medication must be reported to the Patient Safety Department by completing the electronic incident form. A copy of the prescription chart/medication administration chart must also be sent, where appropriate. A copy is forwarded to the Medicines Management Team (MMT) and Head of Medicines Management for further investigation.

For serious incidents a ‘Medication Error Report’ is completed and lessons learnt actioned by Service Line Leaders.

Incidents relating to medication errors or near misses are to be reviewed by the Drugs and Therapeutic Committee via the Head of Medicines Management.

In the majority of cases, medication errors constitute Level 2 incidents but a 7-day report is generally not required due to Medicine Management Team investigation.

- Medicines Policy

2.5 Healthcare Associated Infections (HCAI)

Incidents involving Healthcare Associated Infection should be reported to the Patient Safety Department and the Infection Control Nurse. The Infection Control Nurse will decide whether this is reported as a Serious Incident. These would be defined as:

- Outbreaks of healthcare associated infection (this includes the presumed transmission within a hospital and causes significant morbidity, mortality and or impacts significantly on hospital activity). A clinical area closed as a result of an outbreak would constitute a serious incident.
- Infected healthcare workers (incidents which necessitate consideration of a look back exercise).
- Breakdown of infection control procedures and or serious decontamination failures with actual or potential for cross infection.

2.6 Use of adult psychiatric wards for children aged 16 and under

In accordance with Department of Health Gateway letter 8390 of 29 June 2007 and in order to ensure compliance with the “age appropriate provision” legislative requirement under the Mental Health Act from April 2010 the SHA, via the PCT should be immediately notified, via Patient Safety, if a child of 16 or under is placed on an adult ward. The
notification should include how the child will be moved to appropriate accommodation within 48 hours and in the intervening time, how the ward and staffing have been made appropriate to the child's needs.

Whilst there are occasions where it is appropriate to admit 16 and 17 years olds to adult Mental Health facilities, the PCT, via Patient Safety, should be immediately notified of all incidents relating to 16 and 17 year olds placed on adult wards. The PCT will in each incident need to be assured that it is an appropriate placement (in line with best practice set out in the national service framework). The Patient Safety Department will report this via the Serious Incident procedure.

2.7 Reporting to the Chief Executive/Executive Team

Once notified, the Patient Safety Department will be responsible for ensuring that the Chief Executive and appropriate members of the Executive Team are informed about serious incidents Level 3 or above, and this should occur on the same or next working day.

For incidents relating to information, the Information Governance Officer or the Information Governance Lead will be responsible for ensuring that the SIRO and appropriate members of the Executive Team are informed.

2.8 Incidents reported from other sources

Should a manager have an incident reported to them by a non-Trust source, e.g. via a complaint, or from a service user or another organisation, the manager will complete an electronic incident form, based on the information received, grading at the appropriate level.

2.9 Involving and Informing others

In in-patient settings the Consultant should be informed if the incident has adversely affected a service user or a review of the Care Plan is needed. Similarly the GP may need to be informed in a community based service. Consideration should also be given to the need to inform or involve other parties, including the Care Coordinator, both within and outside the Trust, depending on the nature of the incident.

2.10 Involving and Informing the Police

The Police should be informed and involved in violent incidents or breaches of security, or if some other criminal act is thought to have occurred. The Police should also be informed in the event of an unnatural death, as they have a duty to investigate these on behalf of the Coroner. In such cases the scene of the incident should not be disturbed before the Police arrive. If the Police attend an incident, of whatever type, then the incident form should note the Crime Number, Officers name, number & station base, so they can be contacted again if necessary. Police involvement will be decided on a case by case basis and consider the clinical presentation of individual service users.

In circumstances where a Police or HSE investigation is likely to run concurrent to a potential serious incident Investigation an Incident Co-ordination group should be established. This group should include representation from all NHS organisations involved in the incident, the Police and where required the Health and Safety Executive (HSE). At this group the need for an NHS investigation should be discussed with the Police and/or HSE and an agreement reached about how when this is to be conducted.
Further guidance can be obtained from the Department of Health publication “Memorandum of Understanding - Investigating Patient Safety Incidents, June 2004” and accompanying NHS guidance of November 2006 should be followed in conjunction with the relevant guidance. HPFT and Hertfordshire Constabulary have agreed a local Memorandum of Understanding (MoU) dealing with the investigation of assaults against staff where the suspect is a service user receiving mental health and learning disabilities services.

2.11 Reporting to External Agencies

The Trust will designate a senior member of staff (usually the Executive Director for Quality & Safety with board level responsibility for risk and patient safety) to have responsibility for reporting and follow-up of serious incidents with the appropriate body or bodies within given timescales.

This officer is also responsible for ensuring relevant internal staff are informed of the incident including, as appropriate, the Chief Executive, Chief Operating Officer, Head of Communications and other members of the senior management team.

Reporting timescales
All identified Serious Incidents must be notified to the relevant bodies without delay and within two working days of the incident occurring.

Once notified, the Patient Safety Department will act as the liaison point for all external reporting, although out of office hours, it may be necessary for the manager to contact some external agencies directly. This is the responsibility of the Service Line Leader on call. However, the Patient Safety Department must be kept informed (at the earliest opportunity) during all stages of the process.

2.11.1 Primary Care Trust and East of England Strategic Health Authority (EOE)

i. The Trust will comply with the Serious Incident reporting requirements of the Strategic Health Authority, Eastern Regional Office, as set out in their Serious Incidents Requiring Investigation Policy, July 2010.

The Strategic Health Authority must be informed of all Level 3 & 4 incidents. This information is reported directly to the Primary Care Trust electronically via STEIS who will forward on all information to the SHA on behalf of the Trust. This can only be undertaken by the Patient Safety Department.

ii. In Office Hours
When a Level 3 or 4 incident occurs, the Hertfordshire Partnership Foundation Trust electronic incident form must be completed immediately. The Patient Safety Department will then complete the STEIS Form and inform the Head of Communications.

iii. Out of Hours
When a very serious, high profile Level 3 or 4 incident occurs out of hours which involves the public, or may come to the attention of the media, it is likely that such an incident should also be reported directly and immediately to the Strategic Health Authority by the Service Line Leader or Executive Director on Call.
The Patient Safety Department, and the Head of Communications, must be informed of these reports the next working day.

iv. Reporting Processes for Serious Incidents to the East of England

Once a serious incident has occurred it should be reported within 2 working days using the East of England serious incident initial report form (STEIS), which should be completed by the relevant member of staff within the NHS provider organisation. When completed, it should be emailed to the lead commissioner of the service. The commissioner will then forward a copy to the clinical quality and patient safety directorate at NHS East of England via: eoesha.SUI@nhs.net.

In office hours, if an incident has very significant implications for the NHS in terms of clinical, managerial, media and reputation issues, the commissioning PCT is expected to contact the NHS East of England clinical quality and patient safety directorate directly.

When the incident occurs out of office hours, the on-call NHS East of England senior manager should be informed, who will discuss the incident with the on-call executive director. In either case NHS East of England will agree whether the situation requires escalation and if so they will agree any action that needs to be taken with the relevant NHS organisation. Where there is a communication component to the incident the NHS East of England senior manager on call will inform the communications team, this may include confidential briefing to the Department of Health media centre.

Minimum reporting standards including follow up reports:

- Two working days, once the incident has been identified for receipt of the serious incident form by NHS East of England - once the decision has been made to inform the PCT commissioner and NHS East of England.

- NHS East of England will acknowledge receipt of the serious incident within 2 working days.

- A 3 working days report (3 working days from the receipt of the incident at the NHS East of England). The NHS East of England will not ask for these 3 day updates as a regular occurrence but will do so when particularly significant cases have been reported.

- Appendix F: Example 72 Hour Report to SHA

- Brief update in 7 working days from receipt of the incident by the NHS East of England, to identify any immediate actions taken as a result of the incident and or any additional relevant information that may have emerged during the Trust’s immediate investigation.

- Root cause analysis (or a similar recognised robust process to establish a chronology, identify underlying causes and what further action needs to be taken), with accompanying action plan within 45 working days from notification of the incident to the SHA/PCT. This may be extended on a case-by-case basis on mutual agreement between the provider and commissioner, where a delay is necessary for example whilst awaiting the results of criminal investigations or an

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1 East of England (July 2010) Serious Incidents Requiring Investigation Policy, Section 3, Reporting Processes for Serious Incidents, page 5
inquest. It would be good practice for the commissioning PCT to inform the NHS East of England of the revised timeframe.

These reports must be channelled through the Patient Safety Department.

**NHS East of England In hours:**
Clinical Quality and Patient Safety Team: 01223 597567

**NHS East of England Out of Hours:** Senior Manager on call rota: 07699 732431

2.11.2 The Joint Commissioning Team (JCT)

The Joint Commissioning Team is informed of serious incidents, by the PCT through the same process as the SHA, described above or by the Service Line Leader or Executive Director on Call if urgent/out of hours.

2.11.3 The East of England Specialised Commissioning Group (SCG)

Serious incidents that occur within forensic secure services must be reported to the Specialised Commissioning Group. The Patient Safety Team will notify the SCG and the SHA (following the process described in 2.11.1 above) via eoescg.reports@nhs.net. An initial report form should be sent within 2 days.

- Appendix E: Process for reporting serious incidents for services which are commissioned via the East of England Specialist Commissioning Group – as taken from their current policy framework

2.11.4 The County Council Health & Community Services (HCS) ‘Need to Know’

The person reporting the incident must state whether it is necessary to inform the Director of Health & Community Services under the ‘Need to Know’ Procedure (SSBN 96A24). The Patient Safety Department will then make the necessary report to the Trust Executive Team member responsible for Health & Community Services and the Communications Department within Health & Community Services. Any further reporting to external stakeholders will be then be undertaken by Health & Community Services.

2.11.5 The Health and Safety Executive (HSE)

The Health, Safety & Security Manager will normally make the necessary reports to the HSE. Deaths and injuries to service users through violence/suicide are not required to be reported to the HSE. However, the HSE must be informed if:

- An incident occurs which results in a staff member or a self employed person working on the premises being killed or suffering a major injury (including as a result of physical violence), or a member of the public is killed or taken to hospital.
- If something happens which does not result in a reportable injury, but which clearly could have done, it is in effect a ‘near miss’ dangerous occurrence which must be reported immediately

This also applies to other types of ‘near miss’ where something happens which does not result in a reportable injury, but which clearly could have done. For example in the case of:

- Unintended collapse of any building or structure under construction
- Fire causing suspension of normal work for over 24 hours
- Electrical short circuit or overload causing fire

The reporting process to the HSE during office hours is:
- Inform the line manager and complete the electronic incident form (which also informs the Trust’s Health & Safety Department).
- If urgent the manager must inform the Chief Operating Officer and the Health and Safety Department directly.
- Health & Safety Department to inform the HSE by phone.

➢ Appendix D: Internal Contact Details

The reporting process to the HSE out of office hours for exceptionally urgent cases:

- Inform the on-call manager and complete the electronic incident form.
- The on-call manager will inform the Executive Director on call and will inform the HSE of the incident by phone.
- The on-call manager will inform the Health and Safety Dept the next working day.

➢ Appendix G: External Contact Details

2.11.6 Medical Healthcare Products Regulatory Agency (MHRA)

If the incident involves the failure of the medical device, the Head of Facilities and Maintenance must be informed. He will make the relevant report to the Medical Healthcare Products Regulatory Agency, via the on-line reporting system. In an emergency contact the MHRA for advice

➢ Appendix G: External Contact Details.

If a piece of equipment has failed or malfunctioned it must be reported and removed from circulation, and kept for inspection without being adjusted in any way. It must not be destroyed or discarded until it is know if it is not needed as evidence. For further information refer to the

➢ Medical Devices Management Policy

2.11.7 Her Majesty’s Coroner

If the incident results in an unexpected or unnatural death, the Coroner decides whether to open an Inquest. If an Inquest is opened the Coroner may request statements from specific named staff he believes can assist him in his enquiry. The Patient Safety Manager is the Trust’s point of liaison with the Coroners Office, and will support staff in writing their statements and prepare them for attendance in Court if they are called as witnesses to the Inquest. Legal representation will be arranged if necessary.

➢ Appendix H: Front Sheet for writing Statements for The Coroner

➢ Appendix I: Staff Information Leaflet on Inquests

2.11.8 The Trust Solicitor
Legal Advice may be sought from the Trust Solicitors, if necessary. This would normally be accessed through the Patient Safety Manager, although exceptionally urgent requests for legal advice may be made directly with the agreement of the appropriate Executive Director or Executive Director on Call.

• Appendix G: External Contact Details

2.11.9 The Care Quality Commission (CQC)

As of April 1 2010, as part of the new registration requirements arising from the Health and Social Care Act 2008, organisations are required to notify the CQC about events that indicate or may indicate risks to ongoing compliance with the registration requirements, or that lead or may lead to changes in the details about the organisation in the CQC’s register. For English NHS Trusts most of the requirements are met by providing incident reports about serious incidents and deaths via NRLS reporting systems. The NRLS relevant information is available to the CQC.

Some incident notifications have to be made directly to the CQC. These are:

• In the event of the death or unauthorised absence of a person who is detained or liable to be detained under the Mental Health Act.

• Applications to supervisory bodies or the court of protection to deprive a person of their liberty

• Events that stop or may stop the registered person from running the service safety and properly.

The Directorate Manager Mental Health Legislation completes these reports and therefore relevant information needs to be forwarded to that person to facilitate this.

• Appendix G: External Contact Details

2.11.10 The National Confidential Inquiry into Homicides and Suicides (NCI)

The National Confidential Inquiry into Homicides and Suicides is automatically informed, by SHA in the event of a probable Homicide or Suicide. The Directorate Manager Mental Health Legislation will later ensure that a report is completed by the relevant doctor and may need to request further information from the Service. In addition the Directorate Manager Mental Health Legislation will complete the quarterly reports on Homicides and Suicides.

2.11.11 The Hertfordshire or Norfolk or Essex Safeguarding Children Board (HSCB)

Any allegation regarding Safeguarding Children must be reported to the Head of Social Work & Safeguarding or Head of Nursing and Patient Safety, who will liaise with the relevant people within the Local Authority and PCT, following our internal procedure for Safeguarding Children.

• Policy and Procedure for Managing the Risks Associated with Safeguarding Children & Child Protection
• Appendix D: Internal Contact Details
2.11.12 The National Reporting and Learning System (NRLS)
The Patient Safety Department will be responsible for reporting all incidents that are related to Service Users to the National Reporting and Learning System, as part of their routine reporting. This includes Serious Incidents.

2.11.13 The National Health Service Litigation Authority (NHSLA)

The Patient Safety Department will be responsible for reporting serious incidents to the National Health Service Litigation Authority, as per the guidance, if there is potential for a claim to be made.

2.11.14 NHS Protect

For incidents involving physical and non-physical assaults against NHS staff, where a member of staff is subjected to a physical or non-physical assault, from April 2010 there will be a requirement to report this to NHS Protect via the Security Incident Reporting System (SIRS). This includes all assaults, and not only those which reach the threshold of a "serious incident".
Introduction

The circumstances surrounding each incident vary in terms of levels of harm and numbers of people involved, risk exposure, financial loss, media interest and the need to involve other reporting stakeholders; therefore the response to each incident should be proportionate to the scale, scope and complexity of each incident. This section outlines suggested steps to manage a serious incident.

Serious incidents should be managed by a Senior Manager, preferably at Director level. If and when necessary, staff can contact the Executive Director on call at any time via Oak/Beech reception.

Steps must be taken to ensure members of staff and the service users are not put at further risk by the after effects of the incident. It is the responsibility of the person in charge to ensure that the team takes necessary steps needed to make the situation safe as quickly as possible and to consider the needs of the service users and staff in doing this. This may involve a formal risk assessment especially in the case of a violent incident.

If staff are affected by an incident, the Service Line Leader should take steps to support the staff, they may also consider it necessary to send staff home. Refer to section 3.13 for further guidance and information on support for staff. Clearly they also need to ensure the service is adequately covered for the remaining service users, particularly in In-patient settings.

If service users are affected the Senior Manager should arrange for contact to be made with the service user, carers or relatives and information given about the incident, the level of support they may wish to receive and how and who will provide this. The HPFT ‘Guidance following the death of a service user and the support of the bereaved’ provides guidance when notifying relatives/carers of the sudden death of a service user.

Refer to item 3.12 for the requirements for communication with and ongoing support for service users, relatives, carers and the general public.

- Appendix K: Information Leaflet for Service User Relatives and Carers

If the incident falls within the definition of ‘major’ i.e. affecting “such numbers of causalities as to require specialist arrangements by the Trust” (see Major Incidents & Emergencies Policy and Procedure & Business Continuity Plan), then senior leadership is essential in deciding which policy to follow and in being responsible for the on-going management.

The senior person managing the incident should secure any written and electronic records for any service users adversely affected by the incident. In the case of a death, a complete copy of the records should be made for release to anyone else, such as the Pathologist or the Coroner.

See also, Independent Investigation of Serious Patient Safety Incidents in Mental Health Services 2008.
3.1 Preserving Evidence

Depending on the seriousness of the incident, managers should consider the need to preserve the scene and retain any physical evidence, either by seizure of particular items, and/or by photographing or sketching the area, as appropriate. In the case of any Level 3 or 4 incident any written or electronic records should also be secured and a complete copy made immediately.

3.2 Risk Register

If serious risks are identified through the analysis of adverse incidents they must be graded and recorded on the relevant Risk Register as described in the Risk Management Policy.

- HPFT Risk Management Policy

The Local and Trust Risk Register are management tools to enable the Trust to create a comprehensive picture of the risks it faces. A Risk Register is simply a list of risks deemed to threaten the achievement of the organisation’s objectives. Together with the Board Assurance Framework, the Risk Register is the hub of the internal assurance system, since they contain the objectives, risks and controls for the whole organisation.

When a risk is identified through a serious incident, the manager of the relevant service is responsible for ensuring that the Risk Management Policy is enacted and the processes defined in the procedure are undertaken for their service. This means that they need to ensure that risk assessments are undertaken in the format described and that the Risk Register is appropriately used, monitored, and reported through the appropriate channels.

All levels of staff are responsible for managing risks and are therefore required to participate with these procedures. Service Line Leaders and Managing and Clinical Directors are responsible for ensuring that appropriate action is taken and monitored once a risk is identified.

The Risk Management Policy describes the ‘Risk Assessment Process’ and the ‘Risk Management Process’. The Risk Assessment Process, using the Risk Grading Matrix, enables all service areas to take a systematic approach to identifying things that have gone, or could go wrong and to assess and prioritise or rank them, so that resources can be targeted at the most significant risks. The Risk Management Process then ensures that a systematic approach is taken to planning and monitoring the ‘mitigating actions’ which will be implemented to control or minimise the significant risks identified.

The Risk Grading Matrix from the Risk Management Policy is attached in Appendix O.

- Appendix O: The Risk Grading Matrix

This is also used to grade the level of risk associated with serious incidents.

The primary purpose of investigating an incident is to ascertain:
- What happened?
- How did it happen?
- Why did it happen?

So that if it was found to be predictable and preventable, appropriate action can be taken to prevent future occurrences of the same type.
While it is recognised that human error is sometimes perceived as the cause of incidents, the root cause is often a more complex series of factors that have been lying dormant or have been tolerated and have come together to allow the incident to occur.

It is recognised that human behaviour can be difficult to predict so some incidents involving self-destructive behaviour by service users may be impossible to prevent. However, unless these incidents are investigated to identify the underlying, tolerated or dormant factors, any potential for learning will not be realised.

To achieve this, the incident investigation process must be:
- Fair and equitable.
- Focused on learning and change.
- Focused on identifying contributory factors and root causes.

This should mean that it will be a rare occurrence for a reported incident to lead to disciplinary action being taken and the Disciplinary process will only be used where it is clear that the actions of those involved included an intention to harm, a criminal act, serious professional misconduct or continued professional misconduct.

- Appendix A: Incident Decision Tree

3.3 Deciding the appropriate level of Investigation

It is unrealistic to suggest that all incidents should be investigated to the same degree across the Trust. The key deciding factor is the ‘level’ attributed to the incident when it was initially reported, the 7 Day Report, and for serious incidents the decision of the responsible Executive Directors. The responsible Executive Directors will consider the seriousness and complexity of the incident, making further recommendations for investigation and by whom, to ensure that lessons are learned by the Trust and any necessary changes to practice are made. This will apply i.e. to Level 3 and Level 4 incidents and will be co-ordinated by the Patient Safety Manager. The usual level of investigation for incidents is as follows:

3.3.1 Deciding the appropriate level of Investigation

For Level 2, 3 & 4 incidents, a 7 Day Investigation Report must be prepared within a max. of 7 working days, and must be signed off by the Service Line Leader. This should be sent to the responsible Service Line Leader, and the Patient Safety Manager.

Following the 7 Day Investigation Report, there is discretion as to whether any further investigation is carried out for a Level 2 incident. If an investigation is not thought to be necessary in a particular case, due primarily to the lack of potential for learning, a reasoned and justifiable decision needs to be made promptly in conjunction with the relevant Service Line Leader and /or Practice Governance Lead and Lead Nurse, documented in the incident file and communicated to the Patient Safety Manager.

3.3.2 Level of Investigation for Level 3 & 4 Incidents
When a Level 3 & 4 incident occurs (serious) a 7 Day Investigation Report will be prepared and the circumstances of the incident and 7 Day report will be submitted to the PCT for consideration, review of grading and to recommend what further action should be taken under the Learning From Incidents Policy. This will be co-ordinated by the Patient Safety Manager.

Following consideration by the PCT, if the incident is graded at Level 2 under the East of England Serious Incidents Policy criteria, a 72 hour report will be required. The Patient Safety Manager will inform the Service Line Leader and coordinate.

- Appendix F: Example 72 Hour Report to SHA

Level 4 incidents are so serious that they require an inquiry led by agencies external to the Trust, as soon as possible. It should take note of the relevant guidance, Independent Investigation of Incidents in Mental Health, Department of Health 2005 and Good Practice Guidance, National Patient Safety Agency, 2008 which describes the action to be taken in relation to homicides by a person in receipt of specialist psychiatric services. The responsibility for commissioning an external inquiry depends on the nature of the incident and such incidents are expected to be discussed with the Regional Director of Public Health or the SHA Chief Executive and liaison maintained with the Trust Managing Director and the Patient Safety Team to agree the appropriate way forward.

3.4 7 Day Investigation Report

The 7 Day Investigation Report must be completed within a maximum of 7 working days. The report contains a synopsis of the incident using the basic principles of Root Cause Analysis also giving a summary and brief history of the person involved and details of the actions taken at the time of the incident, along with recommendations provided by the Service Line Leader.

This report is necessary in order to assist the team and the Service Line Leader to:
- Fully understand the seriousness and the level of the incident; identify and mitigate against any immediate risks.
- Assist the PCT to decide what type of further investigation, if any is needed
- Provide an update to the Chief Executive and other Executive Directors as necessary
- Provide the SHA with a 1 week follow up report (if this is a serious incident reported to the SHA when it occurred – see Section 2.11.1)

- Appendix L: 7 Day Report Template

Following completion of the 7 day report, if no further investigation is indicated, the Service Line Leader should complete an Action Plan, using the template within the 7 Day Report form. The template is set out for the recommendations to be listed and for the actions to be included, along with timescales and responsibilities.

Should the findings of a 7 day report conclude that a disciplinary investigation be considered, the Managing Director should liaise directly with the Director of Human Resources.

Who should undertake it?
Any senior member of staff who has undergone training in 7 Day Report Writing may undertake the 7 Day Investigation. The Service Line Leader responsible for the service
must agree and sign off the final report. The outcomes and learning from these investigations should be collated and circulated by Practice Governance Leads as Learning Notes.

3.5 Commissioning the more in-depth Investigation

For Level 3 and 4 incidents the responsible Managing and Clinical Directors, having considered the information available from the 7 Day Report and the grading and recommendation for further investigation from the PCT, will commission a Root Cause Analysis investigation. The Managing Director should formulate written Terms of Reference. These should be made available to the relevant staff and to the service user and their family (if applicable).

The Terms of Reference ‘commission’ an investigation and help to determine whether more than one investigator is necessary, or if clinical or other advisors need to be available. The NPSA recommends a multi-Disciplinary team of investigators for serious and complex incidents, at least one of whom should be trained in Root Cause Analysis.

3.6 Root Cause Analysis (RCA) Investigation

This method of investigation can be applied to clinical and non-clinical incidents. The aim of this process is to identify and record the direct, contributory and root causes of the incident, complaint or claim to enable the organisation to learn from the events. The information obtained can then be analysed and common causes and trends highlighted. Appropriate preventative action can then be taken to avoid a recurrence, and so develop a safer service.

This section describes a practical model for investigation and the evidence upon which it is based. It is a structured and systematic approach that may be used in any setting and will facilitate a comprehensive investigation and identification of issues that need further work/resolution or areas of good practice that can be learned from. It is anticipated that members of staff will find this approach to investigation less threatening and will promote a climate of openness.

3.6.1 Who should undertake the RCA?

The Patient Safety Team holds a list of people who are trained in Root Cause Analysis investigation, wherever possible, and can expect to undertake 1 –3 investigations per year. The Service Line Leader must select from this. The lead investigator will normally be someone not working day to day in the service concerned but, provided relevant specialist advice is available, they can be from any discipline.

Factors to consider in selecting the lead investigator:

- Knowledge and experience of investigation
- Not directly involved with the service in question (for Level 3)
- Availability

3.6.2 Who else should be involved or informed about the RCA?

In addition to the people selected to investigate or to provide expert advice to the investigation team, the Managing Director commissioning the Investigation must
consider whom else within the Trust or externally should be involved in the Investigation and who should be informed about it. There are many possibilities to consider many of whom will be obvious in the particular circumstances of the incident in question.

In some cases, there may be more than one provider involved in the care and treatment and it may be necessary for the Managing Director commissioning the investigation to liaise with the other provider(s) and agree a process/protocol for joint investigation and joint Terms of Reference to be drawn up. The Patient Safety Manager will liaise with the relevant Commissioners to agree a joint protocol for investigation.

There is a commitment under the Strategic Health Authority Procedure for Follow up Reporting of Serious Incidents to provide further information after the initial report of a serious (Level 3) incident.

These follow up reports are required by the PCT/SHA at:

- 1 week – identifying any immediate actions taken as a result of the incident and / or any additional relevant information that may have emerged during the Trust’s immediate investigation
- 8-12 weeks – RCA with accompanying action plan. This may be extended on a case-by-case basis where a delay is necessary for example whilst awaiting the results of criminal investigations or an inquest.
- 6 months – progress update on lessons and implementation of actions

The Managing Director responsible for commissioning and monitoring the investigation and the communication around the incident, should link with the Patient Safety team who co-ordinates the follow up reports to the PCT/SHA to ensure that these reports are made in a timely way.

### 3.6.3 How long will it take to complete the RCA?

It is desirable that the process is completed as promptly as possible. This must be balanced with the need to be appropriately thorough. The Service Line Leader and Investigator(s) should set their proposed timescales at the outset and communicate these to the Managing Director and the Patient Safety Department. The Senior Manager should then report on any departures from the planned timescale as the investigation progresses.

45 days should be seen as the absolute maximum period for a Level 3 investigation.

### 3.6.4 The RCA Investigation Process

i) Gathering the information
This is a critical aspect of the Investigation and needs devoted time and good organisation. The gathering of appropriate information requires good planning and cannot be compromised. The NPSA recommends that 60% of the total time spent on the Investigation should be spent gathering the relevant information.

ii) Sources of Information
Information regarding the incident and its contributory factors may be obtained from several sources and the investigator(s) may need to decide, with appropriate advice, which sources of information are to be pursued. For example a 7 Day Investigation would not normally involve interviews.
Information could potentially be obtained from the following sources:

- Clinical Records
- Statements by staff
- Interviews with staff
- Interviews with service users
- Interviews with relatives/carers
- Other relevant agencies (GP, Police, voluntary sector, advocacy etc.)
- Guidelines, policies and procedures
- Incident reports
- Risk assessments and Care Plans
- Maintenance records of equipment involved
- Clinical audits
- Staff Rotas
- Training and Supervision Records

The local manager will already have preserved evidence relating to:

- The place or environment in which the event took place (by sealing it off, photographing it)
- The equipment involved (by taking it out of use)
- The paper work related to the event.

Investigators should visit the environment where the incident took place, preferably before any changes are made and note the layout. A sketch of the area and its layout, annotated with the location of persons involved, and witnesses to the incident, should be made, if not already available. Photographic evidence of the environment should also be sought, if available. Any piece of equipment involved in the incident should previously have been removed and preserved.

It is also important to elicit information about the custom and practice in the workplace in which the incident occurred. The information obtained can help to shape the context in which factors that leave an area vulnerable to incidents may have occurred.

iii) Obtaining Statements from Staff

The Investigator may be given statements already prepared by staff or may request them either in place of, or as a prerequisite to, interviewing them. Staff should be given the Guidelines for writing Witness Statements when asked to prepare a statement. This Guidance is also applicable if the Coroner or Police require a statement.

- Appendix C: Making a Witness Statement, Guidelines for staff

iv) Preparing to Interview Staff

(Interviews are usually only undertaken as part of a Level 3 investigation)

The Investigator should review the Care Records and any written statements and obtain a chronology of events prior to undertaking interviews. This will help to identify all the people involved with an incident, either directly (i.e. witnessed the event) or indirectly who should be interviewed. All will have a different perspective on the incident and will help in identifying the underlying causes of the incident and putting it in to context. It is recognised that staff are likely to be feeling stressed at this time and may need support.

Prior to any interview the following key messages should be explained:

- The organisations open culture.
The investigation process including how the interview will be conducted
What can be gained in terms of organisational learning
Who may see the final investigation report

A definite time for the interview should be arranged, allowing staff to make appropriate
arrangements for cover and to gather their thoughts. They should be informed that
they may bring a friend, colleague or union representative for support and to ask
questions and contact the investigator(s) prior to the interview if they wish.

v) Undertaking Staff Interviews
Interviews with staff should be undertaken in private and, if at all possible, away from
the immediate place of work in a relaxed setting. It is best undertaken by a pair of
interviewers and in a facilitative manner. It may be useful to agree that one interviewer
will take the lead, whilst the other takes notes and explores issues in greater detail if
needed. If a member of staff or other person being interviewed wishes a ‘supporter’ to
be present, this should be permitted.

The purpose of the interview is to find out what happened and what may have caused
it to happen. This should be explained at the outset. If when staff are interviewed, it
becomes clear that an error or mistake has occurred, this should be allowed to
emerge naturally from the conversation. Errors and mistakes are rarely wilful and the
staff member may need additional support. If at any point during an investigation it
comes to light that an individual had behaved recklessly, maliciously or outside the
reasonable boundaries of their professional sphere, the investigator will advise the
Service Line Leader, and the disciplinary procedure may be instigated.

There are distinct phases to the interview to move through in order. One of the key
aims is to identify contributing factors that may be categorised as follows:

- Service User Factors
- Individual Factors
- Task Factors
- Communication Factors
- Team and Social Factors
- Education and Training Factors
- Equipment and Resource Factors
- Working Condition Factors
- Organisational Factors
- Management Factors

A record should be kept of each interview to aid analysis. If the content of the interview
is to be referred to specifically in the final report, then the interviewee should have the
opportunity to check it for factual accuracy, and sign it like a written statement.

The investigator should take the opportunity in the interview to inform the member of
staff that an Executive Summary of the investigation will be disclosed to the service
user or their family as a matter of course, and that the full investigation report may be
disclosed to families/carers upon request. Staff should be advised that whilst in the
first instance all reports will be anonymised, there will be rare occasions where the
report may be disclosed in a non-anonymised form, and where reasonably practicable
the staff members will be advised in advance of disclosure.
vi) Interviewing Service Users, Family Members and Carers

The service user involved in a serious incident and their family, often have a vital role to play in completing an understanding of the full picture surrounding an incident and it is appropriate to involve them in the investigation process, if they agree. The decision to interview service users or their family should be made by the investigator in consultation with the Service Line Leader. The service user/family/significant others should be given sufficient information by the manager in order to help them to decide whether they wish to be directly involved by being interviewed or not.

The interview process may be a daunting prospect for some individuals. Therefore, service users and/or their family or carers should also be offered the opportunity to set out their views, or any information they wish to provide relevant to the incident, in writing.

Ideally, if service users/members of the family do decide to be interviewed, the Service Line Leader will introduce the Investigator to them reiterating the explanation about the Trusts overall policy, the scope of the investigation and that the outcome will be shared with them when the investigation is concluded. The interviews can be planned and carried out using the same principles as above, with obvious adaptation to the focus of questioning and with appropriate sensitivity. At this stage they should already have been given the Information Leaflet describing this.

- Appendix K: Information Leaflet for Service User Relatives and Carers

3.6.5 Analysing the RCA information gathered

The chronology of events is very important in the investigation and must be mapped out to allow identification of problem areas and areas of good practice in the sequence of events. The two common methods of mapping are:

- Narrative chronology
- Diagrammatic timelines

As the investigator maps the chronology of events, further questions will be generated. Some will be issues relating to the chain of events or issues needing clarification. Others will be "Why" questions so as you try to understand how the event happened and others will relate to whether certain practices were appropriate or acceptable.

The fact-based questions can be answered with relative ease by going back to the people involved in the incident. The "Why" questions may require the involved parties with the support of the investigation team to explore the unanswered questions. The questions about practice may need clinical advisory input to determine. If appropriate specialist advice has not already been arranged, by the Commissioning Manager, the Investigator must make them aware of the need at this point. It may also be necessary to consult the Managing Director regarding the Terms of Reference, as significant issues may be raised to consider reconfiguring or broadening them.

i) Problem Identification and Prioritisation

When all the relevant information about the incident has been gathered, the Investigating team is ready to perform the root cause analysis. There are a variety of tools and techniques to identify and prioritise problems available. The key options are:

- Investigation Team Analysis
- Local multi-professional Review Meeting
ii) Problem Exploration and Identification of Lessons
The problems, which have now been identified, should be explored using Root Cause Analysis tools. Key root cause analysis tools and techniques recommended in the Guide are as follows. More detail can be found on the National Patient Safety Agency website at [www.npsa.nhs.uk](http://www.npsa.nhs.uk)

- Brainstorming
- The Five Whys
- Fishbone Diagrams
- Cause and Effect Charting

3.6.6 The RCA Report

i) Report Format
The Internal Investigation Report is produced by the Investigator(s) once the Root Cause Analysis is complete. The investigator must use discretion in circulating drafts for correction & consideration. The report must be easy to follow and clearly present the salient points and the lessons that can be learned for the future from the retrospective analysis of the incident. An Executive Summary should also be produced for the purposes of sharing specific information about the Investigation and its findings when this has been arranged in advance. Guidance on how to write the report and a template for both the report and the Executive Summary can be found in Appendix M.

- Appendix M: Template and Guidance for Completion of RCA Report

In addition, the NPSA provide an electronic report format which can be used by investigators by following the link below:

- [http://www.nrls.npsa.nhs.uk/resources/?entryid45=59847](http://www.nrls.npsa.nhs.uk/resources/?entryid45=59847)

ii) Recommendations
Recommendations must be focused on addressing the root causes or fundamental issues associated with the incident, i.e. those things that once addressed will prevent the problem from recurring. These are the areas where learning is most valuable. Recommendations should make explicit where responsibility lies for considering or acting on them and should also include some indication of the risk of doing nothing. Some recommendations may be specific to the service area concerned and some may be applicable across a range of services, or the whole Trust. Recommendations can include supervisory and training issues if this has been identified as a problem.

iii) Review of Risk
The Patient Safety Department will also apply the Risk Grading Matrix used to prioritise identified risks, to all incidents of Level 3 and above, to score the level of risk associated with the incident and monitor the resulting action plans to control and minimise the risk with the services concerned.

Applying the Risk Grading Matrix centrally results in more accurate prioritisation of risks, enabling the Trust to target appropriate risks. In order to assure improvement, the assessment should be routinely repeated and documented, particularly when the action plan following an investigation has been fully implemented.

- Appendix O: The Risk Grading Matrix

3.6.7 Distribution, disclosure and storage of the RCA Report
Once finalised, the Internal Investigation Report is a confidential Patient Safety document produced solely for the purpose of learning from the detailed analysis of an incident. The Report therefore has a controlled internal distribution, limited to staff with a legitimate need to know the outcome of the Investigation, including the relevant Managing and Clinical Directors, Managers and Patient Safety Manager. An Executive Summary of the Investigation Report is produced for the purpose of sharing with others although this should only be disclosed outside the Trust with the knowledge and consent of the Managing Director who will consult with the Patient Safety Manager.

The Trust aims to be open with service users and their families when an incident has occurred. The written Executive Summary of the investigation will be disclosed to affected service users, family and carers as a matter of course, detailing the remit of the investigation, the investigation findings and recommendations. A full copy of the RCA Report will be disclosed to the service user or their family upon request.

A separate ‘investigation file’ should be maintained by the Investigator to store the investigation material and the Internal Investigation Report/Executive Summary etc, none of which should be stored in an individual service user’s Care Records.

3.6.8 Action Planning following the RCA Report

i) Local Multi-Professional Review Meeting
When the RCA Internal Investigation Report is complete, the Managing Director/Service Line Leader should arrange to meet with the team in the service where the incident occurred, together with the Investigator(s). The purpose is to discuss the findings and conclusions of the investigation and allow the team the opportunity to reflect on this in relation to their own views about the root causes and lessons to be drawn from them. The meeting should end with an agreed Action Plan. The Managing Director will have circulated the Internal Investigation Report prior to the meeting and must facilitate discussion, on the production of a draft Action Plan that the team can own.

Key issues to cover are:

- Does the team largely agree with the findings of the report? (Disagreements should be noted and considered by the Investigator)
- What changes should happen as a result of the incident and the Investigators recommendations?
- Who should be responsible for implementing each of the actions?
- What is the timescale for each action?
- When and how will they be reviewed and the resulting service improvements reported on and shared?
- Are there Service-wide/Trust-wide actions that should be fed back through the Trust’s Practice Governance structure?

ii) Action Plan Format
The ‘commissioning’ Managing Director must delegate an appropriate member of senior staff to draw up the agreed Action Plan using the Trust Action Plan Template and to be responsible for the overall implementation and monitoring of the whole plan, including the final step of reporting on the resulting service improvements. The frequency and method of progress reporting will also be agreed between the Managing Director and the person responsible for the Action Plan. It is important to
note that Action Plans are formulated which are achievable, and have suitable
timescales and responsibilities.

➢ Appendix N: Action Plan for Incidents Template

A copy of the final Internal Investigation Report and Action Plan and the details agreed
between the Managing Director and person responsible for overseeing the
implementation and monitoring of the Action Plan, must be communicated to the
Patient Safety Manager, the relevant Practice Governance Lead and to others as
agreed within each service area.

3.7 Panel Review Investigation

Following receipt of the 7 Day report, the Executive Director for Quality & Safety may
recommend a Panel Review, or the decision to undertake a Panel Review may be
considered after a Root Cause Analysis (Internal Investigation) is undertaken or
completed. This decision will usually be taken because it is apparent that the incident
already meets one or more of the criteria listed below.

If the decision to undertake a Panel Review is taken very soon after the incident, it will
need to incorporate the principles of Root Cause Analysis and at least one of the experts
undertaking the process will need to have those skills.

The Executive Director for Quality & Safety (consulting with stakeholders if necessary) will
determine whether a Panel Review is necessary, preferably involving a Board nominated
Non-Executive Director as a member of the Panel.

The decision regarding Panel Review will be based on a number of factors concerning the
incident itself and the quality and findings of the Internal Investigation.

The Executive Director for Quality & Safety will consider, but is not confined to, any of the
following factors:
• The seriousness or complexity of the incident and its outcome
• The significance of the issues of concern identified by the Internal Investigation
• Where differences exist in views as to the nature or causes of the incident
• Where there is public interest in the incident in question

If it is decided that a Panel Review is not necessary, the process is complete and full
attention can be given to the implementation of lessons.

Timescales: Incidents leading to an independent investigation or inquiry or those
considered high risk will continue to be monitored by the SHA/PCT or Local Authority until
evidence is provided that each action point has been implemented. Incidents involving
adult or child abuse are referred to local safeguarding arrangements.

For Panel Reviews which will result in independent investigations allow up to 26
weeks/six months for completion of investigation. Extensions can be granted on an
individual case-by-case basis by the SHA/PCT

3.7.1 What is investigated through a Panel Review?

If the decision to commission a Panel Review is made, the Executive Director for
Quality & Safety and Stakeholders if relevant, decide the Terms of Reference. The
broad aims will be to:
• Consider and review the care given (or management of an issue).
• Review the events leading to the incident, the incident itself and the immediate aftermath.
• Consider contributing or contextual issues that may have affected the outcome.
• Review the local recommendations already made and further these if necessary. Report on the Panel findings and recommended actions to ensure that such and incident does not recur.

3.7.2 Who sits on the Panel and what do they do?

The Executive Director for Quality & Safety will appoint the Panel Review Chair. The Panel will normally comprise three people, selected as appropriate according to the nature of the incident. A Non-Executive Director will normally be appointed to Chair the Panel. One member will normally be a senior clinician or social care practitioner (as appropriate to the incident), who has had no recent involvement in the case, or the service directly concerned. The Executive Director for Quality & Safety, who commissioned the Internal Investigation will not be a member of the Panel Review. The role of the Panel Review is to continue the process of extracting learning from the incident by offering an objective examination of information relating to the incident and subsequent investigation, to build on the information gathered via the procedure so far, all of which will assist the services to determine not only ‘what happened’ but also ‘why’ and ‘how’ it happened.

The Panel Review once convened, and having considered its Terms of Reference, will decide if it requires specialist advice or assistance in gathering information, and will approach the Executive Director for Quality & Safety for this assistance to be provided. The Panel Review Chair will be responsible for the format, conduct and reporting of the Panel. The individual responsibilities of the Panel members will be discussed and agreed at the outset.

The Panel will examine all documentation and witness statements and will question relevant witnesses including service users and the family members of directly affected service users, if they wish to be involved. They will examine relevant equipment and visit the area in which the incident took place as appropriate. Specific consideration will be given to ensuring that anyone called as a witness receives appropriate support during all stages. Anyone called before the Panel Review will have a right to choose to be supported by a friend, colleague, trade union official or advocate. Suitable waiting rooms will be provided for all parties.

Should any evidence emerge during the Panel Review suggesting serious failings on the part of specific individuals, which has not been identified previously, the Chair must halt the proceedings and consult with the Executive Director for Quality & Safety, who must decide (with advice if necessary) whether to defer to the Trusts Disciplinary Procedure or not. If the Disciplinary Procedure is enacted, the Executive Director for Quality & Safety and the Panel Review Chair must consult to decide if the Panel Review can continue, perhaps with reviewed Terms of Reference, without prejudicing the Disciplinary Investigation and the rights of the staff member concerned.

3.7.3 The Panel Review Report

The Chair of the Panel Review will report the outcome and recommendations of the Review verbally to the Executive Director for Quality & Safety immediately following completion. The Panel Review Report will be submitted to the Executive Director for
Quality & Safety within the timescale they agree, which will not exceed 3 weeks following the Panel meeting.

The Panel Review Report should offer the Service the benefit of the reflection and expert opinions of the Panel, and recommendations for inclusion in a corrective Action Plan for implementation by the service.

This report has the same confidential status as the Internal Investigation and is not to be filed in the relevant service users Care Records or shared with people in the Trust beyond those that need to know the outcome. As a Patient Safety document produced for the purposes of self-examination and learning, the Panel Review Report should only be disclosed outside the Trust with the knowledge and consent of the Managing Director who will consult with the Patient Safety Manager.

The Trust aims to be open with service users and their families when an incident has occurred. The written Executive Summary of the investigation will be disclosed to affected service users, family and carers as a matter of course, detailing the remit of the investigation, the investigation findings and recommendations. A full copy of the Panel Review Report will be disclosed to the service user or their family upon request.

The Executive Director for Quality & Safety will take the Report to the next available Trust Board meeting having been scrutinised first by the Clinical Risk & Learning Lessons Group and the Quality & Risk Management Committee (Q&RMC) on behalf of the Integrated Governance Committee (IGC). After the above meetings the Strategic Health Authority and/or the relevant Commissioning body will also be given a copy of the Report of the Panel Review together with the Action Plan and follow up progress report.

3.7.4 Implementation and Monitoring of Action Plans

The findings of the Report and Action Plan will have implications for the service concerned and potentially could have implications Trust wide and/or for other Trusts. The Practice Governance framework provides an opportunity for ensuring that lessons can be learnt across the Trust and, where appropriate, shared more widely. It is vital that Strategic Business Units continue to monitor and improve the systems in place for transferrable learning following RCA investigations/Panel Reviews. Learning may not be confined only to the ward or team involved in the care and treatment of a service user and should be shared across the service with common learning opportunities being identified.

The Managing Director must appoint an appropriate Service Line Leader to be responsible for the development and monitoring of an Action Plan to implement the investigation recommendations; they are accountable for providing assurance in relation to the service’s response to the recommendations.

- Appendix N: Action Plan Template for Incidents

If significant risks have been identified through the investigation, then the assessment and prioritisation of risks process must be followed and if appropriate the risk should be added to the Risk Register.

- Appendix O: Risk Grading Matrix
The nominated Service Line Leader will report on progress made in implementing recommendations and what service improvements have been made, through the Line Management Structure and to the relevant Practice Governance Group. In addition, they must provide written evidence when recording whether a recommendation was not accepted or acted upon, together with a rationale for same. This information will be held on the central Datix database by the Patient Safety team.

A final completed Action Plan should be made no later than 6 months after the investigation is published. This should go to the SHA and PCT, and this process should be monitored via the Clinical Risk & Learning Lessons Group, the Quality & Risk Management Committee (Q&RMC) and the Integrated Governance Committee (IGC) on behalf of the Board.

The lessons from the investigation will be fed into the Patient Safety and Practice Governance systems within the Trust at all relevant points. When the actions have been implemented, the residual risks previously identified should be re-assessed to monitor improvement.

There is a centralised system (Datix) within the Patient Safety Department to monitor action plan implementation and evidence. Regular reports go to Service Line Leaders to assist with monitoring the performance of implementation of action plans and embedding these within practice.

3.8 The SHA’s duty to carry out Independent Investigations of Incidents in Mental Health Services

The Strategic Health Authority is responsible for commissioning independent investigations. An incident may be considered to warrant an Independent Inquiry following the Trust’s Internal Investigation, in such cases as:

- Homicides committed by someone under CPA in past 6 months
- To comply with Article 2 of the European Court of Human Rights
- Where there is thought to be systemic failure in service delivery

In these circumstances the SHA is responsible for the timing, investigation process, Terms of Reference, appointing investigators and publication and distribution of reports.

The Patient Safety Team liaises with the SHA regarding any serious incident which is likely to fall into one of the categories the SHA must independently investigate.

The Patient Safety Team will provide the necessary information and guidance within the Trust in liaison with the SHA nominated lead. This process may also result in further learning concerning an incident which has already been investigated internally.


3.9 Concerns about Practice

If at any stage the incident reveals concerns about the practice of a Trust employee or employees, then the Incident Decision Tree should be applied and if deemed appropriate as a result, the Disciplinary Procedure should be followed.
If a member of staff identifies a shortfall in their practice as a result of an incident, and can rectify it, we expect them to do that at once and let their manager know about the action they have taken. If they identify a shortfall in someone else’s practice they should discuss it with them to give them a chance to rectify it if they can, or raise it with the manager. In some cases the concern will be raised through the Trust’s Whistleblowing Policy.

See HPFT Whistleblowing Policy

3.10 Communication and Support for Service Users, Relatives and Carers

Following a Serious Incident, the Trust should ensure that a communications plan is devised and agreed to ensure that appropriate service users and their families are communicated with in a co-ordinated way; this may require an Incident Co-ordination Group, depending on the incident, and should follow the Good Practice Guidance from the National Patient Safety Agency.


3.10.1 Communication and Support for Service Users

Both clinicians and managers must consider the needs of service users who may have been adversely affected by an incident, e.g. by being involved in, or witnessing the incident. Levels of support required and the degree of information to be shared should be reviewed, and all communication with service users and carers should meet the individual’s communication needs. The Service Line Leader must ensure that service users are informed of any potential effects and offered appropriate support and counselling and if appropriate should be informed of the lessons which have been learned.

Staff undertaking the role of engaging with service users following a serious incident, need to be appropriately skilled and supported themselves. Advocates and friends/carers may, at times, be usefully involved in supporting affected service users, having given due regard to the service user’s wishes, confidentiality and overall best interests. Service users should also be consulted in advance regarding their wishes, before the Service Line Leader authorises any response to an approach from the media (which would be made in liaison with the Head of Communications). Such discussions and decisions must be documented in the incident file.

3.10.2 Communication & Support for Relatives/Carers

It is important that the needs of relatives and other significant people are addressed and that a person’s individual communication needs are met. Contact should be made at the earliest appropriate opportunity and appropriate support should be offered.

People with communication needs, for example those who speak another language or have sensory problems may need special consideration to communicate and staff need to source support to manage and accommodate these needs. Please refer to the Trust guidance on Communicating with Service Users from Diverse Communities.
Following Serious Incidents, the Service Line Leader responsible for co-ordinating the management of the incident, should offer to meet with the family or arrange for the family to meet with key staff (appropriately supported). Guidance for these meetings is provided within the Trust’s Being Open Policy.

Being Open involves apologising and explaining what happened to patients and/or their carers who have been involved in a patient safety incident. It ensures communication is open, honest and occurs as soon as possible following an incident. It is best practice for more than one person to meet with families and for a liaison to be maintained during the whole process of investigation, through to the learning which emerges which should be shared with families. If there is likely to be interest from the media, the family should be asked their wishes in relation to the Trust’s response to any media contact, and this should be recorded and the Head of Communications should be informed.

Additional support and guidance for relatives and carers can be accessed via the Department of Health document ‘Help is at Hand’. A summary of this guide can be found as an appendix to this policy (Appendix P) and the full guide can be accessed via this link:


When meeting with the family, this guide can be printed off and offered to them.

If the incident resulted in the death or serious injury of a service user, it is important that the process of maintaining contact with relatives and carers during the period of investigation is recognised and facilitated. The Service Line Leader is responsible for providing a senior point of contact for the family and letting the Head of Communications and Patient Safety Department know who this is (if not themselves), so that communication between the Trust and relatives is co-ordinated and maintained throughout the investigation.

“It is only by ensuring good communication when a patient safety incident occurs that we can begin to look at ways to prevent reoccurrence.” Being Open, NPSA 2005.

For serious incidents it is recommended that the communication/liaison role should be kept separate from the Investigator role.

When a full Root Cause Analysis is to be commissioned and undertaken, the Investigator should not be left in the position of needing to explain the policy to families. It is therefore important that the Service Line Leader gives clear and correct information to the relatives from the outset. A leaflet has been developed for relatives to assist Service Line Leaders to provide clear, helpful information. They should give the leaflet to the relatives and talk through:

- The Trust’s Learning from Incidents Policy
- The scope and purpose of the investigation
- What will be shared with them through the investigation and timescales
- What they will be given when it is concluded including learning.

➤ Appendix K: Information Leaflet for Service Users, Relatives and Carers
Ongoing support

The level of on-going support required by service users, relatives or carers should be advised by senior staff who know their circumstances best. The Service Line Leader, who communicates with the family in a consistent and timely manner, should nominate a contact person/co-ordinator to maintain regular liaison with the family as the investigation progresses. This will be a staff member who can demonstrate a range of diverse skills and competency, in offering support to those affected by a serious incident. This support could include providing information, offering guidance and advice, and facilitating links with other agencies which help victims, relatives and carers through serious events.

3.11 Communication and Support for Staff

Following an event of any kind (which may most often be an ‘incident’ but could equally be harassment, a complaint, a claim or any other challenging situation at work) the line manager, if necessary in consultation with their senior manager, must consider the need for information and support for affected staff. The manager should take steps to manage and support the staff who are affected by an incident and to ensure they have sufficient information about the Trust’s procedures and sufficient individual support.

This may include considering if it is necessary to send staff home or take other steps to ensure that they are not put at further risk by the after effects of the incident or circumstance. The decision will be based on factors such as the severity and traumatic/stressful nature of the event and the proximity of particular staff. Other possible action to provide immediate or on-going support may include the following:

- Providing an informal or formal post incident support session as soon as possible.
- Arranging a formal Critical Incident Debriefing session for staff
  - Contact 07659 100089
- Employee Assistance Helpline
  - Contact 0800 328 1437 for:
    - Advice concerning the availability of Counselling - Staff Confidential Counselling Service
    - Arranging a session with the Harassment & Bullying Adviser Service
- Providing access to trade union advice
  - Contact the Staff Side Secretary on 01923 427379
- Referring an individual to Occupational Health or seeking their advice
- If relevant, explaining the Trust’s internal investigation procedure and guiding individuals on how they will be expected to contribute to the process, such as preparing a statement and/or being interviewed in the event of their being called as a witness
- Giving staff the opportunity to access professional advice from their relevant professional body/union.

Ongoing support for staff

Any or all of the above support mechanisms can be used by staff on a voluntary basis at any point following the stressful event. However, if a particular individual is experiencing difficulties associated with the event the manager or the staff member can insist on making a referral to Occupational Health for assessment and support.
All members of staff working in the service in which a serious incident occurred, whether or not they were directly involved in the incident, must be provided with information by the manager about the stages of the investigation and how they will be expected to contribute to it. The information given to staff during the investigation should be fully documented.

A clear message must be given that the investigation is entirely separate to any disciplinary process, being conducted in an open, non-judgemental way. Staff must receive information about the final findings and lessons learnt by being invited to the ‘local multi-professional review’ meeting. This will also encourage staff to think about how they and their colleagues work and identifying any shortfalls in practice and putting them right or telling managers where they can although this can be difficult and challenging.

As well as this Policy, other useful documents to read which will support staff to take the right action are:

- HPFT Whistleblowing Policy
- Harassment & Bullying Policy
- Stress Management Policy and the Disciplinary and Grievance Procedures

3.12 Members of the Public

Consideration should be given to any members of the public affected by an incident. Similarly, if an incident involves a number of service users, or has potentially affected a wider group, the manager must consider if there is a need for a strategy to deal with multiple enquiries etc. The Trust’s Major Incidents & Emergencies Policy and Procedure & Business Continuity Plan must be followed in these circumstances.

- HPFT Major Incidents & Emergencies Policy and Procedure & Business Continuity Plan
3.13 Media Involvement

Staff should not answer media enquires relating to an incident themselves, but refer them immediately to:

**Head of Communications**
Tel: 01727 804557  
Fax: 01727 804270

If staff are aware that a service user or their family have or may contact the media, they should make an accurate record of the information and inform the Head of Communications immediately.

In either case, the Head of Communications, in liaison with the Managing Director or Service Line Leader will issue any Press Statement (if appropriate).

On occasions the media should actively be informed of a serious incident and this would be dealt with by the Trust’s Head of Communications or the East of England Head of Communications once any affected members of the public, service users and their family, or staff or contractors, have been informed. Accurate records should be kept of these exchanges.

For further guidance on media management refer to section 2.8 of the National Patient Safety Agency National Framework for Reporting and Learning form Serious Incidents Requiring Investigation.
Introduction

Learning following an incident is defined as safety related policy, practice and process issues that have contributed to the incident, from which others can learn. Examples of learning are given below:

- Solutions to address the root causes of incidents
- Identification of the components of good practice that reduced the potential impact of the incident, and how they were developed and supported.
- Systems and processes that allow early detection or intervention that will reduce the potential impact of the incident.
- Lessons from conducting the investigation that may improve the management of investigations in future.
- Documentation of identification of the risks, the extent to which they have been reduced, and how this is measured and monitored.
- An anonymised summary of external investigations reports to assist learning within the Trust.

4.1 The Process for Analysing & Learning from Individual Incidents

Analysis of the root causes of individual incidents and near misses will result in the identification of issues from which the service can learn. These must be translated into recommendations for change and action plans. These must then be monitored and reviewed to ensure that the service does learn the lessons and make improvements for the future.

Lessons to be learned will also be communicated across the Trust through a variety of channels such as staff e-mag, e-bulletins, learning publications produced by the Strategic Business Units, Screen Savers, presentations and seminars for staff, meetings with service users and families, staff intranet, minutes of Practice Governance and Patient Safety meetings, so that the valuable intelligence gained from the in-depth analysis of individual incidents is shared and benefits all future services and service users.

Reports and action plans will be shared routinely with Managing and Clinical Directors and Practice Governance Leads across the Trust irrespective of their involvement in the incident. These will be shared with the Practice Governance Groups and colleagues as appropriate for further dissemination and discussion with team/units involved.

The Clinical Risk & Learning Lessons Group, which reports to the Quality & Risk Management Committee and the Integrated Governance Committee, will also play a key role through its internal assurance processes, in ensuring that lessons learnt from analysis result in a change in culture and practice in the organisation, both through the ‘effectiveness measures’ described later and through the other governance monitoring processes covered in the Terms of Reference.

The key objective of the Clinical Risk & Learning Lessons Group is to “Oversee Patient Safety processes to achieve a well coordinated and cohesive approach to the management of risks of all types providing substantial assurance of the safety of services and the organisation to the Board and to our service users specifically to: (amongst other things) achieve a measurable reduction in severity of patient safety incidents and other types of incidents within the Trust”.

PART 4 - Guidance and Procedure for Learning from Incidents
The Clinical Risk & Learning Lessons Group also play a key role in governance processes relating to serious incident reports, scrutinising routinely all Root Cause Analysis investigations and Panel Reviews. Their role is to provide assurance in relation to quality and safety, determining where themes are recurring and providing assurance to the Trust Board that these areas are addressed and continuous learning is implemented and monitored within the Trust. This is undertaken by a Scrutiny Group who routinely review all internal investigations and give feedback on quality, themes/trends emerging from investigations and escalate risk issues.

4.2 The Process for Analysing & Learning from Aggregated Data

4.2.1 Analysis of Incident Data

All reported incidents are stored on the Datix Database. This allows systematic analysis of the aggregated incidents reported over any time period. The Patient Safety Co-ordinator prepares Incident Reports both on a regular programmed basis and in response to ad hoc requests or as spot checks. The regular programmed reports include for example (not an exhaustive list):

- Quarterly Incident Reports for the Quality & Risk Management Committee
- Quarterly Serious Incident Report for Quality & Risk Management Committee
- Quarterly Reports for the Health and Safety Committee
- Annual Reports on both incidents and serious incidents to the Governance Groups and the Board
- Annual Suicide Report for the various Groups and the Board - highlighting trends within the Trust data & comparative data in the county and the United Kingdom

Each of these contains as a minimum:

- Data covering the number of incidents at each level of severity, in categories according to type of incident and business stream/service (including near misses)
- Qualitative analysis concerning changes in reported incidents, demonstrated by the data, and where possible hypothesis validated by the services
- Learning which can be drawn from this and shared, and the actions needed
- The yearly analysis will take into account a 3-year time span, which will highlight the most notable trends and represent areas of significant risk

Many ad hoc reports are requested either by or through the Practice Governance forums, the Patient Safety Groups and Strategic Business Units Quality & Risk Management meetings, to analyse and learn lessons from ‘all incidents’ (meaning Incidents, Complaints, PALS & Claims).

Trends and themes emerging from incident reports are identified via the Patient Safety Meetings, Practice Governance meetings and Team meetings, as shown in Flowchart 4.5 below. Managers and Practice Governance Leads have access to electronic data on incidents in their service areas via the Datix Web-manager, which provides an analysis tool for identifying trends in order to improve service delivery. These are then measured against regional and national statistics to provide patient safety metrics which give assurances to the Trust that services are learning from adverse incidents.

4.2.2 Analysis of Aggregated Complaints, Claims & Incidents Data
The Trust aspires to regular analysis of ‘all incidents’ across Incidents, Complaints, PALS and Claims. The Datix Database facilitates this by the fact that all these types of incidents are recorded on the Datix system.

The aim is to routinely produce a range of quarterly and annual reports using the aggregated data from all types of incident which will contain as a minimum:

- Minimal data covering the number of all the various incidents by severity, type, business stream/service etc (including near misses)
- Focus on qualitative analysis of any trends across all modes of incident
- Learning which can be drawn from this and shared, and the actions needed

All routine reports are produced in the first instance for the Quality & Risk Management Committee’s information/approval. Annual Reports and other significant reports are also presented to the Integrated Governance Committee &/or the Board. The Quality & Risk Management Committee (Q&RMC) monitors the trends emerging through aggregated data about all incidents, and can make recommendations to the relevant service or Committees if there are areas of concern requiring action. All such reports are then made available to services via the Practice Governance network of groups.

Ad hoc reports requested by an individual or service (if not confidential for any reason) will also be shared in a similar way – possibly leading to further requests for reports. The Patient Safety Department will work with the service areas and Practice Governance Groups to continue to develop the reporting facility of the incidents database and provide regular and ad-hoc data which can facilitate learning and the sharing of lessons on a Trust wide basis. This will be assisted by Managers having access to electronic data on incidents in their service areas via the Datix Web-manager.

4.3 Learning from the Analysis of National Incidents & Best Practice

Since April 1999 the Department of Health has required all medical practitioners to contribute to National Confidential Inquiries, the findings of which are published intermittently. This gives Trusts the opportunity to review practice in light of their recommendations and learn from the important lessons contained in these reports.

The Trust aims to have a systematic approach to reviewing these reports in line with the “Policy and Procedures for the Implementation of Recommendations for Best Practice”, and ensuring that changes in practice take place. This will be achieved by regular reports on Reviews and Action Plans, with identified responsibility for implementation and timescales clearly defined.

The Trust will determine whether recommendations are relevant to the services provided, by reviewing all Confidential Inquiry reports. The Trust will pay particular attention to the 5 year reports from the National Confidential Inquiry into Suicides and Homicides such as “Avoidable Deaths” (2005), and will also use the NCISH annual reports as a way of benchmarking Trust performance against national averages.

The Trust will also pay attention to regional trends around Serious Incidents using reports provided by the East of England Strategic Health Authority.

Wherever possible, the Trust will publish information on the lessons learnt for all staff to reflect on their practice within their own service areas. Lessons will be communicated
across the Trust through a variety of channels such as learning notes produced by Practice Governance Leads and the Patient Safety Department and the SBU’s Sharing Good Practice newsletters, combining internal and external learning so that the valuable intelligence gained from national incidents is shared and benefits all future services and service users.
4.4 Communicating Learning – Internal (Individual Incidents)

Level 1
No further action

Level 2
7 Day report
No further action (unless exceptional circumstances e.g. clusters)
Consider learning note

Level 3
Internal investigations completed
Report and action plan to Clinical Risk and Learning Lesson groups
Learning note
Report and action plan disseminated to Practice Governance & Patient Safety Groups
Circulated to teams
Level 3 consider for newsletter
Level 4 - include in newsletter - consider other means of sharing

Practice Governance Lead

Practice Governance Lead

Practice Governance Lead
4.5 Communicating Learning – Internal (Aggregated)

Level 1

Level 2

Level 3

Level 4

Aggregated Quarterly Patient Safety Reports to Clinical Risk & Learning Lessons Group, Quality & Risk Management Committee & IGC

Monthly Executive Serious Incident Reports

Aggregated Quarterly Reports to all Strategic Business Units

Other Aggregated Reports to all Strategic Business Units via Datix Web Manager (dates of reports may differ)
4.6 Communicating Learning - External

Level 1

No further action

Level 2

No further action

Level 3 or 4

Root Cause Analysis or Panel Review

Full report to PCT

Full report to Clinical Risk & Learning Lessons Group

Evidence of implementation to PCT prior to closure

Learning shared across healthcare organisations of outcomes reported to the PCT Board
5.1 Version Control

**STANDARD**

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<th>Author</th>
<th>Status</th>
<th>Comment</th>
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<td>Patient Safety Manager</td>
<td>Draft</td>
<td>Fully reviewed and re-written. Policy title change</td>
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5.2 Archiving Arrangements

**STANDARD:**

This document will be reviewed every two years or whenever national policy, guideline or changes to the NHSLA standards or national guidance require to be considered (whichever occurs first), by the Patient Safety Team following which it will be subject to re-ratification by the Quality & Risk Management Committee. Feedback will be actively sought from staff and other stakeholders as to this policy’s usefulness and applicability.

All policy documents when no longer in use must be retained for a period of 10 years from the date the document is superseded as set out in the Trust Business and Corporate (Non-Health) Records Retention Schedule available on the Trust Intranet.

A database of archived policies is kept as an electronic archive administered by the Compliance and Risk Facilitator. This archive is held on a central server and copies of these archived documents can be obtained from the Compliance and Risk Facilitator on request.

5.3 Associated Documents

**STANDARD**

This procedural document should be used in conjunction with the following HPFT policies all of which are available on the HPFT staff website:

5.3.1 Child Protection & Safeguarding Children

The Trust’s policy: Managing Risks Associated with Safeguarding Children & Child Protection details the local process, which links with the agreed multi agency Hertfordshire, Essex and Norfolk Child Protection Procedures that all staff must follow.

- Managing Risks Associated with Safeguarding Children & Child Protection
5.3.2 Safeguarding Adults

Incidents involving vulnerable adults must be reported in accordance with the HPFT Safeguarding Adults Policy and Local Authority Interagency Safeguarding Adults Policy and Procedures.

- HPFT Safeguarding Adults Policy

Guidance on what constitutes an incident involving a vulnerable adult can be found in the local procedure document.

5.3.3 Violence and Aggression

For specific guidance of the management of such incidents refer to the Prevention and Management of Non-Physical and Physical Assaults policy.

- Prevention and Management of Non-Physical and Physical Assaults Policy

5.3.4 Links with Other Policies

Depending on the incident, it may also be appropriate to consult various other Trust Policies, including, for example:

- Health & Safety
- Fire Policy
- Infection Control
- Management Of Needlestick Injuries And Incidents Involving Exposure To Blood And Body Fluids
- Medicines Management Policy
- COSHH
- Moving and Handling
- Compliments, Concerns & Complaints Policy & Procedure
- Major Incidents & Emergencies Policy and Procedure & Business Continuity Plan
- Clinical Risk Assessment and Management of Individual Service Users
- Risk Management Policy
- Absent without Leave
- Guidance following the death of a service user and the support of the bereaved
- HPFT Information security policies
- Communicating with service users from diverse communities
- Information Risk Policy
- Management of Medical Devices
- Patient Safety Training Prospectus
- Outbreak of Infection Control
5.4 Supporting References

5) Seven Steps to Patient Safety. A guide for NHS staff www.npsa.nhs.uk
6) NPSA Root Cause Analysis Tool Kit www.npsa.nhs.uk/rcatoolkit/course/index.htm
9) Safety First, A report for patients, clinicians and healthcare managers (Dec 2006) www.doh.gov.uk
11) Checklist for Reporting, Managing and Investigating Information Governance Serious Incident

Website: http://www.connectingforhealth.nhs.uk/systemsandservices/infogov/security/risk/sichcklist.pdf

5.5 Comments and Feedback – List people/ groups involved in developing the Policy.

People/groups involved in the consultation.

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<th>Lead Nurses</th>
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<td>Quality &amp; Standards Manager</td>
<td>Practice Governance Leads</td>
</tr>
<tr>
<td>Compliance and Risk Facilitator</td>
<td>Directorate Manager MHA Legislation</td>
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<td>Head of Facilities &amp; Maintenance</td>
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<td>Quality &amp; Standards Facilitator</td>
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<td>PACE Manager</td>
<td>Head of Records &amp; Access to Information</td>
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<td>Equalities Manager</td>
<td>Head of Medicines Management</td>
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## Incident Types

<table>
<thead>
<tr>
<th>Level</th>
<th>Type of incident (examples only)</th>
<th>Initial reporting</th>
<th>Investigation</th>
<th>Review/Inquiry</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>Accidents to users/visitors/staff on Trust property</strong>&lt;br&gt;Accidents to staff (community)</td>
<td>Electronic Incident form</td>
<td>Line manager to decide on need</td>
<td></td>
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<tr>
<td></td>
<td>Verbal aggression</td>
<td>Inform police as appropriate &lt;br&gt;(Inform manager on call/manager where immediate managerial response is required)</td>
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<tr>
<td></td>
<td>Attempted assault – minor (inpatient area)</td>
<td>Consider need for Health and Safety Manager involvement</td>
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<tr>
<td></td>
<td>Assault with no physical injury (inpatient area)</td>
<td>Consider Safeguarding Adults and Children</td>
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<tr>
<td></td>
<td>Sexual behaviour causing risk to self/others, or serious offence to others</td>
<td>Consider need for Medicines Management Team Involvement</td>
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<tr>
<td></td>
<td>Self harm - minor¹ or Self harm (community)</td>
<td>Consider need for Infection Control Nurse involvement</td>
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<td></td>
<td>Minor damage to property¹ or Minor theft¹</td>
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<td></td>
<td>Unexpected death (community)</td>
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<td></td>
<td>Failure of medical device equipment with no or negligible adverse consequence including vital communication systems</td>
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<tr>
<td>2</td>
<td><strong>Attempted assault – serious (inpatient area)</strong></td>
<td>As Level 1, plus: &lt;br&gt;Immediately inform manager/on call manager &lt;br&gt;Manger to inform CQC if detained patient is AWOL, or an incident significantly interferes with service delivery</td>
<td>Line manager arranges initial summary report&lt;br&gt;Inform Service Line Leader &lt;br&gt;Service Line Leader to inform Assistant Director Adult Care Services, where social care is provided</td>
<td>Line manager and Service Line Leader to decide on need, based on preliminary report</td>
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<td></td>
<td>Assault/attempted assault (community MH &amp; LD, CAMHS)</td>
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<td></td>
<td>Assault resulting in physical injury (inpatients and community)</td>
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<td></td>
<td>Fire setting (minor)</td>
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<td></td>
<td>Unexpected death (inpatients)</td>
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<td></td>
<td>Attempted Suicide</td>
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<td>Self harm (acute children’s)</td>
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<td>property damage significantly interfering with service delivery</td>
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<td>Serious self harm (inpatients/community)²</td>
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<td>Inpatient absent without leave</td>
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<td>Serious threat</td>
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<td>Failure of medical device with serious consequences</td>
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<td>Potential severe adv. reaction to clin. intervention/ medication</td>
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<td>Any incident that may adversely affect the Trust public standing</td>
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<td>3</td>
<td><strong>Suicide, suspected Suicide or very serious attempted Suicide</strong></td>
<td>As Level 2, plus: &lt;br&gt;Manager informs Service Line Leader/ on call exec/health authority/CQC /National Confidential Inquiry</td>
<td>As Level 2 plus: &lt;br&gt;Serv. mgr arranges prelim investigation &amp; liaison with family. Service mgr liaises with Trust Board &amp; Health Authority, &amp; A.D. Social Services (where rel.)</td>
<td>Serv. Mgr &amp; board reps. decide level. &lt;br&gt;i) Review –chair external to locality (within 2 months) &lt;br&gt;ii) Panel Review - panel external to locality (within 3 months) &lt;br&gt;Findings/recommendations to clinical governance groups + review recs.</td>
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<td>In-patient attempted Suicide by ligature</td>
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<td>Serious assault/rape</td>
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<td>Serious criminal activity</td>
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<td>Serious breach of security e.g. Intruder abduction of child</td>
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<td>Sexual behaviour causing risk to self/others, or serious offence to others (Children’s)</td>
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<td></td>
<td>Inpatient absent without leave from a secure unit</td>
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<td>4</td>
<td>Local Safeguarding Children Board Child Protection Procedures</td>
<td>As at Level 3.</td>
<td>As at Level 3.</td>
<td>Service Line Leader and board representative review preliminary investigation for urgent action. Regional Health Authority arranges External Inquiry.</td>
</tr>
</tbody>
</table>
MAKING A WITNESS STATEMENT
Guidelines for Staff

There are many circumstances in which you may be called upon to provide a written statement, please use the following guidelines when preparing a witness statement:

a) For the Coroner, after a death has been referred to him.
b) Following an accident/untoward incident or complaint
c) In response to a claim of clinical negligence – report to solicitors.

The report should be directed to the purpose for which it is required, it is therefore important that you recognise what type of statement you are being required to give.

You must assume that the reader knows nothing of the facts of the case, of the patient’s medical history or Trust procedures. The statement will thus form a story, which will tell a lay person the circumstances of the facts as you remember them. Avoid jargon and abbreviation.

In all cases a witness statement also aims to preserve any information that is NOT apparent from the case notes, in a form that can be given in evidence should the witness not be available for investigation, inquest or trial. This may not always be applicable, particularly in relation to reports for the Coroner, when the request for a statement is made many months after your last contact with the service user.

The following guidelines should guide the preparation of all witness statements:

The statement should be objective, without criticism and non judgmental. Include facts, not opinions.

1. Write down your full name, address, place of work and brief CV details, e.g. your current job, grade, and specialty.
2. State the purpose for which the statement has been requested and by whom i.e. court proceedings, care proceedings, inquest
3. Remind yourself of the case through a careful reading of the relevant medical, paramedical and/or nursing records and state what documents have been reviewed in preparation of your statement. You may need to mention which medical records you had access to when you wrote your statement.
4. Write a narrative, a sequential log of events, which reflects precisely what you recall, what you did and did not do, whom you spoke to, who you called, and at what stage you ceased to be involved in the case. Put events in order in which they happened giving precise dates and times.
5. Depending on your position and the purpose for which the statement has been requested, it may be appropriate to include history of presenting condition, relevant medical history, clinical condition found on examination, diagnosis and treatment given and over what period. It may also be helpful to include final outcome of care episode and date discharged, as well as future treatment and prognosis.
6. If you discover any inaccuracies in the service user’s notes then explain these as part of the statement and prepare an amendment note for the notes, which must be signed and dated.
    UNDER NO CIRCUMSTANCES ALTER THE NOTES AFTER THE EVENT
7. Write reasons for your actions and omissions.
8. Do not include hearsay or opinion comment, stick to the FACTS.
9. Your statement should be written in the first person i.e. “I was asked by Staff Nurse Jane Smith to record Mr Green’s blood pressure”.
10. The final paragraph of your statement should read:
    “This statement is true to the best of my knowledge and belief”.
11. When you are happy with your statement then sign and date it. You should also print your full name and job title.
12. Though desirable it is not necessary for your statement to be typed. If hand written, ensure that it is legible and is written in a pen that will permit photocopying. Use only one side of each page, wide margins and double line spacing are recommended.
13. Each page should be numbered consecutively and it is helpful if each page is headed with a reference to the complaint, claim, or incident.
14. Do not UNDER ANY CIRCUMSTANCES store the statement in the service user’s care records.
15. Witness statements should be written as near (in time) to the event as possible, to reduce the risk of memory loss. Do not delay when asked to prepare a statement.

If you need help or advice in writing a statement, ask your manager or contact the Patient Safety Department.

When you have written your statement ask a senior colleague to read it through and approve it.

Keep a copy of your signed statement in a safe place.
USEFUL INTERNAL CONTACTS
INTERNAL USE ONLY

Andrew Wellings
Head of Facilities & Maintenance
Trust Head Office
99 Waverley Road
St. Albans
Hertfordshire
AL3 5TL
Tel: 01727 804772
Fax: 01727 804422
andrew.wellings@hertspartsft.nhs.uk

Dennis Hunt
Health, Safety & Security Manager
Trust Head Office
99 Waverley Road
St. Albans
Hertfordshire
AL3 5TL
Tel: 01727 804896
Fax: 01727 804422
dennis.hunt@hertspartsft.nhs.uk

Dawn Crump
Patient Safety Manager
Trust Head Office
99 Waverley Road
St. Albans
Hertfordshire
AL3 5TL
Tel: 01727 804725
Fax: 01727 804306
dawn.crump@hertspartsft.nhs.uk

Bela da Costa
Legal Services Lead
Trust Head Office
99 Waverley Road
St. Albans
Hertfordshire
AL3 5TL
Tel: 01727 804225
Fax: 01727 804306
bela.dacosta@hertspartsft.nhs.uk

Executive Director on Call
Contactable via PICU
Tel: 01923 850501

For Norfolk & North Essex
Contact Little Plumstead
Tel: 01603 711165

Tina Kavanagh
Directorate Manager for MH Legislation
Tel: 07885 377088
Fax: 01727 804341
tina.kavanagh@hertspartsft.nhs.uk

Mary Mumvuri
Head of Nursing & Patient Safety
Trust Head Office
99 Waverley Road
St. Albans
Hertfordshire
AL3 5TL
Tel: 01727 804918
mary.mumvuri@hertspartsft.nhs.uk

Jemima Burnage
Head of Social Work & Safeguarding
Trust Head Office
99 Waverley Road
St. Albans
Tel: 01727 804717
Fax: 01727 804270
Email:
jemima.burnage@hertspartsft.nhs.uk

Head of Marketing & Communications
Trust Head Office
99 Waverley Road
St. Albans
Hertfordshire
AL3 5TL
Tel: 01727 804557
Fax: 01727 804397

Occupational Health
QE2 Block
Hemel Hempstead General Hospital
Hillfield Road
Hemel Hempstead
Hertfordshire
HP2 4AD
Tel: 01442 287486
ohadvisors@hertspartsft.nhs.uk

Staff Side
Union Offices (RCN and Unison)
The Postgraduate Centre
Harperbury
Harper Lane
Radlett
Herts WD7 9HQ
Tel: 01923 427379
Tel: 01923 427371

Critical Incidents Debriefing
Tel: 07659 100089

Staff Counselling & Harassment & Bullying Adviser
contact Employee Assistance Helpline
Tel: 0800 328 1437
Process for reporting serious incidents for services which are commissioned via the East of England Specialist Commissioning Group – as taken from their current policy framework

- Provider informs the SCG on serious incident
- Provider completes initial report form and forwards to goescg.reports@nhs.net clearly identifying the PCT the patient falls under

incident logged on SCG database and unique SCG reference number allocated
- SCG admin files provider initial report
- SCG acknowledges receipt of initial report using standard response to Provider with unique reference
- SCG admin escalates immediately to relevant Case Manager, NHS East of England, relevant PCT using standard response and unique reference, (2 day min)

YES
Serious Incident?

NO

Relevant managers are notified of incident:
- Managers responsible for staff involved
- “Risk Manager”
- Appropriate other managers e.g. HR, L&D etc

If internal to SCG:
- Incident investigated and analyses (e.g. Root Cause Analysis) locally as appropriate
- Recommendations made
- Approved actions implemented and progress monitored
- Feedback to staff involved in incident
- Progress report to corp gov and relevant mgt to monitor and evaluate actions

Use Incident Decision Level Allocation as per SHA guidance

- SHA to allocate unique reference number and advise SCG
- SHA to advise Level of incident to SCG clearly identifying unique SCG reference number
- SHA to advise Case Manager and further action expected
- Provider to submit 3 day report only when SHA requests one when case deemed significant

- Incident investigated and analysed (e.g. Root Cause Analysis) at appropriate
- Recommendations made
- Approved actions implemented and progress monitored
- Management report sent to SCG within x working days (with summary report to responsible PCT and SHA)

- Provider to send a summarised report of findings within 7 working days to PCT, SCG and SHA
- Provider to send a summarised report of RCA within 45 days
- Actions monitored by Commissioners and Case Managers

- Closure Form completed by SCG Case Manager and sent to SHA and Provider
- Evaluation form (lessons learned and actions taken) completed by SCG Case Manager

- Medical Directorate sends quarterly report to the Board, who scrutinise performance and ensure learning and improvements have taken place
Report
(Example 72 Hour Report)

ORGANISATION
SI (Trust REF)
SHA ref --------

72hr report: Submitted -- -- --

Background

Summary

Immediate action taken

Next steps / proposed actions for further investigation

Report signed off by: ______________________________(name)

______________________________ (role)
EXTERNAL CONTACTS

East of England Strategic Health Authority
2-4 Victoria House
Capital Park
Fulbourn
Cambridge
CB1 5XB
Tel: 01223 587 500

Medical & Healthcare Products Regulatory Agency (MHRA)
151 Buckingham Palace Road,
Victoria,
London, SW1W 9SZ
www.mhra.gov.uk
Central Enquiry Point 020 3080 6000

Health & Safety Executive
Woodlands
Manton Lane
Manton Lane Industrial Estate
Bedford
Tel: 01234 220 633

The Head of Facilities & Maintenance will normally make the necessary reports to the HSE and MHRA, unless exceptionally urgent.

Care Quality Commission
National Correspondence
Citygate
Gallowgate
Newcastle upon Tyne
NE1 4PA
Telephone: 03000 616161
Fax: 03000 616171

The Centre for Suicide Prevention
The National Confidential Inquiry into Homicides and Suicides (NCI)
P.O Box 96,
University Of Manchester
Manchester. M20 2EF
www.national-confidential-inquiry.ac.uk
e-mail: nci@manchester.ac.uk

Reports to the MHAC and NCI are normally co-coordinated by Tina Kavanagh, Directorate Manager for Mental Health Legislation

Adult Care Services
Emergency Duty Team:
Tel: 0300 123 4040
EDT Direct Line:
0300 123 4042

Security Management
Andrew Wellings
Security Management specialist for HPFT
Trust Head Office
99 Waverley Road
St Albans
Tel: 01727 804772

Professional Contact Number not for public disclosure

Trust Solicitors
Contact Dawn Crump (Patient Safety Manager) in the first instance for any legal advice.
If needed in an emergency please contact: Executive Director on Call

Executive Director on Call
If needed in an emergency please contact:
Executive Director on Call, details of who can be contacted via PICU on 01923 850 501
### Front Sheet for writing statements for The Coroner

**THIS STATEMENT IS FOR THE ATTENTION OF:** HM CORONER, HERTFORDSHIRE

<table>
<thead>
<tr>
<th><strong>Name of Service User</strong></th>
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<tbody>
<tr>
<td><strong>Address</strong></td>
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<tr>
<td><strong>Date of Birth</strong></td>
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<td><strong>Date of Death</strong></td>
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</table>

**Written by (Your Name)**

<table>
<thead>
<tr>
<th><strong>Job Title</strong></th>
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<tr>
<td><strong>Place of Work</strong></td>
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**This statement is true to the best of my knowledge and belief**

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<tr>
<th><strong>Signed by:</strong></th>
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THE CORONER’S ROLE

The Coroner may be a Lawyer or a Doctor (or hold both qualifications) and is an independent judicial officer who must investigate sudden death when the cause is unknown, violent or unnatural, he must decide:

- Who died
- When
- Where
- How
- The medical cause of death

On the basis of this the coroner must decide on a verdict, which then allows the death to be registered.

Common circumstances when a death will be reported to the Coroner are as follows:

- When no doctor has treated the deceased during his or her last illness;
- When the doctor attending the deceased did not see him or her within 14 days before death;
- When the death occurred during an operation or recovery from an anaesthetic;
- When the death was sudden and unexplained or in suspicious circumstances;
- Where the death might be due to an industrial injury or disease;
- Where the death may be due to an accident, violence, neglect or abortion or any kind of poisoning.

In any cases of doubt the Coroner and his staff, the senior clinicians involved or the Trust’s solicitors will help decide if a death should be reported. If the Coroner decides that the death is not due to a natural cause he must then hold an Inquest.

OPENING AN INQUEST

An inquest is opened once the Coroner decides the death must proceed to inquest. It is a fact finding exercise not a fault finding exercise.

The Coroner’s Officer will do much of the initial investigation and place this before the Coroner to plan who he needs to summon to a hearing.

At the same time, the Trust will be carrying out an investigation under the Learning from Incidents Procedure, and the key documents may also be made available to assist the Coroner.

BEFORE THE INQUEST HEARING

Almost invariably witnesses will be asked to submit a written statement before the Inquest Hearing. The request will normally go from the Coroner’s officer, via the Trust’s Patient Safety Team to the professional concerned.

Statements should contain a full, but concise, factual account in chronological order of the professionals’ personal involvement in the case. It should be typed and passed to the Trust’s Patient Safety Team for onward transmission to the Coroner and a copy should be
LEGAL ADVICE/SUPPORT
Whether or not there is legal representation at the Inquest will depend on the circumstances of each case and the issues involved. The fact that the relatives are legally represented does not necessarily mean that a Trust must also be represented.

This will be decided in discussion for each case.

MUST THE RELEVANT PROFESSIONALS ATTEND?
Yes. The invitation from the Coroner’s Court is really an Order and the Coroner can subpoena personnel if necessary.

Support within the Trust is available through the Legal Services Lead, and a pre-meeting to discuss the Inquest will usually be arranged.

WHAT IS IT LIKE BEING IN COURT?
The inquest hearing is held in a court, but there are no ‘parties’ at an Inquest, no indictment, no prosecution, no defence and no trial.

It is not part of the Coroner’s role to probe into potential issues of medical negligence although sometimes an Inquest may be followed by a civil claim for damages or a formal complaint and then a claim. Remember any report prepared for the Coroner may later be shown to the deceased’s personal representative or solicitors, if a civil claim for damages is subsequently made.

In specific instances, Inquests must be heard in front of a Jury made up of between 6 & 11 people. They hear all the evidence with the Coroner and come to a verdict after the Coroner addresses and directs them.

AT THE HEARING
Witness will be told of the date, time and place of the Inquest and should ensure that they are punctual and appropriately dressed. The order in which witnesses are called is decided by the Coroner.

Each witness should take with them a copy of their statement. If legal representation has been arranged, time will be arranged to meet the solicitor or Barrister before the hearing starts. In complex cases meetings are likely to be arranged on a day before the Inquest is scheduled.

Each witness will begin by taking the oath or affirming and will then be asked questions by the Coroner. The Coroner may decide simply to read the statement and dispense with the need for the witness to attend.

The proceedings in the Coroner’s Court are taped and it is important that the Witnesses’ replies are audible and concise. Concentrate on answering the question as it has been asked and avoid medical jargon that the family will not understand, where possible.

It is important for witnesses to have all the clinical facts at their fingertips. If necessary ask for an opportunity to refer to records or statement before answering the question. If it is so, do not be afraid to say that you cannot recollect, that you do not know or that you are not the right person to answer.
When the Coroner has finished his examination of each witness the relatives or their Lawyer may ask questions. Usually where a number of relatives have attended and there is no legal representation, one member will be appointed as spokesperson.

If the Trust is legally represented the Trust’s representative will then have an opportunity to ask further questions.

**POSSIBLE VERDICTS**
Unlike a trial, if the Trust has representation the representative has the right to address the Coroner on the facts at the close of the evidence. Typically when the evidence has been completed the Coroner will sum this up before giving his verdict. The verdict (with some notable exceptions) is made on the “balance of probabilities”.

The Coroner’s Rules 1984 suggests a number of possible verdicts: e.g. natural causes, industrial disease, dependence on drugs, unlawful killing, accidental/misadventure. Where the evidence is inconclusive an open verdict will be recorded.

A verdict of Suicide can only be recorded where the Coroner is of the opinion that the evidence supports this, “beyond reasonable doubt” and this will be, in most cases, given in a narrative form.

No verdict will be framed in such a way as to determine any question of civil liability and this is specifically precluded by the Coroner’s Rules. The Coroner does have power to make recommendations under the Rules, where he believes that action should be taken to prevent the recurrence of similar fatalities.

**WILL THE CORONER CRITICISE THE CARE?**
The Coroner cannot criticise as such but can add “lack of care” as a rider to another verdict. In fact, it is recommended that the term “neglect” should now be used instead of “lack of care” to avoid the confusion. Neglect in this context means a gross failure to provide adequate nourishment or liquid, or provide or procure basic medical attention or shelter or warmth for someone in a dependent position (because of youth, age, illness or incarceration) who cannot provide it for himself.

Failure to provide medical attention for a dependent person, whose physical condition is such as to show that he obviously needs it, may amount to neglect. It is now clear however that neglect can rarely, if ever, be an appropriate verdict on its own.

**PUBLICITY**
Unless the Inquest involves issues of national security it will be held in public and the press may be present. It is generally wise not to speak to reporters after the hearing, but if they approach you refer them to the Head of Communications.

**CONTACTS**

<table>
<thead>
<tr>
<th>Patient Safety Manager</th>
<th>Head of Marketing &amp; Communications</th>
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<tr>
<td>Trust Head Office</td>
<td>Trust Head Office</td>
</tr>
<tr>
<td>Patient Safety Department</td>
<td>99 Waverley Road</td>
</tr>
<tr>
<td>99 Waverley Road</td>
<td>St Albans</td>
</tr>
<tr>
<td>St Albans</td>
<td>Herts AL3 5TL</td>
</tr>
<tr>
<td>Herts AL3 5TL</td>
<td>Tel: 01727 804557</td>
</tr>
</tbody>
</table>

Tel: 01727 804725
HERTFORDSHIRE PARTNERSHIP NHS FOUNDATION TRUST

GENERAL CHECKLIST FOR MANAGEMENT OF SERIOUS INCIDENTS

✓ Ensure service users, staff, visitors, members of the public and environment are safe and the necessary medical attention has been sought and contact emergency services as required.

✓ Take any equipment involved out of use if necessary. This should be retained untouched and in safekeeping for examination. The environmental conditions should be noted e.g. flooring-wet or dry, lighting, power points, weather conditions, temperature, visibility, overcrowding etc. and preserved if possible. If appropriate and possible it may be of value to take photos as supporting evidence.

✓ Report the incident immediately and verbally to the person in charge of the ward/depv/unit where the incident occurred. Identify who informs the service user, relatives and others involved in the network.

✓ Designated person in charge/Service Line Leader to grade the incident using the Trust’s grading classification.

✓ If the incident is reportable under the R.I.D.D.O.R regulations, the person in charge is to inform the Trust Health & Safety Advisor. If this is not possible it should be advised on the next working day.

✓ If graded as serious, the incident must be reported immediately to the Service Line Leader on duty, for the area where the incident occurred, who in turn will inform the police where appropriate, unless a 999 emergency. The Service Line Leader will seek advice from the Executive Director (Executive on Call).

✓ Electronic Incident Form to be completed where the incident first happened and by the member of staff to whom the incident was first reported if possible. Record only know facts – not opinion.

✓ Where applicable, please identify any witnesses and attach any statements

✓ The person in charge is to secure any relevant paper records until they can be passed to the Service Line Leader. Set up an annex file where patient is not deceased, (this may involve photocopying of the most recent section of case notes) and all originals are to be secured. This only applies to areas not using Electronic Patient Records.

✓ The designated person in charge will ensure that the circumstances of the incident are reviewed with the staff involved as soon as possible after the incident, and any necessary post-incident support arranged.

✓ The designated person in charge in conjunction with the Service Line Leader will discuss, with the responsible consultant, the most appropriate course of action for notifying other service users and relatives/carers and nominate an appropriate member of staff to undertake family liaison.

✓ The Service/Clinical Manager will ensure that the incident is fully documented in the relevant service user’s notes.
Information Leaflet for Service Users, Relatives and Carers

Introduction to the Trust

The Hertfordshire Partnership Foundation NHS Trust provides Mental Health, Learning Disability and Child Adolescent Mental Health Services across Hertfordshire.

The Trust aims to provide the best possible care and wants people to have a positive experience of its services but unfortunately on rare occasions serious incidents can occur, despite the best efforts of staff, and such incidents are extremely distressing to those affected.

What is a Serious Incident?

We define a ‘Serious Incident’ as anything which causes unintended or unexpected harm, loss or damage to a service user or member of staff”.

What happens when a serious incident occurs?

The Trust take such occurrences very seriously and has a thorough process of investigation and this leaflet aims to explain what will happen in event of serious incidents and to help/guide those affected

Trust investigations are very thorough and carried out according to guidelines, and the investigation will identify any failings or areas where improvements should be made so that services are safer in the future.

The aim is to minimise and manage the risks associated with each incident, and to learn from them, thereby developing safer services and minimising risks for the future.

How does the Trust liaise with you?

When a serious incident has occurred, the Senior Manager will arrange for an appropriate member of staff to liaise with you and be your designated point of contact. They will contact you and you will be given information about the incident and discuss the level of support that you may wish to receive, and what form that will take, and whom will undertake it.

If there is likely to be interest from the media, you should be asked your wishes in relation to the Trusts response to media contact.

The Senior Manager may commission an investigation (into the more serious incidents) and will define the scope of the investigation for the investigator.

You will be invited to contribute to the investigation if you wish, although you do not have to participate if you do not wish to. The Trust, wherever possible, will be open and give as much information as it is possible.

If you want it, contact can be maintained with you throughout the investigation and other relevant support provided.
When the investigation is complete, the written Executive Summary of the investigation will be provided to you, detailing the remit of the investigation, the investigation findings and recommendations.

The Trust will routinely share information regarding serious incidents and any lessons learned from it, in an anonymised form and the senior manager will discuss this fully with you.

**What can you do if you are unhappy with what happens?**

We hope that you will feel satisfied with this process, but if at any point in the process you feel dissatisfied, you have a right to complain about the incident itself and/or the Trust process of investigation and liaison with you.

If at any time you have any questions or concerns you should not hesitate to get in contact with whoever has been communicating with you following the incident at any time, as it may be possible to resolve your concerns immediately.

If you are unable to do this or feel unhappy with the way your concerns are handled, these will be escalated to the senior manager.

Alternatively you may contact:

The Complaints Manager  
Trust Head Office  
99 Waverley Road  
St Albans  
Herts AL3 5TL  
Tel: 01727 804356

This will commence the Trust’s Complaints Procedure, and you will receive a leaflet explaining what will happen then.

The Trust would like to involve users and carers in developing services within the organisation. We want to learn where services require development, and where we are doing well. The Trust will use this knowledge to continually build and improve its services to the benefit of all involved.
7 Day Report Template

This report should be completed using the principles of Root Cause Analysis. The report will seek to investigate the facts to determine the underlying reasons as to why the incident occurred and actions necessary to reduce the likelihood of the incident recurring.

SECTION A
Service User Profile

<table>
<thead>
<tr>
<th>Initials:</th>
<th>Date of Birth:</th>
<th>Date of Death:</th>
</tr>
</thead>
<tbody>
<tr>
<td>MHA Status:</td>
<td>CPA Status:</td>
<td>Diagnosis:</td>
</tr>
<tr>
<td>Directorate:</td>
<td>Service:</td>
<td>Unit/Team:</td>
</tr>
<tr>
<td>Consultant:</td>
<td>CPN:</td>
<td>Social Worker:</td>
</tr>
</tbody>
</table>

Reference Number:

Incident Background

<table>
<thead>
<tr>
<th>Level:</th>
<th>Type:</th>
<th>Category:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Incident:</td>
<td>Time of Incident:</td>
<td>Date Incident Reported:</td>
</tr>
<tr>
<td>Last Contact with Service User prior to Incident:</td>
<td>Was contact by telephone or face-to-face?</td>
<td>How was Trust informed of the incident?</td>
</tr>
</tbody>
</table>

Summary of Incident

Give a description of the incident

Service User Profile. Give background and relevant information about service user

Using a timeline, give a detailed chronological account of the events leading up to the incident, the incident itself and actions taken immediately after

Date/Time

SECTION B
### Analysis/Findings

In your analysis, consider **all** factors relating to the care and treatment of the service user, taking into account the following:

- Was there a failure to adhere to/apply any Trust policy, **for example**:
  - Care Programme Approach Policy
  - Risk Assessment of Individual Service Users Policy
  - Supportive Observation of Service Users Policy (inpatient)
  - Consent to Examination or Treatment
  - Alcohol/Drug Misuse Policy and Procedure
  - Medicines Policy
  - Discharge Policy
  - Resuscitation Policy
  - Learning From Incidents Policy

If so, which one and how?

- Was the risk assessment and management of the individual involved in the incident appropriate and robust? When was the last CPA review?

- What were the last contacts with the service user prior to the incident and what was the adequacy of support arrangements?

- Was there adequate communication between the service user, their carers and the Trust, health professionals and external agencies (if applicable)?

- How compliant was the service user with their treatment plan?

- If the service user was detained under the Mental Health Act 2007, were all relevant policies and legal regulations adhered to?

- If the service user was subject to section 17 leave, was there compliance with Section 17 leave of Absence Policy and Procedure?

- Please identify any good practice which has emerged during your investigation.

- Please investigate whether there were any issues with training, supervision and resourcing.

---

Have you identified any environmental factors which have contributed to this incident occurring?

---

### Recommendations/Actions to be Taken

Identify all recommendations following the investigation. Detail what action will be taken to minimise the risk of a reoccurrence of an incident of a similar nature and state who is responsible for actioning and by when.

<table>
<thead>
<tr>
<th>RECOMMENDATIONS/ ACTIONS</th>
<th>TIMESCALE FOR COMPLETION AND LEAD MONTH / YEAR</th>
<th>ACTION / EVIDENCE OF IMPLEMENTATION</th>
<th>SUPPORTING DOCUMENTATION</th>
<th>TIMESCALE COMPLETED MONTH / YEAR</th>
</tr>
</thead>
</table>
Has the immediate risk been assessed? What measures have been put in place to minimise risk of reoccurrence?

Does any act or omission by staff suggest a need to follow the disciplinary procedure?

Does this incident meet the criteria for reporting to the Care Quality Commission? (this section to be completed by Executive Directors and Patient Safety Manager)

Where appropriate, has a Senior Manager contacted the service user's family/carer? Has a member of staff been appointed to liaise with them and act as a designated point of contact?

### Incident Investigator

<table>
<thead>
<tr>
<th>Name:</th>
<th>Designation:</th>
<th>Base:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Telephone:</th>
<th>Email:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Report Completed by (if different from above)

<table>
<thead>
<tr>
<th>Name:</th>
<th>Designation:</th>
<th>Base:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Telephone:</th>
<th>Email:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Please confirm that the manager commissioning the investigation has accepted this report as final

<table>
<thead>
<tr>
<th>Final Report:</th>
<th>YES NO</th>
<th>Name of Manager:</th>
<th>Date:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

RETURN YOUR COMPLETED REPORT TO: Risk Management Department, Trust Head Office, Hertfordshire Partnership NHS Trust, 99 Waverley Road, St Albans, and Hertfordshire, AL3 5TL

OR EMAIL TO: Incidents@hertspartsft.nhs.uk
INTERNAL REVIEW INTO THE CARE
AND TREATMENT OF XX PROVIDED BY
HERTFORDSHIRE PARTNERSHIP NHS
FOUNDATION TRUST

Report for the Managing Directors

Month/Year
## Index

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<th>Page</th>
</tr>
</thead>
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<td>Terms of Reference</td>
</tr>
<tr>
<td>1.3</td>
<td>Methodology</td>
</tr>
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<td>1.4</td>
<td>Background</td>
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<td><strong>Implementation and learning Opportunities</strong></td>
</tr>
<tr>
<td></td>
<td>Appendix 2</td>
</tr>
<tr>
<td></td>
<td>Internal Investigation</td>
</tr>
<tr>
<td>---</td>
<td>------------------------</td>
</tr>
<tr>
<td></td>
<td>The nature and severity of the incident will determine how the investigation is conducted, the data gathered, and the tools and the techniques used. However, there are some generic elements of a Root Cause Analysis investigation (RCA) and the analysis should be visible within an investigation report utilising the RCA methodology. The RCA investigation needs to be initiated as soon after the event as is practicable and the RCA report needs to be written and submitted to the Managing Director who has commissioned it as soon as possible thereafter. It is important that the service user/victim/relatives are engaged within the investigation appropriately. The report needs to be written in a way that is accessible and understandable to all readers.</td>
</tr>
<tr>
<td>1.2</td>
<td>Terms of Reference</td>
</tr>
<tr>
<td></td>
<td>These will be written by the Managing Director commissioning the investigation and forwarded to the investigators with a clear timescale for the investigation</td>
</tr>
<tr>
<td>1.3</td>
<td>Methodology</td>
</tr>
<tr>
<td></td>
<td>This should include a brief description of how the investigation has been carried out and the data sources used i.e. medical records, statements, interviews, training schedules, staff rotas, equipment, etc. This list will vary depending on the type of incident being investigated. The investigation team membership should be documented(a multidisciplinary team composed of clinical, managerial &amp; an RCA trained investigator)</td>
</tr>
<tr>
<td>1.4</td>
<td>Background</td>
</tr>
<tr>
<td></td>
<td>Details of the background leading up to the incident, which could include a service user’s history if relevant to the investigation. Names of staff should not feature in the RCA investigation report.</td>
</tr>
<tr>
<td>1.5</td>
<td>Incident Chronology</td>
</tr>
<tr>
<td></td>
<td>Factual account of the incident, as indicated by the Terms of Reference, in chronological order. This may take the form of tabular timeline, cause and effect chart, timeline, or narrative chronology.</td>
</tr>
<tr>
<td>1.6</td>
<td>Issues identified during the investigation</td>
</tr>
<tr>
<td></td>
<td>The findings should highlight contributory factors &amp; root causes. This may also include good practice identified. List each concern individually.</td>
</tr>
<tr>
<td>1.7</td>
<td>7 Day Report Recommendations</td>
</tr>
<tr>
<td></td>
<td>As part of your investigation, please consider whether these have been implemented and how fully and effectively.</td>
</tr>
<tr>
<td>1.8</td>
<td>Recommendations</td>
</tr>
<tr>
<td></td>
<td>List each recommendation individually</td>
</tr>
<tr>
<td>1.9</td>
<td>Conclusion</td>
</tr>
<tr>
<td>1.10</td>
<td>Appendices – List documentary evidence</td>
</tr>
<tr>
<td></td>
<td>Copies of relevant documentation</td>
</tr>
<tr>
<td></td>
<td>Methodology used and relevant diagrams e.g. fishbone, cause and effect chart etc.</td>
</tr>
<tr>
<td></td>
<td>Full Chronology, timelines if not in main report</td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
</tr>
<tr>
<td>2</td>
<td>Executive Summary</td>
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<tr>
<td>2.1</td>
<td>Background</td>
</tr>
<tr>
<td>2.2</td>
<td>Details of investigation</td>
</tr>
<tr>
<td>2.3</td>
<td>Findings</td>
</tr>
<tr>
<td>2.4</td>
<td>Recommendations</td>
</tr>
</tbody>
</table>

| 3 | Action Plan | Following submission of the full investigation report to the Managing Director who has commissioned the investigation, and feedback to the relevant clinicians/teams, the Service Line Leader will be responsible for producing an Action Plan. Highlighting the issues for action locally and Trust wide. |

| 4 | Implementation and Learning Opportunities | Following the submission of the Action Plan we request a brief report on plans to implement the Action Plan, evidence it has occurred where possible and identification of learning opportunities and how these will be introduced within the Trust. |
### Action plan for Incidents: RCA / Panel Review / Independent Investigation (please delete)

<table>
<thead>
<tr>
<th>Service User’s Initials:</th>
<th>Date Action Plan Sent:</th>
<th>Datix Reference Number:</th>
<th>Incident Date:</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Recommendation (taken from the Investigation report)</th>
<th>Action</th>
<th>Expected timescale for completion</th>
<th>Person responsible for action</th>
<th>Level of recommendation (Team, Service, Service Stream, Organisation)</th>
<th>Evidence of implementation / Supporting documentation (please specify review date)</th>
<th>Progress (to be completed prior to recommendation s being finalised)</th>
<th>Lag rating / date action completed (MM/YY)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td></td>
<td></td>
<td></td>
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<td></td>
</tr>
<tr>
<td>2.</td>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Person completing:**
**Position:**
**Date completed:**

**Person signing off:**
**Position:**
**Date signed off:**
**Step 1: CONSEQUENCE TABLE**

<table>
<thead>
<tr>
<th>Category</th>
<th>1: Insignificant</th>
<th>2: Minor</th>
<th>3: Moderate</th>
<th>4: Major</th>
<th>5: Catastrophic</th>
</tr>
</thead>
<tbody>
<tr>
<td>Injury</td>
<td>Minor injury not requiring first aid and managed to service user’s satisfaction locally.</td>
<td>Minor injury or illness, first aid treatment needed</td>
<td>RIDDOR / Agency reportable / Adverse event which impacts on small number of service users</td>
<td>Major injuries, or long term incapacity / disability (loss of limb)</td>
<td>Incident leading to death or major permanent incapacity/event which impacts on large numbers of public</td>
</tr>
<tr>
<td>Quality of the Service User Experience / outcome</td>
<td>Reduced quality of service user experience not directly related to direct care</td>
<td>Unsatisfactory service user experience directly related to direct care - readily resolvable</td>
<td>Mismanagement of service user care, short term effects (more than a week)</td>
<td>Mismanagement of service user care, long term effects (more than a week)</td>
<td>Totally unsatisfactory service user outcome or experience</td>
</tr>
<tr>
<td>Complaints / Claims</td>
<td>Locally resolved complaint</td>
<td>Justified complaint peripheral to clinical care</td>
<td>Below excess claim. Justified complaint involving lack of appropriate care</td>
<td>Claim above excess level. Multiple justified complaints</td>
<td>Multiple claims or single major claim</td>
</tr>
<tr>
<td>Service / Business Interruption</td>
<td>Interruption in a service which does not impact on the delivery of direct care or the ability to continue to provide the service</td>
<td>Short term disruption to service with minor impact on direct care</td>
<td>Some disruption in service with unacceptable impact on patient care / non-permanent loss of ability to provide service</td>
<td>Isolated loss of service which has serious impact on delivery of direct care resulting in major contingency plans being invoked</td>
<td>Permanent loss of core service or facility / disruption to facility leading to significant ‘knock on’ effect across the service</td>
</tr>
<tr>
<td>Staffing and Competence</td>
<td>Short term low staffing level (less than 1 day) where there is no disruption to direct care</td>
<td>Ongoing low staffing level results in minor reduction in quality of direct care</td>
<td>Late delivery of key objective / service due to lack of staff. Minor error due to ineffective training. Ongoing problems with staffing level</td>
<td>Uncertain delivery of key objective / service due to lack of staff. Serious error due to ineffective training</td>
<td>Non-delivery of key objective / service due to lack of staff. Loss of key staff. Critical error due to insufficient training</td>
</tr>
<tr>
<td>Financial</td>
<td>Small loss (up to £10,000)</td>
<td>Minor loss (up to £100,000)</td>
<td>Moderate loss (up to £1 million)</td>
<td>Major loss (up to £10 million)</td>
<td>Catastrophic loss (in excess of £10 million)</td>
</tr>
<tr>
<td>Inspection / Audit</td>
<td>Small number of recommendations which focus on minor quality improvement issues</td>
<td>Minor recommendations which can be addressed by low levels of management action</td>
<td>Challenging recommendations but can be addressed with appropriate action plan</td>
<td>Enforcement Action. Low rating. Critical report.</td>
<td>Prosecution. Zero Rating. Severe critical report</td>
</tr>
<tr>
<td>Adverse Publicity / Reputation</td>
<td>Coverage in media, little effect on public confidence/staff morale</td>
<td>Local media – Short term. Minor effect on staff morale/public attitudes</td>
<td>Local media – Long term. Impact on staff morale and public perception of Trust</td>
<td>National Media less than 3 days. Public confidence in organisations undermined. Usage of services affected</td>
<td>National media more than 3 days. MP Concern (Questions in House)</td>
</tr>
</tbody>
</table>

**Step 2: LIKELIHOOD TABLE**

<table>
<thead>
<tr>
<th>Descriptor</th>
<th>Rare</th>
<th>Unlikely</th>
<th>Possible</th>
<th>Likely</th>
<th>Almost Certain</th>
</tr>
</thead>
<tbody>
<tr>
<td>Frequency</td>
<td>Expected to occur less than annually</td>
<td>Expected to occur at least annually</td>
<td>Expected to occur at least monthly</td>
<td>Expected to occur at least weekly</td>
<td>Expected to occur at least daily</td>
</tr>
<tr>
<td>Probability</td>
<td>Less than 1%</td>
<td>1 – 5%</td>
<td>6 – 20%</td>
<td>21 – 50%</td>
<td>Greater than 50%</td>
</tr>
</tbody>
</table>

**Step 3: Risk Grading Matrix**

<table>
<thead>
<tr>
<th>Likelihood</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>5</th>
</tr>
</thead>
<tbody>
<tr>
<td>Probability</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Key</th>
<th>1 – 7 = Low Risks (Green)</th>
<th>8 – 14 = Medium Risks (Amber)</th>
<th>15 – 25 = High Risks (Red)</th>
</tr>
</thead>
</table>

**Risk Grading Matrix**

The following assessment process will be applied to all risks to give a comparative score from 1 to 25.

**Step 1:** Chose the most appropriate row for the risk issue from the category on the left, and estimate the potential consequence or adverse outcome using the descriptions in each row.

**Step 2:** Estimate the likelihood of this level of consequence/adverse outcome occurring, on a scale of 1 to 5 by assigning a predicted frequency of the adverse outcome occurring, or by assigning a probability of it occurring in a given timeframe.

**Step 3:** Multiply the consequence and likelihood scores for the Risk Grading i.e.:

Consequence x Likelihood = Risk Grading
Help is at Hand

A guide to practical and emotional issues following suicide or sudden, traumatic death

Bereavement by suicide or other sudden traumatic death can be particularly difficult for people, who often need both practical and emotional support in dealing with their loss. The professionals who are best placed to offer such support or point people in the right direction – hospital staff, the police, funeral directors and prison staff, for example – may also need support themselves.

This useful guide covers:

• Practical information – e.g. the role of coroners, inquests.
• Grief and the experience of bereavement.
• Issues for particular groups – e.g. parents, young people, children.
• Where to find further support and advice.

To order Help is at Hand:
Tel: 0300 123 1002
E-mail: dh@prolog.uk.com
Fax: 01623 724 524
Minicom: 0300 123 1003
Or write to: DH Publications Orderline, PO Box 777, London SE1 6XH quoting 286523/Help is at Hand

Alternatively, to download a pdf file of the guide, visit www.dh.gov.uk (enter Help is at Hand in the search box)

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Our vision

‘to be the leading provider of mental health and specialist learning disability services in the country’

To be a leading provider, we must offer high quality care with excellent treatment outcomes, within a safe environment which meets the needs of service users.

Our vision is underpinned by eight goals which inform our entire strategy.

- To deliver high quality integrated health and social care services in accordance with recovery principles
- To be the provider of choice for service users, carers, the community and commissioners
- To work in partnership with the community to promote the wellbeing of others, whilst making a positive contribution to the environment
- To be the employer of choice where staff are highly valued, well supported and rewarded
- To create a dynamic and flexible working environment where staff are motivated and committed to providing high quality care
- To embed a learning culture where staff develop their full potential and deliver excellent care
- To ensure a sustainable future through income growth and efficient use of resources
- To be an innovative and learning organisation that embraces new and modern approaches to health and social care