journey to change

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

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Incident reporting and serious incident review policy

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Contents

1 Introduction

Everyday millions of people are treated safely and successfully in the NHS. However, when something does go wrong and incidents happen, it is important that lessons are learned to prevent/minimise the same incident occurring elsewhere. Patient Safety is about working to prevent incidents/harm in healthcare, which in this context means injury, suffering, disability, or death. When something goes wrong in healthcare it is usually the result of problems in the systems staff work in rather than an individual themselves. The Trust needs to comply with the NHS Constitution to ensure all NHS patients are treated in a safe environment and protected from avoidable harm. We must ensure that any learning from patient safety events is actioned and disseminated to minimise the risk of similar incidents occurring. Tees Esk and Wear Valley NHS Foundation Trust (TEWV) employees are all accountable and responsible for the safety of people using our services. The willingness of all Trust staff to recognise safety issues, initiate incident reporting, engage in investigations, identify learning, and implement actions when an incident occurs, is key to the Trust's ability to be able to manage, and mitigate, the risks of harm occurring to our patients.

This policy is critical to the delivery of Our Journey To Change (OJTC) and our ambition to co-create safe and personalised care that improves the lives of people with mental health needs, a learning disability or autism. OJTC sets out why we do what we do, the kind of organisation we want to be and the three big goals we are committing to within our business plan.

This policy:

- embeds a strong and just safety culture to ensure that staff are fully aware of their statutory, professional, and contractual role in Duty of Candour to be open, honest, and transparent within the incident investigations approaching patients, families, and carers as equal partners
- embeds an open and just patient safety culture that supports any staff member when identifying safety incidents; whilst also providing support to any staff members that have been involved in errors or incidents
- supports the trust to work with our partners to undertake joint investigations where appropriate and sharing learning to improve the quality of care we deliver to people using our services throughout the whole system.

⚠ The aim of a patient safety investigation is to find how and why an incident happened to minimise reoccurrence and support a '**Just culture',** through assessing all incidents in line with this will ensure that:

- You are cared for and supported if you make an error

- If your behaviour has been risky by not adhering to policies or procedures, you will be asked why at the start of the investigation
- If you have behaved recklessly, been careless and intentionally putting patients, staff or yourself at risk and have not followed policy and procedures then you will be held accountable for your actions.

Following identification of serious incidents, the review and investigations are led by the Patient Safety Team (PST) who are based in the Nursing and Governance Directorate; the reviewers are independent of clinical services. The allocated reviewer will work with the patient, their family and relevant clinical services during the investigation to identify key lines of enquiry as well as areas of actionable learning. The reviewer will prepare a report, in collaboration with the family and clinical services which will be approved through the Trust's Governance processes. Actionable learning will be identified in a SMART action plan produced by services in collaboration with the PST reviewer. Learning may be identified for individuals and the area in which the incident has occurred. Systems wide learning may feed into existing trust-wide programmes of work, may be escalated to external partners where required or discussed at the most appropriate forum to identify further actions required. This will be determined during the governance processes on a case-by-case basis. Once the report and improvement plan are agreed then these are shared with the Integrated Care Board, families, and where required, Coroners, to provide assurance and maintain the confidence of the public of our commitment to the safety of our patients and staff.

The PST's review of incidents is currently completed according to the guidance and principles of the NHS England Serious Incident Framework (NHS England 2015). The National Patient Safety Strategy is introducing new ways of working in relation to Patient Safety investigations; this policy will require further updates once these changes are fully implemented by the Trust. The date for full implementation of the new Patient Safety Incident Response Framework (PSIRF) is September 2023.

2 Why we need this policy

2.1 Purpose

This policy aims to inform staff of their roles and responsibilities in relation to reporting, managing, reviewing, and learning from all incidents involving patients, staff and or visitors. This includes being open, honest, and transparent with patients their family and/or carers if something has gone wrong during the care and treatment we have provided.

The primary aim of a good quality patient safety incident investigation is to accurately, and thoroughly, identify what happened (problems arising) and why (causal factors); and recommend strong/effective systems-based improvements to prevent or significantly reduce the risk of a repeat incident.

2.2 Objectives

The core objectives of this policy are to:

- Establish the principles by which all incidents are openly reported within the Trust and where appropriate externally, and that they are systematically reviewed in line with the national framework and regulatory requirements.
- Detail the need for analysis and understanding of overall organisational, departmental / service specific incident trends and the importance of utilising this information to initiate, timely quality improvement activity to embed relevant changes in practice.
- Provide details of the process of incident reporting, reviews and investigations, and the timescales to be achieved.
- Outline the processes in place for ensuring that patients and their family/carers are approached as equal partners throughout the investigation.
- Detail the expectations that all Trust staff will report incidents, support investigations, learn lessons, identify good practice, and use this to improve their own practice as well as the services they provide.
- To promote the application of the Trust's statutory and legal responsibility of Duty of Candour, as well as supporting staff to comply with their own professional duties in relation to this.
- To ensure Never Events are recognised and reported in line with Trust and national guidance.
- To provide details in relation to the training requirements for staff in relation to incident identification, reporting, investigations, and improvements from learning identified.

3 Scope

This policy applies to reporting, managing, and supporting the process of incident review in an open, honest, just, and transparent way for all TEWV employees.

Where there is inter-agency working there should be a partnership agreement in place between the different organisations to inform on how incidents will be reported and reviewed in the respective organisation's information governance processes.

3.1 Who this policy applies to

This policy applies to all Trust staff both clinical and non-clinical and informs them of their roles and responsibilities.

3.2 Roles and responsibilities

Role	Responsibility
Chief Executive and Trust Board	• The Chief Executive has overall accountability for Trust wide regulatory and legislative compliance, creating a culture of proactive management of safety and risk. • The Trusts Board of Directors has responsibility for the maintenance of patient safety and provision of a safe environment. • The Board has responsibility for ensuring there are resources and governance structures in place to ensure monitoring, implementation and to gain assurance of the delivery of safe high-quality care. • The members of the Trust Board will be advised of all serious incidents, clusters themes and trends including where there is a high risk of recurrence and a high impact outcome, via the relevant committees or Executive Management Group.
Quality Assurance Committee	• The Quality Assurance Committee (QuAC) has devolved responsibility from the Trust Board for monitoring clinical quality and effective risk management. • The QuAC also has responsibility for the management of patient safety, including the receipt and follow up of patient safety investigation reports and improvement plans. • The QuAC receives reports about trends in patient safety incident reporting and learning, receiving information to provide assurance in relation to effective implementation and evaluation of improvements initiated. • The QuAC receives reports from both Care Groups, reports from the Executive Quality Assurance and improvement Group (EQAIG) and the Annual Patient Safety Report detailing trends, themes and quality improvements implemented as a result.
Management Group	• The Lead Director has executive responsibility for the development and monitoring of this policy and associated guidelines (in cases of unexpected death, suspected suicide) which will be approved by the Management Group (MG). • The members of the MG ensure that this policy is fully implemented within their areas of responsibility in a timely manner, and that there are sufficient staff at the appropriate senior level involved.
The Executive Director of Nursing & Governance, Director of Quality	• Provide leadership and support in relation to promotion of a just safety culture and ensure there are structures in place corporately, to support the analysis of incident reporting so

Governance and Associate Director of Patient Safety	that there is early identification of safety issues, the appropriate identification and then initiation of improvement actions. • Have responsibility for ensuring that there are accessible, supportive systems in place to promote timely reporting, review, and investigation of all incidents. • Utilise all areas of risk, incidents, complaints, claims and inquests, to ensure learning and improvements from all are included in relevant quality improvement plans. • Establish consistent processes for gaining assurance about the implementation and embedding of safety and quality improvements. • Ensure there are the resources and opportunities available for education of all identified staff in relation to incident reporting, investigation, analysis, identification of learning and the generation of SMART (Smart, Measurable, Achievable, Realistic, Timely) improvement plans. • Ensure that staff involved in Patient Safety Reviews have the appropriate skills, training, and capacity.
Patient Safety Team (PST) including the Central Approval Team (CAT)	• Provide a cohort of trained, skilled staff to initiate and coordinate patient safety investigations, either in relation to individual incidents or thematic analysis. • Provide oversight to incidents reported on the Datix system and identify those where further investigation may be required. • Identify and make recommendations as to the incidents that may be a serious incident and report via the appropriate national reporting systems. • Maintain communication with the various Commissioning services to ensure there is a free flow of information sharing and updating in relation to patient safety investigations. • Identify cases that require internal review by the relevant team/service. • Identify any themes in incident reporting and make recommendations to the Director of Quality Governance towards consideration of the commissioning of a thematic analysis. • Provide advice and support to patients and their families in relation to the occurrence of safety incidents, promoting their involvement in the development of the scope of any review as equal partners. • Ensure that the regulatory, legal, and contractual aspects of incidents are considered and followed up accordingly.

	• Collaborate with internal services and external organisations to ensure that investigations are joined up and not fragmented, with the patient as the focus. • Link with the Trust's Legal and Coronial staff to ensure that learning is identified across all areas of risk. • Have processes in place to ensure the timely follow up of action and improvement plans linked to serious incidents or thematic analysis reviews. • Provide patient safety expertise, education, and support to other Trust services. • Be directly involved with other services and teams who are initiating quality improvements, to provide expertise in relation to patient safety requirements. • Share learning obtained from patient safety investigations at every opportunity.
Clinical Directors, Medical Staff, General Managers Associate Directors of Nursing, Service Managers	• Have operational responsibility for the implementation of this policy and associated guidelines (in cases of unexpected death, suspected suicide) within their own area of management accountability; also ensuring the required resources are available to do this. • Provide leadership and support in relation to promotion of a just safety culture and ensure there are structures in place, within individual services, to support the analysis of incident reporting so that there is early identification of safety issues, the appropriate identification and initiation of improvement actions. • Promote the culture of openness, honesty, and transparency in reporting of incidents. This will include consideration of the statutory and professional duty of candour with patients and families. • When appropriate take an active role in and or ensuring that relevant staff members are proactively using data and analysis to support the development, and implementation of quality improvement to reduce the harm to patients. • Guarantee there are appropriate governance structures in place, in their services, that evidences the use of all areas of risk, incidents, complaints, claims and inquests, to ensure learning and improvements are included in relevant quality/safety improvement plans. • Ensure that data and analysis obtained from incident monitoring will be considered at appropriate Care Group governance meetings.

	• Have clear processes established for obtaining assurance about the consistent implementation of quality/safety improvements and maintaining the evidence of this. • Ensure there are opportunities for education for all staff in their relevant services, in relation to incident reporting, just culture, review, identification of learning and the generation of SMART (Smart, Measurable, Achievable, Realistic, Timely) improvement plans. • Ensure there are appropriate support structures in place for staff involved in any incidents and any resulting investigations.
Modern Matrons, Practice Development Practitioners, Ward, and Team Managers	• Provide leadership and support within their area of responsibility, for all staff to promote a just safety culture and compliance with this policy. • Promote the culture of openness, honesty, and transparency in reporting of incidents whether or not they have caused harm. This will include consideration of the statutory and professional duty of candour with patients and families. • Regularly access the IIC to ensure they are aware of the incident profile in their own area, across all levels of harm and use this information to plan quality improvements or training needs for their own staff. • Promote involvement of all staff, in their area, in incident reporting, investigations and improvements; this should be used to support the generation of local safety and quality initiatives. • Ensure there is information available to all staff, in their area, relating to the key safety issues and risks identified, and what improvements have been identified and implemented from learning. • Identify and utilise opportunities to provide support for staff in their area involved in stressful situations.
All staff – clinical and non-clinical	• Are responsible for reporting any safety incidents that they are aware of, to ensure appropriate review and investigations can be completed in line with this policy. • Raise any concerns they have about clinical or non-clinical issues, either using the incident reporting system or via line management, as appropriate • Staff will maintain awareness of their relevant professional bodies' requirements in relation to involvements in incident reporting, investigation, and resolution. This will include

	consideration of the statutory and professional duty of candour with patients and families. • Are required to be involved in any incident investigation where they have been involved or can provide specific and/or specialist knowledge to support the investigation.
Specialist Operational and Training Teams	• All specialist teams will provide advice and guidance for incident reviews regarding incidents within their area of expertise when requested. • Assist in identifying, implementing, and monitoring, any changes in practice or learning linked to their area of expertise. • Provide the relevant information pertinent for action plans linked to previous complaints; CQC action plans; audits; surveys or patient experience reports.

⚠ **Any member of staff who has concerns about patient and/or staff safety can contact the Freedom to Speak Up Guardian Freedom to Speak Up Policy (Whistleblowing/Raising concerns), Ref: HR-0017**

4 Policy

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

- The importance of timely incident reporting.
- The significance of effective incident management.
- The importance of establishing a “Just Culture” in relation to incident recognition, reporting and review.
- The need to work collaboratively on the review of incidents in the given timescales.
- The relevant national, regulatory, and contractual requirements in relation to incident reporting and investigations.
- The value of patient safety investigations to establish service or care concerns, identify any contributory factors to implement actions to ensure there is learning with the relevant team, across the Trust and where necessary with external organisations.
- All actions implemented in response to lessons learned will be monitored by relevant service leads and through appropriate governance structures, to ensure the identified issues are addressed and assurance gained following evaluation of impact.
- The high level of importance of informing and involving patients and families/carers as equal partners throughout the whole process of a patient safety investigation at any level.
- The need to implement and evaluate any resulting action plans and retain evidence of this.
- Use of the policy and data collection relating to safety incidences determine trends and themes for continuous quality improvement.

The Trust is committed to developing a culture which allows staff to raise concerns through appropriate channels, particularly in relation to patient safety. All Trust staff are proactively encouraged to report any safety concerns using this policy and will be provided with any required support throughout this process.

It is recognised that there are occasions when staff do not feel able to raise concerns and issues through established reporting systems. The Trust has established the Freedom to Speak Up Policy (Whistleblowing/Raising concerns) HR-0017; this policy provides details of the Trust's framework for staff who wish to raise concerns outside of the incident reporting process for any reason. The policy is available via the Trust's intranet site, but direct contact can be made with the Trusts Freedom to Speak up Guardian through the following email address: tewv.freedomtospeakup@nhs.net

4.1 Incident Reporting

Responding appropriately when things go wrong in healthcare is a key part to promoting continual improvements in relation to the safety of services provided by the Trust and the NHS.

Timely reporting and review of all incidents is essential to improving patient safety. This process begins with reporting any incidents that impact on patients, visitors, staff, or Trust service provision, clinical or non-clinical and covering all levels of harm. Any incident should be reported on the Trust's incident reporting system Datix **within 24 hours** of occurrence or being identified, if this is not possible then this should be escalated to the relevant line manager.

Datix is always available to all staff on the Trust Intranet Homepage. This system provides the Trust with a robust system for collecting data in relation to incident occurrences and trends. Reporters are requested not to use patient or staff names in the incident description when incident reporting, these should be added as contacts.

Appendix 6 provides an outline of the processes in place to review how/why an incident has happened, identify learning, and implement actions to reduce the impact, or possibly prevent the recurrence of similar incidents.

4.1.1 Incident Reporting and Management system

Local business continuity plans must reflect that the incident reporting and management system is a critical system. In event of the system becoming unavailable for any reason, BCPs must identify where paper or electronic copies of incident report forms are located.

The person recording the incident on the paper/ electronic form is also responsible for the entry onto the system within 48 hours of the system coming back online. This is to ensure that the detailed fields not captured on the temporary backup form can be correctly completed by the person witnessing/ first to know about the incident. The only exception to this is where agency or bank staff complete these and are not available to complete the process by adding to the system.

4.1.2 Immediate Action

The immediate safety or well-being of the patient, staff member or visitor, affected or involved in the incident is paramount. The response to managing an incident must be proportionate to the severity of impact or harm, the patient/person involved in the incident must be made safe and appropriate actions taken. This may involve first aid or emergency treatment, where appropriate the emergency paramedic ambulance must be called using the locally agreed route. Consideration should be given to making the area safe should the accident/incident/near miss be related to the general environment or a particular activity. For example, a contractor activity may have resulted in an accident, it would be appropriate to cease the activity, secure any tolls/ladders etc. in use and secure the area until it can be made safe.

4.1.3 Incident Management

A Datix form must be completed and submitted **within 24 hours** of the incident, identifying whether it is an actual or potential serious incident. The staff member responsible for completing the Datix is the one who is first aware of the incident. In the event of this type of incident, if the patient is detained under the MHA (1983), the Mental Health Legislation Office must be informed as soon as possible to enable the Care Quality Commission (CQC) to be informed.

If the incident is an actual or suspected serious incident the reporter informs the service manager of the incident. If the incident has occurred out of hours, the reporter will inform the senior manager first on call who will decide whether escalation to the Director on Call is required.

For incidents that appear to have led to moderate or higher harm; the ward/team/unit manager will ensure the Duty of Candour processes are implemented in line with the Duty of Candour policy (see check list **Appendix 5**). Out of hours this may be delegated to the nurse in charge by the senior manager on call; the responsibility for this will be resumed by the ward/team manager the next working day.

Duty of Candour policy and all decisions and actions **must** be fully recorded on case notes in PARIS.

The policy requires that, where possible a face-to-face meeting should be held, as soon as practicable, to explain what happened and what we know to-date. Regulation 20 of the Health and Social Care Act 2008 (regulated Activities) Regulations 2014 informs that after the notification and disclosure of the incident this **must** be followed by a written notification given or sent to the relevant person. The letter sent to the patient, family or carer must be saved in 'letters' on Paris and a record that it was sent made on PARIS.

If the incident is an unexpected death or suspected suicide the appropriate senior manager will ensure a staff debrief is carried out with the staff involved. It is important for senior managers to ensure staff are cared for and supported when an incident has occurred. Where appropriate, staff will be asked to provide a written account **(memory capture see appendix 8**), of what they can remember about the incident.

Where an unexpected inpatient death is thought to be due to a patient safety event, the Patient Safety Team should also be notified by telephone in office hours, 01913336522 or the following working day or by email out of hours TEWV.patientsafety@nhs.net

4.1.4 Health and Safety Reportable Incidents

Where staff, visitors, member of the public, contractor or patient incidents may fall under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR). The incumbent Manager/Lead must follow the RIDDOR Procedure and contact the Health and Safety Team. RIDDOR reporting criteria can also be located within the RIDDOR procedure.

The Health, Safety and Security Team will:

- Report all RIDDOR incidents to the HSE.
- Carry out investigations for all RIDDOR incidents.
- Keep a record of all over 3-day incapacitations of workers.

4.1.5 Security and Physical Harm Incidents to Staff, Visitors and Contractors

Where staff, visitors or contractors are involved in incident that has resulted in harm attributed to violence and aggression, the incumbent Manager/Lead must contact the Local Security Management Specialist (LSMS) based within the Health, Safety and Security Team.

Where the Police have been called, this should be annotated on the Datix Incident form and the Criminal Incident Reporting Procedure should be followed. Where criminal damage to property has occurred, a Datix Incident form should be raised and the LSMS to be notified.

4.1.6 Never Events

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

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

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

4.1.7 Incidents involving safeguarding and Public Protection

Safeguarding – for all incidents reported, consideration must also be given to exploring if there are any safeguarding concerns involving children or 'adults at risk' (as defined by the Care Act 2015). If any safeguarding concerns are identified, then you must refer to the Safeguarding Children Policy, Safeguarding Adults Policy and Domestic Abuse Procedure and/or contact the Trust Safeguarding & Public Protection team. This will provide advice, support and further guidance for the initiation and process of the relevant multi-agency safeguarding reviews e.g. Child Safeguarding Practice Reviews, Safeguarding Adults Reviews, Domestic Homicide Reviews etc

Public Protection – Multi-Agency Public Protection Arrangements (MAPPA) is designed to reduce the risk of further serious violent or sexual offending, but from time to time offenders do go on to commit such offences. When the most serious offences are committed a MAPPA Serious Case Review may be commissioned to examine whether the MAPP arrangements were applied properly, and whether the agencies worked together to do all they reasonably could to prevent the further offending. There may be lessons for the future, or good practice to disseminate. For more guidance refer to the Trust MAPPA Policy.

- Allegations of sexual abuse against children or vulnerable adults must be reported through the Incident Reporting and Management System (Datix) as a serious incident.
- Allegations of serious abuse by children or vulnerable adults against healthcare staff must be reported on the Incident Reporting and Management System (Datix) as a serious incident.

4.1.8 Learning Disabilities Mortality Review Programme (LeDeR)

In addition to internally reporting and learning from Learning Disability deaths, there is also a requirement to report them externally. We need to ensure that throughout the Trust we report the death of a patient (aged four years and older) with a Learning Disability to what was previously known as the LeDeR Programme; this has been renamed as Learning from Life and Death Reviews. There is a new platform for reporting learning disability deaths. Please use the following link to register a notification: via an online form on the LeDeR website

LeDer reviews are now also undertaken for all autistic people over the age of 18 who have been told by a Doctor that they are autistic and had this written in their medical records. These deaths are also reported via the link below.

Website for reporting and further LeDeR information is: LeDeR - Home

OR Call 0300 777 4774

For further information please see the Learning from Deaths: The Right Thing to do policy CORP 0065.

4.2 The Patient Safety Incident Review Process

The patient safety incident review process ensures serious incidents are identified, reviewed, and progressed through the Trust governance process in a consistent way. The patient safety incident reviewing, and approving process is currently being decentralised.

All Datix forms are reviewed for accuracy and to ensure a full account of the incident has been provided.

Whilst in the process of decentralisation, this could be done by:

1. The Service (ward/Team Manager/Modern Matron, Service Manager) for those areas on the decentralised (2-stage-process) who are reviewing and approving their own incidents.

Or

2. By the Central Approval team /Patient safety Team who will seek additional information from teams if required.

Following review, the correct level of harm as set out below should be assigned:

- **Serious incidents** (unexpected death) including incidents involving severe harm (permanent or long term).
- **Moderate harm** (short term harm requiring additional treatment or a procedure).
- **Low harm** (minimal harm requiring additional observation or minor treatment).

- **No harm** incidents (No injury). Any patient safety incident that occurred but no harm was caused to the patient.
- **Near miss** incidents. Any patient safety incident that occurred but no harm was caused to the patient.

4.2.1 Incidents

Incidents identified as no, low harm and "near misses" will be reviewed and where necessary the harm level confirmed; if no further actions are required, they will be approved. The details for all incident reports are available on the Integrated Information Centre (IIC), which is accessible on the Trust Intranet site.

There is also a Standard Operating Protocol (SOP) for Team Managers to Review and Report on Incident Information via the IIC; this SOP provides advice about how to access and utilise the data available on the IIC. Responsibilities are outlined in this document to ensure the data is used effectively to raise awareness of trends and themes in incident reporting to support local and organisational learning. This information should be used identify potential quality improvement activity and to assist in identifying additional training needs.

4.2.2 Near Miss incidents

The Serious Incident Framework (NHS England 2015) identifies that it may be appropriate for some 'Near Miss' patient safety investigations to be reviewed as a serious incident investigation; this should be considered when the outcome does not necessarily reflect the potential severity of harm that could be caused if a similar incident occurs again.

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

4.2.3 Clinical Huddle

If there has been harm to a patient and there is potential for a patient safety investigation being required, the CAT will request a member of the clinical service to attend the Clinical Huddle to enable identification of the key issues and to seek assurance on immediate actions being implemented locally to prevent further issues or prevent recurrences.

Following review of the incident and discussion at the Clinical Huddle with the clinical team / service, a decision will be made in relation to the level of investigation (**see Appendix 4**)

- **No further investigation** - The relevant team will be requested to complete and update all sections of the Early Learning Review (ELR) template and return to the PST. This should

also be shared with the relevant service managers by the clinical team involved and via the local governance routes within the Care Group.

- **Early Learning Review required** – this was previously known as a Head of Service review and is to be completed by the relevant Clinical service. Timescale for completion will be determined on a case-by-case basis depending on the nature of the incident and associated learning. This could range from 72 hours to 6 weeks. The Early Learning Reviews should be taken through local governance processes within each care group. (**For more information on the Rapid Review process/Early Learning Reviews please see appendix 7**).

All Clinical Huddle decisions are recorded on datix and shared with the senior corporate staff and directors.

Where necessary the PST liaise with the Trust's Legal Representatives to ensure required information is available for a potential legal claim and if necessary, reported to NHS Resolution as per their reporting guidelines.

The operational manager of the service involved in a serious incident (usually the Service Manager) has a role in managing the incident ensuring appropriate follow up, supporting staff

4.2.4 Serious Incidents / Patient Safety Investigations

When a serious incident is confirmed, the PST report the incident on the Strategic Executive Information System (StEIS) **within 2 working days**. The Rapid Review will be completed with the information received at the Clinical huddle, anonymised and used to develop the Early Learning Report which will be shared with the relevant Commissioners **within 3 working days**.

Any serious incident can also be reviewed at any time on the Integrated Information Centre (IIC) once it has been approved by the PST. Serious Incident (SI) data is inputted into the Patient Safety electronic system and the incident is allocated to a PST reviewer for a full review of the care and treatment provided. The PST will retain a copy of all reports and evidence from patient safety investigations and will support the monitoring process of SI Action Plans.

The PST are trained in using a variety of tools to identify service and care problems, contributory factors, lessons learned as well as good practice. They will work in close collaboration with clinical / operational services, specifically with the Service Manager or equivalent to support investigations and provide support in the generation of SMART (Smart, Measurable, Achievable, Realistic, Timely) improvement plans.

PST Reviewers will, in conjunction with the Family Liaison Officer (FLO), unless informed otherwise, contact the patient/families and carers at the beginning of the incident review process; they will need to clarify what actions the service has already taken.

The purpose of this contact is to explain and offer involvement in the review process and to discuss timescales for the patient safety investigation. Where necessary, they will also offer condolences and sympathy on behalf of the Trust. The Service or General Manager will already have sent a condolence letter, explained the process of review and that they will be offered the opportunity to be involved in the review process, the PST add to this contact with the family. When the review is complete the PST Reviewer and/or the FLO will offer to meet up with family to consider the findings and any learning identified to be taken forward in an action plan, in conjunction with senior staff from the service involved.

It is essential that where appropriate services contact families, in keeping with the Duty of Candour Policy, soon after the incident to explain what we know now and the fact that a review will be taking place to investigate further. Openness and transparency are paramount at all stages of the investigation process.

All staff involved and identified in the Early Learning Review report and those invited by the PST reviewer are expected to attend the relevant investigation and feedback meetings, which the PST reviewer leads. At the initial meeting the scope of the patient safety investigation will be discussed and agreed, this should include any considerations identified from the patient or their family.

Where a patient safety incident involves external organisations, the PST Reviewer will identify the appropriate representatives to assist in the investigation to ensure there is a fully inclusive and collaborative document, that will answer all the patients and families concerns, as well as those raised by the involved organisations.

Throughout the investigation the PST Reviewer will consider the framework in the “Just Culture Guide” (NHSE/I, 2018) with the service involved in the case; where necessary decisions made as a result of this assessment will be logged and referenced in the report. However, details of other concurrent Trust investigations will not be included.

After gathering all relevant information, meeting with family and staff linked to the patient safety investigation, the PST Reviewer will write up their findings in a draft patient safety investigation report, arrange a feedback meeting with relevant staff to confirm their findings and to confirm the content for factual accuracy. It is important that the local staff and managers attend this feedback meeting to ensure the details reflect the incident accurately and so that any findings presented by the PST Reviewer are considered and where necessary reviewed to ensure agreement is achieved.

At this meeting the service will be asked to identify and agree actions to be put in place, or confirm actions already taken and completed. Actions should be developed in response to key learning identified at any time within the patient safety investigation, this can include anything initiated immediately following an incident occurrence. It is unlikely that a patient safety investigation will be completed with no areas for learning or required actions being identified, the Trusts Commissioners expect an improvement plan to be supplied with complete approved reports.

The PST Reviewer will present the draft patient safety investigation report to a Locality Panel made up of senior members of staff including Service Managers, Associate/Deputy Medical Director, Modern Matron, and the Consultant Psychiatrist. The purpose of this meeting is to ensure that a thorough account of the incident has been conducted, with the relevant people, that the report is factually accurate and that a SMART improvement plan is formulated to address actionable learning. The PST Reviewer will amend the draft report and action plan with agreed points from the Locality Panel.

The Director Panel is the final stage to review and 'sign off' the patient safety investigation report. The Director Panel is made up of a Medical Director representative, an Executive Director, and an Associate Director of Nursing and Quality. The PST Reviewer, Associate Director of Patient Safety and relevant service representatives will also be present to discuss both the report and improvement plan.

If the Director Panel has an alternative view and / or, requests additional information or actions the PST Reviewer will work with the service representatives to carry out the additional work. Any additional work will be shared by emailed to the members of the Director Panel where the report was discussed, and they will respond by return of email and state whether they approve the amendments and support the report being 'signed off'.

When the Director Panel chair and members confirm they accept the report, this is final assurance to the organisation that the patient safety investigation governance process is complete. The report and action/ improvement plan are then "proof read" by the PST and saved as PDFs version for distribution. The final report and action / improvement plan will be supplied to the service, the ICB/Provider Collaborative and where necessary, the relevant Coroner. The service involved is responsible for ensuring the report is distributed to staff members who were involved in the patient safety investigation and others as they deem appropriate.

Where families have chosen to be involved in the review process, arrangements will be made for the PST reviewer, and/or the FLO, to keep the family up-to-date with the report's progress sharing copies of drafts throughout the process. On completion of the report, a further meeting will be held with the patient/family, reviewer/FLO and with the family's agreement a representative from services. At this meeting, anything agreed as part of Duty of Candour regulatory discussions should also be covered, to resolve any family expectations.

Involving families as equal partners throughout the investigation process is paramount in keeping with a culture of openness and transparency. Any translation and/or interpretation issues should be identified at the outset

The PST will upload the lessons learnt to Strategic Executive Information System and Datix

Action / Improvement Plan owners are responsible for ensuring these are fully implemented within agreed timeframes and that there is evidence available to show the evaluation of the impact of actions. Completed improvement plans must be forwarded to the PST on email to TEWVpatient.safety@nhs.net to enable them to be forwarded to the ICB or Provider Collaborative. As part of the Patient Safety Transformation work Improvement Plans will all be retained on the Incident Reporting and Management System (Datix).

4.2.5 Thematic Reviews

Both the NHS Serious Incident Framework (2015) and the new PSIRF recognise that managing, investigating and learning from incidents in healthcare requires a considerable amount of time and resource. Advising that care must be taken to ensure there is an appropriate balance between the resources applied to the reporting and investigation of individual incidents and the resources applied to implementing and embedding learning to prevent recurrence.

It is identified that organisations should have processes in place to identify incidents that indicate the most significant opportunities for learning and prevention of future harm. This allows the Trust to commission a thematic patient safety investigation where it identifies a group of incidents of similar type, or in a similar setting or amongst similar groups of patients, to identify common causal or contributing factors. This allows the Trust to develop one comprehensive action/ improvement plan which can assist in improving the use of resources available for quality improvement activity and future monitoring.

The commission of such thematic patient safety investigations will be through direct request from the Trust Board / Executive Team, or by recommendation from the Associate Director of Patient Safety and the PST to the Executive Director of Nursing and Governance and Director of Quality Governance. If services or departments recognise that there may be a safety issue that needs to be considered for this approach, this should be communicated to the Associate Director of Patient Safety with details of any relevant evidence. Clear terms of reference must be in place for each thematic review together with a trajectory for completion.

4.2.6 Investigation Tools

To support Trusts undertaking patient safety investigations, NHS England / Improvement have provided some investigative tools that can be used, with the relevant training, to assist in examining incidents in more depth. The NHS England Serious Incident Framework (2015) previously identified tools from the National Patient Safety Agency (NPSA); these have now been

archived in preparation for the publication of the National Patient Safety Strategy in 2022-23. The NHS England website now details information in relating to undertaking Patient Safety Incident Investigations with newer resources available for Trusts to access when undertaking investigations. The tools and resources provided will be updated as the Patient Safety Incident Response Framework and the associated educational curriculum is introduced.

The PST Reviewers have been trained in incident investigation and utilise the following tools to assist in this:

- Structured Case Review tool
- Contributory Factors identification grid
- Fishbone diagram
- Tabular timeline

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

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

When a death in custody (DIC) or serious incident occurs, Spectrum staff complete the 24-hour report which is submitted to the Nort- East and Yorkshire Specialised Commissioning Team (NHS England) who will then report the incident on StEIS. If the prisoner is involved with a Mental Health In-Reach Team provided by TEWV a Datix form will be completed. A 72hr report is then completed by Spectrum, usually competed by the Head of Healthcare, or nominated deputy. If the Trust has provided recent care to the prisoner there is an expectation that the Mental Health Team Manager or nominated deputy will be involved in completing the 72hr review to enable early learning and any immediate actions required to be identified.

The Reconnected to Health Serious Incident Review Group (SIRG) is attended by all the health providers working within prisons including Spectrum, TEWV and Humankind.

Each provider has trained serious incident reviewers, allocation for incidents will be discussed and agreed during SIRG if not before. TEWV serious incident reviewers (based within the Patient Safety Team) will lead reviews of unexpected deaths unnatural deaths.

The aim is to review the healthcare and treatment that was provided. The process for this review is in the form of a multi-disciplinary type meeting. During the MDT meeting there is an opportunity to identify good practice, lessons to be learned and to ensure that an appropriate action plan is developed. This process will look to review the deaths of all prisoners in custody and is not restricted to unexpected deaths.

The report generated from the review is discussed and approved across the providers during SIRG before being sent to NHSE by Spectrum's Quality Incident Team.

4.4 Homicide Incident investigation and reporting in mental health

Homicides committed by those in receipt of mental health care have devastating consequences for the family of the victim(s), patients and their families and can have a profound impact on all parties involved. These incidents often require complex multi-agency investigation involving internal and external stakeholders across geographical and organisational boundaries. There is a regionally led standardised approach to investigating such incidents (Single Operating Model for Investigating Mental Health Homicides within the NHS England 'Serious Incident Framework' (2015)). The main purpose of which is to:

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

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

4.4.1 Homicide Review Process

This has three defined stages:

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

a. In the event of an incident all relevant and known details should be reported on the Datix system as soon as staff are aware.
b. The incident will be reviewed and reported on StEIS as outlined in section 4.3
c. The PST will inform NHS England and the relevant Commissioner incident/quality lead
d. NHS England quality lead will alert the Regional Investigations Team and ensure with the provider that the 72-hour report/review is completed by the provider
e. The 72-hour report informs of the immediate actions taken or initiated relating to:
    - Providing assurance that the safety of staff patients and the public is protected
    - Assessing the incident in more detail to confirm if a full investigation is required

- Proposing the appropriate level of investigation
- Communicating with relevant individuals and organisations including the families of victims and perpetrators, Police, Coroner, HSE, NHS Improvement and the CQC, as required.

f. The provider should actively seek the details of the victim/s and families at an early stage.

Stage 2 – Provider focussed internal investigation

a. The relevant commissioner (usually the quality lead) will ensure the Trust undertakes a robust internal investigation, the Regional Team will assist with Terms of reference and where possible with family involvement of the victim and perpetrator with their concerns being noted
b. The internal Trust investigation report should be completed within the agreed timescale and all materials linked to the investigation stored.
c. The final report will be shared with CCG lead, sub-region quality lead, families, and the Investigation Team.

Stage 3 – Independent Investigations Review Group (IIRG)

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

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

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

Please refer to the NHS Serious Incident framework (2015) for further details in relation to the conduct of an independent investigation.

4.4.2 Contact with families of victims and perpetrators

Where appropriate the PST Reviewers, or the FLO, will contact families of victim and perpetrator, this will be done with advice from and, in conjunction with, NHS England and the police. The purpose of this contact is to offer condolences / sympathies on behalf of the Trust and to explain

the internal investigation process to relatives. The reviewer should offer to meet up with families on conclusion of the internal investigation to highlight the findings and any learning identified to be taken forward in the action plan.

4.5 Information Governance Incidents

Information incidents are logged using the Trust's incident reporting and management system (DATIX). The Information Governance team receives alerts from the system and they undertake a risk assessment for the incident in line with the Data Security and Protection (DS&P) Toolkit.

Where a personal data breach is assessed as being likely to result in a risk, a notification to the Information Commissioner's Office (ICO) will be made within 72 hours by the Information Security Officer or Privacy Office. Dependent on the level of risk identified, this may need to be investigated as a serious incident.

A personal data breach means a breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, personal data. This includes breaches that are the result of both accidental and deliberate causes. It also means that a breach is more than just about losing personal data.

A personal data breach can be broadly defined as a security incident that has affected the confidentiality, integrity, or availability of personal data. In short, there will be a personal data breach whenever any personal data is accidentally lost, destroyed, corrupted, or disclosed; if someone accesses the data or passes it on without proper authorisation; or if the data is made unavailable and this unavailability has a significant negative effect on individuals.

4.6 Communication with and Support for Staff

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

It is recognised as part of their work that critical incidents are unavoidable for staff working within mental health services, exposing staff to actual and potentially traumatic events. There is always the potential for us to be impacted psychologically and emotionally by the work that we do, and this can also have a cumulative effect over time if regular support is not sought or provided in a timely consistent manner. Unidentified or untreated critical incident stress reactions can significantly impact on emotional, physical, cognitive and social functioning. The Trust therefore offers an approach to supporting staff following a critical incident through the Post Incident Peer Support Service (PIPS). PIPS provides first line co-ordinated support for employees in the recovery from critical incident stress reactions utilising the evidenced based Critical Incident Stress Management (CISM) model. The model is a group approach which is structured and time-limited, through

facilitating peer support meetings up to 21 days post incident to help staff who have been exposed to a potentially traumatic event or series of events during the course of their work. Peer support meetings are facilitated by peers of all grades and professions within the organisation, who have been trained in the CISM model.

Peer support meetings are confidential, separate to operational debriefs, and attendance is voluntary. They are based on sound research into the psychological benefits of social support and aim to foster resilience and psychoeducational support to colleagues by; providing an opportunity to talk about the event/s and their impacts, discuss normal response to stressful events, and to think about ways of coping and signposting for additional support if appropriate.

Referrals can be made by any member of staff as follows:

North Yorkshire, York & Selby Care group - tewv.postincidentpeersupportnyy@nhs.net

Durham, Tees Valley & Forensics Care Group - tewv.postincidentsupport.dtv@nhs.net

4.6.1 Just Culture

It is recognised that when something goes wrong in healthcare it is usually the result of problems in processes or systems, rather than the fault of the individual members of staff. The Trust supports and fosters a “no blame” patient safety culture; avoiding the use of sanctions without due consideration of all the factors involved.

NHS England have published the “Just Culture Guide” (2018, **Appendix 3**) which helps the Trust by providing a framework and some principles that need to be considered when assessing how to progress with investigations and if formal management actions are required.

An important part of a just culture is being able to explain, to any relevant parties, what approach will be taken after an incident occurs and why. The guide can be used as a reference point for organisational Human Resource and incident reporting policies, to identify the appropriate response to a member of staff involved in an incident according to the circumstances involved. It can also support and protect staff from unfair targeting. Using the guide can help protect patients by removing the tendency to treat wider patient safety issues as individual issues. Moving away from scrutinising individuals allows consideration of a wider cohort, where, for example there may be a wider training need or a need to make a change in a system or procedure.

Supporting staff to be open about mistakes, treating everyone equally and fairly, allows valuable lessons to be learnt so the same errors can be prevented from being repeated.

4.7 Sharing and Learning Lessons

Everyday millions of people are treated safely and successfully in the NHS. However, when incidents do happen, it is important that lessons are learned to prevent/minimise the same incident occurring elsewhere. Patient Safety investigations are a well-recognised way of doing this.

Investigations support analysis of the details available about an incident and allow consideration of the factors identified, to understand if anything could have been done differently to prevent the overall outcome. This analysis identifies areas for change and helps the investigation team, and the Trust, develop recommendations for actions/improvements that are SMART and will lead to the delivery of safer care for our patients.

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

- Departments / operational services will use the information provided in the IIC to effectively raise local awareness of trends and themes in incident reporting and any learning. This information will be used to identify potential quality improvement activity and to assist in identifying any additional training needs.
- The IIC will provide an analysis of trends emerging from high numbers of incidents involving either a specific type of incident, an individual member of staff, an individual patient, or a particular service.
- Patient Safety Investigations and Serious incident reviews will include an analysis of actual care given against Trust agreed practices and policy, to identify areas for learning and any identified lapses; SMART actions will be developed as a result.
- Where incidents involve external organisations, investigations will be undertaken collaboratively, and lessons learned shared to initiate relevant actions.
- Lessons learnt from incidents, and investigations, will be shared by Action Plan Owners via local governance structures within the Care Groups. These groups will monitor the completion of actions and ensure they gain assurance in relation to the positive evaluation of the impact of these. This assurance, or otherwise, will be shared with the Board through regular reporting mechanisms.
- The Organisational Learning Group will oversee the effectiveness of measures put in place in response to identified learning.
- Learning that requires rapid dissemination will be cascaded through either SBARDs or urgent patient safety briefings
- Learning from patient safety incidents will be disseminated by learning bulletins and critical incident review meetings
- The Learning Library on the Trust's intranet will provide a resource for all staff
- The learning data base will capture themes and the effectiveness of actions already in place should similar themes continue
- Learning which requires rapid escalation will be done so through existing reporting structures such as on-call oversight meetings/Sitreps
- Incidents linked to Medical Devices or Medications will be investigated and, where necessary, reported to the Medicines & Healthcare products Regulatory Agency (MHRA) via the yellow card system, the Trusts Medical Device Safety Officer or the Medicine Safety officer.
- Any patient safety investigation that identifies learning that may also impact on the wider health economy should be escalated to NHS England/Improvement, regional or national

Patient Safety Teams via the Patient Safety Specialist who will ensure this is escalated to the Patient Safety Specialist forum.

- Details of any incidents involving medical staff needs to be escalated to the medical education department. The PST will do this for serious incidents investigated.

The reporting of incident analysis, lessons learned, and quality improvement will be provided to the Trust Board through the Quality Assurance Committee. Where there are concerns about completion of actions, or lack of assurance about the level of impact from actions, these should be escalated through the most appropriate governance structure as soon as possible.

For non-clinical incidents, the reporting of incident analysis, lessons learned and improvement assurance to the Trust Board will be through the Executive Management Meeting, following analysis, action / improvement implementation and resulting assurance, from the various relevant working groups.

5 Definitions

Term	Definition
Accountability	Responsibility to someone for some activity with an obligation to demonstrate and take responsibility for performance of agreed expectation
Contributory Factors	The contributory factors are those things that contributed to or had an influence on the incident occurring.
Incident Reporting and Management System (DATIX)	DATIX is the Trust's electronic Risk Management Software System implemented to collate incidents completed by staff following an incident.
FLO	Family Liaison Officer
Incident	An incident is defined as an event or circumstance that resulted, or could have resulted, in unnecessary harm, loss or damage - such as physical or mental injury to a patient, staff, visitors or members of the public, environmental or reputational damage to the Trust.
Mistake	A wrong action attributable to poor judgement, ignorance or inattention. To misunderstand or do something wrongly, improperly or faultily, to err in opinion or judgement.
PARIS	PARIS is the Electronic Care Record System in use within Tees, Esk and Wear Valleys NHS Foundation Trust
Patient	As a guide, this is any NHS funded patient on a current caseload or discharged from a caseload in the previous 6 months. The Serious Incident Framework, NHS England 2015 advises that each case should be considered individually – it may be appropriate to declare a serious incident for a homicide by a person discharged from mental health care more than 6 months previously.
PSIRF	Patient Safety Incident Response Framework
PST	Patient Safety Team - see section 3.2 Roles and Responsibilities.
Responsibility	Being responsible for something with a liability to be called to account by someone for conduct or actions.

Learning Lessons	As a Trust we strive to learn from each incident, key ways in which learning takes place is through supervision, debriefings and patient safety investigations. The agreed approach will be influenced be a range of factors specific to what needs to be addressed and may include: • **Team/peer group review** culminating in the development of a plan identifying specific actions to take place. • **Coaching or mentoring** – this would generally be conducted on an individual one to one basis. • **Managerial/clinical supervision** linking to the development of agreed objective(s) supported by a Personal Development Plan. • **Mediation** – where it is identified that working relationship issues may need to be addressed.
Serious Incident (SI)	Serious Incidents in the NHS are defined in the Serious Incident Framework (NHS England 2015) as including: • Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in: ➢ The unexpected or avoidable death of one or more people. This includes - suicide/self-inflicted death; and - homicide by a person in receipt of mental health care within the recent past *(it may be appropriate to declare a serious incident for a homicide by a person discharged from mental health care more than 6 months previously)* ➢ Unexpected or avoidable injury to one or more people that has resulted in serious harm; ➢ Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional, in order to prevent: - the death of the service user; or - serious harm; ➢ Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where:

	- healthcare did not take appropriate action/intervention to safeguard against such abuse occurring or - Where abuse occurred during the provision of NHS-funded care. This includes abuse that resulted in (or was identified through) a Child Safeguarding Practice Review (CSPR), a Safeguarding Adult Review (SAR) or other externally led investigations. A Never Event - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death. See the Never Events Policy and Framework for the national definition and further information.
StEIS	Transfer of Strategic Executive Information System (StEIS) is the NHS England system used to report and monitor the progress of Serious Incident investigations across the NHS.
Systems-based Review	This is defined as a structured and systematic review of an incident to establish a chronology of all the events leading up to the incident, identifying any causal or contributing factors that may have led to the incident. The aim of which is to understand what happened, identify how future incidents may be prevented and provide a set of conclusions in the final report that are fair, evidenced and reasoned.
RIDDOR	Reporting of Incidents, Diseases and Dangerous Occurrences Regulations

6 Related documents

This policy is to be read in conjunction with TEWV:

- Organisational Risk Management Policy CORP-0066
- Harm Minimisation (Clinical Risk Assessment and Management) Policy, CLIN-0017
- Safeguarding Adults Policy
- Safeguarding children Policy
- MAPPA Procedure
- Domestic Abuse Procedure
- PREVENT Procedure
- Protocol for the Distribution of Safety Alert Broadcasts and Trust Safety Notices
- Standard Operating Protocol for Team Managers to Review and Report on Incident Information via the IIC (August 2021)
- Physical Health and Wellbeing Policy CLIN-0084

- Health & Safety Policy HS-0001
- Freedom to Speak Up Policy (Whistleblowing/Raising Concerns) HR-0017
- Duty of Candour Policy Being Open, Honest and Transparent CORP-0064
- Supporting Staff and Learning from Medication Incidents PHARM-0045
- Claims Management Policy CORP-0011
- Learning from Deaths Policy: The right thing to do CORP-0065
- Criminal Incident Reporting Procedure
- Security Procedure

7 How this policy will be implemented

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

7.1 Implementation action plan

Activity	Expected outcome	Timescale	Responsibility	Means of verification/ measurement
webinars will be held as the Trust transitions from the 2015 incident reporting framework to the new PSIRF	Staff are aware of each stage of development and transition	Commencing January (monthly) to full implementation date in September 2023	Associate Director of Patient Safety	Attendance records Compliance with policy monitoring via existing measure contained in main body of policy

7.2 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
All new staff	Induction incident reporting and investigation	1 hour (awareness)	One off
Managers	Manager training for incident reporting, reviewing, and Approving	1 hour	One off
All staff	Webinars – ongoing	Hour long webinars to help staff transition to PSIRF	Ongoing
Staff undertaking serious incident reviews	PSR training	All new incident reviewers to receive PSIRF compliant training	One off – frequency to be determined by National Team
Board members	National patient safety training	2 hours	One off
All staff	National patient safety training	2 hours	One off
Patent specialist training	Patent specialist training	Ongoing up to level 5 levels 1 and 2 released	On-going

8 How the implementation of this policy will be monitored

The Associate Director of Patient Safety and the PST will be responsible for ensuring monitoring of the policy, associated processes, and procedures. The policy and processes and procedures will be audited before the proposed review date.

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

- National Reporting and Learning System (NRLS) benchmark reports will be reviewed, and subsequent actions monitored by the relevant governance/assurance groups. The Trust will be transitioning to the Learning from Patient Safety Event (LFPSE) as part of National Development work during 2023. This policy will be updated in 6 months to reflect National Changes and full transitions to the Patient Safety Incident Response Framework.
- Weekly Executive Director Group reports monitoring the completion of SIs.
- Monthly performance reports monitoring the completion of SI action plans.
- Annual performance report at the end of Q4 identifying numbers SI progress against completion and thematic analysis of any causal factors**.** Monthly reports from Care Groups/

Governance Boards that monitor the aggregation of incidents, complaints, claims and present trend analysis.

- Suicide Prevention Audit will be review and subsequent actions monitored by the Patient Safety Group.
- Audits will be conducted by Audit One team to assess compliance with the Serious Incident Reporting and Management processes and procedures. The outcomes of these checks will be reported through the EAIG
- An annual report will be completed of the key themes from lessons learnt to demonstrate sustainability of their implementation within the organisation. The outcome of this report will in the first instance be reported to the Organisational Learning group

9 References

- NHS England » Serious Incident framework
- NHS England » Patient Safety Incident Response Framework (PSIRF)
- NHS England » A just culture guide
- NHS England » Revised Never Events policy and framework

10 Document control (external)

To be recorded on the policy register by Policy Coordinator

Date of approval	26 April 2023
Next review date	26 April 2026
This document replaces	CORP-0043-v8.2 Incident Reporting and Serious Review Policy
This document was approved by	EQAIG
This document was approved	25 April 2023
This document was ratified by	Executive Directors Group
This document was ratified	26 April 2023
An equality analysis was completed on this policy on	13 December 2022
Document type	Public

FOI Clause (Private documents only)	N/A

Change record

Version	Date	Amendment details	Status
v9	26 April 2023	Full review with changes. These changes include how we are gradually implementing the new Patient Safety Incident Response Framework (PSIRF) which replaces the National Serious Incident Framework 2015. Also includes the Incident Reporting and Management System section 4.1.1 which was added in response to an outage of the current system and lack of BCP in the policy.	Ratified

Appendix 1 - Equality Analysis Screening Form

Please note: The Equality Analysis Policy and Equality Analysis Guidance can be found on the policy pages of the intranet

Section 1	Scope
Name of service area/directorate/department	Directorate – Nursing and Governance
Title	Incident Reporting and Serious Incident Review Policy
Type	Policy
Geographical area covered	Trust-wide
Aims and objectives	This policy aims to inform staff of their roles and responsibilities in relation to reporting, managing, reviewing, and learning from all incidents involving patients, staff and or visitors. This includes being open, honest, and transparent with patients their family and/or carers if something has gone wrong during the care and treatment we have provided.
Start date of Equality Analysis Screening	13/12/2022
End date of Equality Analysis Screening	13/12/2022

Section 2	Impacts
Who does the Policy benefit?	Staff, patients, carers
Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or Business plan impact negatively on any of the protected characteristic groups?	• **Race** (including Gypsy and Traveller) **NO** • **Disability** (includes physical, learning, mental health, sensory and medical disabilities) **NO**

	• **Sex** (Men, women and gender neutral etc.) **NO** • **Gender reassignment** (Transgender and gender identity) **NO** • **Sexual Orientation** (Lesbian, Gay, Bisexual and Heterosexual etc.) **NO** • **Age** (includes, young people, older people – people of all ages) **NO** • **Religion or Belief** (includes faith groups, atheism and philosophical beliefs) **NO** • **Pregnancy and Maternity** (includes pregnancy, women who are breastfeeding and women on maternity leave) **NO** • **Marriage and Civil Partnership** (includes opposite and same sex couples who are married or civil partners) **NO** • **Armed Forces** (includes serving armed forces personnel, reservists, veterans and their families **NO**
Describe any negative impacts	None
Describe any positive impacts	Staff will be aware of their roles and responsibilities in relation to reporting, managing, reviewing, and learning from all incidents involving patients, staff and or visitors. This includes being open, honest, and transparent with patients their family and/or carers if something has gone wrong during the care and treatment we have provided. It also outlines what families can expect from serious incident investigations

Section 3	**Research and involvement**
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC reports or feedback etc.)	National Patient Safety Framework 2015 PSIRF Documentation Duty of Candour
Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	Yes Event held about changes made that have been reflected in this policy

If you answered Yes above, describe the engagement and involvement that has taken place	Families, carers, and operational services have attended two patient safety events where the content of this revised policy has been discussed. Patient safety incident reporting, reviewing and approving are all under a period of transformation as we decentralise incident reviewing and approving. We are also transitioning from the Serious Incident Framework of 2015 to the Patient Safety Incident Reporting Framework (PSIRF) and this policy may not reflect all changes being made from the date of ratification to the date of PSIRF being fully implemented by September 2023
If you answered No above, describe future plans that you may have to engage and involve people from different groups	

Section 4	**Training needs**
As part of this equality analysis have any training needs/service needs been identified?	Ongoing training needs to be reviewed as the transformational work remains on-going
Describe any training needs for Trust staff	TBC
Describe any training needs for patients	TBC
Describe any training needs for contractors or other outside agencies	TBC

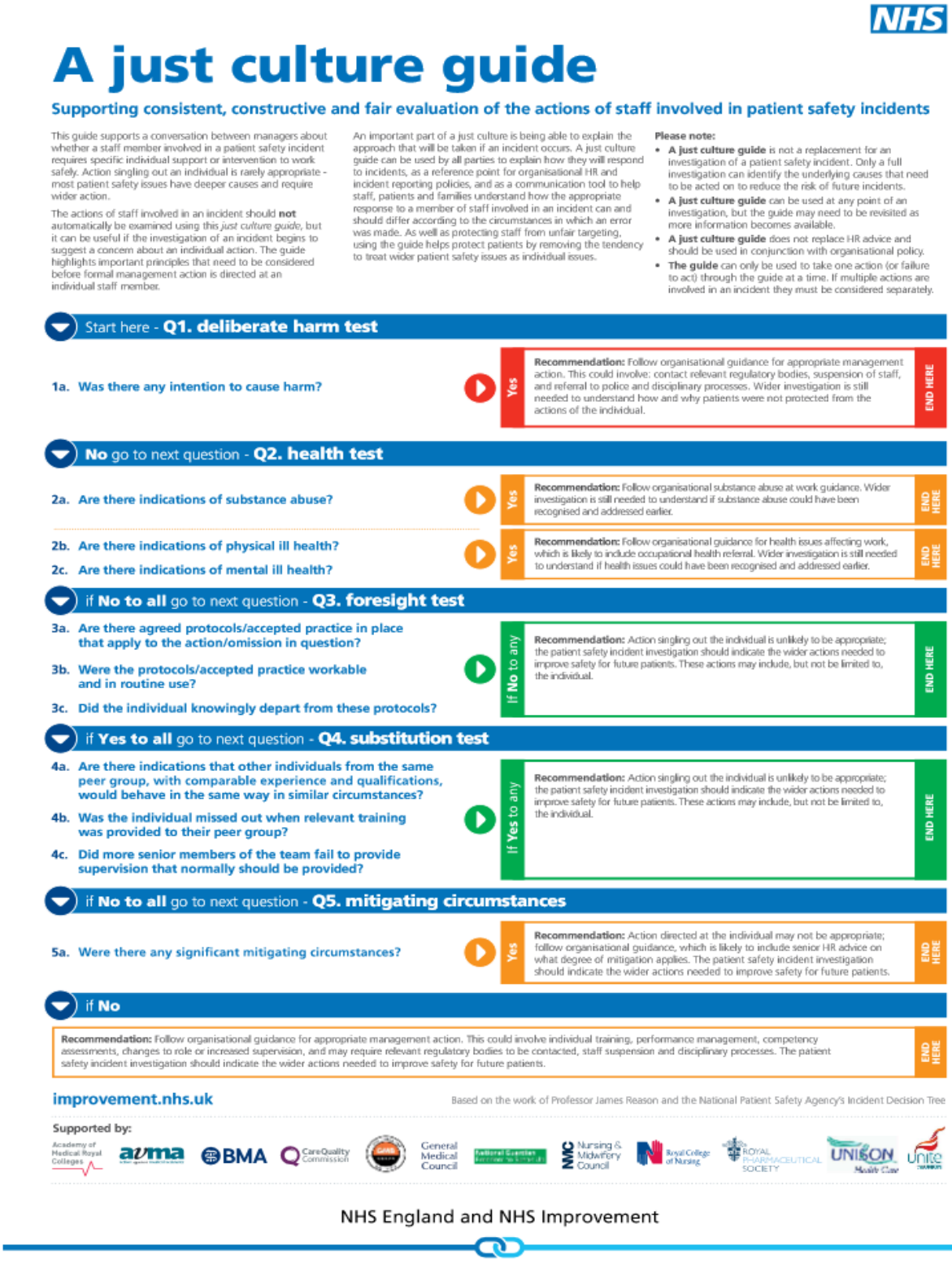
Check the information you have provided and ensure additional evidence can be provided if asked

Appendix 2 – Approval checklist

	Title of document being reviewed:	Yes / No / Not applicable	Comments
1.	**Title**		
	Is the title clear and unambiguous?	Yes	
	Is it clear whether the document is a guideline, policy, protocol or standard?	Yes	policy
2.	**Rationale**		
	Are reasons for development of the document stated?	yes	
3.	**Development Process**		
	Are people involved in the development identified?	Yes	More development needed due to transition to PSIRF from 2015 framework and procurement process in place for new incident reporting system
	Has relevant expertise has been sought/used?	Yes	
	Is there evidence of consultation with stakeholders and users?	Yes	
	Have any related documents or documents that are impacted by this change been identified and updated?	Yes	
4.	**Content**		
	Is the objective of the document clear?	Yes	
	Is the target population clear and unambiguous?	Yes	
	Are the intended outcomes described?	Yes	
	Are the statements clear and unambiguous?	Yes	
5.	**Evidence Base**		
	Is the type of evidence to support the document identified explicitly?	Yes	
	Are key references cited?	yes	
	Are supporting documents referenced?	Yes	
6.	**Training**		
	Have training needs been considered?	Yes	
	Are training needs included in the document?	Yes	

	Title of document being reviewed:	Yes / No / Not applicable	Comments
7.	**Implementation and monitoring**		
	Does the document identify how it will be implemented and monitored?	Yes	
8.	**Equality analysis**		
	Has an equality analysis been completed for the document?	Yes	
	Have Equality and Diversity reviewed and approved the equality analysis?	Yes	Approved 13 Dec 2022
9.	**Approval**		
	Does the document identify which committee/group will approve it?	Yes	
10.	**Publication**		
	Has the policy been reviewed for harm?	Yes	No harm
	Does the document identify whether it is private or public?	Yes	Public
	If private, does the document identify which clause of the Freedom of Information Act 2000 applies?	N/A	

Appendix 3- A Just Culture Guide



NHS

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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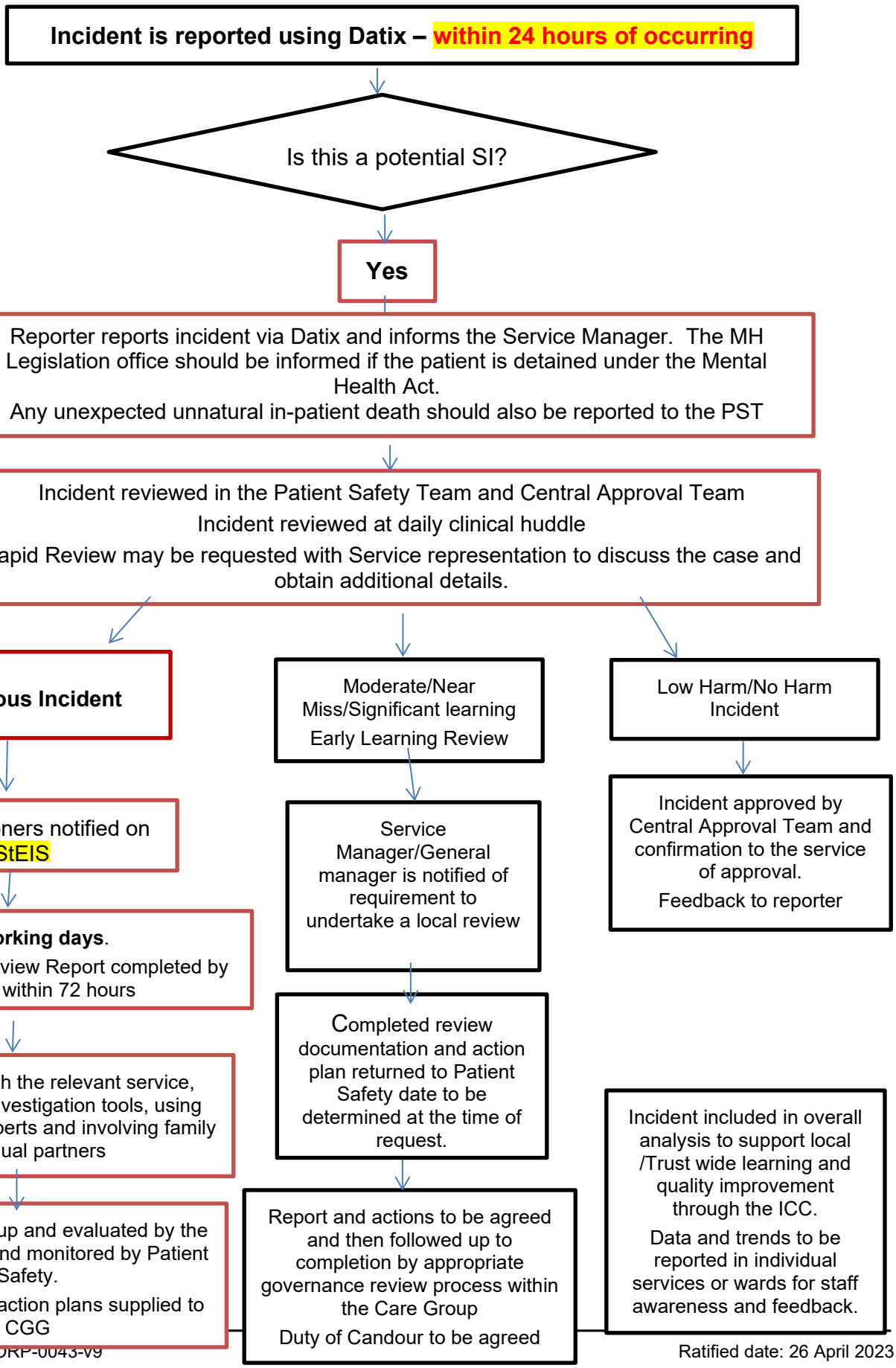
NHS England and NHS Improvement

Appendix 4 - Incident reporting process flow



Appendix 5 – Duty of Candour Checklist

NHS
Tees, Esk and Wear Valleys
NHS Foundation Trust

DUTY OF CANDOUR CHECKLIST

Action/s required	Y/N
A registered Healthcare Professional immediately notifies the relevant person after being made aware of an incident.	
If the relevant person cannot be contacted or doesn't want to be involved this must be recorded in the case notes on Paris	
Offer the relevant person a face to face meeting and/or written notification to explain facts known at the time and what will happen next i.e. a review of the care and treatment and that they can be involved in the review	
Complete a DATIX as soon as practicable and inform the Head of Service	
Record the incident as well as actions taken for Duty of Candour, including any failed attempts to contact the relevant person or where the relevant person has declined communication in case notes on Paris. **This is classed a formal record for Duty of Candour.**	
Save all Duty of Candour letters on PARIS in letters and record in case notes on PARIS the letter has been sent and to and by whom; copy of the letter to Patient Safety Inbox Tewv.patientsafety@nhs.net	
In the event of the death of a patient death a condolence letter must be sent to the relevant person from the appropriate registered healthcare professional that knew the patient.	

Appendix 6 - Moderate harm and near miss incident review process

	RESPONSIBILITIES FOR MODERATE HARM AND NEAR MISS INCIDENTS
REPORTING	A Datix report is submitted by the service. The incident is reviewed and approved by either the Central Approval Team or the Clinical Service (those on the 2 stage process)
NOTIFICATION	For Moderate Harm and Near Miss Incidents the Patient Safety Team requests an Early Learning Review (ELR) review on the form in Appendix 7
TIMESCALES	When an Early Learning Review is requested, it needs to be completed within 6 weeks of the request. Depending on the nature of the incident, the Patient Safety Team may request an earlier date for completion. This will be monitored on a case by case basis.
ACTIONS	The General Manager retains the role and responsibility of overseeing any action plan and ongoing monitoring from the review. The General Manager review process also assures that where the Duty of Candour and or the culture of candour policy applies that all necessary actions have been followed through and recorded on PARIS. The person carrying out the Early Learning Review has the responsibility to give the assurance in the report that the Duty of Candour Policy has been fully implemented.
LEARNING LESSONS AND GOOD PRACTICE	All completed reviews will be shared with relevant Care Groups, governance groups within 8 weeks of the request. It is the role of the appropriate Care Group governance group to give final assurance that all Duty of Candour / Culture of Candour actions have been implemented in line with Duty of Candour policy.
STORAGE	All Early Learning Reviews will require a mechanism to be in place within Care Groups to centrally store the incident review forms and associated completed actions (including evidence). This must be up to date and accessible for audit/assurance purposes.

Appendix 7 – EARLY LEARNING REVIEW TEMPLATE

Patient Details	
Name:	**Dob:**
PARIS ID: **DATIX Number**	**Gender:**
Directorate/Team	**Inpatient/Community:**
GP Practice:	**CCG:**
Incident Details	
Incident Type: Eg. Unexpected Death	**Incident Date:**
Incident Description: *What happened?* *When did it happen?* *Which service was the patient accessing at the time / or the most recent service.* *What support where they receiving?* *Cause of death if known?* *How was the service informed of the incident*	
Incident Review	
Chronology of care Do not copy and paste risk assessments and intervention plans – give a summary Do not use Staff Names use job role Do not use abbreviations If external agencies are mentioned give an overview of what this service is. If information is taken directly from Paris please summarise the information rather than copy and paste. • *Who was the patient* • *Which Teams are currently involved?* • *Overview of historical contacts with services (brief overview), for example, The patient was first known to services in 2010 following an incident. The patient was assessed in A&E by the Liaison Psychiatry Team, following assessment the patient was discharged / opened to the Community Mental Health Team. The patient was discharged in ….*	

- *All contacts recorded in the chronology should include and outcome and level on engagement. Or in 2019 the patient referred to, this referral was rejected, or the patient disengaged and was discharged etc.*
- *Details of current diagnosis and date given*
- *Details of current medications – who prescribes this GP or Trust Services. Any significant physical ill-health / medical history?*
- *Last medic Review*
- *Other services involved? Social Care, Drug & Alcohol.*
- *Detail of most recent Assessment, Safety Summary, Care Plan and Intervention Plan – summarise only (do not copy and paste)*
- *Detail of most recent contacts and an overview of the interventions offered.*
- *How was the patient at the last contact in terms of mental state and presentation?*
- *Self-Harm?*
- *Suicidal ideation?*
- *Was there a crisis / safety plan in place?*

Areas of good practice:

Identify any areas of good practice identified

Areas of learning:

Identify any areas of learning for the team/organisation. This should reflect any areas where the care and treatment provided was not to the usual standard of the Trust

Where possible reference these to trust policy, such as record keeping, harm minimisation, CPA, supportive observation and engagement.

Action

Actions taken

Detail any actions already taken by the service/organisation to prevent further incidents and ensure immediate safety of patients

Who took this action?

How was it implemented?

The date of this action.

How this action will be monitored and reviewed.

Additional Check List

1. *For inpatient incidents – please confirm that CCTV footage has been saved even if the incident was not on the ward,*
2. *Arrangements made to provide patient safety with paper records – Inpatients*
3. *Has the death module been completed within Paris?*

Actions required

Detail any further action required by the service/organisation to prevent further incidents and ensure immediate safety of patients

- *Who is responsible for taking these actions forward*
- *When will these actions be complete?*
- *Who will review?*
- *Do individual staff require individual discussion?*
- *Is this a team action?*
- *How will this be shared or communicated with the team.*
- *How will the service know that this has been embedded*

(Please refer to 'assurance statements' doc attached to email for further guidance.)

Duty of Candour:

Has the Statutory Duty of Candour been applied: Yes/No

Next of Kin Details – Including address

If next of kin details are not on Paris, try to obtain these from the GP or other involved agencies.

Name:

Relationship to patient:

Contact details:

Has the next of kin been informed of the incident?

Has support been provided/offered to next of kin

Detail what support was offered. Was this accepted or declined?

Date the condolence letter sent:

Staff Support

What support has been provided/offered to the staff involved or impacted by the incident

Detail what support was offered.

Was this accepted or declined?

Ask staff to complete a memory capture from (copy at end of review)

Governance Details

Reviewer from the clinical service:

Name

Role

Contact details

Person who will be lead for this incident within services

Name

Role

Contact details

Please provide the names of any staff who need to be contacted regarding the future investigation into this incident

Name

Role

Contact details

Patient Safety Team Assessors: **Name** **Role** **Contact details**
Outcome: **No further investigation required** ☐ **Further investigation required (StEIS report)** ☐

Appendix 8 – Staff Memory Capture Form

Staff Memory Capture Form

This form is *a template to help staff to recall the events of an incident as they remember them.*
What is required?
You may find it helpful to write your memory capture in two parts:
1: What I can recall about the care and treatment I was giving to the patient, before during and after the incident
2: What I can recall of the shift – No patient receives their care in a vacuum. There are always other activities going on. It is important that 'this incident' is considered with a good understanding of what else was happening.

Staff Name:	**Job Title:**
Date of Incident:	**Date of Memory Capture:**
Memory Capture Details:	

Confidentiality: *It is important to understand that this document, as with all statements and reflective diaries are disclosable and can be requested by the Coroner, and representatives of the patient. This should not deter you from giving a complete account of your involvement in the patient management, or your experience of the environment, team working etc on the day. It should however remind you to write correctly, so that what you write is not misinterpreted or misconstrued.*