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Incident recording and response policy

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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. Equally, when care is delivered well, sharing areas of good practice in a systematic way can support improved learning and therefore prevention of future incidents

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 incidents 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 recording, 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 an open, transparent 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 psychological support to any staff members that have been involved in errors or patient safety 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 as follows

- We will engage with and involve those affected by patient safety incidents.

- We take a system based approach to understanding what happened and identifying learning
- We will understand the interdependencies that might have impacted upon the patient safety incident
- We will undertake a considered and proportionate response to patient safety incidents
- We will be transparent about areas of learning

The process of managing patient safety incidents has been demonstrated with a flowchart (please see appendix 4)

The National Patient Safety Strategy has introduced new ways of working in relation to Patient Safety investigations; this policy has been updated in line with the national implementation of the new Patient Safety Incident Response Framework (PSIRF).

1.1 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 recording 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.

2 Why we need this policy

2.1 Purpose

This policy aims to inform staff of their roles and responsibilities in relation to recording, 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 in an open and transparent way, identifying areas of systemic learning and opportunities for improvement; and recommends strong/effective systems-based improvements to prevent or significantly prevent 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 recorded 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 recording, reviews and investigations, and the timescales to be achieved.
- Outline the processes in place for ensuring that patients and their family/carers are approached and consulted as equal partners throughout the investigation.
- Detail the expectations that all Trust staff will record patient safety incidents, support investigations, learn lessons, identify good practice, and use this to improve their own practice as well as the services they provide.
- Detail the expectations that all Trust staff will record health and safety incidents (including staff, visitors, contractors etc.), 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 recorded in line with Trust and national guidance.
- To provide details in relation to the training requirements for staff in relation to patient safety incident identification, recording, investigations, and improvements from learning identified.

3 Scope

This policy applies to recording, 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 recorded 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 Trust's 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 Patient Safety Incident Investigations (PSII), clusters, themes and trends including where there is a high risk of recurrence and a high impact outcome, via the relevant committees or Executive Directors 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 oversight, receipt and follow up of patient safety incident investigation reports and improvement plans.

	• The QuAC receives reports about trends in patient safety incident recording 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 Review of Quality Group (ERoQG) 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, oversight and monitoring of this policy and associated guidelines (in cases of unexpected death, suspected suicide) which will be approved by the executive 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 Chief Executive, Chief Nurse, Deputy Chief Nurse and Associate Director of Patient Safety	• 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 patient safety incident recording so that there is early identification of safety issues, the appropriate identification and then initiation of improvement plans. • Have responsibility for ensuring that there are accessible, supportive systems in place to promote timely recording, review, and investigation of all incidents. • Utilise all areas of risk, incident, 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 patient safety incident recording, investigation, analysis, identification of learning and the generation of SMART (Specific, Measurable, Achievable, Realistic, Timely) improvement plans. • Ensure that staff involved in PSII's have the appropriate skills, training, and capacity.
Patient Safety Team (PST)	• Provide a cohort of trained, skilled staff to initiate and coordinate patient safety incident investigations, either in relation to individual incidents or thematic analysis.

	• Provide oversight to incidents recorded on the Trust incident reporting system and identify level of response through the patient safety daily huddle. • Through the patient safety daily huddle, identify and make recommendations as to the incidents that may be a PSII and record via the appropriate national recording systems. • Maintain communication with the Integrated Care Boards (ICBs) to ensure there is a free flow of information sharing and updating in relation to PSII's. • 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 workstream actions and improvement plans linked to patient safety incidents and thematic analysis reviews. This will feed into the Organisational Learning Group as described in appendix 4. • 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, Operational Directors, Medical Staff, General Managers, Associate Directors of Nursing and Associate Directors of Therapies and Service Managers.	• Have operational responsibility for the implementation of this policy and associated guidelines contained within the PSIRP (Patient Safety Incident Response Plan) and flowchart 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 patient safety incidents so that there is early identification of safety issues, the appropriate identification and initiation of learning and improvement.

	• Promote the culture of openness, honesty, and transparency in recording of patient safety 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 on the Trust incident reporting system' 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 incidents 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 patient safety incidents The Trust incident reporting system, just culture, review, identification of learning and the generation of thematic learning and improvement plans as per PSIRP and Flowchart • Ensure there are appropriate support structures in place for staff involved in any incidents
Speciality Development Managers	• Work closely with the patient safety team in order to analyse, identify and disseminate learning from patient safety incidents. • Support teams Trust wide to implement workstreams on specific areas of learning, including oversight, timely assurance and dissemination of learning. • Support quality assurance and compliance teams to incorporate workstream activity in further governance requirements.
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 recording of patient safety 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 Trust incident reporting system' 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 The Trust incident reporting system recording, thematic learning 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 psychological support for staff in their area involved in stressful situations.
All staff – clinical and non-clinical	• Are responsible for recording any safety incidents that they are aware of, to ensure appropriate review and investigation can be completed in line with this policy. • Raise any concerns they have about clinical or non-clinical issues, either using the Trust incident reporting system' recording system or via line management, as appropriate • Staff will maintain awareness of their relevant professional bodies' requirements in relation to involvements in incident recording, 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 where they have been involved or can provide specific and/or specialist knowledge to support the investigation or learning.
Specialist Operational and Training Teams	• All specialist teams will provide advice and guidance for safety 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 workstreams, learning linked to previous complaints; CQC action plans; audits; surveys or patient experience reports.
Health and Safety Team	• Reviewing and investigating non-patient incidents. • Reporting RIDDOR incidents to the Health and Safety Executive (HSE).

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 patient safety incident recording.
- The importance of timely non-patient safety incident recording (e.g. staff, visitors, contractors etc.)
- The significance of effective patient safety management.
- The significance of effective staff safety management.
- The importance of establishing a “Just Culture” in relation to recognition of incidents, recording and review.
- The need to work collaboratively on the investigation of incidents with the identified PSIRF tools in the given timescales.
- The relevant national, regulatory, and contractual requirements in relation to PSIRF
- The value of patient safety investigations to establish service or care concerns, to ensure there is learning with the relevant team, across the Trust and where necessary with external organisations.
- The value of health and safety investigations to ensure that there is learning across the Trust.
- The importance of following the RIDDOR Reporting Procedure.
- All actions implemented in response to lessons learned will be monitored by relevant service leads and in line with the flowchart, to ensure the identified issues are addressed and assurance gained following evaluation of impact. This will have oversight from the patient safety team and Quality Assurance (QA) team.
- The high level of importance of informing and involving patients and families/carers as equal partners throughout the whole process of a patient safety learning any level.
- The need to implement and evaluate any resulting action plans and retain evidence of this.
- Use of the flowchart, PSIRP, the Trust incident reporting system 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 record 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 recording 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 recording 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 Patient Safety Incident Recording

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. NHS England have disseminated a new approach called the Patient Safety Incident Response Framework detailed below:

NHS England » Patient Safety Incident Response Framework

Timely recording and review of all incidents is essential to improving patient safety. This process begins with recording any incidents that impact on patients, visitors, staff, or Trust service provision, clinical or non-clinical and covering all levels of harm. Any incidents should be recorded on the Trust's incident recording system by completing and submitting a record within 24 hours of the incident, identifying level of severity. If this is not possible then this should be escalated to the relevant line manager. The staff member responsible for completing the record is the one who is first aware of the incident.

The Trust incident reporting system 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.

Appendix 4 provides an outline of the processes in place to review how/why an incident has happened, identify and implement actions to reduce the impact, identifies tools to be explored and learning opportunities to support the minimising of recurrence of similar incidents.

4.1.1 Immediate Action/Hot Debrief/Psychological Support

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 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 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.

A hot debrief, also referred to as a rapid reflection is an opportunity for staff and those affected to come together immediately after an incident and consider any immediate support needs and immediate areas of learning. The hot debrief tool has been built in to the Trust incident reporting system to support its completion.

4.1.2 Incident Management

Under the PSIRF framework, there are nationally identified responses to patient safety incidents, and also a locally identified plan APPENDIX 6. This will offer teams and the patient safety team an immediate understanding of the response required. The local plan will be reviewed and may be adapted as work streams and Multi-Disciplinary Teams (MDT) reviews of themes are undertaken.

As detailed in Appendix 4, No and low harm incidents can be reviewed, investigated, and approved at service level and will need to be done alongside a hot debrief and psychological support as appropriate. Any identified themes should be populated in the Trust incident reporting system in order to monitor quality and trends.

Following identification of patient safety incidents that are moderate or higher in terms of harm severity, the review and investigations are co-ordinated by the PST through a daily huddle. The huddle discussion will identify, in conjunction with staff from the relevant service, the appropriate review tool and timescales for completion, the outcome of which is brought back and presented in the huddle.

Where it is identified that the severity of the incident meets the criteria for a full patient safety incident investigation or homicide review, this will be undertaken by a reviewer independent of the service in which the incident occurred.

Allocated reviewers will work with the patient, their family and relevant clinical services from the commencement of the investigation to identify key lines of enquiry as well as areas of actionable learning. The reviewer will prepare a record, in collaboration with the family and clinical services which will be approved through the Trust's Governance processes.

Learning may be identified for individuals, staff teams, care groups and the organisation Organisational wide learning will feed into existing Trust-wide programmes of work and will be escalated to external partners where required or discussed at the most appropriate forum to identify further actions required. This is overseen by the Organisational Learning Group in line with the flowchart in Appendix 4.

Learning identified within PSII records are shared with the Integrated Care Board (ICB), 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.

Following identification of a PSII in the patient safety daily huddle, 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 categorised as moderate, severe or fatal harm in terms of severity the recorder should inform their line manager. If the incident has occurred out of hours, the recorder will inform the Tactical 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 (as detailed in Appendix 4 flowchart); the ward/team/unit manager will ensure the Duty of Candour processes are implemented in line with the Duty of Candour policy. Out of hours this may be delegated to the nurse in charge by the Tactical on call; the responsibility for this will be resumed by the ward/team manager the next working day.

Duty of Candour policy – In line with the Duty of Candour Policy, all decisions and actions **must** be fully recorded on the electronic patient record and on the Trust incident reporting system

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 on the patient's electronic patient record, an entry made to confirm it was sent and the relevant field on the Trust incident reporting system completed.

If the incident is of moderate harm severity or above, the appropriate manager will ensure this is recorded immediately on the Trust Incident reporting system and a staff hot debrief is carried out with those involved. It is important for managers to ensure staff are cared for and psychologically supported when an incident has occurred. Where appropriate, staff will be asked to provide a written account (memory capture form) of what they can remember about the incident.

Where an unexpected inpatient death is thought to have occurred, the Patient Safety Team should also be notified by telephone in office hours, 0191 333 6522 or the following working day or by e-mail out of hours tewv.patientsafetyteam@nhs.net

4.1.3 Never Events

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

- Failure to install functional collapsible shower or curtain rails

There are others that under certain circumstances relate to all NHS care providers:

- 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
- Falls from poorly restricted windows
- Chest or neck entrapment in bedrails
- Misplaced nasogastric or orogastric tubes
- Scalding of patients

For specific details, please see the NHS England Never Incidents Framework.

4.1.4 Incidents involving safeguarding and Public Protection

Safeguarding – for all incidents recorded, 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. These 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.

An incident is 'something unexpected or unintended has happened, or failed to happen, that could have or did lead to patient harm.'

This incident type encompasses all patient safety 'incidents'.

In relation to safeguarding, the definition relates to the care and service we are providing, so considering whether harm or abuse has/ or could have occurred to one or more patients whilst under our care and we have direct input over the management of this.

All patient safety incidents involving these safeguarding concerns should be recorded as an incident on the Trust incident reporting system ensuring that the safeguarding section of the incident form is completed.

It is recognised that many safeguarding concerns and referrals do not meet the definition of a patient safety incident above and we need to record these differently.

- Any safeguarding concerns that that do not involve a patient safety incident for the Trust, but for which a referral is made to the local authority should be recorded as an Outcome.

- Any safeguarding concerns that do not involve a patient safety incident and do not result in a referral to the local authority should be recorded in the patients electronic record only and do not need recording on the Trust incident reporting system .

All Safeguarding concerns, actions and any referrals should always be recorded in the patient electronic patient record.

For further guidance please refer to Trust safeguarding policies or contact the Trust Safeguarding & Public Protection team tewv.safeguardingadults@nhs.net

4.1.5 Learning Disabilities Mortality Review Programme (LeDeR)

In addition to internally recording and learning from Learning Disability deaths, there is also a requirement to record them externally. We need to ensure that throughout the Trust we record 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 recording learning disability deaths. Please use the following link to register a notification via an online form on the LeDeR website: LeDeR - Home

LeDer reviews are now also undertaken for all people with autism over the age of 18 who have an autism diagnosis and had this written in their medical records.

OR Call 0300 777 4774

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

4.2 Health and Safety Incidents

4.2.1 RIDDOR

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 recording criteria can also be located within the RIDDOR procedure.

The Health, Safety and Security Team will:

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

4.2.2 Security and Harm Incidents to Staff, Visitors and Contractors

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

Where the Police have been called, the relevant details including, the force wide incident number/police officers identifying details should be added in addition to any other relevant fields on the Trust incident reporting system incident form and the Criminal Incident Recording Procedure should be followed. Where criminal damage to property has occurred, an incident form should be raised and the LSMS to be notified. tewv.hss@nhs.net

For further details please see the Health and Safety (non-patient) Incident Decision and Investigation Framework at Appendix 7

4.3 Incident Recording and Management system

The Trust's incident recording system is a critical system to support patient and non-patient safety and learning and should be used to record, review and approve all incidents, both patient safety and non-patient safety. (e.g. staff visitors and contractors). It should also be used to record any unexpected deaths and safeguarding referrals that do not meet requirements of an incident.

The system meets the requirements for the national patient safety reporting system (Learning From Patient Safety Events or LFPSE) which means that all patient safety incidents are submitted to the national system for learning. It also supports us to implement the Patient Safety Incident Framework (PSIRF) process and incorporates the required tools and processes.

All staff in the Trust have access to be able to record an incident on this system via the Trust's intranet page but reviewers and approvers of incidents must firstly undertake appropriate reviewer training.

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

The person recording the safety 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.

4.4 The Patient Safety Incident Response Process

The patient safety incident response process ensures all patient safety incidents are identified, reviewed, and progressed through the Trust governance process in a consistent way.

The process is described in the flowchart in appendix 4

4.4.1 Incidents

Where an incident is low no harm, this should be aligned to the themed learning and approved.

All incidents of moderate or above severity of harm are reviewed within the daily patient safety huddle to determine the appropriate level of response. This is in addition to the local review of the incident.

Responsibilities are outlined in this document to ensure the data is used effectively to raise awareness of trends and themes in incident recording to support local and organisational learning. This information should be used identify potential quality improvement activity and to assist in identifying additional training needs.

4.4.2 Patient Safety Daily Huddle

The patient safety daily huddle takes place on all weekdays except bank holidays and considers all incidents where harm has been recorded as moderate, severe or fatal in the period preceding that huddle. As a minimum the huddle include patient safety team and safeguarding team representatives. Others are invited as appropriate in line with the terms of reference.

The huddle discussion will identify the appropriate proportionate response to the recorded incident and in conjunction with the service arrange for the appropriate level of review to be undertaken. In line with PSIRF a range of tools will be considered to promote opportunities to understand any system issues or learning . the recommended tools are within an NHS toolkit. Below is direct access to patient safety tool kit:

https://www.england.nhs.uk/publication/patient-safety-learning-response-toolkit/

All patient safety daily huddle decisions are recorded on the Trust incident reporting system and shared with the appropriate senior staff within the Trust.

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 and recorded to the ICB as necessary.

4.4.3 Patient Safety Incident Investigations (PSII's)

Where it is proportionate to conduct a PSII review, these will be undertaken by experienced reviewers within the patient safety team and experienced clinical staff who will be provided with training in carrying out these investigations. This ensures, learning, current expertise and promotes staff across the Trust having enhanced patient safety knowledge.

When a PSII is confirmed, the After Action Review (AAR) and any other identified tools must be confirmed as complete or completed at the earliest opportunity. The expectation is that this will be within 10 working days except under exceptional circumstances. The completed tools will be reviewed and approved by senior staff within the service, received by the patient safety team for consideration in the daily huddle and where appropriate anonymised and shared with other relevant agencies e.g. ICB, CQC etc . These could be shared with coroners and service users and families where appropriate.

Any PSII can also be reviewed at any time on once it has been approved by the PST. Data is inputted into the Trust incident reporting system and the incident is allocated to a reviewer for a full review of the care and treatment provided. The PST will retain a copy of all records and evidence from patient safety investigations and will support the monitoring process of PSII 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 learning and improvement plans.

PST and/or reviewers will liaise with teams and, 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 incident investigation. Where necessary, they will also offer condolences and sympathy on behalf of the Trust. The Service or General Manager will already have ensured a condolence letter has been sent from the most appropriate person within

the service. This supports the condolence letter being personalised, should have explained that the Trust would be undertaking a review and that they will be offered the opportunity to be involved in the process. When the review is complete the PST and/or reviewer and/or the FLO will offer to meet up with the 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 After Action Review report or other tools 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.

Depending on the nature of the incident subject matter experts will be sought and utilised through the investigation process. Examples of this could be clinical experts in that speciality who are independent of that specific service, safeguarding practitioners, physical health care practitioners.

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 and/or 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 record. 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 incident investigation, the PST and/or 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 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 incident 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 a safety action plan (Part A for local actions and Part B for organisational learning) to be supplied with complete approved reports.

The PST or reviewer will present the draft patient safety investigation report to an assurance 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; Part A identifying local improvements required, and Part B suggesting wider organisational learning, actions or themes 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 consists of Senior Trust representatives and an ICB representative in line with the terms of reference and is the final stage of the internal quality assurance processes. The PSII Reviewer, a PST representative 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.

We will try accommodating any communication needs/adjustments and that we will make reasonable adjustments if required to ensure patients, carers and their families are able to fully participate in the process

The PST will upload the lessons learnt to Strategic Executive Information System and the Trust incident reporting system'

Local team level Improvement Plans and learning 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. Patient Safety Team will work with teams to ensure monitoring of evidence completion. Completed improvement or learning plans must be forwarded to the PST on email to tewv.patientsafetyteam@nhs.net to enable them to be forwarded to the ICB or Provider Collaborative and Nursing and Governance Clinical Audit Team Part B (Organisational Learning identified) need to be submitted to ensure it is added to the organisational safety learning plan As part of the Patient Safety Transformation work Improvement Plans will all be retained on the Trust incident reporting system.

4.4.4 Organisational Learning Group

The new PSIRF recognises 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 recording 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 identify a group of incidents of similar type, or in a similar setting or amongst similar groups of patients, a 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.

We have introduced a monthly 'organisational learning group' whose purpose is to

- Develop and maintain processes to learn and improve after patient safety incidents, complaints, safeguarding, leadership visits, investigations etc.
- To alert the Trust of systemic areas for improvement and / or safety issues.
- To ensure the group escalates or delegates concerns or issues to the appropriate forums / workstreams.
- To ensure the organisation has a structure that supports learning and improvement with strong triangulation and governance through:
    - clear collation of information
    - transparent processes to explore and investigate issues based in the PSIRF principles of Just Culture.
    - Work with care groups and clinical networks to identify and theme learning opportunities.

    - Ensure governance structure that will implement and monitor any identified changes.
    - Disseminate learning and developments through a variety of identified solutions.
- Proactively seek out best practice and provide guidance to fundamental standards, clinical networks and care groups to ensure that safe high-quality care remains at the forefront of service delivery.
- To invite identified work streams to feedback areas of development and positive practice to update and share progress.
- Review and raise awareness of wider system learning from across a range of organisations or publications for discussion.

A regular monthly thematic patient safety review will be implemented and then discussed at Organisational learning meeting in order to establish allocation of workstreams required. If services, departments or the use of tools recognise that there may be a safety issue that needs to be considered , 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 learning workstream together with a trajectory for completion.

4.5 Deaths in prison/police custody: Incident Recording and Investigating process

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 PSII occurs, Spectrum staff complete the recording of the incident to ICB, the CQC notification and the notifiable incidents form for NHS England. Representatives from Spectrum and TEWV will discuss and identify which provider will lead on the early case review/patient safety incident investigation process and who will complete the report. Regardless of which organisation is leading it Is expected that both organisations will work together in the review process. TEWV staff will need to complete a record on the Trust incident reporting system. The early case review/PSII will go through the Spectrum panel process with TEWV representative as a core member. A copy of the record will be shared with patient safety to enable learning.

The Spectrum Learning Response Approval Group (LRAG) is attended by all the health providers working within prisons including Spectrum, TEWV and Humankind.

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 referred to as an early case review. (After Action Review) 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 but also feeds into wider

organisational learning. 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 LRAG before being sent to NHSE by Spectrum's Quality Incident Team.

4.6 Homicide Incident investigation and recording 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 NHS England). 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 incident/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.

4.6.1 Homicide Review Process

This has three defined stages:

Stage 1 – Incident recording and After Action review

a. In the incident of an incident all relevant and known details should be recorded on the Trust incident reporting system as soon as staff are aware.
b. The incident will be reviewed and recorded on the Trust incident reporting system,
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 After Action review /review is completed by the provider

e. The After Action review 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 Homicide' incidents are a national defined as a priority for PSII.
   - Communicating with relevant individuals and organisations including the families of victims and perpetrators, Police, Coroner, Health and Safety Executive (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 Independent review commissioned by the provider TEWV has a partnership with Spectrum CIC to undertake homicide reviews. This fulfils the requirement for a PSII.

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 Trust's commissioned investigation record, 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 any further investigation or action 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.

4.7 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.

4.8 Information Governance Incidents

Information incidents are logged using the Trust's incident recording system 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 PSII.

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.

4.9 Communication with and Support for Staff

Following a recorded 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 incidents. 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). This should be offered as part of the hot debrief .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 incident or series of incidents 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 incident/s and their impacts, discuss normal response to stressful incidents, 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

4.10 Sharing and Learning Lessons

The introduction of the PSIRF has created the opportunity to apply a range of triangulated, system-based approaches to learning from patient safety incidents. These can provide considered and proportionate responses to patient safety incidents and supportive oversight that focuses on strengthening responses and system improvements.

Investigations and patient safety tools support analysis of the details available about an incident and allow consideration of learning identified, to understand if anything could have been done differently to prevent further similar incidents from occurring. This identifies areas for change and helps the PST and the Trust, develop recommendations for actions/improvements that will lead to the delivery of safer care for our patients.

In particular the following will take place in relation to sharing and learning lessons:

- Learning that requires rapid dissemination will be cascaded through 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 scalation will be done so through existing recording structures such as on-call oversight meetings/Sitreps
- Incidents linked to Medical Devices or Medications will be investigated and, where necessary, recorded 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 PSII's
- The Trust incident reporting system 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 Incident Investigations and other PSIRF tools will include an analysis of actual care given against Trust agreed practices and policy, to identify areas for learning and any identified lapses
- Where incidents involve external organisations, investigations will be undertaken collaboratively, and lessons learned shared to initiate relevant actions.

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 organisational learning group and/or 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 Review of Quality Group, following analysis, action / improvement implementation and resulting assurance, from the various relevant working groups.

Areas for improvement can relate to a specific local context or to the context of the wider organisation. While the approach to developing safety actions is similar for both there, are differences in the team involved as well as (in some instances) the reporting mechanisms. Teams may have individual actions (Part A in action plans) but may also identify wider organisational learning (part B in action plans). See Table 1.

Table 1. Safety action development guide extract. (NHSE, Aug 2022)

	Local context	Organisation context
Definition	Specific area for improvement highlighted by a single (or multiple) learning responses	Broader area for improvement identified across several learning responses – likely not in response to any single patient safety incident but incidents with common contributory factors across events. Likely require radical system redesign
Examples of areas that may require improvement	Environment layout and characteristics (e.g. light, noise) Tool design Task design Training	Deep routed organisational issues, likely with long histories and dynamics, e.g.: • Staffing, rotas, etc • IT infrastructure • Workload • Fatigue • Culture • Handovers • Procurement • Policies
Development Team	Learning response team Involvement of local team to design and implement Quality improvement team Those affected by the incident	Learning response team Involvement of local and broader team to design and implement (e.g. leadership, management) Quality improvement team Those affected by the incident
Tools	SEIPS/HFIX (Appendix A – Safety Action Development Guide) iFACES (Table 3 Safety Action Development Guide)	
Methods for developing safety action	Interviews Observations Focus groups Desktop reviews Simulation/testing Standards quality improvement methods such as PDSA cycles	Qualitative review of patient safety learning response findings Surveys Literature reviews – what has worked well elsewhere? Focus groups Consensus panel – reaches a wider group of members with experience of work
Expectation for recording	Included in learning response report (e.g. patient safety incident investigation (PSII) report) after an individual incident response or in wider safety improvement plan as appropriate.	Included in a safety improvement plan bringing together findings from various responses

Definitions

Term	Definition
Accountability	Responsibility to someone for some activity with an obligation to demonstrate and take responsibility for performance of agreed expectation
CITO	Electronic Patient Record System in use within Tees, Esk and Wear Valleys NHS Foundation Trust
Contributory Factors	The contributory factors are those things that contributed to or had an influence on the incident occurring.
Incident Recording and Management System InPhase	The Trust incident reporting system is the Trust's electronic Risk Management Software System implemented to collate incidents completed by staff following an incident.
FLO	Family Liaison Officer
Incident	Patient safety incidents are any unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving healthcare. Reporting them supports the NHS to learn from mistakes and to take action to keep patients safe.
Mistake	A wrong action attributable to poor judgement, ignorance or inattention. To misunderstand or do something wrongly, improperly or faultily, to err in opinion or judgement.
Patient	As a guide, this is any NHS funded patient on a current caseload or discharged from a caseload in the previous 6 months.
PSIRF	Patient Safety Incident Response Framework
PSIRP	Patient Safety Incident Response Plan
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 incidents, key ways in which learning takes place is through Fundamental standards, SDM's PDPs, organisational learning meetings 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: • **Organisational Learning Group** – see above • **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.
PSII (Patient Safety incident investigation)	• PSII's are one method to extensively review and investigate an incident and can be seen on the national and/or local action plan. These are 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.
Systems-based Review	This is defined as a structured and systematic review of an incident to establish a chronology of all the incidents 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

5 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 (currently undergoing review and due to convert to a policy).
- Domestic Abuse Procedure
- PREVENT Procedure
- Protocol for the Distribution of Safety Alert Broadcasts and Trust Safety Notices
- 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
- Duty of candour NHS video
- 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 Recording Procedure
- Security Procedure
- PSIRP

6 How this policy will be implemented

- Mandatory policy briefing and training on incident recording 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 recording and management system is available for all staff.
- This policy will be published on the Trust's intranet and external website.

6.1 Implementation action plan

Activity	Expected outcome	Timescale	Responsibility	Means of verification/ measurement
Drop in sessions on PSIRF Tools and processes	Staff are aware of their responsibilities and the requirements under the PSIRF framework and policy	Until December 2024	Associate Director of Patient Safety/ Deputy Chief Nurse	Weekly meeting held February - March 2024 Monthly meetings held April - December 2024 Staff at sessions had their questions /feedback answered/ considered.
Webinars held as the Trust transitions from the 2015 incident recording framework to the new PSIRF	Staff are aware of the PSIRF framework and where appropriate their responsibilities.	Completed by end January 2024	Associate Director of Patient Safety/ Deputy Chief Nurse	Initial webinar held Trust wide diary invite Further webinars held weekly in January 2024. Compliance with policy monitoring via existing measures contained in main body of policy
Weekly preparing for PSIRF communications	All staff are aware of the new PSIRF framework and changes	November 2023 – March 2024 (and ongoing)	Associate Director of Patient Safety/ Deputy Chief Nurse	A weekly preparing PSIRF communication included in staff briefing newsletter and intranet page from 7 December until 29 January 2024
PSIRF specific intranet page established	All staff are aware of the new PSIRF framework and changes	December 2023	Senior Project Manager	Intranet page established and communicated containing key PSIRF information
Targeted PSIRF Briefing sessions held with key members of staff	Key staff involved in recording and reviewing patient safety incidents understand and implement the new processes and requirements	September 2023 - January 2024 (and ongoing)	Associate Director of Patient Safety/ Deputy Chief Nurse	Sessions held with the following key staff: • Care Groups • Associate Directors of Nursing • Associate director of therapies • Associate medical directors • Business support managers • Service managers

Activity	Expected outcome	Timescale	Responsibility	Means of verification/ measurement
				• Matrons • Lead psychiatrist.
Training provided on the Trust incident reporting system for recorders and reviewers	Staff are trained on how to use the system for recording and reviewing, approving incidents and understands what constitutes as a quality response	October 2023 ongoing	Patient Safety Team	100% of staff having access to InPhase have been trained Level 2 Reviewer sessions provided from October 2023 and continuous Level 1 recorder sessions provided from October 2023 to December 2023 Level 1 and level 2 training to be provided on ESR for relevant staff
PSIRF Training on tools for all relevant staff	Staff understand the SPIRF framework and tools	March – May 2024 and ongoing	Associate Director of Patient Safety/ Deputy Chief Nurse	PSIRF training for key staff held in March and April 2024 Duty of Candour training held for key staff March – April 2024 PSIRF Train the training provided to key staff in May 2024 PSIRF training rolled out wider after May 2024.
Revised documentation and supporting guidance provided to staff and available on intranet page (to be tested and updated following feedback)	Staff are following the correct processes for recording and reviewing incidents and have an opportunity to feedback.	29 January – ongoing	Associate Director of Patient Safety/ Deputy Chief Nurse	Prior to 29 january 2024 following available on intranet page • PSIRF Plan on intranet page • Template available on intranet page • MDT meeting guidance and agenda • Tools and link to NHSE website

Activity	Expected outcome	Timescale	Responsibility	Means of verification/ measurement
				Buy the end of April the Serious incident Policy will be updated, ratified and published on intranet (and website)

6.2 Training needs analysis

Staff/Professional Group	Type of Training	Duration	Frequency of Training
All staff	The Trust Incident recording system' Incident Recording	2 hour (awareness)	One off
Reviewers and Approvers	The Trust Incident reporting system' reviewer Training	2 hours	One off
All staff	Patient safety syllabus level 1: Essentials for patient safety	Approximately 40 minutes	One off
All staff	Patient safety syllabus level 2: Access to practice	Approximately 40 minutes	One off
Key identified staff	NHS professionals PSIRF Training including and techniques	2 days	One off
Key identified staff (Patient Safety Team)	NHS Professionals PSIRF Train the Trainer	2 days	One off
Key identified staff	Internal PSIRF Training	Tbc	One off
Key staff	NHS Professionals Duty of Candour training	3 hours	One off
All staff	Webinars – ongoing	Hour long webinars to help staff transition to PSIRF	Ongoing
Key identified staff to be Patient Safety Specialists (Associate Director of Patient Safety, Chief Nurse and Deputy Chief Nurse)	Patient Safety Specialist training level 3-5	Ongoing modules through blended learning	One off

7 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:

- The Learning from Patient Safety Incident (LFPSE) as part of National Development work during 2023 is now in situ.
- Weekly Executive Director Group reports monitoring the completion of PSIIs.
- Monthly performance reports monitoring the completion of action plans.
- Quarterly MDT review of incidents, workstreams and actions will review progress and organisational learning will monitor.
- Annual performance reports at the end of Q4 identifying numbers PSII 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 PSII Recording and Management processes and procedures. The outcomes of these checks will be reported through the Executive Review of Quality Group.
- 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
- Monitoring against the PSIRF standards

  Further work is being undertaken to develop full measurement of PSIRF but currently the PSIRF standards monitoring are in place

Number	Auditable Standard/Key Performance Indicators	Frequency/Method/Person Responsible	Where results and any Associate Action Plan will be reported to, implemented, and monitored; (this will usually be via the relevant Governance Group).
1	100% compliant with Policy, Planning and Oversight PSIRF standards	Deputy Chief Nurse/Associate Director of Patient Safety	Patient Safety Incident Management Board/Executive review of Quality Group where appropriate
2	100% compliant with Competency and Capacity and Oversight PSIRF standards	Deputy Chief Nurse/Associate Director of Patient Safety	Patient Safety Incident Management Board/Executive review of Quality Group where appropriate
3	100% compliant with Engagement and involvement of those affected by patient safety incidents PSIRF standards	Deputy Chief Nurse/Associate Director of Patient Safety	Patient Safety Incident Management Board/Executive review of Quality Group where appropriate
4	100% compliant with Proportionate responses PSIRF standards	Deputy Chief Nurse/Associate Director of Patient Safety	Patient Safety Incident Management Board/Executive review of Quality Group where appropriate

8 References

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

9 Document control (external)

To be recorded on the policy register by Policy Coordinator

Date of approval	21 May 2024
Next review date	21 May 2027
This document replaces	CORP-0043-v9 Incident Recording and Serious Review Policy

This document was approved by	ECLS (Executive Clinical Leaders Sub-group)
This document was approved	15 May 2024
This document was ratified by	Management Group
This document was ratified	21 May 2024
An equality analysis was completed on this policy on	10 April 2024
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 Recording 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.	Withdrawn
v10	21 May 2024	Full review to reflect implementation of PSIRF within the Trust. Changes and clarifications made throughout the document. This includes: • Removing references to previous Serious Incident Framework (e.g. Serious incidents) • Removing any references to Datix the previous incident system • New processes in line with PSIRF • Organisational learning group purpose • Emphasis of Just Culture underlying the policy • Health and Safety Incidents amendment to wording and appendix	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 Recording and Response 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 recording, 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. This aligns with the new PSIRF (Patient Safety Incident Response Framework) requirements.
Start date of Equality Analysis Screening	January 2024
End date of Equality Analysis Screening	5 April 2024

Section 2	Impacts
Who does the Policy benefit?	Staff, patients, carers
Will the Policy, Service, Function, Strategy, Code of practice, Guidance, Project or	• **Race** (including Gypsy and Traveller) **NO**

Business plan impact negatively on any of the protected characteristic groups?	• **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 recording, 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. This outlines the new policy which aligns to PSIRF requirements

Section 3	**Research and involvement**
What sources of information have you considered? (e.g. legislation, codes of practice, best practice, nice guidelines, CQC records or feedback etc.)	See references

Have you engaged or consulted with service users, carers, staff and other stakeholders including people from the protected groups?	Yes
If you answered Yes above, describe the engagement and involvement that has taken place	Families, carers, and operational services have attended two patient safety incidents where the content of this revised policy has been discussed. Staff in care groups and directorates have been involved in the development of our new incident reporting system and PSIRF processes through consultations, an event held on 8 June 2024 and subsequent engagement work.
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?	no
Describe any training needs for Trust staff	n/a
Describe any training needs for patients	n/a
Describe any training needs for contractors or other outside agencies	n/a

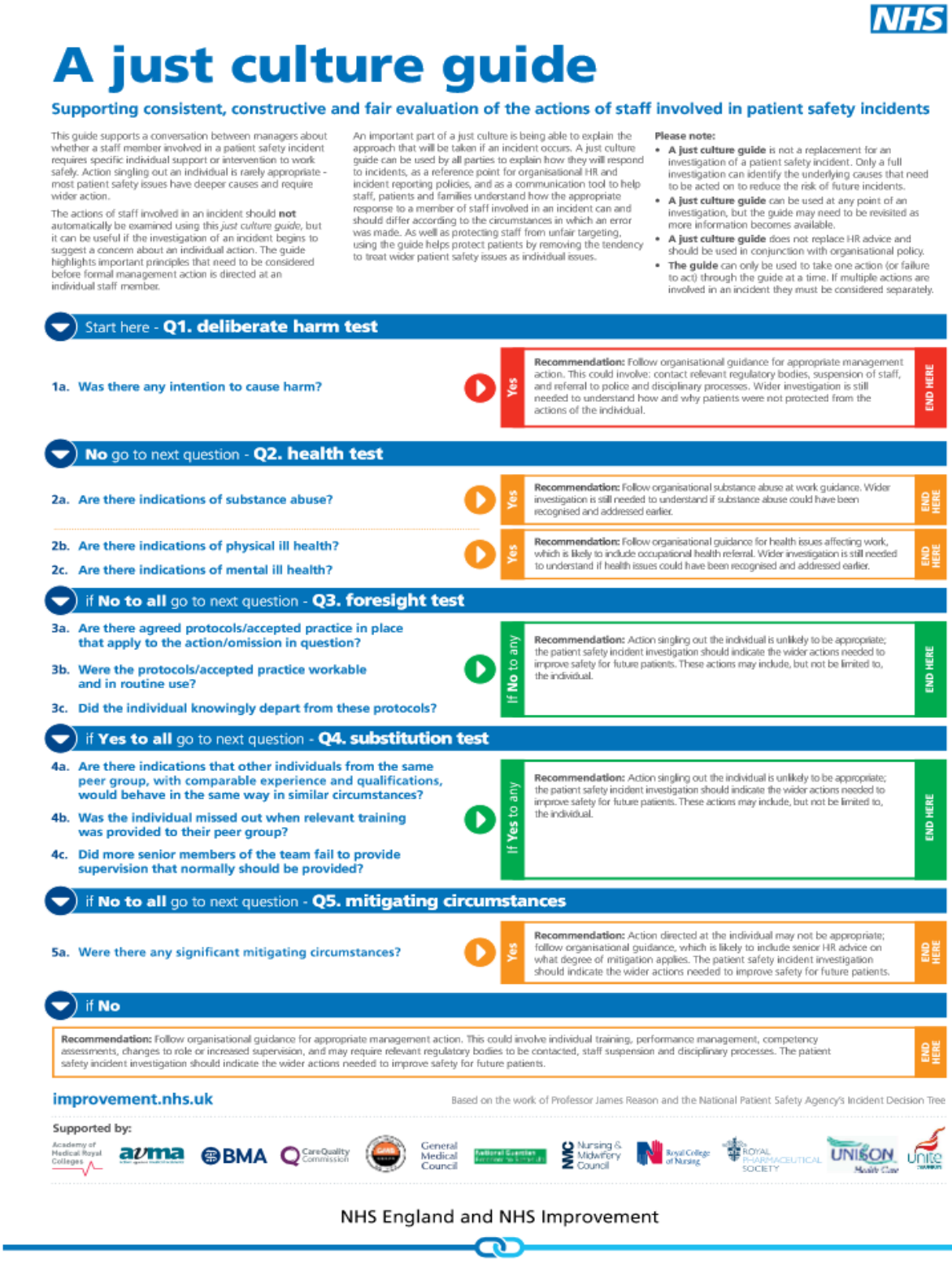
Check the information you have provided and ensure additional evidence can be provided if asked

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	
	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	
7.	**Implementation and monitoring**		

	Title of document being reviewed:	Yes / No / Not applicable	Comments
	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	Happy to approve policy. Suggested we also include that we will try accommodating any communication needs/adjustments and that we will make reasonable adjustments if required to ensure patients, carers and their families are able to fully participate in the processes.
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

improvement.nhs.uk

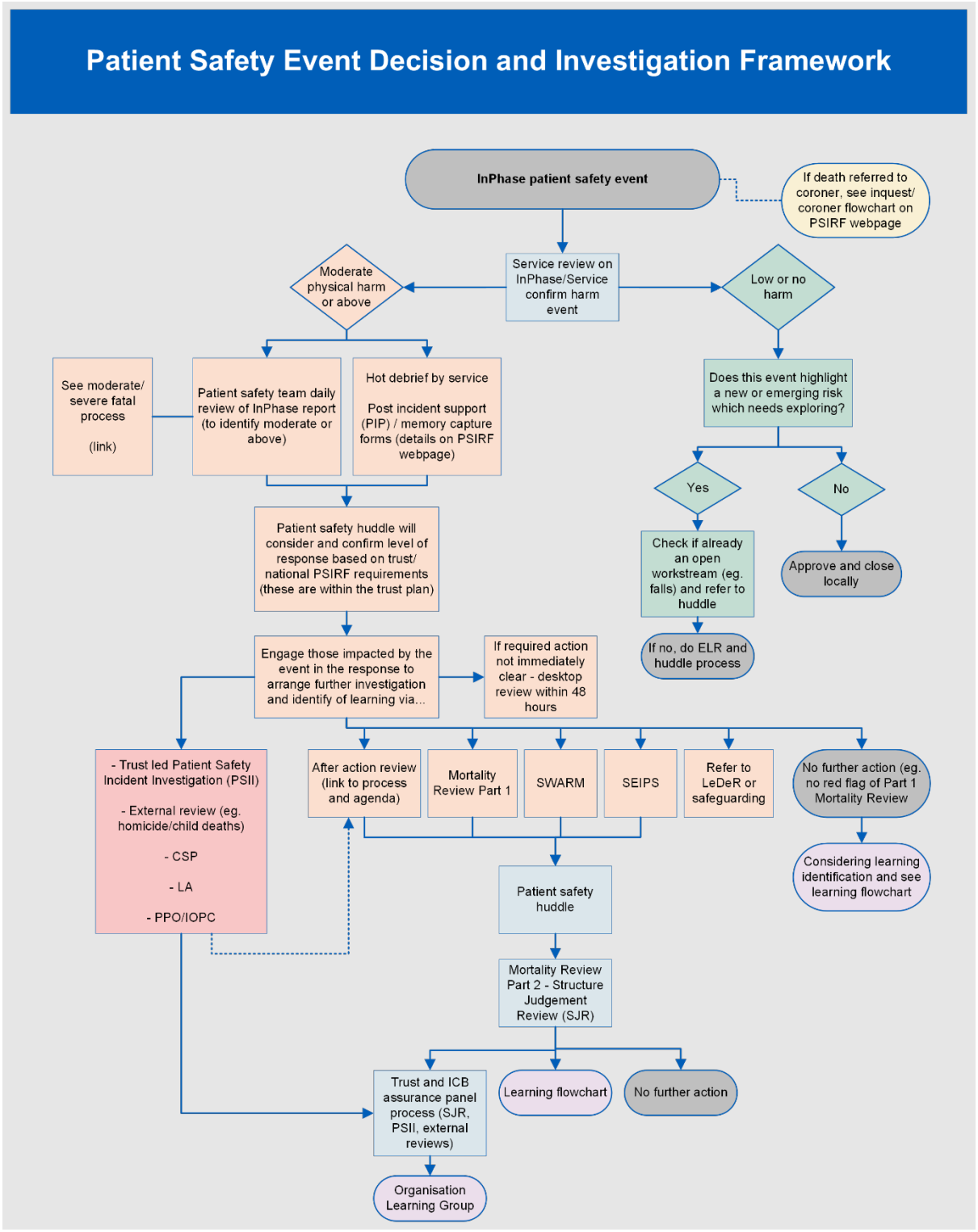
Based on the work of Professor James Reason and the National Patient Safety Agency's Incident Decision Tree

Supported by:

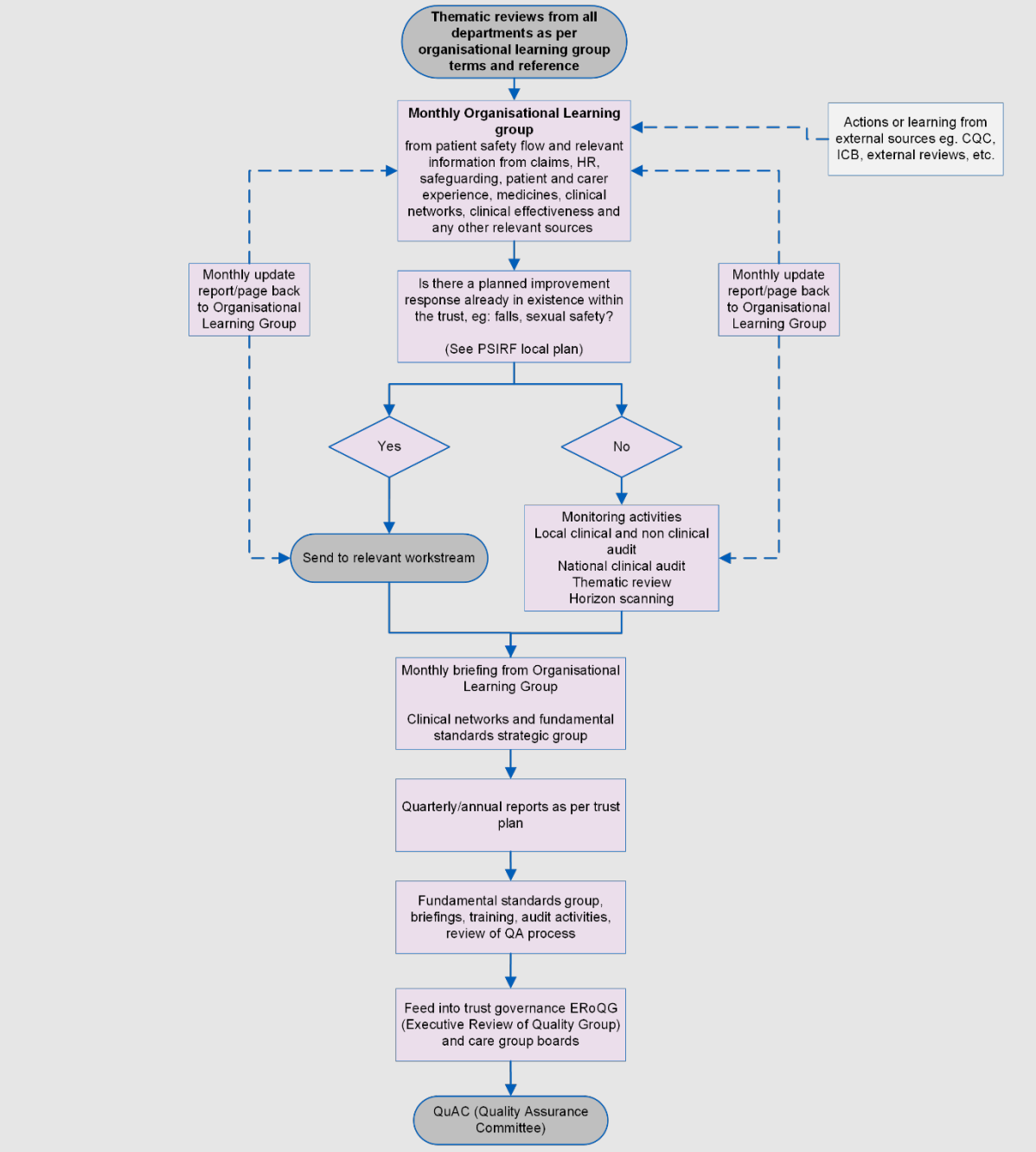
Academy of Medical Royal Colleges · avma · BMA · Care Quality Commission · General Medical Council · National Guardian · NMC Nursing & Midwifery Council · Royal College of Nursing · Royal Pharmaceutical Society · UNISON Health Care · unite

NHS England and NHS Improvement

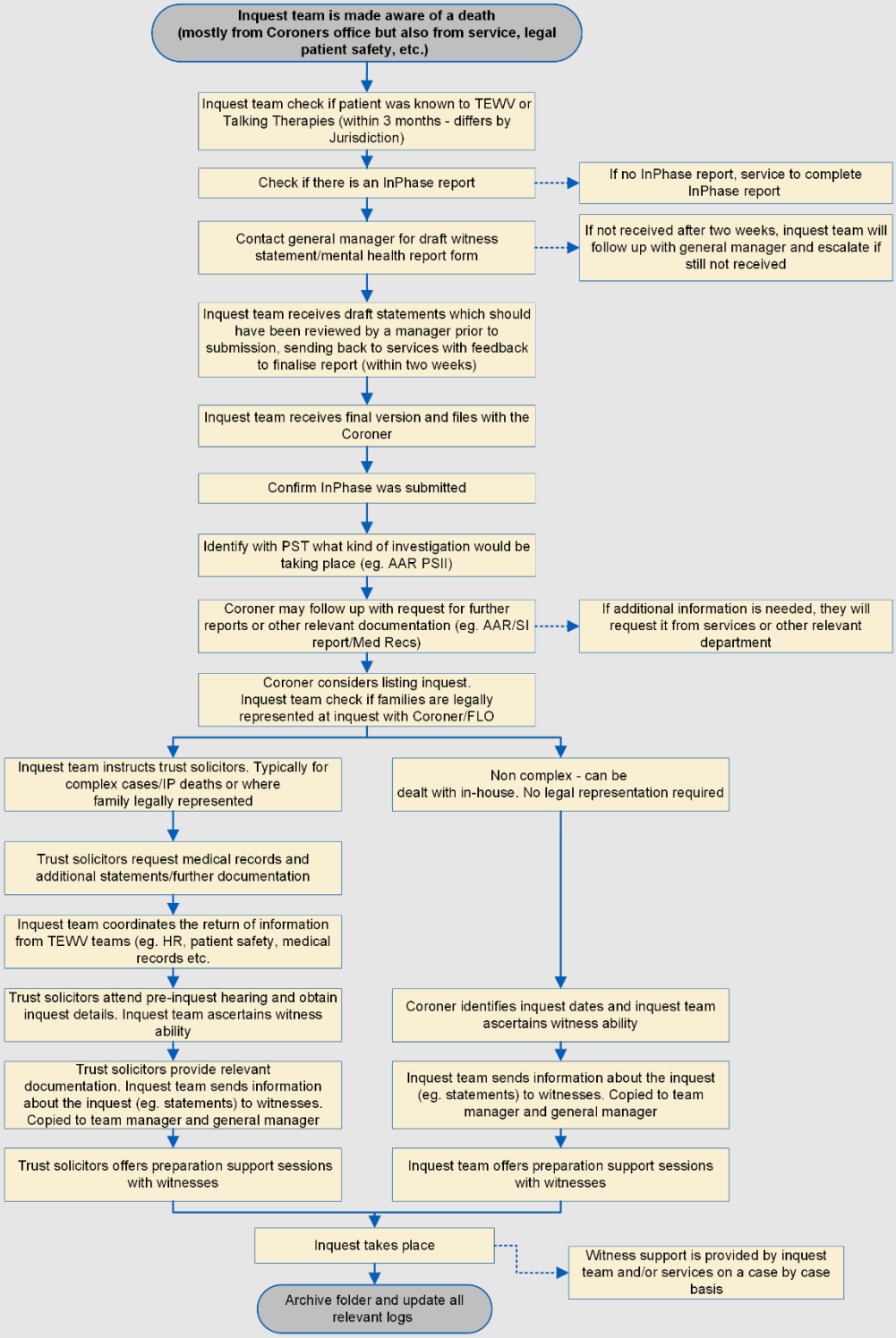
Appendix 4 Patient Safety Incident Response Flowcharts



Patient Safety Event Learning Process



Inquest Team Coroners Process



Appendix 5 – PSIRF Tools

The Patient Safety Incident Response Framework (PSIRF) promotes a range of system-based approaches for learning from patient safety incidents.

National tools have been developed that incorporate the well-established SEIPS framework (Systems Engineering Initiative for Patient Safety). Organisations are encouraged to use the national system-based learning response tools and guides, or other system-based equivalents, to explore the contributory factors to a patient safety incident or cluster of incidents, and to inform improvement.
NHS England » Patient safety learning response toolkit

Key tools include the following:

- Patient safety incident investigation report template
- Learning Response Review and improvement tool
- System Engineering initiative for Patient Safety (SEIPS)
- Terms of Reference Investigation template
- After Action Review
- After Action Review Learning handbook
- MDT Review
- Swarm Huddle
- PSII

The Trust has its own version of the AAR template which is incorporated into the Trust incident reporting system.

Appendix 6 - Extract from TEWV PSIRF plan

Please see over page.

Patient Safety Incident Response Plan – National Focus

Patient safety incident	Type of Investigation										Who By					Improvement work/ Existing workstreams
See Glossary for terms	**PSII**	**ELR /AAR**	**External**	**SJR**	**LeDeR**	**Refer to safeguarding**	**Organisation**	**PPO/IOPC**	**CSP**	**LA**	**Patient Safety team**	**Service**	**NHSE Commission MH homicide review**	**Safeguarding**	**DHR Panel**	
Deaths of patients detained under the MHA (1983) or where the MCA (2005) applies	✓	✓	✓								✓		✓			ELR/AAR – MDT involvement in services – policy and process group have already started this at an event on ELR/AAR reviewed by policy and process group – development work to continue. Policy and process group meet every month – chaired by Associate Director of Patient Safety
Suicide, self-harm, or assault resulting in the death or long-term severe injury of a person in state care or detained under the MHA	✓	✓									✓	✓				As above

Patient Safety Incident Response Plan – National Focus

Patient safety incident	Type of Investigation										Who By					Improvement work/ Existing workstreams
See Glossary for terms	**PSII**	**ELR /AAR**	**External**	**SJR**	**LeDeR**	**Refer to safeguarding**	**Organisation**	**PPO/IOPC**	**CSP**	**LA**	**Patient Safety team**	**Service**	**NHSE Commission MH homicide review**	**Safeguarding**	**DHR Panel**	
Deaths of Persons with mental illness whose care required case record review as per the Royal College of Psychiatrists' mortality review guidance which have been determined to be more likely than not due to problems in care	✓			✓							✓	✓				
Incidents meeting the Never Incidents Criteria 2018 (or its replacement)	✓	✓									✓					Environmental risk group

Patient Safety Incident Response Plan – National Focus																
Patient safety incident	**Type of Investigation**										**Who By**					**Improvement work/ Existing workstreams**
See Glossary for terms	**PSII**	**ELR /AAR**	**External**	**SJR**	**LeDeR**	**Refer to safeguarding**	**Organisation**	**PPO/IOPC**	**CSP**	**LA**	**Patient Safety team**	**Service**	**NHSE Commission MH homicide review**	**Safeguarding**	**DHR Panel**	
Mental health-related homicide	✓		✓										✓	✓		New process now in place. Homicide reviews are commissioned externally and feed into Organisational Learning Group
Child Deaths	✓										✓					
Deaths of persons with learning disabilities					✓											Mortality review process now part of PSIRF process.

Patient Safety Incident Response Plan – National Focus

Patient safety incident	Type of Investigation										Who By					Improvement work/ Existing workstreams
See Glossary for terms	PSII	ELR /AAR	External	SJR	LeDeR	Refer to safeguarding	Organisation	PPO/IOPC	CSP	LA	Patient Safety team	Service	NHSE Commission MH homicide review	Safeguarding	DHR Panel	
Safeguarding incidents in which: • babies, children, or young people are on a child protection plan; looked after plan or a victim of wilful neglect or domestic abuse/violence. • adults (over 18 years old) are in receipt of care and support needs from their local authority. the incident relates to FGM, Prevent, modern slavery and		✓								✓				✓		Safeguarding team and meetings internally and external SAB boards.

Patient Safety Incident Response Plan – National Focus

Patient safety incident	Type of Investigation										Who By					Improvement work/ Existing workstreams
See Glossary for terms	**PSII**	**ELR /AAR**	**External**	**SJR**	**LeDeR**	**Refer to safeguarding**	**Organisation**	**PPO/IOPC**	**CSP**	**LA**	**Patient Safety team**	**Service**	**NHSE Commission MH homicide review**	**Safeguarding**	**DHR Panel**	
human trafficking or domestic abuse/violence																
Incidents in NHS screening programmes							✓									These are incident specific

Patient Safety Incident Response Plan – National Focus

Patient safety incident	Type of Investigation										Who By					Improvement work/ Existing workstreams
See Glossary for terms	PSII	ELR /AAR	External	SJR	LeDeR	Refer to safeguarding	Organisation	PPO/IOPC	CSP	LA	Patient Safety team	Service	NHSE Commission MH homicide review	Safeguarding	DHR Panel	
Deaths in custody (e.g., police custody, in prison, etc) where health provision is delivered by the NHS	✓							✓								Prison specific reviews (PSII's) as well as external clinical reviews and PPO
Domestic homicide									✓							External homicide reviews.

Our patient safety incident response plan: local focus

Patient safety Priority	Type of Investigation									Who by							Improvement work required OR within existing work-steams
	PSII	Locally led PSIII	ELR	External Review	SJR	LeDeR	Refer to safeguarding	Organisational	PPO/IOPC	CSP	LA	Patient Safety team	Service	NHSE Commission MH homicide review	Safeguarding	DHR Panel	
Sexual Safety			✓										✓				Sexual safety meetings that feed into Executive Review of Quality Group i.e., number of incidents – emerging themes
Reducing incidents of Suicide and Self-harm			✓										✓				Preventing suicide and self-harm group chaired by medical Director and suicide prevention leads. This will also feed into wider ICB suicide prevention networks. .
Safeguarding including PAMIC and think family.			✓										✓				Reports to Exec review of quality and Quac..
Physical Health			✓										✓				Physical health meeting and sub groups – reports to Exec review of quality
Reducing Restrictive Interventions			x										x				Positive and Safe Group – reports to Exec review of quality and Quac.
Dual Diagnosis			x								x						Public health – working group and Physical health group
Safe transfers			x														Inpatient review group
Medication Management													x				Drugs and therapeutic's meetings

Our patient safety incident response plan: local focus

Patient safety Priority	Type of Investigation									Who by							Improvement work required OR within existing work-steams
	PSII	Locally led PSIII	ELR	External Review	SJR	LeDeR	Refer to safeguarding	Organisational	PPO/IOPC	CSP	LA	Patient Safety team	Service	NHSE Commission MH homicide review	Safeguarding	DHR Panel	
Falls			x										x				Falls group that works to the physical health group
Autism			x			x							x				SDM's and Organisational learning group.

Appendix 7 - Health and Safety (non-patient) Incident Decision and Investigation Framework

- Non-patient safety event.
- If RIDDOR also refer to RIDDOR Procedure.
- Service review on the Trust's incident reporting system.
- If Service identifies a level of risk and requires support from Health and Safety Team or the LSMS contact the team, 0191 333 6375, tewv.hss@nhs.net
- The Health and Safety Team or LSMS may require assistance from teams for some investigations. Where this is required a nominated lead(s) should be appointed as a contact for this.
- The Nominated lead(s) may be requested to:
    - View and archive CCTV.
    - Gather statements from individuals involved.
    - Provide details of staff training and competence.
    - Provide photographs (where applicable).
    - Provide relevant clinical information in respect of incidents involving patients (e.g., incidents of violence and aggression).
    - Act as the facilitator for investigation meetings.
    - Provide any relevant outside agency reference numbers/information (e.g., Police).
- The Health and Safety Team or LSMS will:
    - Collate the data.
    - Provide, advice, support, and guidance.
    - Identify any required recommendations.
    - Chair / minute any meetings where appropriate.
    - Author a report, content to be agreed by the Service.
    - Escalate findings where appropriate.