Cheshire and Wirral Partnership
NHS Foundation Trust

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Incident reporting & management policy

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Type of document	Policy
Target audience	All CWP staff
Document purpose	This policy covers the reporting and investigation processes for all clinical and non-clinical incidents including Serious Incidents requiring investigation, near misses and hazards and applies to incidents involving people who access our services, visitors or carers, the public, employees or business of the Trust.

Approving meeting	Quality Committee	Date 20-Apr-20
Implementation date	20-Apr-20	

CWP documents to be read in conjunction with	
HR6	Essentials mandatory training policy
FR1	Integrated governance strategy
CP78	Treatment and management of pressure ulcers
CP6	The management of challenging behaviour, violence and aggression
CP3	Health records policy
GR3	Risk management policy
CP25	Therapeutic observation policy for inpatients
CP10	Safeguarding adults policy
CP40	Safeguarding children policy
CP49	Admission of children and young people to AMH wards
CP17	Guidelines following the unexpected death of a service user
CP14	Prevention and management of slips, trips and falls
GR47	Learning from deaths policy
GR19	Out of hours clinical management support
GR35	Safe vehicular transport of service users and others
MH8	Missing persons policy and procedures including AWOL
GR12	Media Relations policy
HR3.8	How to raise and escalate concerns in work incorporating the whistleblowing policy

Document change history	
What is different?	Updated to reflect new job titles and terminology within the organisation. Section relating to Pressure ulcers removed in line with NHS Improvment guidelines. Updated to include the new Quality Assurance checklist
Appendices / electronic forms	Appendix 4 has been updated due to the change in terms of reference for the Immediate Safety Assurance Forum (ISAF). Updated Appendix 5 with the new Quality Assurance checklist. Notification of Deaths Regulation 2019 referenced within the policy
What is the impact of change?	Changes to terminology.

Training requirements	No - Training requirements for this policy are in accordance with the CWP Training Needs Analysis (TNA) with Education CWP.

GR3Document consultation	
Clinical Services	Who within this service have you spoken to
Corporate services	Who within this service have you spoken to
External agencies	Who within this service have you spoken to

Financial resource implications	None

External references

1. Specific Condition 35 (Standard NHS Contract, 2013/14)
2. 'Being Open' (National Service user Safety Agency, 2009)
3. Serious Incidents Framework 2013/14 (NHS Commissioning Board
4. Never Events (Department of Health; National Service user Safety Agency, 2010)
5. NHS England Serious Incident Framework March 2015
6. Berwick Report 2013 A promise to learn – a Commitment to act
7. Francis, R. (2013) Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry. London: The Stationery office
8. Implementing the pressure ulcer framework in local reporting systems and reporting to NRLS (NHS Improvement, March 2019)
9. Notification of Deaths Regulations 2019

Equality Impact Assessment (EIA) – Initial assessment	**Yes/No**	**Comments**
Does this document affect one group less or more favourably than another on the basis of:		
- Race	No	
- Ethnic origins (including gypsies and travellers)	No	
- Nationality	No	
- Gender	No	
- Culture	No	
- Religion or belief	No	
- Sexual orientation including lesbian, gay and bisexual people	No	
- Age	No	
- Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
Is there any evidence that some groups are affected differently?	No	
If you have identified potential discrimination, are there any exceptions valid, legal and/or justifiable?		
Select		
Is the impact of the document likely to be negative? - If so can the impact be avoided? - What alternatives are there to achieving the document without the impact? - Can we reduce the impact by taking different action?	No N/A N/A N/A	
Where an adverse or negative impact on equality group(s) has been identified during the initial screening process a full EIA assessment should be conducted. If you have identified a potential discriminatory impact of this procedural document, please refer it to the human resource department together with any suggestions as to the action required to avoid / reduce this impact. For advice in respect of answering the above questions, please contact the human resource department.		
Was a full impact assessment required?	No	
What is the level of impact?	Low	

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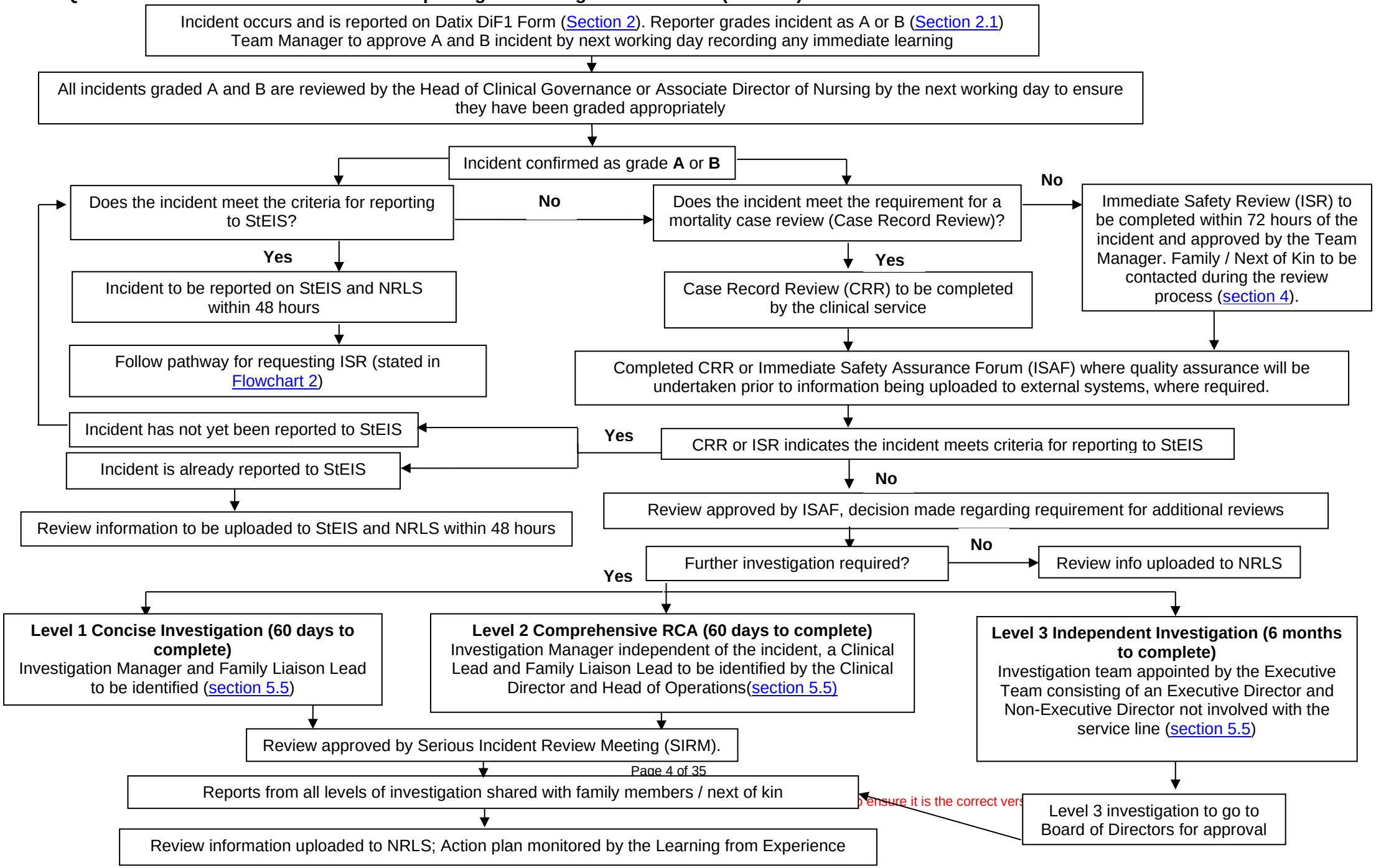
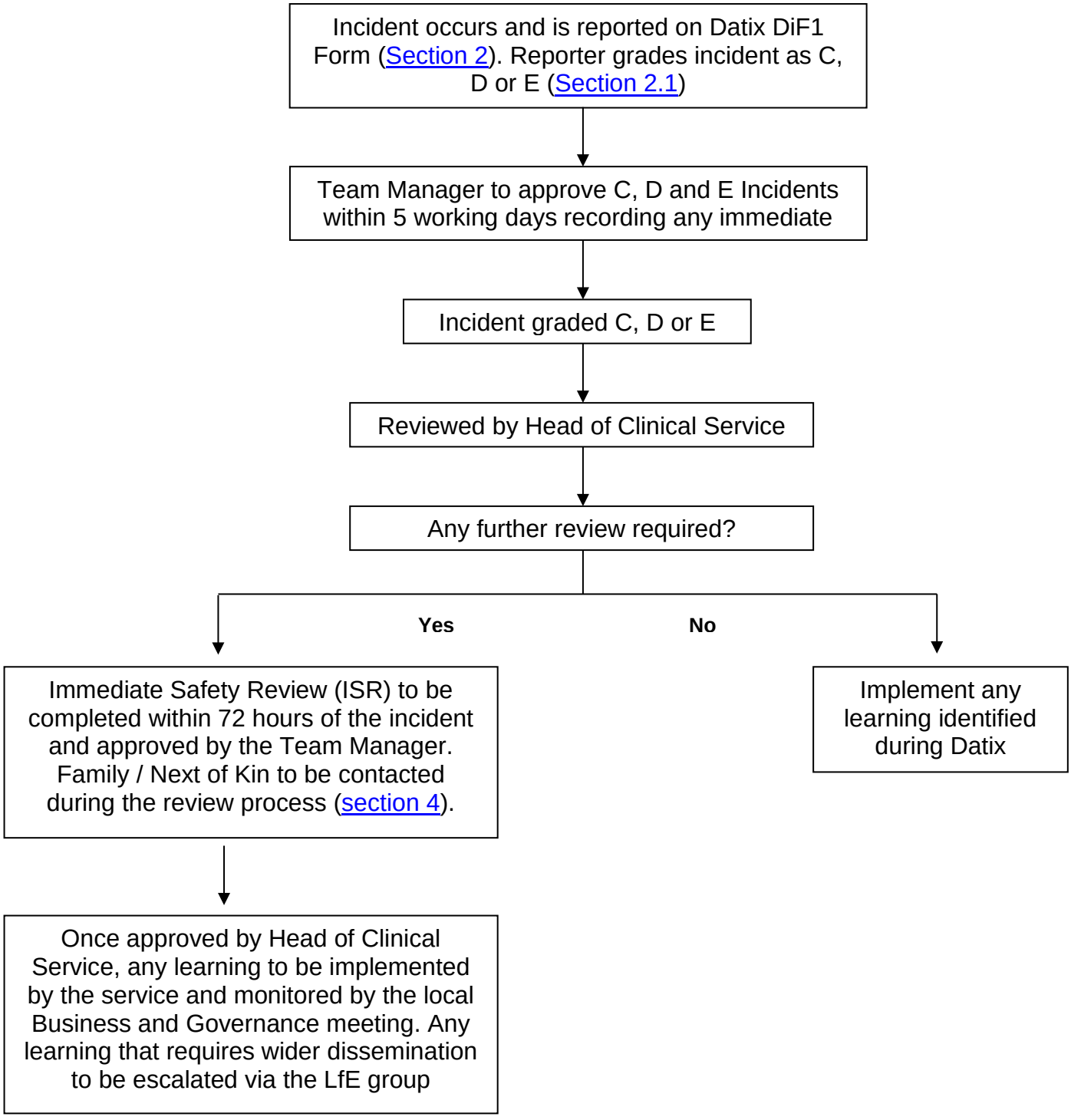
Quick reference flowchart 1 – Incident Reporting and Management Process (A and B)



Quick reference flowchart 2 – Incident Reporting and Management Process (C, D and E)



1. Introduction

This policy covers the reporting and investigation processes for all clinical and non-clinical incidents including Serious Incidents requiring investigation, near misses and hazards and applies to incidents involving people who access our services, visitors or carers, the public, employees or business of the Trust.

The reporting and management of incidents is a critical tool in assisting the organisation to effectively manage risk. The reporting of incidents and near misses provides valuable information which can help improve safety, prevent the recurrence of incidents and facilitate lessons learnt across the organisation. The goal is to promote the prevention of loss or harm through the development of safer working practices that will benefit staff, people who access our services, and the general public, and improve the trust's services.

This policy is for all staff includes the principles of "Being Open" and embraces the "Duty of Candour". Where incidents occur we need to evidence openness, honesty and transparency so that early warning systems can work. Expectations of the Duty of Candour include ensuring that any patient/service user harmed by the provision of a healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it. The Duty of Candour became a contractual obligation in April 2013 and a CQC registration requirement in October 2014.

The Trust recognises that incidents may occur because of problems with systems, processes, designs or by individuals and factors relating to human behaviour. It is the policy of the Trust to promote a positive approach to incident reporting throughout the organisation. Cheshire and Wirral Partnership NHS Foundation Trust (CWP) aims to foster a culture where all incidents and near misses are reported and appropriately reviewed. Staff are encouraged and will be supported to be open and honest about events and issues that have or could cause damage to people, property or the organisation.

This policy reflects the revised Serious Incident Framework published by NHS England (March 2015) aligned with the policies for the Clinical Commissioning Groups which CWP work with.

The NHS England national frameworks can be found at the following links:

- NHS England Serious Incident Framework: Supporting Learning to prevent recurrence
- NHS England Serious Incident Framework 2015/2016 – Frequently asked questions

2. How to report incidents and near misses involving staff, people who access our services and others

All incidents, including SUIs and near misses, must be reported as soon as possible after becoming aware of the incident, not least as best practice but to also ensure that the trust complies with its regulatory and contractual obligations.

All incidents must be reported using the trust's electronic incident reporting form on DATIX, called a DIF1 form (or paper copy if not available - as part of business continuity for example).

This can be accessed through the CWP intranet and at the following address: http://datix.cwp.nhs.uk/datix/datixlive/

For staff using the portal this can be accessed through http://apps.cwp.nhs.uk
The quick reference flowchart1 and 2 outline the incident reporting process / procedure.

2.1. Incident grading

Below is the current grading of Incidents that are graded as category A – E. The following matrix provides guidance on categorisation based on the type of incident.

Category	General definition	Level of harm / outcome	Examples of types of incident
A	Incidents that result in death or cause such serious harm that they place a service user or staff member's life in jeopardy.	Death / catastrophic	(See section 5.3/Appendix 1a - for serious incident guidance) – Alleged homicide – Unexpected death – International / national adverse publicity – Under 16 admission to an adult ward – Significant safeguarding referral (Appendix 1b)
B	Incidents that are not life threatening, but which acutely jeopardise the wellbeing of a service user or member of staff.	Severe / major	– Serious self-harm or unexplained serious injuries which require transfer to an acute setting when under CWP care services – Fall resulting in a serious injury which requires transfer to an acute setting for an intervention, e.g. fractured neck of femur or head injury – Aggravated assaults – Non adherence to Mental Health Act – Serious breach of information governance reported to the Information Commissioner's Office. – Admission of 16 – 17 year old to adult wards – Absence without leave for service users who present a significant risk to themselves or the public (Appendix 1d)
C	Incidents which moderately affect, or have the potential to affect, the health or the psychological wellbeing of the individual involved.	Moderate	– Deliberate self-harm resulting in moderate injury when under CWP care services – Fall resulting in a moderate injury, e.g. deep cut which may require stitches, marked bruising etc. – Accidental injuries which result in moderate harm – Missing people who access our services – Assaults resulting in moderate harm – Mixed Sex Accommodation breaches

D	Incidents which result in minor injury.	Low / minor	– Deliberate self-harm resulting in minor injury when under CWP care services – Fall resulting in a minor injury – Accidental injuries – Assaults resulting in minor harm – Missing people who access our services
E	Incidents which result in no injury and are classed as a near miss.	No harm	– Fall resulting in no injury – Medication incidents that are picked up prior to potentially causing harm

3. How incidents are reported to external agencies

Some incidents require reporting to external agencies. The types of incidents that require reporting and the designations of the individuals who are responsible for reporting these incidents are outlined below.

Incident type As defined by the relevant agency	**External agency**	**Duties and responsibilities**
Service user safety incident	National Reporting and Learning System (NRLS)	Incidents assistant
RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrence Regulations)	Health and Safety Executive	Health & Safety Advisor
Relevant physical assault against staff	Counter Fraud and Security Management Service	Local Security Management Specialist
Fire	DH Estates and Facilities Management	Fire Safety Officer
Medical devices / equipment incidents	MHRA	Line manager/ Health and safety advisor
Adverse drug reaction (serious or related to new drug)	Committee for Safety of Medicines	Any health professional
Sudden and unexpected death (in patient) Detained service user	Police, HM Coroner Care Quality Commission	Head of Clinical Service Mental Health Act Law Manager
Serious incidents – Appendix 1 Incidents that meet criteria for STEIS	Clinical Commissioning Groups or other commissioners e.g. North West specialist/ secure commissioners NHS England via STEIS NRLS	Incidents assistant
Safeguarding incident	Referred to local authority (as appropriate as per safeguarding reporting thresholds)	Trust safeguarding lead

Relevant infection prevention and control incident	Health Protection Agency / NHS England / Clinical Commissioning Groups or other commissioners	Director of Infection, Prevention and Control (DIPC)
Incidents likely to result in litigation	NHS Litigation Authority	Incidents manager
Estates/ environment issue	DH Estates and Facilities	Associate director of operations – Estates and facilities
Significant disruption to service continuity / major incident	Public Health England / NHS England / Clinical Commissioning Groups or other commissioners (as appropriate)	Emergency planning coordinator and Head of Operations

4. Being Open, Apologising and Duty of Candour

All staff are encouraged to report service user safety incidents. Dependent upon the severity of the incident it may be necessary to inform a senior manager who can then ensure that the appropriate level of support is offered to the staff member(s) involved.
Where an incident occurs, staff must inform the service user, their family and/ or carers that an incident has occurred, explain if something had gone wrong and apologise, if appropriate, and explain what was learnt to reduce the likelihood of this happening again in line with 'duty of candour' requirements under the standard NHS contract (Appendix 2). This must take place within **10 days** of the incident occurring. The follow up actions and support for the family / carer must be recorded within the clinical notes on the service user record and within the Datix incident form.
The aftermath of an incident can have consequences on the health and welfare of those affected including the service user, carers, family members, other people who access our services and staff.

5. Different levels of investigation appropriate to the severity of the incident

5.1 Incidents initially reported as grade A or B severity

Incidents that are reported and graded as category A or B are reviewed by either Head of Clinical Governance and/or Associate Director of Nursing and Therapies within 48 working hours, to confirm the grade of incident. This is to ensure that incidents that meet the criteria for external reporting requirements are managed appropriately.

5.2 Incidents reported grade C, D and E severity

- Grade C, D and E incidents are managed and reviewed through locality/ service line arrangements;
- There must be consideration as to whether any lessons can be learned from the incident;
- Completion of the lessons learned section within the managers sign off (DIF2-electronic managers sign off form) form is a mandatory field where all lessons learned must be recorded;
- Lessons learned are also shared within the learning from experience meetings of the respective care group. Where learning is Trustwide to be shared within the Learning from

Experience report.

5.3 Serious Incidents confirmed as grade A and B severity

A serious incident is an event in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious Incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organization's ability to deliver ongoing healthcare.

The occurrence of a serious incident demonstrates weaknesses in a system or process that need to be addressed to prevent future incidents leading to avoidable death or serious harm to patients and/or staff, future incidents of abuse to patients or future significant reputational damage to the organisations involved. Serious Incidents therefore require reviews in order to identify the factors that contributed towards the incident occurring and the fundamental issues (or root causes) that underpinned these. Serious Incidents can be isolated, single events or multiple linked or unlinked events signaling systemic failures within a commissioning or health system. See Appendix 1 for how to assess whether an incident is a serious incident.

5.4 Immediate actions following a Serious Incident (Grade A and B severity)

When a serious incident is reported, the ward or team where the incident occurred should undertake immediate action to:

- Ensure that the incident details are reported clearly and factually;
- Determine whether further information is needed;
- Ensure that people accessing our services, staff and the public are safe and ensure this is captured on the incident DIF 2 form
- Where it is clear that an investigation is required for example an unexpected death the Head of Operations should nominate an investigation manager immediately.

Clinical Director and Head of Operations must oversee this process and agree it with the manager signing off the incident. This is required to happen within 48 working hours, to ensure that the safe services department is able to meet external reporting timeframes.
Following a death or serious incident, a family liaison lead needs to be identified (see Appendix 3) who will liaise with the people who access our services or relatives and/ or carers in order to:

- offer an explanation, apology, condolences and support and
- give them the opportunity to raise their concerns and views
- provide a copy of the Trust's Duty of Candour Leaflet (which can be obtained from the trust's website)
- Follow up the information shared in writing to the patient/ relatives or carers

5.4.1 Immediate Safety Review following a Serious Incident

The incident department will ask the Head of Operations/Head of Clinical Services, or their nominated person, to identify an appropriate senior clinician to complete the immediate safety review whenever the information received via Datix, suggests that the incident may meet the criteria for a serious incident review. The purpose of the immediate safety review is to prompt a review of the care that is

provided following a patient safety incident, in addition to remedial action taken immediately following the incident.
The Immediate Safety Review must:

- give assurance that the service is safe to continue to deliver care
- consider the safety of the environment and people (service users, staff, visitors)
- demonstrate that the current risk assessment and care plan met Trust policies
- identify any areas of immediate learning and actions for services to complete

The Immediate Safety Review will help determine whether a review is required.

5.5 Level of Investigation following a Serious Incident

The level of investigation following a serious incident varies on a case-by-case basis. This should be proportionate to the incident and provide the most opportunity for learning. This will be overseen by clinical staff within clinical governance team to ensure there is a consistent approach in the decision making. All reviews will be coordinated by locality governance/operational support teams and overseen by the trust's Clinical Governance Department. Refer to the quick reference guide for specific duties for the individuals / teams outlined above and the respective timeframes for these. Investigation templates are available in the management tool kit on the trusts web page.

- **Investigation not Required**

Serious incidents that are undeclared from the reporting system, on the basis of natural causes/ expected deaths and other circumstances, (e.g. discharged appropriately from trust services) an immediate safety review can constitute the review. In addition an action plan may also be required.

The immediate safety assurance forum will advise in these situations as part of their review of all reported incidents and will alert the appropriate commissioner. Learning is cascaded in the same way as learning from investigations. This is outlined in section 6. Clinical services may wish to undertake concise investigations on lower severity incidents to facilitate learning. In these cases this can be decided through local care group governance structures and any learning uploaded onto Datix.

- **Level 1: Concise investigations (60 days to complete)**

These are suited to less complex incidents which can be managed by individuals or a small group of individuals at a local level. An investigation manager must be allocated and a family liaison lead can be identified.

Level 1 and 2 investigation reports will be approved by the Clinical Director and Head of Operations within the care group. As part of this approval process, the Clinical Director and Head of Operations must be assured that the investigation has been conducted to a high standard, that all reasonable outcomes have been drawn from the analysis contained in the investigation, and that the recommendations of the investigation are robust enough to act as mitigations against potential recurrence of an incident of a similar nature occurring again in the future. These decision making processes should be indicated by completion of the quality assurance checklist Appendix 5. The clinical director and Head of Operations can sign off the report via electronic signature. Once the report is approved, it should forwarded to the incident team to include in the Serious Incident Review Panel meeting , who will Quality Assure the report prior to sending to the respective commissioners .

The Head of Operations will oversee the necessary amendments are made before finally approving the report.

- **Level 2: Comprehensive root cause analysis review (60 days to complete)**

These are suited to complex issues which should be managed by a multidisciplinary team involving subject experts. The investigating manager can be from the service line/ locality where the incident occurred, but they must be independent of the incident and not involved in the team where clinical care was being provided. An investigation manager will be appointed by the locality in discussion with the clinical director and Head of Operations to ensure that the needs of the service are taken into account. The investigating team will be determined on a case by case basis, one of which must be trained in RCA methodologies.

There is a minimum of two key roles:

- Investigating manager
- Clinical lead
- and where possible Family Liaison lead independent of the care being provided (Appendix 3)

It is preferable, however, to have at least one member on the investigation team who is independent of the service line where the incident occurred, although it is acknowledged that this is not always possible. It is also preferable for the investigation team to have members who have expertise in the area under review. If this is not possible, then it should be agreed at the outset who will be consulted by the investigating team to provide expert advice. There must be clinical leads appointed to support the investigation manager, one of which must be medical (the locality medical lead).
Level 2 investigation reports will be approved as outlined in Level 1.

- **Level 3: Independent investigations (6 months to complete)**

An independent review panel will be appointed by the executive team, usually including an executive director and non-executive director, will be formed. No members of the review team will be directly involved with service line /locality in which the incident occurred. The terms of reference need to be agreed by the panel and with the Director of Nursing, Therapies and Patient Partnership.

Level 3 investigation reports will be approved by the Board of Directors following the approval process outlined in Level 1.
Investigation documentation must **not** be filed in a service user's health records as they do not form part of the service user's health record (health records policy).

5.6 External Factors – Investigation extension required

If there are external factors, e.g. safeguarding investigations, police investigations, availability of witnesses, complex multi-agency involvement and joint investigations, the extent of service user / family concerns etc. that may impact on the trust's ability to complete the investigation within the contracted timeframes. In these incidences the investigating manager must flag this to the locality governance/operational support team within 30 working days of commencing the investigation, who will then liaise with the relevant commissioner to request an extension to the timeframe.

- **NHS England Homicide - Independent reviews**

NHS England is responsible for commissioning independent investigations of homicides, where appropriate. This includes determining when an independent investigation is necessary, appointing an independent investigation team, agreeing terms of reference, publishing and distributing the resultant report and ensuring a process for subsequent action to address the issues raised. The trust and its employees are responsible for co-operating with an independent review.

The trust will co-operate and work within memoranda of understanding which have been agreed by the NHS and other national bodies including the (former) National Service user Safety Agency (NPSA), the Health and Safety Executive, the Counter Fraud and Security Management Service, the Police and the Crown Prosecution Service.

- **Joint Investigations**

If there is a serious incident involving a number of different trusts/ organisations, there may be a joint/ multi-agency investigation conducted. This will normally be led by the primary agency/ organisation involved in the person's care or the organisation in which the serious incident occurred. In these incidences, the incident team will report the incident to STEIS if there are care or service delivery issues suspected/ identified for which the trust is responsible. For investigations which are multi-agency, the final report and lessons learned will be shared with all the organisations involved.

- **Incident investigations and the complaints process**

When the trust is completing a serious incident investigation at the same time as a complaint investigation, the incident and complaint investigations can be concurrent and the investigating manager can investigate both at the same time. The staff/ service user/ family must be informed that a serious incident investigation is also being undertaken and have the investigation processes explained to them, so that the staff/ service user/ family are clear with the timeframes involved and understand the investigation processes and feedback mechanisms.

- **Referral to disciplinary process**

The reporting of an actual or apparent adverse event by any members of staff acting in good faith will not lead to disciplinary action against the person reporting the incident. Where an employee makes a self-report of an adverse event which relates to their own misconduct, the incident may be subject to a HR investigation but self-reporting will be considered in mitigation. Malicious, negligent, false-reporting or other abuse of the incident reporting system will be considered as a disciplinary matter in accordance with the trust's disciplinary policy and procedure.

Any statement taken during the review may be required as part of the disciplinary process. It is important to note that staff may be supported by their union appointed representative throughout the incident investigation process should they wish.

Managers should consider throughout the review of an incident whether or not there is a disciplinary case to answer. The incident decision tree, which should be used throughout the review of an incident, should be referred to Appendix 6. This is a framework to decide the cause of serious incidents, identifying contributory systems issues to individual actions and culpability.

The disciplinary investigation and report will be a separate process and conducted independently of the incident investigation, but can be conducted at the same time. Both the incident investigation and the disciplinary investigation must be presented to the Director of Nursing, Therapies and Patient Partnership except where medical personnel are involved where this is presented to the Medical Director

- **HM Coroners' enquiries and inquests**

An unexpected death where natural causes are not suspected should be reported to the coroner in certain circumstances (see Appendix 7 for further guidance). Doctors should seek advice from Consultants/ Medical director if they are not sure. All doctors need to be aware of the new Notification of Death regulations that came in force in 2019.

Staff may be asked to provide written statements for the coroner. These will be requested at the commencement of an RCA, and will be used to inform the RCA investigation report and also be held on file until the inquest is listed.

6. Learning from Incidents

6.1 Actions following Serious Incident Investigation

When an investigation report has been completed (level 1, 2 or 3) and approved, the actions from the action plan will be logged onto the trust's incident reporting and management system, Datix, by the locality governance/operational support team. Actions are then themed and analysed by Locality Surveillance Support Managers to identify key lines of learning required.

The Clinical Director and Head of Operations of each care group are responsible for ensuring that governance processes are in place to implement and monitor actions for all recommendations, and also have accountability for ensuring changes in practice in order to embed learning and mitigate the potential for recurrence of similar incidents. Locality/care group governance/operational support teams are responsible for updating Datix to report progress against actions on receipt of evidence.

6.2 How incident reporting is analysed

The complaints and incidents team contribute to the learning from experience report, which is written 3 times a year. It aggregates information on incidents, claims, complaints, compliments, PALS and inquests. It includes information on the following as a minimum content, which includes quantitative and qualitative analysis:

- Numbers, types and severity of incidents reported per care group and location;
- Reports to external agencies;
- Number and themes of complaints (both formal and informal concerns) per care group and location;
- Number and themes of concerns raised by staff;
- Numbers of compliments;
- Aggregated analysis and lessons learned from incidents, complaints, claims, PALS and inquests;
- Recommendations to the board and to service lines

Locality Quality Surveillance Support Managers produce bi-monthly locality data packs for each team/ward. This includes a breakdown of incident and complaints activity and learning themes triangulated with other team/ward factors such as staffing levels, mandatory training.

Progress against the status of actions, and the recurrence of themes, is reported to Compliance, Assurance and Learning, who will take a decision regarding escalation of concerns with the follow up and implementation of actions, via implementation of performance improvement measures, for example performance reviews. This process will be in line with the integrated governance strategy.

6.3 How incident information can determine the risk profile

It should be noted that any potential risk identified from an incident, complaint or claim investigation will be included on the appropriate service line and locality and/ or strategic risk register, with outlined risk reduction measures at any time following such an occurrence. Any high level risks identified, i.e. risks scoring 15 or above are considered for inclusion on the strategic risk register. For further information see GR3 Risk Management Policy.

6.4 How safety lessons are shared

The trust shares safety lessons internally via the following:

- Lessons learned outlined within the learning from experience report and the share learning bulletin which is cascaded to management and clinical services;
- Safety bulletins circulated to staff, when an urgent safety lesson needs to be cascaded.

The trust shares safety lessons externally via the following:

- Liaising with staff from outside the organisation of incidents involving other trusts/ organisations;
- Reporting incidents externally via the National Reporting and Learning System (NRLS) which allows other trusts to learn lessons from safety alerts published through the Central Alerting System (CAS);
- By proactively sharing learning outcomes for the health economy, via the Learning from Experience Report with the Commissioners.
- Reporting the learning from experience report to commissioners.

The learning from experience report is submitted and approved by Quality committee prior to going to the board of directors. The report is cascaded to all staff.

Appendix 1 – Serious Incident Assessment

1a. Serious Incidents

Assessing whether an incident is a serious incident

In many cases it will be immediately clear that a serious incident has occurred and further investigation will be required to discover what exactly went wrong, how it went wrong (from a human factors and systems-based approach) and what may be done to address the issues to prevent the incident happening again.

Whilst a serious outcome (such as a death of a patient who was not expected to die or where someone requires on going/long term treatment due to unforeseen and unexpected consequences of health intervention) can provide a trigger for identifying serious incidents, outcome alone is not always enough to delineate what counts as a serious incident.

Where it is not clear whether or not an incident fulfils the definition of a serious incident providers and commissioners must engage in open and honest discussions to agree the appropriate and proportionate response. It may be unclear initially whether any issues in a system or process (including acts or omissions in care) caused or contributed towards a serious outcome, but the simplest and most defensible position is to discuss openly, to investigate proportionately and to let the investigations decide.

If a serious incident is declared but further investigation reveals that the definition of a serious incident is not fulfilled – for example there were no acts or omissions on care which caused or contributed towards the outcome the incident can be downgraded. This can be agreed at any stage of the investigation and the purpose of any downgrading is to ensure efforts are focused on the incidents where problems are identified and learning and action are required.

Serious incidents identified (or alleged) through the complaints route, or any other mechanism, must be treated in line with the principles in this Policy to ensure that it is investigated and responded to appropriately. If the investigation reveals that there were no weaknesses/problems within the care provided which either caused or contributed to the incident in question, the incident can be downgraded.

Serious Incidents in the NHS include:

Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:

- Unexpected or avoidable death of one or more people;
  - suicide/self-inflicted death; and homicide by a person in receipt of mental health care within the recent past each case should be considered individually
- Unexpected or avoidable injury to one or more people that has resulted in serious harm;
- Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent the death of the service user; or serious harm;
- Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where:
  - Healthcare did not take appropriate action/intervention to safeguard against such abuse occurring or where abuse occurred during the provision of NHS-funded care. This includes

abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), or other externally-led investigation, where delivery of NHS funded care caused/contributed towards the incident

- **A Never Event**- defined as serious incidents although not all result in serious harm or death. See Never Events Policy and Framework for the national definition and further information.
  - NHS England Revised Never Events Policy and Framework
- An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:
- Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues;
  - Property damage;
  - Security breach/concern
  - Incidents in population-wide healthcare activities like screening and immunisation programmes where the potential for harm may extend to a large population;
  - Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS);
  - Systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/ unit closure or suspension of services); or
  - Activation of Major Incident Plan (by provider, commissioner or relevant agency)
  - Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation.

Serious Incident Categories agreed with the CCGs

Categories for reporting on to STEIS (Adapted from: National Patient Safety Agency (NPSA) Reporting Criteria and Thresholds for Serious Incidents). This list is not exhaustive and will be reviewed annually

Incident Type	Threshold
Abscond	Escape from within the secure perimeter of medium or high security mental health services by patients who are transferred prisoners Secure Unit Patient who is a transferred prisoner escaping from medium or high secure mental health services where they have been placed for treatment subject to Ministry of Justice restrictions. ***(NE: Escape of a transferred Prisoner)*** Patients detained under the Mental Health Act, and current risk assessment confirms current risk of: • violence/risk to others • self-harm • neglect • exploitation (vulnerable adult) Informal patient and current risk assessment confirms current risk of: • violence/risk to others • self-harm • neglect • exploitation (vulnerable adult)
Accident Whilst in Hospital	Accident on NHS premises or whilst receiving NHS funded care which results in: • permanent harm to one or more patients where the outcome requires life-saving intervention or major surgical/medical intervention or will shorten life expectancy This includes entrapment of an adult in bedrails (NE: Entrapment in bedrails) Patient scalded by water during bathing (NE: Severe scalding of patients)
Admission of under 18s to adult mental health ward	Include all admissions of an under 18 yr. old to an adult MH inpatient unit. Include the actual age of service user and the reason for admission describing if the admission was required because of clinical need or lack of a bed in an age appropriate setting or staffing levels.
Adverse media coverage or public concern about the organisation or the wider NHS	Incidents where there may not be permanent harm or death but result in a repeated pattern of negative media attention for the organisation for example: • An incident is reported in more than one local paper and television or national media and the organisation is being criticised for the quality and safety of patient care. This does not include workforce, financial issues for example where the impact is on an employed individual and does not affect patient care
Allegation against HC non-Professional	Where a member of staff shows gross disrespect for the dignity of a patient/deceased patient. Serious:

	• verbal and/or physical aggression • criminal acts involving patients or staff • complaints about a member of staff or primary care contractor or any incident relating to a staff member where significant adverse media interest could occur • breach of confidentiality • fraud Where there are any allegations of abuse against adults who work with children, the incident should also be reported to the Local Authority Designated Officer (as per ****** Children's Board) who has a responsibility to be involved in the management and oversight of individual cases and will also provide advice and guidance to employers and voluntary agencies
Allegation Against HC Professional	Where a member of staff shows gross disrespect for the dignity of a patient/deceased patient. Serious: • verbal and/or physical aggression • criminal acts involving patients or staff • complaints about a member of staff or primary care contractor or any incident relating to a staff member where significant adverse media interest could occur • breach of confidentiality • fraud
Ambulance Accident - Road Traffic Collision	Where: • patients/staff or the public have been harmed and ambulance personnel had contributed to the RTA • there had been a significant impact on business continuity in terms of delays to the assessment and transfer of patients
Ambulance Delay	Where: • there had been a significant impact on the assessment and treatment of patients with the potential for permanent harm and ambulance services had contributed to the delay • there had been a significant impact on business continuity in terms of delays to the assessment and transfer of other patients and other organisations had contributed to the delay
Ambulance (general)	Permanent harm to one or more patients or staff Local media – long term – moderate effect – impact on public perception of Trust and staff morale National media >3 days – public confidence in organization.
Assault (unknown assailant)	Physical harm to one or more patients or staff Local media causing long term or moderate effect regarding impact on public perception of Trust and staff morale. National media >3 days affecting public confidence in organisation

Attempted Homicide by Inpatient (in receipt of mental health services)	Inpatient in receipt of mental health services who tries to kill another person
Attempted Homicide by Inpatient (not in receipt of mental health services)	Inpatient who is not in receipt of mental health services who tries to kill another person, e.g. a patient being cared for in acute or primary care
Attempted Homicide by Outpatient (in receipt of mental health services)	Outpatient in receipt of mental health services who tries to kill another person
Attempted Homicide by Outpatient (not in receipt of mental health services)	Outpatient who is not in receipt of mental health services who tries to kill another person, e.g. a patient being cared for in acute or primary care
Attempted Suicide by Inpatient (in receipt of mental health services)	An inpatient in receipt of mental health services who tries to kill themselves
Attempted Suicide by Inpatient (not in receipt of mental health services)	An inpatient who is not in receipt of mental health services who tries to kill themselves, e.g. a patient being cared for in acute or primary care
Attempted Suicide by Outpatient (in receipt of mental health services)	An outpatient in receipt of mental health services who tries to kill themselves
Attempted Suicide by Outpatient (not in receipt of mental health services)	An outpatient who is not in receipt of mental health services who tries to kill themselves, e.g. a patient being cared for in acute or primary care
Bogus Health Workers	Permanent harm to one or more patients Local media – long term – moderate effect – impact on public perception of Trust and staff morale National media >3 days – public confidence in organisation
Communicable Disease and Infection Issue	Outbreaks of infection that involve presumed transmission within healthcare settings: • cases/outbreaks of infection with an NHS-attributable food, water or environmental source • case of blood borne or other virus infection in a healthcare worker or patient that necessitates consideration of a look-back exercise • failed vaccination cold chain affecting significant numbers of patients • call and recall system failures affecting significant numbers of patients • exposure to chemical agents or radiation caused by failures in healthcare settings

Confidential Information Leak	Major breaches of confidentiality such as the loss or theft of personal identifiable records or information, hard copy or electronic An incident involving the actual loss of personal information that could lead to identity fraud or have other significant impact on individuals should be considered as serious this includes incidents rated 3-5. Grade 3: Serious breach of confidentiality e.g. up to 100 people and/or damage to a services reputation/low key media coverage Grade 4: Serious breach with either particular sensitivity e.g. sexual health details, or up to 1,000 people affected and/or damage to an organisations reputation/media coverage Grade 5: Serious breach with potential for ID theft over 1,000 people affected and/or Damage to NHS reputation/National media coverage Incidents rated as 1 and 2 should also be reported as grade 0 for notification only.
C.Diff and Health Care Acquired Infections	Which results in: • death or permanent harm to one or more patients where the outcome requires life-saving intervention or major surgical/medical intervention which will shorten life expectancy
Delayed diagnosis	This includes missed and miss-diagnosis, and delays in out-patient appointments which results in: • permanent harm to one or more patients where the outcome requires life-saving intervention or major surgical/medical intervention will shorten life expectancy
Drug Incident (general)	To include Medication Never Events: • Wrongly prepared high-risk injectable medication (new) • Maladministration of potassium-containing solutions (modified) • Wrong route administration of chemotherapy (existing) • Wrong route administration of oral/enteral treatment (new) • Intravenous administration of epidural medication (new) • Maladministration of Insulin (new) • Overdose of midazolam during conscious sedation (new) • Opioid overdose of an opioid-naive patient (new) • Inappropriate administration of daily oral methotrexate Resulting in: • permanent harm or death to one or more patients, where the outcome requires life-saving intervention or major surgical/medical intervention or will shorten life expectancy And • Wrong gas administered or failure to administer any gas (NE: Wrong gas administered) • Intravascular air embolism introduced during IV infusion/bolus dose or through haemodialysis circuit.(NE: Air embolism)

Failure to act upon test results	Where the failure results in: • permanent harm to one or more patients where the outcome requires life-saving intervention or major surgical/medical intervention or will shorten life expectancy
Failure to obtain consent	Where the procedure or treatment results in: • permanent harm to one or more patients where the outcome requires life-saving intervention or major surgical/medical intervention or will shorten life expectancy
Health and Safety	Which resulted in closure of a facility which had consequences for business continuity: • Chemical incident • Fire • Accident on NHS premises which results in: • permanent harm to one or more staff, visitors or members of the public where the outcome requires life-saving intervention or major surgical/medical intervention or will shorten life expectancy
Homicide by Inpatient (in receipt)	For use where HSG Guidance applies
Homicide by Inpatient (not in receipt)	For use where HSG Guidance applies
Homicide by Outpatient (in receipt)	For use where HSG Guidance applies
Homicide by Outpatient (not in receipt)	For use where HSG Guidance applies
Hospital Equipment Failure	Hospital estate infrastructure which leads to: • Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked • Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked
Infected Health Care Worker	Infected healthcare worker where the infection was not known and no controls were in place with a reportable communicable disease e.g. TB, measles etc.
Medical equipment failure	This means medical devices (not hospital infrastructure) which leads to: • Permanent harm to one or more patients where the outcome requires life-saving intervention or major surgical/medical intervention or will shorten life expectancy • Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being invoked

Mental Health Act - Class B incident	Mental Health Act incidents except deaths.
Other (Please specify within incident description)	Misidentification Error Death or severe harm as a result of administration of the wrong treatment following inpatient misidentification due to a failure to use standard wristband (or identity band) identification processes i.e. those that comply with • Mixed Sex Accommodation • Reporting of any unjustified mixing of genders (i.e. breaches) in sleeping accommodation by providers of NHS funded health care. CWP has an agreed protocol with the CCG's.
Pressure Ulcer	These should be reported in line with the NHS Improvement Guidance.
Safeguarding vulnerable adult	Where an individual suffers permanent harm or death as a result of a safeguarding vulnerable adults issue where they are in receipt of health care services
Security Threat	Sustained loss of service resulting in major contingency plans being invoked Local media causing long term or moderate effect causing impact on public perception of Trust and staff morale National media >3 days affecting public confidence in organisation MP concerned (questions in the House)
Serious Incident by Inpatient (in receipt of mental health services)	Which leads to: • Permanent harm to one or more patients where the outcome requires life-saving intervention or major surgical/medical intervention or will shorten life expectancy For acute trust this would mean patients who are on special observations provided by a mental health trust.
Serious Incident by Inpatient (not in receipt of mental health services)	Which leads to: • Permanent harm to one or more patients where the outcome requires life-saving intervention or major surgical/medical intervention or will shorten life expectancy For mental health trusts this would be for those who are absent, on leave, during transfer etc.

Serious Incident by Outpatient (in receipt of mental health services)	Which leads to: • Permanent harm to one or more patients where the outcome requires life-saving intervention or major surgical/medical intervention or will shorten life expectancy. • Severe harm to a mental health inpatient as a result of a suicide attempt using non-collapsible curtain or shower rails. (NE: Suicide using non-collapsible rails)
Serious Incident by Outpatient (not in receipt of mental health services)	Which leads to: • Permanent harm to one or more patients where the outcome requires life-saving intervention or major surgical/medical intervention or will shorten life expectancy
Slips/Trips/Falls	A slip, trip or fall which occurred on NHS premises or whilst receiving NHS funded care which results in: • Permanent harm to one or more patients where the outcome requires life-saving intervention or major surgical/medical intervention or will shorten life expectancy • This includes falls from unrestricted windows (NE: Falls from unrestricted windows) • All falls that result in the pathway of care being altered and resulting in a longer length of stay.
Sub-optimal care of the deteriorating patient	Where the deterioration was not recognised or not acted upon and this has led to permanent harm or death. This includes failure to monitor vital signs or respond including failure to respond to oxygen saturation levels in a patient undergoing general or regional anaesthesia or conscious sedation for a healthcare procedure (NE: Failure to monitor and respond to oxygen saturation)
Transfusion Incident	Which leads to: • Permanent harm to one or more patients where the outcome requires life-saving intervention or major surgical/medical intervention or will shorten life expectancy This includes transfusion of ABO-incompatible blood components, it excludes where ABO-incompatible blood components are deliberately transfused with appropriate management. (NE: Transfusion of ABO incompatible blood components)
Unexpected Death (general)	Patients, individuals or groups of individuals suffering serious or catastrophic harm or unexpected death whilst in receipt of health services.

Unexpected Death of Inpatient (in receipt of mental health services)	Unexpected death of an inpatient who is in receipt of mental health services (i.e. a patient being cared for in acute or primary care) Death of a mental health inpatient as a result of a suicide attempt using non-collapsible curtain or shower rails. (NE: Suicide using non-collapsible rails)
Unexpected Death of Inpatient (not in receipt of mental health services)	Unexpected death of an inpatient who is not receipt of mental health services (i.e. a patient being cared for in acute or primary care) that does not fit the category of suicide or attempted suicide
Unexpected Death of Outpatient (in receipt of mental health services)	Unexpected death of an outpatient who is in receipt of mental health services (i.e. a patient being cared for in acute or primary care) that does not fit the category of Suicide or attempted Suicide
Unexpected Death of Outpatient (not in receipt of mental health services)	Unexpected death of an outpatient who is not receipt of mental health services (i.e. a patient being cared for in acute or primary care) that does not fit the category of Suicide or attempted Suicide.
Unexpected death of Community Patient (in receipt of mental health services)	Unexpected death of a community patient who is in receipt of mental health services (i.e. a patient being cared for in acute or primary care) that does not fit the category of Suicide or attempted Suicide
Unexpected death of Community Patient (not in receipt of mental health services)	Unexpected death of a community patient who is not receipt of mental health services (i.e. a patient being cared for in acute or primary care) that does not fit the category of Suicide or attempted Suicide
Ward / Unit Closure	Which leads to: • Sustained loss of service which has serious impact on delivery of patient care resulting in major contingency plans being evoked • Disruption to facility leading to significant 'knock-on' effect across local health economy

1b. Safeguarding incidents

For incidents where there are concerns around safeguarding, staff will identify these incidents within the Datix incident form within the safeguarding section. These incidents are reviewed by the safeguarding team on at least a weekly basis to ensure appropriate safeguarding procedures have been followed.

The decision to report a safeguarding incident as an SUI and report this on to STEIS (Strategic Executive Information System – serious untoward incident system run by NHS England), must be taken by the executive lead for safeguarding or nominated deputy. This must also be reported to Care Quality Commission without delay. For further information on reporting Safeguarding incidents please refer to the Safeguarding Adults policy and Safeguarding Children's Policy.

1c. Absence without leave or missing persons

To manage the risks associated with patients who are absent without leave, the missing person's procedure must be followed as outlined in the policy MH8 Missing Persons Policy. The actions taken must be recorded as a clinical note headed 'Missing Person' on the electronic patient record.

Dependent on the nature of the incident, e.g. whether they are subject to any restrictions under the mental health act for example, there may be different external reporting required, for further information refer to MH8 Missing Persons Policy.

Appendix 2 - Duty of Candour and what it means to patients

The trust's principle is that communication with healthcare teams, staff, people who access our services, their relatives and carers must be as open as possible. "Communicating effectively with people who access our services and/ or their carers is a vital part of the process of dealing with errors or problems in their treatment". (NPSA Safer Practice Notice 10).

What is Duty of Candour?

Duty of Candour; **Candour means frankness, openness and honesty.**
The trust therefore needs to be open and honest with patients and their families and carers when things go wrong with their care and treatment.
To meet the requirements of the regulation, the trust has to:

- Make sure it has an open and honest culture across and at all levels within its organisation.
- Tell patients in a timely manner when particular incidents have occurred.
- Provide in writing a truthful account of the incident and an explanation about the enquiries and investigations that organisation will carry out.
- Offer an apology in writing.
- Provide reasonable support to the person after the incident.

The regulations apply to the patient themselves and, in certain situations, to people acting on their behalf, for example when something happens to a child - or to a person over the age of 16 who lacks the capacity to make decisions about their care.

How do the staff at CWP NHS Foundation Trust comply with Duty of Candour?

1. By telling someone if you have been involved in and/or observed where a patient may have been harmed or had the potential to be harmed by something not being done.
2. By reporting the actual and or potential incident on Datix (our integrated risk management system). By doing this, this will inform others and allow for a level of investigation to take place to see what/how/why happened and to learn to minimise the risk of what occurred happening again.

What we have done to ensure that Duty of Candour takes place

1. We ensure patients and family are supported to deal with the consequences and have a key contact identified for the incident
2. We ensure there is an appropriate level of investigation
3. We ensure that the patient/family/patient representative is informed within **10 working days** of the decision that the incident is a moderate/permanent harm incident
4. We ensure that the initial notification should be face to face and this is accompanied with an offer of a written notification
5. We ensure an apology is provided and documented in the patient notes
6. We ensure that a step by step explanation is offered as soon as possible pending the investigation
7. We ensure full written documentation of all meetings are kept with the patient/family and filed in Datix for future reference
8. We ensure full written documentation is kept of all staff interviews and meetings about the incident and filed in the incident/complaint account in Datix
9. We ensure the final investigation will be shared with the patient/family/patient representative

within 10 days of approval

10. The Trust is monitored by the Commissioners as part of our monthly Quality Contract around our contractual obligations to comply with Duty of Candour

The NHS Litigation Authority state that:
"It seems natural and desirable for those involved in treatment which produces an adverse result, for whatever reason, to sympathise with the service user or the service user's relatives and to express sorrow or regret at the outcome. Such expressions of regret would not normally constitute an admission of liability, either in part or full, and it is not our policy to them, nor to dispute any payment, under any scheme, solely on the grounds of such an expression of regret."

Duty of Candour contact **must** be recorded in Datix within the DIF2 form. Feedback should be included in the investigation terms of reference. Dependent on the level of feedback requested from and agreed with the service user and / or their family / carers, they should be kept informed of progress and formal feedback should be given at the end of the review. The feedback will include responses to issues and concerns, lessons learned and changes in practice. Where agreed, the family liaison lead must share the investigation report **within ten working days of being signed off as approved**. This **must** be recorded on Datix.

If you have any questions about Duty of Candour you can contact the IncidentTeam on 01244 393145

Appendix 3 - Family Liaison Lead Role description

CWP's commitment to family liaison

CWP is committed to fully supporting people who use our services and/ or families following incidents which have resulted in serious harm or death.

Purpose of family liaison

The purpose of family liaison is to provide a clear and consistent point of contact for people who have been involved in or care for someone that has been involved in a serious incident. The aim is to provide personal support and to help the person to understand and be fully involved in subsequent processes such as root cause analysis and/or complaints.

Criteria

- At present, the family liaison role will be identified for incidents of apparent suicide and other significant events (Category A and B incidents will be reviewed independently by the locality service director to determine if they feel that the family liaison role would be beneficial).
- It is recommended that first time family liaison leads buddy up with a family liaison lead who has previous experience.

Principles of family liaison

To provide the best support to people who use our services and/ or families, family liaison leads:

- Work with people who use our services and/ or families in a way that is respectful and sensitive to their needs – demonstrating care and compassion.
- Share information about the investigation with service users and/ or families as openly, honestly, transparently, and candidly as CWP's powers and the law allows – this should include determining the application of the following:
  - Best interests – clinical opinion indicates that disclosure would adversely affect the mental health and wellbeing of the person who uses our services.
  - Any written instructions from the person who uses our services about the disclosure of any information to others.
  - Circumstances whereby there are serious concerns relating to a safeguarding adult/ child issue.
  - Circumstances whereby there are serious concerns that the family of the person who uses our services (or other representative) is not acting in their best interests.
- Are the representatives of CWP in its engagement with people who use our services and/ or bereaved families.
- Contribute to a co-ordinated response to the needs of people who use our services and/ or families and advise them (verbally and/ or leaflets) about other agencies offering appropriate support, for example bereavement counselling. (**Hint/note:** keep copies of leaflets with you when meeting with the family.)
- Do not act as advocates, make promises/ raise expectations that cannot be met, nor compromise the independence of the investigation.

Key roles of family liaison

- Liaise with the investigating manager to establish what contact has already been made by CWP services; otherwise make the first contact with the person who uses our services and/ or family. In doing so:
  - Offer an explanation, an apology and/ or condolences, as appropriate.

- Request, and if agreed, arrange to meet at a mutually convenient venue. (**Hint/note:** it is recommended that at any meetings you are accompanied by someone who can record the support you have offered, so that you are able to fully listen during the course of the meeting and have a second person witness your involvement if the need for this arises.)
- Explain how they can be involved in the investigation.
- If the person who uses our service and/ or family chooses not to be involved in the investigation, advise that you will make contact again in two weeks' time.

- If the person who uses our service and/ or family choose to be involved in the investigation:
  - Remain the consistent point of contact between the person and/ or family, CWP services, complaints team etc. throughout the investigation and until the inquest (if applicable) has taken place.
  - Identify the extent of feedback the person and/ or family want to receive, e.g. a copy of the report, verbal feedback, a summary.
  - Identify the person who uses our services and/ or family's questions.
  - Represent the person and/ or family to ensure that their questions are answered, as far as practicable, clearly within the investigation report.
  - Provide documented, two-way communication between the person and/ or family and CWP, which is managed according to the person's and/ or family's needs.
  - Facilitate any requests that the person and/ or family may have, e.g. access to records etc. (**Hint/note:** in the case of access to records – ensure the cost of this is waived and keep copies with you when meeting with the family.)
  - Prepare the person and/or family for any aspect of the report which is likely to be a surprise or is likely to cause distress.
  - Share the final draft report to check for accuracy and, the final report within 10 working days of its approval. (unless the person/ their family specifically ask us not to provide them with the final report)

Any questions / advice?

Contact the Incident Department on 01244 393145

Appendix 4 - Terms of Reference – Immediate Safety Assurance Forum

Main functions of the meeting

- To receive assurance that immediate safety reviews have been undertaken following all serious incidents and that these reviews have been approved by Heads of Operations.
- To ensure that immediate safety reviews consider all aspects of safety for the service users, staff, families and any other stakeholders involved or affected by the incident.
- To ensure that Duty of Candour has been applied as required in line with the quality assurance checklist.
- To collectively identify any lessons learned from the immediate safety review that need to be shared more widely and agree the mechanism and timeframe when this is to happen by.
- To collectively agree whether the serious incident requires further review and if so at what level.
- To agree who will be allocated to undertake any further reviews that are required, inform the terms of reference for the review and agree the timescales for completion.
- To identify any onward referrals that need to be made following the immediate safety review and agree who will be responsible for completing these e.g. safeguarding boards and community safety partnerships.
- To update the forum on decisions made by NHS England and/ or external agencies which need to be considered and actioned by the Trust.
- To review the learning from individual incidents to identify any emerging patterns and themes and agree any actions required in response to these.
- To provide a summary of key learning every 2 months and share this with the appropriate governance groups.
- To consider any issues which need to be escalated to the Executive Team and/ or commissioners.

Frequency

Meetings will be held weekly, every Tuesday 14.00 – 15.00. On the rare occasion where a face to face meeting cannot be held, decisions that cannot wait will be made virtually. Arrangements will be made for locality teams to be able to access the meeting via telephone conferencing facilities.

Quorum

- 1 Executive or Associate Director
- 1 member from the Clinical Governance Team
- 1 representative from each Care Group (HOCS or an identified deputy)

Appendix 5 – Quality Assurance checklist

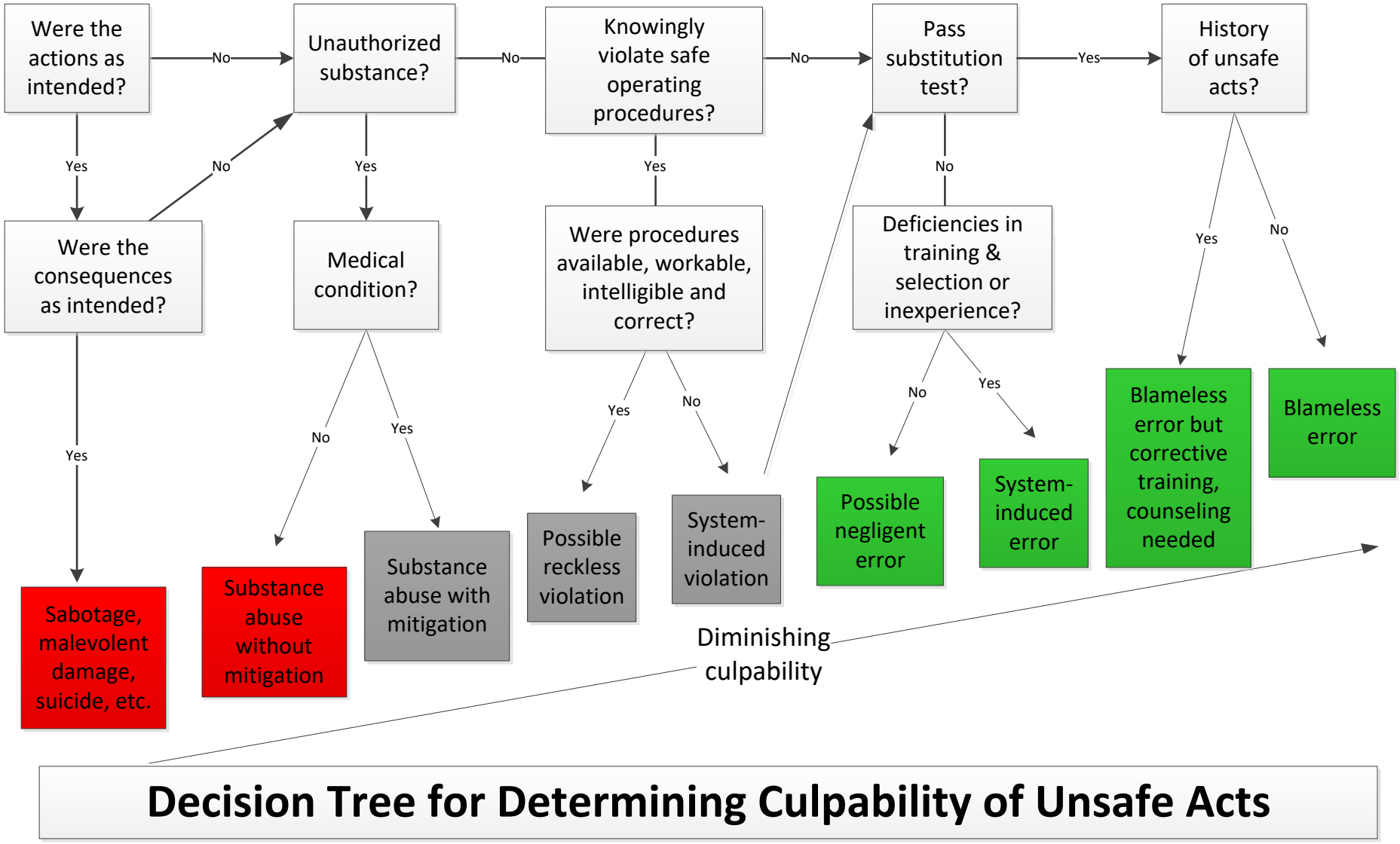
To be completed by Clinical Directors and Heads of Operations when reviewing a serious incident review/ Serious Incident Review Meeting (SIRM)

Quality Assurance Check ***Please add your comments in each section as appropriate***	**Clinical Director** **Name:** **Date of Review:**	**Head of Operations** **Name:** **Date of Review:**	**SIRM notes only** **Review members:** **Date of Review:**
Reports states the name and professional role of each clinical reviewer	Yes/ No	Yes/ No	Yes/ No
There are clear terms of reference	Yes/ No	Yes/ No	Yes/ No
Family views are included in review	Yes/ No	Yes/ No	Yes/ No
Access to appropriate specialist advice is included in the report.	Yes/ No	Yes/ No	Yes/ No
The report states whether there are, or have been, other reviews related to this incident	Yes/ No	Yes/ No	Yes/ No
Reports are succinct and written in plain English	Yes/ No	Yes/ No	Yes/ No
All specialist vocabulary, acronyms and jargon are explained in the report	Yes/ No	Yes/ No	Yes/ No
Review understands how decisions about care, treatment, risk management were made at the time of the incident, taking into account the capability, environment and human factors of the staff	Yes/ No	Yes/ No	Yes/ No
The review takes into account relevant clinical or technical guidance.	Yes/ No	Yes/ No	Yes/ No
The rationale for the conclusions is clear from evidence set out in the body of the report	Yes/ No	Yes/ No	Yes/ No
The rationale for learning is clear from evidence set out in the body of the report	Yes/ No	Yes/ No	Yes/ No
Improvement/action plans are SMART	Yes/ No	Yes/ No	Yes/ No

There is a specific individual that is accountable for delivering the action plan	Yes/ No	Yes/ No	Yes/ No
There is a specific individual accountable for monitoring any actions	Yes/ No	Yes/ No	Yes/ No
It is clear which governance group is overseeing the action plan	Yes/ No	Yes/ No	Yes/ No
Incidental findings lying outside of terms of reference are noted and acted upon	Yes/ No	Yes/ No	Yes/ No
Feedback about the investigation process was sought from patients and families involved	Yes/ No	Yes/ No	Yes/ No
State where learning/findings will be discussed in relevant governance meetings	Yes/ No	Yes/ No	Yes/ No

Name of Final Approver	
Date Approval completed	
Is the report ready for final assurance at Serious Incident Review Meeting?	
The report to be returned to Reviewer for further action	
Further Action Required i.e. Does the patient/family/staff /CCG/Coroner need to be informed of delay	
Amended report expected to be returned to the Governance Team	Insert date

Appendix 6 – Incident decision tree flowchart



Appendix 7 - Reportable Deaths to the Coroner: a Brief Guide.

Always discuss with a senior clinician if in doubt a death should be referred to HM Coroner if either:

- The cause of death is unknown;
- It cannot readily be certified as being due to natural causes;
- The deceased was not attended by the doctor during his last illness or was not seen within 14 days or viewed after death;
- There are any suspicious circumstances or history of violence;
- The death may be linked to an accident (whenever it occurred);
- There is any question of self-neglect or neglect by others;
- The death has occurred or the illness arisen during or shortly after detention in police or prison custody (including voluntary attendance at a police station);
- The deceased was detained under the Mental Health Act
- The death is linked with an abortion;
- The death might have been contributed to by the actions of the deceased (such as a history of drug or solvent abuse, self-injury or overdose);
- The death could be due to industrial disease or related in any way to the deceased employment;
- The death occurred during an operation or before full recovery from the effects of an anaesthetic or was in any way related to the anaesthetic (in any event a death within 24 hours should normally be referred);
- The death may be related to a medical procedure or treatment whether invasive or not;
- The death may be due to lack of medical care;
- There are any other unusual or disturbing features to the case;
- The death occurs within 24 hours of admission to hospital (unless the admission was purely for terminal care);
- It may be wise to report any death where there is an allegation of medical mismanagement.

This note is for guidance only, it is not exhaustive and in part may represent desired local