Incident reporting, Investigation and Learning Policy

Merging previous policies:
RK01 Serious Incidents requiring investigation
RK03 Reporting of Adverse Events
RK04 Policy for investigation, Analysis and Learning from Incidents, Complaints and Claims

Solent NHS Trust policies can only be considered to be valid and up-to-date if viewed on the intranet. Please visit the intranet for the latest version.

Purpose of Agreement	This policy details how Solent NHS Trust report and manage incidents. It includes when and how investigations take place and how the learning from Incidents is shared.
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Amendments Summary: During 3-year review process, these changes were made

Please fill the table below:

Amend No	Issued	Page	Subject	Action Date
Version 3	June 2022	6	Fraud, bribery, corruption wording included	June 2022
		3	Investigated changed to undertaken	June 2022
		24	Equality, Impact Assessment reviewed	June 2022

Review Log:

Include details of when the document was last reviewed:

Version Number	Review Date	Lead Name	Ratification Process	Notes
1	February 2021	Teresa Power	This is a new policy, which incorporated the following policies: RK01, RK03 and RK04	
2	January 2022	Teresa Power	Chair's action approved extension request to September 2022 – in light of changes that will be required once the Patient Safety Incident Response Framework is available (in April 2022). Current policy remains fit for purpose.	No changes made to the policy
3	May 2022	Teresa Power	Policy Steering Group, Clinical Executive Group	Standard review due, no changes to be made, all content remains fit for purpose.

SUMMARY OF POLICY

This policy outlines the process for reporting, managing, investigating, and learning from incidents, including Serious Incidents Investigations (SI's) and Never Events. The policy is an update of previous policies (Reporting Adverse Incidents, Serious Incidents requiring investigation and Policy for investigation, Analysis and Learning from Incidents, Complaints and Claims) and replaces all previous versions of policies related to the investigation of incidents. It should be noted that this policy will also be subject to significant review and change as the National Patient Safety Strategy is implemented (by 2023) and in light of Solent's commitment to engage with and involve our community in creating a Safety Culture within the trust.

Solent views the reporting and investigation of incidents as opportunities to learn and prevent future safety issues taking place. Learning from incidents is of paramount importance in order that an Organisation can understand why an incident occurred, can rapidly identify learning and put actions in place to protect the safety of patients and staff, can share this learning and can prevent similar incidents from occurring again. Learning is shared in a variety of means in Solent. These include

- directly within teams,
- via the Learning from Incidents and Deaths Panel,
- at local and Trust wide Safety Forums,
- through regular patient safety reporting,
- at regular and bespoke training
- on SolNet and via rapid Communication systems

All Incidents including near misses must be reported using the Ulysses (Online Risk Management System) and should be recorded on the day the incident occurred. This policy will detail the recommended and mandated timelines for reporting, reviewing, responding, and investigating incidents. The policy is closely linked to and should be read in conjunction with the Learning from Deaths Policy, the Being Open and Duty of Candour Policy and the Management of Complaints Policy.

Serious Incidents are reported to NHS England. The Investigation is undertaken by an experienced Serious Incident Investigator and the Serious Incident Framework (2015). The policy will also provide guidance for incidents categorised as High Risk or Serious Incidents and clarify the definition of these.

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1. INTRODUCTION & PURPOSE

1.1 Successful incident management is underpinned by a proactive culture whereby effective incident reporting, investigation and learning from incidents take place and reduce the likelihood of incidents reoccurring. This reporting culture contributes to improved service user safety and service provision and makes the Trust a safer place to work and visit for staff, service users and the public.

1.2 The open reporting of incidents (including near misses and 'errors') is positively encouraged by Solent and is viewed as an opportunity to learn and to improve safety, systems and services.

1.3 The Board of Directors endorses the use of the NHS Improvement 'A Just Culture guide' (2018) appendix B, which aims to promote fair and consistent staff treatment within and between healthcare organisations. The just culture guide helps to move away from attributing blame and instead looks to find the root cause when things go wrong. Identifying contributory systems failures is crucial to successful incident management.

1.4 Staff will also be supported through the Freedom to speak up and the Being Open and Duty of Candour Policy. Solent will apply the principles of individual responsibility and corporate responsibility.

1.5 The key principles of Solent NHS Trust's Incident Reporting are that:

- Our community can have confidence that any concerns about safety are highlighted and thoroughly investigated.
- Safety is ensured in all areas of the trust and that incidents that could potentially or have caused safety concerns are identified.
- Key lessons from incidents in any part of Solent NHS Trust can be applied in other areas of the Organisation, in order that the risk of recurrence is reduced, and subsequent loss or harm is avoided or reduced.
- A learning and no blame culture is fostered.
- Any loss of reputation or assets of Solent NHS Trust and its staff is minimised.
- Data and quality metrics of all incidents and near misses is obtained and the appropriate analysis is undertaken to provide intelligence for future improvements.
- Solent fulfils its Statutory and mandatory requirements for incident reporting and investigation.

1.6 The process for the management of Serious Incidents was reviewed by NHS Improvement in 2019 and it is expected that a Patient Safety Incident Response Framework will be published for full roll out in 2021. Solent will review and update this policy in line with any significant changes when full roll out commences.

1.7 The purpose of the policy is to ensure that.

- all incidents are appropriately managed and investigated based on their severity
- there is relevant learning and improvement in care as a result of incidents
- Qualitative and quantitative data analysis is used to highlight any trends which may be occurring and uncover any further need for intervention.

It is therefore essential that all incidents, irrespective of whether they have caused actual harm, or were a near miss, are reported to the Trust in a timely manner. This will help to build an accurate picture of events across the Trust.

2. SCOPE & DEFINITIONS

2.1 This policy applies to locum, permanent, and fixed term contract employees (including apprentices) who hold a contract of employment or engagement with the Trust, and secondees (including students), volunteers (including Associate Hospital Managers), bank staff, Non-Executive Directors and those undertaking research working within Solent NHS Trust, in line with Solent NHS Trust's Equality, Diversity and Human Rights Policy. It also applies to external contractors, agency workers, and other workers who are assigned to Solent NHS Trust.

2.2 Solent NHS Trust is committed to the principles of Equality and Diversity and will strive to eliminate unlawful discrimination in all its forms. We will strive towards demonstrating fairness and Equal Opportunities for users of services, carers, the wider community, and our staff.

2.3 See Glossary in section 10.

3. PROCESS/REQUIREMENTS

3.1 Immediate Response by the Trust

3.1.1 In all instances, the 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.

3.1.2 A safe environment should be re-established. It is essential that all equipment or medication indicated in a safety incident is quarantined retained and isolated in accordance with the Medical Devices Safety Policy and the Medicines Management policy All relevant non-electronic documentation should be copied and secured to preserve evidence to facilitate the investigation and learning.

3.1.3 If there is a risk that a criminal offence has been committed, the immediate vicinity where the incident occurred should be preserved, as far as practicably possible and contact with the police made as soon as possible after the event. It should be noted that any judicial investigation will take precedence over a Solent investigation.

3.1.4 In the event of suspected criminal fraud, bribery and/or corruption offences a report should be made to the Trusts Local Counter Fraud Specialist to investigate further in line with the Trusts Local Fraud, Bribery and Corruption Policy.

3.1.5 Solent are committed to the principle of being open and transparent when an incident occurs. Early discussions and support must be offered to service users, relatives and carers and staff involved in the incident. A sincere and meaningful apology must be given to patients/family, in accordance with the Trust's Being Open and Duty of Candour Policy).

3.1.6 If the incident is a potential adult or child safeguarding concern, a safeguarding alert must also be raised and the Solent Safeguarding team involved in the decision making about ongoing investigations

3.2 Incident Reporting

3.2.0 All incidents (irrelevant of their severity), including near misses, must be reported using the Trust's electronic risk management System– Ulysses. In the event of the electronic system not being available, an incident can be reported using the printable Incident Report Form and sent to the Quality and Safety Team for uploading onto the Ulysses system. The Quality and Safety team are available in working hours via phone, emails, or TEAMs to assist with queries about the completion of incidents reports

3.2.2 Incidents must be reported as soon as possible after an event and no later than 24 hours of the event being identified. In exceptional circumstances there may be a delay in reporting an incident, the reason for the delay must be included in the incident report.

3.2.3 Incidents are factual accounts of events and must include relevant details of the incident and immediate actions taken including support offered to individuals involved. They should be as detailed as possible regarding location, time, those involved and any other relevant details. They should not include opinion, supposition, conjecture, and personal identifiable information.

3.2.4 The person nominated by the service as a reviewer has some vital responsibilities in managing incidents which include review of the event, ensuring staff and patients are safe and supported, determination of severity and alerting senior staff about serious events. It is for this reason that incidents are sent electronically to the designated reviewer. The designated reviewer must review the incident details and complete the initial submission of the incident using Ulysses within 5 days of notification. Reviewers are encouraged to provide feedback to staff following the reporting of the incident and the closure of the incident.

3.2.5 The Quality and Safety team will carry out an audit of this quarterly and will report to the Quality Improvement and Risk Group where review is not taking place within the appropriate timelines.

3.2.6 Further guidance on reporting incidents using Ulysses can be found on SolNet.

3.3 Grading

3.3.1 All reported incidents and near misses are initially graded by the Quality and Governance Administrators and not as part of the reporter's or reviewer's process. The Quality and Governance Administrators review all Incidents reported on Ulysses and undertake Validation using the guidance from the NRLS. (See Glossary)

3.3.2 The incident is validated based on the information available, using guidance from the NRLS. The incident can be regraded at any time, for example following the Incident Review process or an Investigation. It is for this reason that the information contained within the report should be as full possible.

3.4 Near-miss incidents

3.4.1 Near miss incidents are not the same as negligible or minor incidents and should never be treated as such. A near miss is an unplanned event that did not result in injury, illness, or damage – but had the potential to do so. Only a fortunate break in the chain of events prevented an injury, fatality, or damage; in other words, a miss that was nonetheless very near. In some cases, these are so serious as to constitute a High Risk or Serious Incident despite the harm being averted.

3.4.2 Near misses should be dealt with in relation to the potential harm that would have occurred had the actual incident not been avoided. For example, if a near miss had the potential for moderate, major, or catastrophic harm the incident should be considered in the same way as an actual incident at a moderate, major, or catastrophic level. Near misses which would have resulted in negligible or minor harm should be dealt with in the same way as actual negligible or minor incidents with the local team or services learning from these via the same process as actual low-level incidents.

3.4.3 The potential severity of the harm averted in the near miss had it impacted upon a patient, staff member or visitor will determine the appropriate level of investigation pursued.

3.5 Moderate, Major, Catastrophic Incidents

3.5.1 Incidents with an actual impact of moderate or above, must be reported and escalated to relevant Heads of Service/Clinical Directors and designated Executives by the team manager within 24 hours of the incident occurring, or to the on-call duty manager if out of hours.

3.5.2 The statutory Duty of Candour must be engaged for all patient safety incident where there is moderate harm to the Service user, duty of candour is determined at an Incident Review meeting. See the Being Open and Duty of Candour policy.

3.6 Incident Review meetings

3.6.1 Incidents graded moderate and above except for Pressure Ulcers are subject to an Incident review meeting (IRM). The purpose of the IRM is to consider if whether any immediate actions need to be taken or learning shared. The IRM will also review the level of investigation required or whether an incident meets the Serious Incident Framework or the Trust's definition of a High-Risk Incident. On occasions Incidents graded minor or below can still be subject to an IRM. See SolNet for further information.

3.6.2 The meeting will always be chaired by the Chief Nurse, Chief Medical Officer, or their nominated Deputy (Assoc Nurse Director/Associate Director of Quality & Governance/ Associate Medical Director). This is a minimum requirement for Quoracy.

3.6.3 The meeting will also bring together senior service line staff, safeguarding, IG, Infection prevention and control staff, clinicians, other providers and significant participants and CCG colleagues depending on the nature of the incidents. This list is not exhaustive and the IRM can have any representatives who are able to contribute relevant information and context to the chair.

3.6.4 The purpose of the meeting must relate to a safety issue and is not for Services to share or discuss purely operational or communication issues or to facilitate engagement with other providers.

3.6.5 **Process for identifying an incident, that requires an Incident review meeting**
This meeting can be convened via several triggers:

- Heads of Quality and Professionals/CDs can submit a request via the Quality and Safety team.

- By the Quality and Safety Team during the Validation process an incident can be identified, this will be discussed with the Head of Quality and Professions

- At the request of the staff named above as chairs

- At the request or based on an issue raised by external bodies such as the CQC, CCG or other providers but the chair will retain the final decision as to whether this is required.

3.6.6 IRMs, in most cases, are organised to take place within 5 days of the Incident being identified for a review. However, it is recognised that for incidents of greater than moderate harm, the incident is risk assessed by the Quality and Safety Manager to ascertain if a review meeting needs to take place sooner. There are exceptions to this timing including IG breaches which have nationally mandated timelines to which Solent must adhere. These are detailed in the relevant policies for specific departments.

3.6.7 Managers are required to have undertaken a review of the incident before the meeting and to add a chronology to the Incident reporting form. An incident Management Form (IMF) should be provided with as much notice to the meeting as possible to ensure full details are available prior to decision making. The additional information is required to enable the chair of the meeting to decide the level of investigation required.

3.6.8 The Incident review meeting actions are documented by a Quality and Governance Administrator on the Incident form. The meetings are usually recorded to ensure accuracy in completing the notes, but the recording is deleted immediately after notes are written for good governance of data purposes.

3.6.9 In the case of a patient death services may be required to produce a structured judgement tool to determine quality of care and any potential gaps. This is detailed in the Learning from Deaths Policy and will be requested on a case by case basis.

3.7 Serious Incidents

3.7.1 Under the Serious Incident Framework (NHS England 2015) serious incidents are no longer defined by grade, but every incident considered on an individual basis:
'Serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. …Serious incidents can be isolated, single events or multiple linked or unlinked events signalling systemic failures within a commissioning or health system'.

3.7.2 In line with the SI Framework, all incidents meeting the criteria for reporting via the Strategic Executive Information System (StEIS) as Serious incidents. These can be found at Appendix C

3.7.3 The Quality and Safety team will report any serious incidents meeting the criteria on StEIS within 48 hours of the identification of the serious incident. A copy of the Incident form, including the chronology and the commissioning brief will be shared with the appropriate CCG or other commissioning body as per contractual arrangements within 72 hours of the identification of the serious incident. The team have developed guidance on the Trust's approach to the SI investigation and the sign off process. This guidance is on SolNet.

3.7.4 The Quality and Governance team will ensure serious incidents are also shared via the National Reporting and Learning System (NRLS) within 2 days of identification in accordance with current guidance.

3.7.5 It should be noted that both StEIS and NRLS will be discontinued as per National Health Service England (NHSE) plans within 2021/22 and this policy and process will be reviewed to reflect any changes.

3.7.6 A commissioning brief will be written to determine the scope and limitation of any investigation. These are the responsibility of the Head of Quality and Professions or a nominated deputy with support from the Quality and Safety Team. The Associate Director of Quality and Governance (or nominated deputy) approves the Commissioning brief before it is shared with the CCG.

3.7.7 At the time of writing all serious incidents require root cause analysis investigation. Reports (eRCA) are completed using Ulysses.

3.7.8. Solent have a bank of experienced Serious Incident Investigators who are trained in investigation and are not related to any of the services in which they carry out investigations. The roles and responsibilities of the Serious Incident Investigators are documented in the Serious Incident Framework (2015). The Head of Quality and Professions are responsible for ensuring that all serious incidents in their service line are investigated. The Quality and safety manager is responsible for monitoring that deadlines and appropriate standards or investigation are met that the report meets the requirements of the Serious Incident Framework 2015. They will also liaise with the CCG if a delay is anticipated to ensure that Solent does not breach deadlines for completion.

3.7.9 On occasion it may be necessary for an external investigator to investigate a Solent incident. It is important that the investigator is provided with support from the Quality and Safety Manager and is provided with all the relevant access and information they require for the investigation. A memorandum of understanding will be provided. This will include, policies and procedures, a list of contacts, service line support and admin support.

3.7.10 Solent Serious Incident Investigators may be required to undertake an external Investigation for another Organisation. On this occasion, it is important the neighbouring Trust develops a memorandum of understanding and shares this with the Investigator. Solent will provide support to the investigator throughout the investigation.

3.7.11 In accordance with the Trust's Being Open and Duty of Candour policy, investigators will involve the service user and/or their carers/family or significant other in the investigation process unless there is an identified and documented reason not to do so. In all cases, service users, carers/family or significant others will be informed that the Trust is undertaking an investigation into the incident.

3.7.12 For the majority of cases, service users, carers/families or significant others will be offered the opportunity to participate in the investigation and this will involve the Service manager sending a letter to the service user, carers/family or significant others providing the lead investigator(s) contact details. The investigator will then arrange to talk to or meet with the service user, carer/family or significant other. A patient or next of kin's questions will be included in the Commissioning Brief if it is directly relevant to the incident. If a patient or next of kin's questions are not directly related to the incident, these will be managed under the Complaints Policy.

3.7.13 Where the service user, carer/family or significant other do not wish to be involved in the actual investigation, once the report and action plan are completed, they will be contacted again to advise them of the report completion and to ascertain how they would like to receive feedback on the findings. A copy of the finalised report will be shared, or discussed, with them, where this is requested. The decision to not participate or where family cannot be identified should be recorded on the Ulysses record.

3.7.14 Where an incident involves other providers or organisations, an invitation to the IRM will be offered and in most cases the opportunity to carry out a joint investigation will be made available at this point. Joint investigations should be just as they are described with all parties able to provide timelines, information and interviews for the investigator who should retain absolute independence and not be seen to represent Solent alone. Ideally all parties should be brought together to review and update the investigation together rather than in sequence in order that valuable discussion is held. Principles of joint investigation are detailed in the Hampshire and Isle of Wight (HIOW) joint agreement for investigation to which Solent is fully committed.

3.7.15 Serious Incident reports and the action plans should be written with the patient or their family in mind and the language and style must reflect a person-centred approach. The patient and /or their family members will be named in a report following their consent. The information within a report can be extremely distressing for a person to read and in some cases, this cannot be avoided. This is however, exacerbated if the report is written in a way that uses complicated or jargonistic language. The report should avoid jargon, complication, and extraneous information. It should be written in such a way that a person with no previous experience of healthcare can understand. Action plans should be constructed to be meaningful and reflect the desire to address any care or service delivery concerns raised and to prevent future incidents.

3.7.16 It is the Head of Quality and Professions responsibility to organise the sharing of the report with the patient or their family. The letter summarising the findings and process of investigation will accompany the report. It is important to provide the patient or their family with a choice on how they would like to receive the investigation. This may be in person or by email or post. Opportunities should be made for a follow up appointment to discuss any questions. Following the appointment, if the patient or their family still have concerns, it will be necessary to manage through the Complaints policy.

3.7.17 The Family Liaison Manager (FLM) will be offered for supporting families in the event of an unexpected death or serious event and will usually participate in the sharing of the completed report. The completed investigation report, when shared with the family should, where appropriate be undertaken with direct support from the FLM.

3.7.18 In the event of an unexpected death that constitutes a Serious Incident the Investigation report will be requested by the Coroner. Serious Incident Investigators will be requested to attend inquests as a witness.

3.8 Never Events

3.8.1 Never events are serious, largely preventable service user safety incidents that should not occur if the available preventative measures have been implemented i.e. in-patient suicide using non-collapsible rails. 'Never events' are defined by NHS England from the evidence base and reviewed periodically (NHS England 2018). See Appendix D for a list of the current 'Never Events' that apply to the Trust. They will be investigated using a SI methodology.

3.8.2 Quality and Governance (Quality & Safety Team) will immediately report a Never Event to the Chief Nurse who will inform the Board and other stakeholders. Reporting of these events is also required to the CQC and this will be undertaken by the Chief Nurse or their nominated deputy.

3.9 High risk Incidents

3.9.1 High Risk Incidents are incidents that Solent deem as serious in themselves or due to the scale, scope for replication or implications of the event. They do not meet the Serious Incident Framework 2015 standards. They can be escalated to a Serious Incident at any part in the investigation. The chair of the Incident Review meeting will decide when a high-risk incident investigation is required.

3.9.2 High Risk Incidents may be investigated using root cause analysis, though this is not always the case. Where they are investigators should do so using the eRCA module, on Ulysses and are usually investigated within a Service line. On occasions the chair of the Incident Review meeting identifies a bank Serious Incident Investigator is required to investigate.

3.10 External Reporting Requirements

Dependent upon the type of incident and/or severity of the incident being reported will dictate whether additional action/reporting to external agencies is required and this will be determined on a case by case basis. See appendix E

3.11 Reporting of Incidents to the Care Quality Commission

It is a requirement that some serious incidents must be reported directly to the CQC, as determined in the CQC, Statutory notifications for NHS bodies provider guidance (2013) Incidents falling into this category will be identified by the Quality and Governance Team and it will be agreed who will report to the CQC at the Incident Review meeting.

3.12 Communication following an Incident the Being Open and Statutory Duty of Candour Policy

3.12.1 The Trust's Being Open and Statutory Duty of Candour policy makes it compulsory on the Trust to disclose information. In respect of this policy where there is a patient safety incident, that has led to a minimum of moderate harm to a service user, the Statutory Duty of Candour applies.

3.13 Supporting staff and service users following an incident/traumatic event

3.13.1 The line manager/person in charge must ensure all staff and service users involved in a traumatic/ stressful incident are offered support following an incident.

3.13.2 In the first instance a debrief session should be held as soon after the event as possible to allow staff the opportunity to reflect on the situation and explore how it has made them feel. This would usually be organised and facilitated by the team manager. The exact nature of the support mechanisms used will be dependent on the type and severity of the incident and the needs of the individual(s) involved and will always follow the principles of being open as detailed in the Being Open and Duty of Candour policy.

3.13.3 The manager/person in charge should consider actions to protect the individual(s) wellbeing at this time. As appropriate, staff will be offered reasonable access to:

- Immediate medical treatment if required.
- Advice/counselling from Workplace Wellbeing.
- Occupational Health Services.
- Advice from Human Resources.
- Legal advice (at the discretion of the Trust).
- Time away from work (nature of leave to be agreed on a case by case basis).
- Time out to consult with their Union and/or professional body.

3.13.4 Subsequently managers should ensure staff can access on-going peer support within and/or external to the team, as well as support from themselves.

3.13.5 On the completion of an investigation, all individuals involved will be provided with the investigation findings, lessons learned and recommendations for further action. The ward/team manager may wish to consult with the Quality and Governance (Quality & Safety Team) for advice and support.

3.13.6 In cases where a potential misconduct or a potential breach of professional conduct are identified through investigation a separate process which is detailed in Solent's HR Policies will be undertaken. Reference to the HR investigation to be undertaken may be made in the investigation report but no details of the outcome will be shared in the Serious Incident investigation. It may be necessary for the HR Investigation Investigator and the Serious Incident Investigator to undertake joint staff interviews to prevent duplicating responses and to minimise staff's time and distress. The same level of staff support must be in place for staff in these situations as for any other investigation.

3.13.7 Safety events may be brought to the attention of the Quality and Safety team via the Freedom to Speak Up Guardians (FTSU) within Solent. These will be investigated in accordance with FTSU policy and guidelines but, whilst protecting the individual involved, should have the same rigor and professional curiosity as all other investigations.

3.14 Support for Staff called as witnesses:

3.14.1 In the event that a member of staff is called as a witness to Coroner's Court or other external processes in relation to an incident then the staff's line manager must contact the Head of Risk and Litigation. The Head of Risk and Ligation will arrange support and guidance to all witnesses with reference to preparing for and attending court. Further information can be found on SolNet.

3.15 Incidents Involving the Police

3.15.1 Whilst all service user records must be preserved securely and safely for evidence, unless there is a real reason to believe the records will be tampered with, the police do not have the right to seize/remove service user records without a court order being in place.

3.15.2 Where the police do request records for evidential purposes, a formal written request using form DP2 must be completed by the requesting officer. The Police must send this directly to the Information Governance team. The relevant records can then be copied, and the copies released to the police. This is managed by the Information Governance team as a Subject Access Request. Further information can be found in the Subject Access Request policy.

3.16 Media Involvement/Media Enquiries

3.16.1 The Trust's Head of Communications will handle all enquiries from the media; prepare statements for release to the media on behalf of the Trust, etc. Staff receiving any media enquiries must direct these immediately to the Head of Communications, or if out of office hours, the on-call manager.

3.16.2 The Head of Quality and Safety will notify the Head of Communications of all serious incidents likely to cause media interest. Where adverse media coverage is either received or perceived, contact with Portsmouth or Southampton CCG and NHS England's communications leads will be established to agree a media handling strategy. Where necessary, NHS England will brief the Department of Health Media Centre.

3.17 Learning and Sharing

3.17.1 Solent recognise that Safety in Healthcare has traditionally focussed on avoiding harm by learning from error however Solent are committed to recognising the effectiveness of learning from what has gone well by analysing and sharing why it went well. Sharing this learning provides the opportunity for Services to explore how they too can learn from the Incidents. This is called positive learning.

3.17.2 Sharing learning opportunities have been created in Solent by introducing positive learning and deep dives at Learning from Incidents and Deaths panels and Safety Forums. Deep dives provide analysis and an opportunity to explore a trend or theme of patient or staff safety. Safety Forums are open to all staff and are held bimonthly with a purpose of Solent staff being able to join discussions about patient and staff safety. These forums are led by the Quality and Governance team and are a subdivision of the Incidents and Deaths panels.

3.18 Learning from Deaths (See Learning from Deaths Policy)

3.18.1 Refer to the Trust's Learning from Deaths Policy to determine which patient deaths must be reported as an incident.

3.18.2 Following the completion of a Structured judgment tool where the Quality of care score is 2 or below and or has a preventability score of 3 or below, the case will be reviewed at an incident review meeting to determine if it meets the criteria of a Serious Incident or a High Risk Incident. See Learning from Deaths Policy.

3.18.3 Following an Incident Review meeting any unexpected deaths that meet the Serious Incident Framework will be investigated.

3.19 Learning from Incidents and Deaths panel

3.19.1 The Learning from Incident and Deaths panel is held monthly and is co-chaired by the Chief Nurse and the Chief Medical Officer.

3.19.2 The panel is accountable for the following.

- Review and approval of Serious Incident Investigations
- Learning from High Risk Incidents
- Service Line Mortality Reviews
- Learning from Coroners
- Positive Learning
- Deep Dives into Staff and Patient safety incidents
- Ensuring that a plan for meeting the Statutory Duty of Candour is in place.

3.20 Disseminating Learning from a Serious Incident

3.20.1 Quarterly reports are produced by the Quality and Governance Team which provides an analysis of all incidents reported across the Trust. Serious incidents are recorded within these reports in greater detail and all identified causes and lessons learned from them are included. These reports are presented to the Assurance Committee and board. As well as being published on the Trust's intranet site for all staff to access.

3.20.2 Teams are also expected to discuss incidents, complaints and claims at their regular team governance meetings, to feedback findings, heighten understanding and share the learning.

3.21 Learning from Inquests and Claims

The Risk and Litigation Manager provides a monthly update from inquests to the Chief Medical Officer and the learning is reported at the Learning from Incidents and Deaths panel. A Claims report is submitted biannually to the board.

3.22 Wider Sharing of Lessons

3.22.1 Investigations may identify issues of national significance or where the dissemination of national learning is appropriate. Service user safety incidents are reported through NRLS. When updates to the incidents are recorded on the Ulysses system, updates are sent to the NRLS. When an incident is closed, the incident causes and lessons learned are inputted into Ulysses, which then shares the findings with the NRLS and the Care Quality Commission where appropriate.

3.22.2 As the report and action plan is shared with relevant external stakeholders, this enables learning to be shared across organisational boundaries. Where NHS England perceives that lessons learned in one Trust may be relevant to others, this will be communicated through them and assurances sought from individual Trust Boards that necessary measures are either already in place or are being taken to prevent recurrence in their Trust.

3.23 Learning from Safeguarding Adult Review (SARs) and Child Safeguarding Practice Review (CSPRs) and Domestic Homicide Reviews (DHR)

3.23.1 Learning lessons is the prime rationale of Safeguarding Adult Reviews and Child Safeguarding Practice Reviews. Local Safeguarding Adults Boards (LSABs) and Safeguarding Children Partnerships (SCPs) are responsible for commissioning the respective reviews; sharing the learning across all organisations; and monitoring at agreed review periods whether the lessons have been taken on board. The LSAB or SCP is responsible for ensuring that they receive regular progress reports on the respective SAR or CSPR and can act if the delay appears unreasonable.

3.23.2 NHS organisations in partnership with the LSAB or SCP should have local policies for implementing the findings from CSPRs or SARs; a process to report to their own boards, and action plans to implement and monitor changes in practice or recommendations.

3.23.3 Domestic Homicide Reviews (DHR) are managed via the Local Authority who are responsible for sharing the learning across all organisations; and monitoring at agreed review periods whether the lessons have been taken on board.

3.23.4 The Associate Director of Quality and Governance is the Trust's nominated lead for Domestic Homicide Reviews.

3.24 Monitoring actions and changes in practice

3.24.1 Recommendations made following serious incident investigations must be relevant, appropriate, and always follow the Specific, Measurable, Achievable, Realistic and Time- bound (SMART) format. Recommendations that are vague, irrelevant, or unfocused are not acceptable. Similarly, all actions drawn from recommendations must follow the SMART format and must be precise, focused and above all achievable.

3.24.2 All Serious and High-Risk Incident Investigations have an action plan generated from the recommendations. These action plans are monitored through Ulysses where staff are allocated responsibility for ensuring they are completed. These are monitored by the Heads of Quality and Professions. Ulysses also sends reminders to the responsible staff to inform them they have open actions.

4 ROLES & RESPONSIBILITIES

4.1 The Board is responsible for:

- Ensuring robust incident reporting, investigation and management systems are in place and that these are monitored and reviewed and compliant with external regulation
- Ensuring that serious incidents are reviewed, and recommendations/actions implemented
- Ensuring that data from incident reports is analysed to identify themes and trends and appropriate action is taken

4.2 Executive Directors

The nominated Executive Directors are listed below and are responsible for:

- Agreeing Terms of Reference for Executive Level Serious Incident investigations.

- Agreeing lead investigators for Executive Level Serious Incident investigations.
- Ensuring Executive Level Serious Incident investigation reports are heard by a panel, whose membership includes the Chief Medical Officer, Chief Operating Officer and Chief Nurse.
- The Chief Nurse has Final approval of all Serious Incident investigation reports and action plans.
- Performance management of incident management procedures
- Appraising Board members of Executive Level Serious Incidents.

4.3 Chief Operating Officer

The Chief Operating Officer has responsibility for ensuring clinical operations adhere to and abide by the framework set out in this policy.

4.4 Chief People Officer

- Ensuring that support for staff following incidents is available via the Workplace Wellbeing service.
- Ensuring Occupational Health guidance, advice and service is available for staff following incidents and the Employee Assistance Programme.
- Ensuring that an HR representative forms part of Executive Level Serious Incident investigation teams.
- Ensuring that media communications, in relation to incidents, are managed effectively through the Communications Manager.

4.5 Clinical and Corporate Directors

Clinical and Corporate Directors are responsible for ensuring that their staff comply with the requirements set out in this policy. This will be achieved through:

- Ensuring that all incidents/accidents are reported, investigated, and managed in accordance with this policy.
- Ensuring that all staff, including temporary staff, are aware of this policy and their duties regarding incidents/accidents.
- Ensuring all incidents reports and recommendations relating to their care groups are reviewed at the appropriate team or service level to support learning, the reduction of risk and the prevention of recurrence.
- Ensuring all risks identified following the investigation of an incident/accident relating to their care groups are recorded on the appropriate electronic risk register and reviewed and updated as required.
- Ensuring that incidents/recommendations or actions relating to other care groups or services in the Trust are communicated effectively within their services, ensuring any identified risks are recorded on the appropriate electronic risk register and reviewed and updated as required.
- Reviewing the data derived from incident reports to identify any themes or trends for their sphere of responsibility, and taking appropriate action as needed.
- Sharing full reports including lessons learned, recommendations and actions through their care groups and Service governance framework
- Ensuring staff, service users and carers or others involved in incidents are kept informed and receive support as appropriate in line with the requirements of the statutory Duty of Candour.
- Ensuring all staff in their care groups receive training at induction and subsequently as required by this policy.
- Providing support to staff who report incidents, either through incident briefing, clinical supervision, or management supervision.

4.6 Specialist Advisors

Specialist Advisors are staff with areas of knowledge and specialist expertise who are available to support staff in implementing this policy. They include the Head of Quality and Safety, Quality and Safety Manager, Health & Safety Manager, Head of Information Governance and Data Protection, the Lead Nurse for Infection Prevention and Control, Local Security Management Service Advisor and Fire Officer and the Safeguarding Adults and Childrens Lead Nurse (this is not an exhaustive list).

4.7 The Quality and Governance Team

- Act as custodians for the Trust's policies and procedures for the management of incidents and will support the monitoring processes in relation to compliance and implementation.
- Provide advice and support to all staff and ensure training, resources and information is available to enable the effective reporting, investigation, and management of incidents.
- Report externally to the Care Quality Commission, Clinical Commissioning Group (CCG), NHS England/NHS Improvement and other agencies as required.
- Be responsible for reporting via the Strategic Executive Information System (StEIS) and updating as required. Facilitate the timely approval and action planning of serious incident investigations within the care groups.
- Ensure that incidents are shared with the relevant departments, for example Health and Safety though the notifications functionality of Ulysses.
- Maintain the Ulysses database for incidents, investigations and actions plans.
- Keep all accident/incident/investigation information in line with the Trust's records retention requirements set out within the Trust's Records Management Policy.
- Provide a quality assurance review of all incidents reported.
- Monitor adherence to the Being Open and Duty of Candour policy.
- Monitor the completion of action plans within Service Lines.
- Share information and lessons learned following clinical incidents.
- Support staff and service users following an incident where appropriate to do.
- Review investigation reports for serious incidents against standards set by the commissioners and request further information/investigation if required. Review, analyse, and identify trends across Trust.
- Provide a whole range of reports to different levels within the organisation to enable scrutiny of data, identification of risks and the sharing of learning from all incidents.

4.8 Investigation Officers

Investigation Officers are responsible for carrying out thorough investigations into the incidents they are nominated to investigate, in accordance with the commissioning brief, using approved investigation techniques.

4.9 Family Liaison Manager

The family liaison manager is responsible for supporting patients' and their families in the event of a high risk or serious incident.

4.10 Managers

4.10.1 Under Section 7 of the Health and Safety at Work Act 1974, managers for an area are responsible for ensuring incidents are appropriately managed, investigated, acted upon and lessons are learnt.

4.10.2 Managers are also responsible for supporting staff following a traumatic incident and ensuring that service users and carers or others involved in incidents are kept informed and

receive support as appropriate in line with the requirements of the statutory Duty of Candour.

4.11 All Staff

4.11.1 All staff have a duty of care to provide safe services and do no harm, to be responsible for keeping themselves and others safe and are expected to report incidents as part of their general duties under Section 7 of the Health and Safety at Work Act 1974.

4.11.2 All staff members are expected to report incidents and near misses and manage them in accordance with this Policy.

5. TRAINING

5.1 Managers must ensure all staff are aware of this policy.

5.2 The Quality and Safety Team have a suite of Training sessions available on SolNet on the following.

- Incident Reporting
- Incident Reviewing
- Duty of Candour
- Structured Judgment tools
- High Risk Incident Investigation using Ulysses

5.3 It is recommended that Services ensure their new staff access the Incident reporting training and in addition if they are a reviewer, the Incident reviewer training. It is also important that reviewers access the Duty of Candour training.

5.4 It is mandatory for Serious Incident investigators to attend a Serious Incident Investigation training programme. Followed by a two-yearly update.

6. EQUALITY IMPACT ASSESSMENT

6.1 The equality assessment is appended as Appendix A.

7. SUCCESS CRITERIA / MONITORING EFFECTIVENESS

7.1 Compliance will be monitored by the Quality and Governance team through several metrics including:

Auditing timescales have been met in relation to incidents.

- Reported within 24 hours of occurring
- Incident reviews by managers
- Incident Review meetings
- SI's being reported within 48 hours of identification
- Commissioning Brief and the submission to the CCG.
- Auditing the submission of the SI report to the CCG within 60 days.

7.2 Audits will be completed quarterly and reported to board via the Patient Safety Report.

7.3 Any non-compliance to the policy must be reported.

8. REVIEW

8.1 This document may be reviewed at any time at the request of either staff side or management but will automatically be reviewed 1 year from initial approval and thereafter on a triennial basis unless organisational changes, legislation, guidance or non-compliance prompt an earlier review.

8.2 The policy will be reviewed by the Head of Quality and Safety.

9. REFERENCES AND LINKS TO OTHER DOCUMENTS

9.1 Domestic homicide review (https://www.gov.uk/government/collections/domestic-homicide-review)
Never Events 2018 (https://www.england.nhs.uk/publication/never-events)
Serious Incident Framework 2015 (https://www.england.nhs.uk/patient-safety/serious-incident-framework)
Regulation 20: Duty of Candour
(https://www.cqc.org.uk/sites/default/files/20150327_duty_of_candour_guidance_final.pdf)

9.2 **Related Policies**
Being Open and Duty of Candour Policy
Complaints Policy
Freedom to Speak up Policy
Learning from Deaths Policy
Safeguarding Children, Young People and Adults at Risk Policy
Subject Access Request Policy
Local Fraud, Bribery and Corruption Policy

10. GLOSSARY

Term used	Description
Care Quality Commission (CQC)	The CQC is the independent regulator for all health and social care services in England
Clinical Commissioning Group (CCG)	NHS organisations set up to organise the delivery of NHS services in England.
Family Liaison Manager (FLM)	Patient or Family advocate
Grade	A position or degree in a scale, as of quality, rank, size, or progression
Harm	Physical or mental injury, to injury physically, morally, or mentally.
Incident	An unplanned event, act, or omission, which causes injury to people, damage or loss to property or contributes to both.
Investigation	The act or process of investigating, careful search, or examination to discover the truth
Medication Incident	Any incident involving medication, e.g. prescribing, dispensing administration or storage.

National Reporting Learning System	Managed by NHS Improvement, receives and reviews all patient safety incidents for the United Kingdom.
Near Miss	An unplanned event, act, or omission, which does not cause injury or damage but has the realistic potential to do so.
Never Event	Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers. Never events are defined by the NRLS.
NHS E	NHS England. Manage the CCG's
Patient Safety Incident	Any unplanned or unexpected incident which could lead to harm or one or more service users receiving NHS funded care.
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995
Security Incident	• Physical assault of NHS Staff • Non – Physical assault of NHS staff (including verbal abuse, attempted assaults, and harassment) • Theft or criminal damage (including burglary, arson and vandalism to NHS property or equipment (including equipment issues to staff) theft or criminal damage to staff or personal property arising from these types of security incident
Serious Incident	Incidents meeting the criteria set out in the Serious Incident Framework (NHS England 2015) or otherwise defined by the Trust.
Ulysses	The Trust's electronic Risk Management System used for reporting and managing incidents, risks, and complaints
Validation	The quality checking process undertaken by the Quality and Governance Team for all incidents reported on Ulysses following NRLS guidance

Appendix A

Equality Analysis and Equality Impact Assessment

Equality Analysis is a way of considering the potential impact on different groups protected from discrimination by the Equality Act 2010. It is a legal requirement that places a duty on public sector organisations (The Public Sector Equality Duty) to integrate consideration of Equality, Diversity, and Inclusion into their day-to-day business. The Equality Duty has 3 aims, it requires public bodies to have due regard to the need to:

- **eliminate unlawful discrimination**, harassment, victimisation, and other conduct prohibited by the Equality Act of 2010.
- **advance equality of opportunity** between people who share a protected characteristic and people who do not.
- **foster good relations** between people who share a protected characteristic and people who do not.

Equality Impact Assessment (EIA) is a tool for examining the main functions and policies of an organisation to see whether they have the potential to affect people differently. Their purpose is to identify and address existing or potential inequalities, resulting from policy and practice development. Ideally, EIAs should cover all the strands of diversity and Inclusion. It will help us better understand its functions and the way decisions are made by:

- **considering the current situation**
- **deciding the aims and intended outcomes of a function or policy**
- **considering what evidence there is to support the decision and identifying any gaps**
- **ensuring it is an informed decision**

Equality Impact Assessment (EIA)

Step 1: Scoping and Identifying the Aims

Service Line / Department	Quality and Governance	
Title of Change:	New Policy	
What are you completing this EIA for? (Please select):	Policy	*(If other please specify here)*
What are the main aims / objectives of the changes	New Policy	

Step 2: Assessing the Impact

Please use the drop-down feature to detail any positive or negative impacts of this document /policy on patients in the drop-down box below. If there is no impact, please select "not applicable":

Protected Characteristic	Positive Impact(s)	Negative Impact(s)	Not applicable	Action to address negative impact: *(e.g. adjustment to the policy)*
Sex			Not applicable	

Gender reassignment			Not applicable	
Disability			Not applicable	
Age			Not applicable	
Sexual Orientation			Not applicable	
Pregnancy and maternity			Not applicable	
Marriage and civil partnership			Not applicable	
Religion or belief			Not applicable	
Race			Not applicable	

If you answer yes to any of the following, you MUST complete the evidence column explaining what information you have considered which has led you to reach this decision.

Assessment Questions	Yes / No	Please document evidence / any mitigations
In consideration of your document development, did you consult with others, for example, external organisations, service users, carers, or other voluntary sector groups?)	No	
Have you taken into consideration any regulations, professional standards?	Yes	

Step 3: Review, Risk and Action Plans

How would you rate the overall level of impact / risk to the organisation if no action taken?	Low	Medium	High
	■	☐	☐
What action needs to be taken to reduce or eliminate the negative impact?			
Who will be responsible for monitoring and regular review of the document / policy?	The Head of Quality and Safety		

Step 4: Authorisation and sign off

I am satisfied that all available evidence has been accurately assessed for any potential impact on patients and groups with protected characteristics in the scope of this project / change / policy / procedure / practice / activity. Mitigation, where appropriate has been identified and dealt with accordingly.

Equality Assessor:	*Teresa Power*	*Date:*	*30/06/2022*

Additional guidance

Protected characteristic		Who to Consider	Example issues to consider	Further guidance
1.	**Disability**	A person has a disability if they have a physical or mental impairment which has a substantial and long-term effect on that person's ability to carry out normal day today activities. Includes mobility, sight, speech and language, mental health, HIV, multiple sclerosis, cancer	• Accessibility • Communication formats (visual & auditory) • Reasonable adjustments. • Vulnerable to harassment and hate crime.	Further guidance can be sought from: Solent Disability Resource Group
2.	**Sex**	A man or woman	• Caring responsibilities • Domestic Violence • Equal pay • Under (over) representation	Further guidance can be sought from: Solent HR Team
3	**Race**	Refers to an individual or group of people defined by their race, colour, and nationality (including citizenship) ethnic or national origins.	• Communication • Language • Cultural traditions • Customs • Harassment and hate crime • "Romany Gypsies and Irish Travellers", are protected from discrimination under the 'Race' protected characteristic	Further guidance can be sought from: BAME Resource Group
4	**Age**	Refers to a person belonging to a particular age range of ages (e.g., 18-30-year olds) Equality Act legislation defines age as 18 years and above	• Assumptions based on the age range • Capabilities & experience • Access to services technology skills/knowledge	Further guidance can be sought from: Solent HR Team
5	**Gender Reassignment**	"The expression of gender characteristics that are not stereotypically associated with one's sex at birth" World Professional Association Transgender Health 2011	• Tran's people should be accommodated according to their presentation, the way they dress, the name or pronouns that they currently use.	Further guidance can be sought from: Solent LGBT+ Resource Group
6	**Sexual Orientation**	Whether a person's attraction is towards their own sex, the opposite sex or both sexes.	• Lifestyle • Family • Partners • Vulnerable to harassment and hate crime	Further guidance can be sought from: Solent LGBT+ Resource Group
7	**Religion and/or belief**	Religion has the meaning usually given to it, but belief includes religious and philosophical beliefs, including lack of belief (e.g. Atheism). Generally, a belief should affect your life choices or the way you live for it to be included in the definition. (Excludes political beliefs)	• Disrespect and lack of awareness • Religious significance dates/events • Space for worship or reflection	Further guidance can be sought from: Solent Multi-Faith Resource Group Solent Chaplain
8	**Marriage**	Marriage has the same effect in relation to same sex couples as it has in relation to opposite sex couples under English law.	• Pensions • Childcare • Flexible working • Adoption leave	Further guidance can be sought from: Solent HR Team
9	**Pregnancy and Maternity**	Pregnancy is the condition of being pregnant or expecting a baby. Maternity refers to the period after the birth and is linked to maternity leave in the employment context. In non-work context, protection against maternity discrimination is for 26 weeks after giving birth.	• Employment rights during pregnancy and post pregnancy • Treating a woman unfavourably because she is breastfeeding • Childcare responsibilities • Flexibility	Further guidance can be sought from: Solent HR team

Appendix B

NHS Improvement

A just culture guide

Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents

This guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. Action singling out an individual is rarely appropriate - most patient safety issues have deeper causes and require wider action.

The actions of staff involved in an incident should **not** automatically be examined using this *just culture guide*, but it can be useful if the investigation of an incident begins to suggest a concern about an individual action. The guide highlights important principles that need to be considered before formal management action is directed at an individual staff member.

An important part of a just culture is being able to explain the approach that will be taken if an incident occurs. A just culture guide can be used by all parties to explain how they will respond to incidents, as a reference point for organisational HR and incident reporting policies, and as a communication tool to help staff, patients and families understand how the appropriate response to a member of staff involved in an incident can and should differ according to the circumstances in which an error was made. As well as protecting staff from unfair targeting, using the guide helps protect patients by removing the tendency to treat wider patient safety issues as individual issues.

Please note:

- **A just culture guide** is not a replacement for an investigation of a patient safety incident. Only a full investigation can identify the underlying causes that need to be acted on to reduce the risk of future incidents.
- **A just culture guide** can be used at any point of an investigation, but the guide may need to be revisited as more information becomes available.
- **A just culture guide** does not replace HR advice and should be used in conjunction with organisational policy.
- **The guide** can only be used to take one action (or failure to act) through the guide at a time. If multiple actions are involved in an incident they must be considered separately.

Start here - Q1. deliberate harm test

1a. Was there any intention to cause harm?

Yes → **Recommendation:** Follow organisational guidance for appropriate management action. This could involve: contact relevant regulatory bodies, suspension of staff, and referral to police and disciplinary processes. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual. **END HERE**

No go to next question - Q2. health test

2a. Are there indications of substance abuse?

Yes → **Recommendation:** Follow organisational substance abuse at work guidance. Wider investigation is still needed to understand if substance abuse could have been recognised and addressed earlier. **END HERE**

2b. Are there indications of physical ill health?

2c. Are there indications of mental ill health?

Yes → **Recommendation:** Follow organisational guidance for health issues affecting work, which is likely to include occupational health referral. Wider investigation is still needed to understand if health issues could have been recognised and addressed earlier. **END HERE**

if No to all go to next question - Q3. foresight test

3a. Are there agreed protocols/accepted practice in place that apply to the action/omission in question?

3b. Were the protocols/accepted practice workable and in routine use?

3c. Did the individual knowingly depart from these protocols?

If No to any → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. **END HERE**

if Yes to all go to next question - Q4. substitution test

4a. Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances?

4b. Was the individual missed out when relevant training was provided to their peer group?

4c. Did more senior members of the team fail to provide supervision that normally should be provided?

If Yes to any → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. **END HERE**

if No to all go to next question - Q5. mitigating circumstances

5a. Were there any significant mitigating circumstances?

Yes → **Recommendation:** Action directed at the individual may not be appropriate; follow organisational guidance, which is likely to include senior HR advice on what degree of mitigation applies. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. **END HERE**

if No

Recommendation: Follow organisational guidance for appropriate management action. This could involve individual training, performance management, competency assessments, changes to role or increased supervision, and may require relevant regulatory bodies to be contacted, staff suspension and disciplinary processes. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. **END HERE**

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Based on the work of Professor James Reason and the National Patient Safety Agency's Incident Decision Tree

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Appendix C – Example of Serious Incidents

NHS England's 2015 Serious Incident Framework states:
Serious Incidents in the NHS include:

- Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:
- Unexpected or avoidable death of one or more people. This includes
  - suicide/self-inflicted death; and
  - homicide by a person in receipt of mental health care within the recent past.
- Unexpected or avoidable injury to one or more people that has resulted in serious harm.
- Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional to prevent:
  - the death of the service user; or
  - serious harm.

• Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking, and modern-day slavery where:
- healthcare did not take appropriate action/intervention to safeguard against such abuse occurring; or
- where abuse occurred during the provision of NHS-funded care.
This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally led investigation, where delivery of NHS funded care caused/contributed towards the incident.

• An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:

- Failures in the security, integrity, accuracy, or availability of information often described as data loss and and/or information governance related issues
- Security damage.
- Property damage.
- Incidents in population-wide healthcare activities like screening and immunisation programmes where the potential for harm may extend to a large population.
- Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS).
- Systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/ unit closure or suspension of services; or
- Activation of Major Incident Plan (by provider, commissioner, or relevant agency)

• Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation.

This list is NOT exhaustive nor in any order of importance. Contact the Quality and Governance team for advice.

Appendix D – List of Never Events

Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

Incidents are never events if:

• The incident either resulted in severe harm or death or had the potential to cause severe harm or death.
• There is evidence that the never event has occurred in the past and is a known source of risk (for example through reports to the National Reporting and Learning System or other serious incident reporting system).
• There is existing national guidance or safety recommendations, which if followed, would have prevented the incident from occurring.
• Occurrence of the never event can be easily identified, defined, and measured on an ongoing basis.

The term should not be used for incidents that do not meet these criteria. The types of incident that currently meet these criteria are listed below.

Medication
Administration of medication by the wrong route
Overdose of insulin due to abbreviations or incorrect device
Mis selection of a strong potassium solution
Overdose of Methotrexate for non – cancer treatment
Mis -selection of high strength midazolam during conscious sedation

Mental Health
Failure to install functional collapsible shower or curtain rails

General
Falls from poorly restricted windows
Chest or neck entrapment in bed rails
Transfusion or transplantation of ABO-incompatible blood components or organs
Misplaced naso- or oro-gastric tubes
Scalding of patients
Unintentional connection of a patient requiring oxygen to an air flowmeter

Surgery
Wrong site surgery
Wrong implant/ prosthesis
Retained foreign object post procedure

Appendix E – External reporting

Type of Incident	Example(s)	Reporting Criteria	Who Reports
Criminal	Service user/carer/visitor/staff deliberately causing harm/damage	Must be reported immediately to the police, via telephone and to risk via the electronic reporting system	Person in charge receiving notification from staff member
Drug/ Medication	Adverse reaction to drug Controlled Drug incident	All incidents must be reported to Chief Pharmacist via the electronic reporting system	Person in charge receiving notification from staff member
Learning Disability Death	Death of a service user with a learning disability	All incidents to be reported via the electronic reporting. Following usual review processes, death to be reported to LeDeR	Learning Disability Team
Medical Device	Failure of equipment/ device e.g. hoist, syringe driver Human error	All incidents to be reported via electronic reporting to the lead for medical devices	Person in charge receiving notification from staff member
Patient Safety	Harm or potential harm caused in course of Trust duties	All patient safety incidents to be reported to the NRLS via direct upload to database	Quality Governance (Quality & Safety Team)
RIDDOR	Injuries sustained to staff in the course of their work e.g. Moving and handling injury Fracture Occupational dermatitis	All major injuries and any absences from work following the incident for a period of 7 days or more must be reported to the HSE via online reporting	Health and Safety Team
Security	Verbal/physical or potential abuse of staff Loss/damage to staff/NHS property	All patient safety incidents to be reported to the NRLS via direct upload to database.	Local Security Management Specialist/ Clinical Governance (Quality and Safety Team)
Information Governance	Loss of information; breach of confidentiality	All incidents meeting the criteria are to be reported to the Information Commissioner	Head of Information Governance
Serious Incident	Suspected suicide of service user in receipt of care. Refer to Appendix B	Reportable to the CCG and NHS England via online StEIS system. Extreme incidents are also reportable to the CQC, NHS England/Improvement and other stakeholders.	Quality and Governance (Quality and Safety Team)