The Reporting, Management & Learning from Incidents Policy

POLICY NUMBER & CATEGORY	**RS 02**	**Risk & Safety**
VERSION NO & DATE	**4**	**March 2016**
RATIFYING COMMITTEE	**Clinical Governance Committee**	
DATE RATIFIED	**5th April 2016**	
ANTICIPATED REVIEW DATE:	**April 2018**	
EXECUTIVE DIRECTOR	**Executive Director of Nursing**	
POLICY LEAD	**Associate Director of Governance**	
POLICY AUTHOR (if different from above)	**Head of Governance Intelligence & Head of Investigations**	

POLICY CONTEXT

- The requirements of this policy apply to ALL staff in all locations.
- This policy sets out guidance for identification, reporting, management and learning from all incidents (including near misses) and provides a framework for the management and investigations of serious incidents.
- This policy replaces the Incident Reporting and Management Policy (RS02/Version 3) and Incident Investigations Policy (Incorporating 'Being Open') (RS03/Version 2)

POLICY REQUIREMENT (see Section 2)

- All staff must report incidents and near misses as defined in this policy within 1 working day.
- Staff are responsible for undertaking any immediate action to make safe any situation and prevent further risk.
- Managers are required to review incidents in their area of responsibilities and ensure that appropriate actions have been taken to prevent recurrence or further risk.
- All staff who report incidents should receive feedback from their manager
- All incidents will be reported in line with required external reporting arrangements and within defined timescales identified by external stakeholders / commissioners and national guidance.
- Managers must embed a local review process within regular team meetings to ensure thematic review of incidents and benchmarking against similar services. The Black Hole on the trust intranet provides the necessary reports to support this.
- All service areas must agree a local process to review recommendations arising from Serious Incident reviews that incorporates the formulation, implementation and monitoring of SMART actions to achieve sustainable local learning.
- There will be a lead investigator responsible for each Serious Incident investigation. The lead investigator will have responsibility for following the terms of reference and completing an investigation within defined timescales.
- Staff, service users and carers should be kept informed of the investigation process for Serious Incidents (And Untoward Incidents where Duty of Candour is applicable) and be involved at appropriate stages.

CONTENTS

1 INTRODUCTION

1.1 Rationale (Why)

1.1.1 The Trust is committed to ensuring that the care it provides is safe for all those being cared for and providing the care. Where incidents do occur it is vitally important that the Trust learns from these so as wherever possible prevent reoccurrence or otherwise reduce the risk.

1.1.2 The purpose of this policy is to ensure that internally

- There is a clear understanding of what an incident or near miss is.
- How to report an incident on Eclipse, the Trust Risk Management System, please see **Appendix 1**.
- All staff understand their responsibility in reporting incidents and near misses involving staff, patients and others.
- All managers understand their responsibility in managing incidents and near misses involving staff, patients and others.
- All staff understand their responsibility in implementing lessons learnt from incidents and near misses.
- The investigation process adheres to national serious incidents framework and contractual agreements with commissioners and external bodies.
- All staff know who to contact when help is required with any of the former.

1.1.3 Additionally the purpose of this policy is to ensure that the Trust reports all incidents which meet the criteria for notification to external organisations as defined in **Appendix 5**.

1.2 Scope (Where, When, Who)

This policy covers the reporting, immediate response, management and learning from all incidents in all Trust services – including HMP Birmingham.

1.3 Principles (Beliefs)

This policy endorses the application of 7 key principles in the management of all incidents:

1. Openness and transparency
   Acknowledging, apologising, supporting those involved and explaining when things go wrong.

2. Prevention through learning
   Understanding what went wrong, identify opportunities for learning and seek to minimise future reoccurrence.

3. Objectivity
   Ensure an objective approach to learning and an independent approach for investigations.

4. Timeliness and responsiveness

Ensuring a timely approach to reporting, management, investigation and learning from incidents.

5. Systems based
   Utilising a system-based approach to learning, recognising the potential for human error and focusing on weaknesses in system and/or processes.

6. Proportionate
   The scale and scope of incidents management and investigation should proportionally reflect the seriousness of the incident and opportunity for improvement and reducing risks of harm to service users, carers and/or staff

7. Collaborative
   Adapting a collaborative approach to management and learning from incidents, working in partnership with other organisations where appropriate.

2 POLICY

2.1 All incidents must be reported within 1 working day.

2.2 All incidents should be reported on Eclipse via the trust intranet. In areas where this is not currently possible a member of staff should contact the Governance Intelligence (Eclipse) Team who will enter the incident onto the Eclipse system on their behalf. Alternatively where a secure email transfer (please refer to the Information Communication & Technology Policy) arrangement has been established an electronic incident form maybe emailed to the Governance Intelligence Team for entry. **Appendix 1B** clarifies partnership incident reporting arrangements

2.3 All staff (including contractors) must report incidents and near misses as defined in this policy.

2.4 Staff are responsible for undertaking any immediate action to make safe any situation and prevent further risk and ensure the Duty of Candour requirements are met in line with the Duty of Candour Policy (C25).

2.5 Managers are responsible for reviewing incidents reported in their area(s) of responsibility and ensuring that appropriate action(s) have been taken to prevent reoccurrence and further risk.

2.6 Managers should feedback actions and comments following an incident to the initial reporter of the incident; this should be via Eclipse wherever possible

2.7 Managers must embed a local review process within regular team meetings to ensure thematic review of incidents and benchmarking against similar services. The Black Hole on the trust intranet provides the necessary reports to support this.

2.8 There will be a Serious Incident Review lead responsible for each Serious Incident investigation.

2.9 The Head of Investigations will allocate review leads for serious incidents within 1 week.

2.10 The Head of Investigations will define the terms of reference for Serious Incidents investigations and the Serious Incidents Group will ensure these are met.

2.11 The review lead is responsible for ensuring that the final Serious Incident review report is sent to the Clinical Director for sign off within agreed timeframe as per terms of reference.

2.12 The Clinical Director is responsible for ensuring that Serious Incident review reports are signed off within 1 week of receipt from review leads.

2.13 The Serious Incident Group will review completed Serious Incidents review reports prior to submission to external bodies. Where amendments are required, these are to be completed by the review lead within 1 week.

2.14 Staff, service users and carers should be kept informed of the investigation process for Serious Incidents (And Untoward Incidents where Duty of Candour is applicable) and be involved at appropriate stages. These arrangements should be agreed and understood with the service user or carer by operational services as part of the initial contact following the incident.

2.15 If during the period of an investigation, local management consider that there is a case for suspending staff or using the Trust disciplinary procedure, the NPSA incident decision tree (**Appendix 2B**) will be used and this will be required to be reported to the Serious Incident Review Lead and referenced in the Serious Incident Review. Any disciplinary process would be conducted outside of the incident management process.

2.16 All service areas must agree a local process to review recommendations arising from Serious Incidents reviews that incorporates the formulation, implementation and monitoring of SMART actions to achieve sustainable local learning.

3 PROCEDURE

3.1 Definitions and thresholds

3.1.1 Definition of an Untoward Incident

3.1.1.1 An incident is any event or circumstance arising that could have or did lead to unintended or unexpected harm, loss or damage to BSMHFT, commissioned services, patients, carers, visitors, staff, other members of the public, premises, property, other assets, information, or any other aspect of the organisation. Incidents come to light via the incident reporting system, complaints or claims process, PALS and provider organisations. They can involve any number of different factors, e.g. injury, damage, loss, fire, theft, violence, abuse, accidents, ill health, non-compliance with legal requirements, contract etc.

3.1.1.2 A “Near Miss” is an incident that did not lead to harm, loss or damage but had serious potential to do so. The outcome does not always reflect the potential severity of harm that could be caused should it reoccur. A near miss should be seen as an opportunity for learning and may, at times, be treated as a serious incident.

3.1.2 Definition of a Serious Incident

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

3.1.2.2 **Appendix 3** sets out circumstances in which a serious incident must be declared. Every incident must be considered on a case-by-case basis. Inevitably, there will be borderline cases that rely on the judgement of the people involved but **Appendix 3** contains a list of likely circumstances which would be classified as serious incidents

3.1.3 Assessing whether an incident is a Serious Incident

3.1.3.1 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, and what may be done to address the weakness to prevent the incident from happening again.

3.1.3.2 On occasions where the level of incident/grading level is less clear, a discussion between the operational managers and Head of Investigations will occur. It may be necessary to discuss with commissioners for further clarity on whether an incident meets external reporting criteria.

3.1.3.3 Similarly if further information becomes available this too may require further discussions with the Head of Investigation with a view of reviewing the incident level/ level of investigation required.

3.2 Reporting of Incidents

The policy takes account of the reporting protocols between the trust and external organisations such as HMP Birmingham, please refer to **Appendix 1B**.

3.2.1 Reporting of Untoward Incidents & Near Misses

3.2.1.1 All untoward incidents are to be reported on the "untoward incident form" on Eclipse

3.2.1.2 An incident report should be completed by a member of staff who was involved in or who witnessed the incident wherever possible. Where there were no witnesses the staff member who identified that the incident occurred should report the incident.

3.2.1.3 In scenarios where a historical incident has been identified through a corporate process (such as Complaints/Claims/Safeguarding) that was not reported on Eclipse, it is the responsibility of the department that was first made aware of the incident to report it retrospectively on Eclipse.

3.2.1.4 All staff are responsible for any immediate action to ensure that any remaining risk is managed and no further harm is caused. These actions should be recorded on the eclipse incident form.

3.2.1.5 Where staff are unsure whether an incident meets the criteria for a Serious Incident they should discuss the incident with a senior colleague, alternatively discuss with a member of the governance team. If this is not possible they should report the incident as a Serious Incident and it will be assessed against the Serious Incident criteria (**Appendix 3**).

3.2.2 Reporting of Serious Incidents (SIs)

3.2.2.1 All serious incidents are to be reported on the "serious incident form" on Eclipse

3.2.2.2 Where an incident, reported as an untoward incident, which meets the criteria for a Serious Incident, is identified it will be escalated within the Eclipse system by instruction of the Head of Investigations. The appropriate managers will be notified that the incident has been incorrectly reported and that the incident should now be managed as a Serious Incident.

3.2.2.3 The Head of Investigations will be responsible for confirming whether any incident is formally classified as a Serious Incident. Where further information becomes available or arbitration is required the Head of Investigations will be responsible for reinforcing or determining that the Serious Incident should be reclassified to an untoward incident.

3.2.2.4 The Head of Investigations will be responsible for ensuring that any Serious Incident is reported on STEIS (Commissioners Serious Incidents System) within 2 working days.

3.2.2.5 The Head of Investigations is responsible for notifying any other commissioners and external stakeholders which would not be informed through reporting on STEIS.

3.2.2.6 Never Events: These are incidents which are classified nationally as incidents which should not happen. **Appendix 6** sets out the Never events which are applicable to the Trust. These would initially be identified as

Serious incidents and if they meet the never event criteria will be escalated by the Head of Investigations to the Associate Director of Governance.

3.2.3 **Raising Concerns**

3.2.3.1 The Trust is committed to ensuring that all staff are open and honest and work in an environment of a fair and just culture. Staff can also refer to the Trust's Raising Concerns Policy (HR20) for further guidance. The Trust will follow the principle that staff are positively supported who admit to being involved in incident or to making mistakes. Staff will be supported in reporting confidentially. Wherever appropriate, preventative action such as training will be undertaken, rather than disciplinary action.

3.2.3.2 In some situations a member of staff may not feel comfortable reporting an incident which is sent to team management. In these cases a staff member can use the Dear John process to escalate concerns. Should the Dear John process identify any quality/safety issues then an incident should be reported on Eclipse so learning could take place in an open and transparent way.

3.3 Immediate response to an incident

3.3.1 Staff are responsible for undertaking any immediate action to make safe any situation and prevent further risk following the incident.

3.3.2 Staff should consider additional immediate response that is appropriate for the incident scenario in line with other Trust polices. For example, contacting emergency service, supporting other service users post incident.

3.3.3 In the event of an injury to any person involved in Health and Social Care activities or on health and social care premises, the priority is to manage the situation safely and ensure that no further harm can occur.

3.3.4 Arrangements must then be made for the injured person to receive appropriate first aid/medical attention. If the injured person is a member of staff and the injury is minor, a First Aider should be contacted. If the injured person is a service user, a doctor should be contacted. In some circumstances, a "crash call" or a 999 emergency call may be required.

3.3.5 In the event of a missing or absconded service user, the Missing Patients Policy (C37) must be followed.

3.3.6 If a member of staff is distressed following an incident, s/he should be offered support promptly. It may be appropriate for the individual to be sent home. The Clinical Service/Nurse manager must be advised of this action. Other individuals should also be offered support where appropriate.

3.3.7 Staff support should include an initial debrief or opportunity on the day to discuss events and feelings associated with this. Emotional support should be seen as separate to any meetings to inform the wider team of the details of an incident.

3.3.8 Staff should then report the incident on Eclipse to ensure appropriate escalation as per section 3.2 of the policy.

3.3.9 Where Duty of Candour is applicable, an apology should be issued as soon as possible and a lead for the Duty of Candour is to be assigned. Face to face to contact with the relevant person is required within 10 working days (Refer to the Duty of Candour policy (C25)).

3.4 Management of incidents

3.4.1 Informing / involving service users & carers and the Duty of Candour

3.4.1.1 Being open when things go wrong is fundamental to the partnership between service users/carers and those who provide their care. The Trust aims to establish an environment where service users/carers receive the information they need to enable them to understand what happened and the reassurance that everything possible will be done to ensure that a similar type of incident does not reoccur.

3.4.1.2 Service users who are directly involved in or affected by any incident/near miss must be informed promptly and given an open and transparent explanation as required. This may include adherence to the Duty of Candour policy (C25).

3.4.1.3 Where appropriate, a staff member should be assigned locally to offer support to family/ carers following an incident. This should always be offered following suspected suicides or incidents resulting in severe harm.

3.4.1.4 Occasionally there may be an incident where it will be necessary to contact various service users e.g. if a member of staff has a notifiable disease and has contact with a large number of service users in the course of their work. These service users must also be contacted as a matter of course. Advice should be sought from a service user's Consultant Psychiatrist and clinical team if there is concern or doubt about the information affecting a person's mental state. The Health Protection Agency will provide support and specialist advice in these cases (see Trust Infection Prevention & Control procedures).

3.4.2 Staff support

3.4.2.1 Staff affected by incidents should be provided with appropriate support from senior colleagues. This may involve organising further independent support or referrals and ensuring duties are covered. It should be recognised that support needs may change over time and that immediate support on the day must be followed up by longer term support in discussion with staff members.

3.4.2.2 Regular Management Supervision meetings should consider impact of incidents on staff wellbeing and clinical practice

3.4.2.3 Where an HM Coroner/s inquest is to be held, the Trust's legal advisor will meet with staff called upon as witnesses, to explain the procedures involved and the process of the HM Coroner's Court. Senior colleagues should offer support to staff in Coroner's Court and throughout the investigation process.

3.4.3 Management of Untoward Incidents

3.4.3.1 The focus of managing an incident should always be to reduce risks of further harm, and reoccurrence.

3.4.3.2 It is the Manager's responsibility to ensure that appropriate action has been taken to address the incident and check the factual accuracy of the completed sections of the eclipse form. Once the manager is satisfied with the above they are then required to make their comments; provide feedback

to the reporter and sign off as appropriate. This should be completed within 14 days of the incident being reported.

3.4.3.3 Where further information becomes available after signoff the manager should update the eclipse form and attach any relevant documents.

3.4.3.4 Where an incident highlights concerns around practice/performance this should be managed through existing Human Resources policies. The incident decision tree could be utilised to establish further clarity, see **Appendix 2B**.

3.4.3.5 Please refer to **Appendix 2A** for further scenario specific guidance on management of incidents.

3.4.4 Management of Serious incidents

3.4.4.1 The manager is responsible for completing the Serious Incident management report on Eclipse within 72 hours. The management report should check the factual accuracy of the completed sections to the best of available information.

3.4.4.2 Where further information becomes available after signoff the manager should update the eclipse form and attach any relevant documents.

3.4.4.3 Please refer to **Appendix 2A** for further scenario specific guidance on management of incidents.

3.4.4.4 Grading of serious incidents

3.4.4.4.1 Once an incident is identified as being a Serious Incident the Head of Investigations will assign an initial review grade and level i.e. concise internal, panel investigation or independent. **Appendix 4** provides a breakdown of the different review grades.

3.4.4.5 Allocation of review leads

3.4.4.5.1 Review leads will be assigned by the Head of Investigations, from a centrally held list of trained Serious Incident leads, within 7 days of the incident being reported. Any lead will have undergone training in conducting a Serious Incident and report writing. The Serious Incident lead will not have been directly involved either in the care of the individual or team to ensure independence and objectivity.

3.4.4.5.2 Where an investigation requires a panel, members will be drawn from different professional groups to increase expertise.

3.4.4.6 The Investigation process

3.4.4.6.1 The investigation will be conducted in line with the Serious Incident Framework (NHS England, 2015) and utilise a recognised process, usually Root Cause Analysis. The lead will conduct the investigation in line with the Terms of Reference approved by the Serious Incident Group. Where appropriate, the service user or family will be invited to inform the terms of reference. This should be done in consultation with the assigned person who is supporting the family members.

3.4.4.6.2 The review lead will utilise resources to inform a clear timeline of events. These are likely to include the electronic records, incident form, policies, statements and verbal discussions. Once a clear timeline has been established, the review lead may have questions to help understand why

actions have taken place and need to organise interviews with individuals and teams. Consideration should be given to the usefulness of having a group interview. Whilst staff may find this supportive, the review lead should consider how open all staff may feel in discussing actions in front of colleagues. Similarly, the use of written statements should be considered. Actions taken by staff should be benchmarked alongside existing trust policies in order to understand best practice alongside actual practice.

3.4.4.6.3 Reports should be simple and easy to read. They should serve as a standalone document and allow the reader to understand exactly what happened, why it happened and if there is any learning as a result of the investigation. Reports may be seen by family members as well as professionals, commissioners and, when appropriate, coroners.

3.4.4.6.4 Reports should not contain any identifiable patient or staff information.

3.4.4.6.5 Care and service delivery problems, where identified, and root causes should be clear and specific.

3.4.4.6.6 Review leads may request the support and advice of senior professionals to comment on specific areas e.g. a medical view on prescribing procedures. The review lead should make the Head of Investigations aware of any difficulties in completing the investigation in time e.g. difficulties in contacting key individuals for interview.

3.4.4.6.7 Review leads may request support or advice from the governance team in completing SI reviews during the process.

3.4.4.7 **Quality assurance of serious incidents investigations**

3.4.4.7.1 The completed report will be sent to the Clinical Director for local sign off (within 1 week) who will then forward the report to the investigations team.

3.4.4.7.2 The Serious Incidents Group will approve the recommendations and review the Serious Incident review reports prior to external submission.

3.4.4.7.3 Any required amendments following review by the Serious Incidents Group will be discussed with the review leads in order for resubmission to the Serious Incidents Group within 1 week.

3.4.4.7.4 Any significant amendment or concern will be discussed with the Clinical Director.

3.4.4.8 **Independent investigations**

3.4.4.8.1 Following an internal Serious Incident review, there are some circumstances where an external review may be commissioned.

3.4.4.8.2 NHS England is likely to commission an independent review of all homicides committed by mental health patients. There may be occasions where high profile serious incident attracting media attention may also be subject to scrutiny by an independent panel.

3.4.4.8.3 Where a homicide of a family member or someone in a close relationship with the service user takes place, the Safeguarding Board are likely to commission a Domestic Homicide Review. This would be in addition to the internal Serious Incident Review and any NHS England review. A member of the Trust Safeguarding Team will be invited to participate as a member of the investigatory panel

3.4.4.8.4 Where a death of a vulnerable adult or child occurs the local Safeguarding Board will commission a multiagency Serious Case Review or Safeguarding Adult Review

3.4.4.8.5 All staff are expected to contribute fully with externally commissioned investigations.

3.5 Learning from Incidents

3.5.1 The routine reporting of incidents allows for trends and patterns to be identified through the analysis of the information. The Trust Governance Department will produce service area reports every quarter to be presented at the local Clinical Governance Committees where the theme is safety. Key themes should be cascaded to teams by the senior/team managers where areas for action are identified.

3.5.2 The Black Hole on the trust intranet site (Connect) provides interactive reports for teams and service areas to query incidents data. The information on the Black Hole is updated daily.

3.5.3 Managers will be provided with a monthly governance report on the Black Hole to utilise at regular team meetings to learn from incidents data.

3.5.4 Managers must embed a local review process within regular team meetings to ensure thematic review of incidents and benchmarking against similar services. The Black Hole on the trust intranet provides the necessary reports to support this.

3.5.5 Clinical governance facilitators will be notified of all incidents for their area(s) on a weekly basis to gain better insight of local practice and to contribute towards improving local reporting culture, quality of care and safety.

3.5.6 Ad-hoc reports will also be required on occasion to support particular initiatives or for particular Trust specialist officers, e.g. physical assaults on staff, service user falls, serious self-harm. These reports will be provided by the Governance Department on request and some will be published on the Black Hole for ease of access.

3.5.7 Recommendations arising from Serious Incident reviews will be agreed by the Serious Incidents Group. SMART (Specific, Measurable, Achievable, Relevant, Time-bound) actions in response to the recommendations to be formulated, implemented and monitored through local governance processes – as defined in 3.5.8.

3.5.8 Every service area must agree a local process to review recommendations arising from Serious Incidents reviews that incorporates the formulation, implementation and monitoring of SMART actions to achieve sustainable local learning. This process is to be documented in the Terms of Reference of the local forum where this process will be delivered.

3.5.9 The Trust Clinical Governance Committee will be accountable for corporate recommendations arising from Serious Incidents reviews. These recommendations will be governed by the Trust Governance Team with SMART actions assigned by the Trust Clinical Governance Committee.

3.5.10 Incidents data will contribute towards the Integrated Quality Report for consideration at various Trust committees.

3.5.11 The Integrated Quality Report will identify areas for themed analysis and where further more detailed analysis is required. This is part of the wider management of risk where incidents will also be reviewed in conjunction with complaints, claims and PALS concerns in order to identify weaknesses, patterns and themes and implications for practice thereby minimising reoccurrences and improving safety.

3.5.12 Recommendations arising from Serious Incidents Reviews which are applicable to multiple service areas will be cascaded centrally by the Trust Governance Team as advised by the Serious Incident Group.

3.5.13 Findings from the Learning Lessons process will contribute towards internal mock CQC inspection visits.

4 RESPONSIBILITIES

Post(s)	Responsibilities
Chief Executive	Holds overall accountability for clinical and non-clinical risk, which includes the reporting and management of incidents
Executive Director of Nursing	On behalf of the Chief Executive is responsible for co-ordinating the management of clinical and non-clinical risk, which includes the reporting and management of incidents.
Executive Medical Director	Is responsible for communicating practice issues and learning for doctors following incidents.
Deputy Director of Nursing	On behalf of the Executive Director of Nursing is responsible for communicating practice issues and learning for nurses following incidents.
Associate Directors of Operations	To have an understanding of incidents trends in their portfolio to aid decision making and resource allocation.
Clinical Directors	• To ensure learning from incidents is embedded locally in service areas. • To provide assurance to the Trust Clinical Governance Committee that incidents are being reported, managed and learnt from comprehensively. • Signing off serious incident reviews locally within 1 week prior to submission to the Serious Incident Group.
Clinical Service/Nurse Managers	• To have an understanding of incidents trends in their portfolio to aid decision making and resource allocation. • To encourage/support Ward/Team Managers to promote a local learning culture through improved incidents reporting and local learning processes. • To ensure appropriate support is in place for staff, service users and families/carers following incidents. • To complete Eclipse Serious Incident Management Form B for senior sign off as described in **Appendix 1A**.
Ward/Team Managers	• To ensure the accuracy of incident reports and determine and document on the manager's incident form, that

	appropriate action has been taken in response to an incident or a near miss. • To initiate any additional action as necessary. • Have a responsibility to support staff and escalate reporting of incidents in line with risk criteria. • To provide reporters with feedback of actions following an incident. • To embed a local review process within regular team meetings to ensure thematic review of incidents and benchmarking against similar services.
All Staff	• All staff must report any untoward incident, near miss or serious incident within 1 working day. • All staff to ensure accurate recording of incidents on eclipse forms. • All staff must take any immediate action to ensure that any remaining risk is managed and no further harm is caused.
Trust Clinical Governance Committee	• Holds responsibilities for corporate recommendations arising from Serious Incidents Reviews. • Allocate SMART actions in response to corporate themed recommendations arising from Serious Incidents Reviews.
Serious Incidents Group	• Ensuring high quality of Serious Incidents Reviews prior to submission externally. • Formulate recommendations from Serious Incident Reviews.
Mortality Surveillance Group	Responsibility to be clarified at a future date.
Associate Director of Governance	• Delegated responsibility for Risk Management. • Updates to appendices identified in this policy may be approved by the Associate Director of Governance and reported at the next Trust Clinical Governance committee.
Head of Governance Intelligence	• Information Asset Owner for the Eclipse system and Eclipse reporting platform (Black Hole). • Responsibility for uploading patient safety incidents to the NRLS (National Reporting and Learning System) and SIRS (NHS Protect) • Provision of intelligence from incidents data and other governance data sources.
Head of Investigations	• Responsible for initial confirmation of serious incidents and allocating initial review grade • Has responsibility for allocation of review leads and defining terms of reference for investigations. • Responsible for reporting serious incidents to commissioners and entering/updating STEIS report.

5 DEVELOPMENT AND CONSULTATION PROCESS

Consultation summary	
Date policy issued for consultation	01/03/2016
Number of versions produced for consultation	1
Committees or meetings where this policy was formally discussed	
Trust Clinical Governance Committee	TBC

Where else presented	Summary of feedback	Actions / Response

6 REFERENCE DOCUMENTS

- This policy replaces the Incident Reporting and Management Policy (RS02/Version 3) and Incident Investigations Policy (Incorporating 'Being Open') (RS03/Version 2)
- NHS England Serious Incident's Framework 2015/2016
- NHS England Revised Never Events Policy and Framework 2015/2016

7 BIBLIOGRAPHY

- National Patient Safety Agency- NRLS 7 Steps to patient safety in mental health
- NRLS guidance documentation

8 GLOSSARY

- Eclipse: The Trust incident reporting and management system, known nationally as 'Safeguard' which is supplied by Ulysses.
- The Black Hole: The reporting platform on the trust intranet "Connect" that dynamically displays incidents analysis information and provides insight from other governance data sources.

9 AUDIT AND ASSURANCE

Element to be monitored	Lead	Tool	Frequency	Reporting Arrangements
Number of incidents being reported by staff disciplines	Associate Director of Governance	Quality Report	Monthly	Trust Board
NRLS reporting (including CQC notification via NRLS)	Head of Investigations	Organisation Patient Safety Report	Bi-annually	Trust Clinical Governance Committee
Deaths of Detained patients	Head of Investigations	CQC report and internal monitoring tool	Quarterly	Trust Clinical Governance Committee
Reported on STEIS within 48 hours	Head of Investigations	CQRG monthly report	Monthly	Clinical Quality Review Group
Submission of SI reviews within agreed timeframes	Head of Investigations	CQRG monthly report	Monthly	Clinical Quality Review Group
Internal management of incident and serious incidents process	Head of Governance Intelligence	Data Quality Tools	Daily	--
Data quality of Eclipse	Head of Governance Intelligence	Data Quality Tools	Daily	--
External Reporting requirements: *All external reporting is covered in appendix 5*				

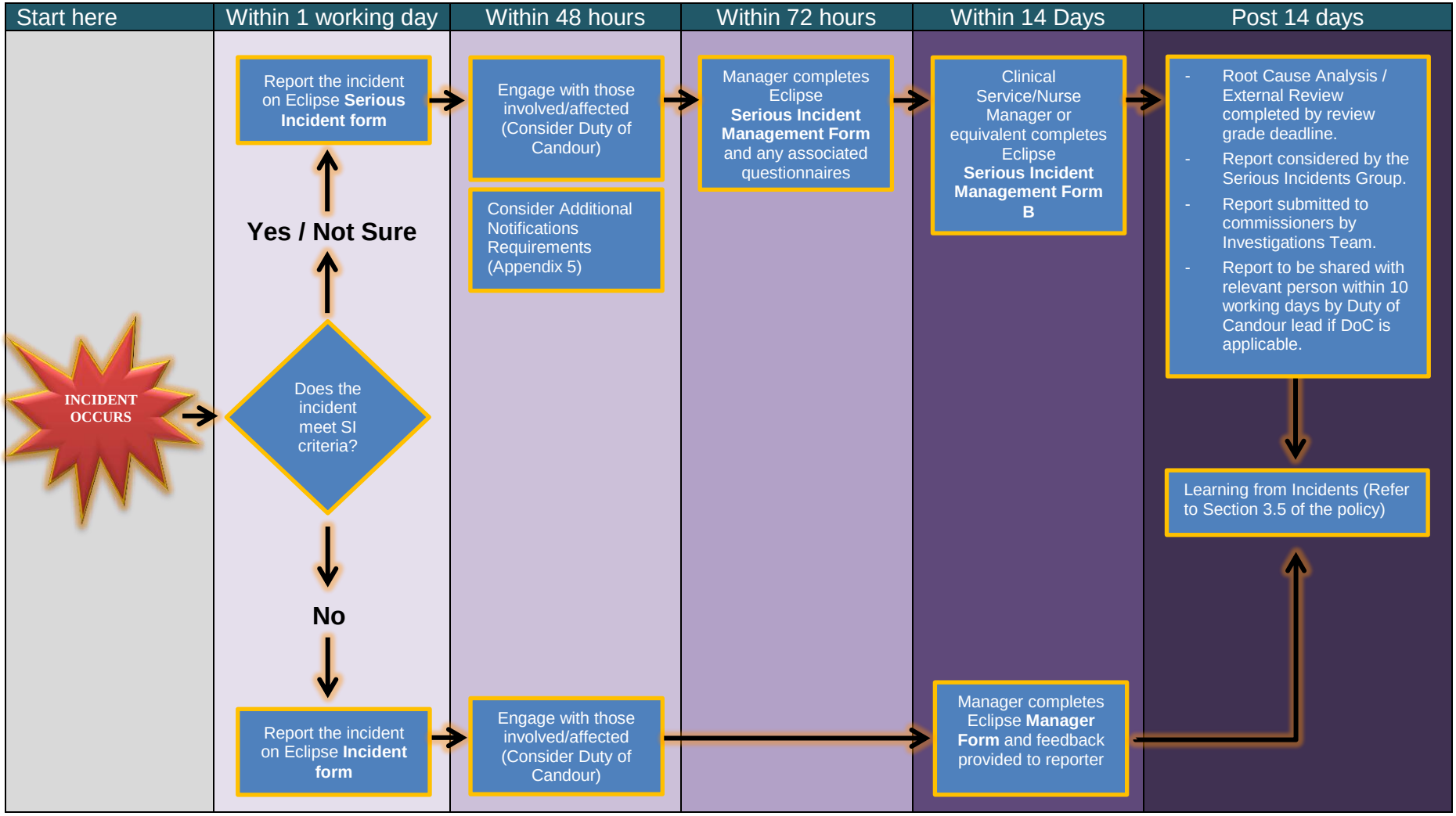
10 APPENDICES

Updates to appendices identified in this policy may be approved by the Associate Director of Governance and reported at the next Clinical Governance committee.

Please refer to the main policy index for a list of appendices.

10.1 Appendix 1: Incident reporting process & procedure guidance

10.1.1 **Appendix 1A: Incident process flowchart**



10.1.2 **Appendix 1B: Partnership Incident Reporting Arrangements**

Partnership	Team or Organisation Name	Incident Reporting Mechanism for ALL Staff
Solihull Emotional Wellbeing and Mental Health Service / SOLAR	Barnardos	Eclipse
Wolverhampton	360 (Young People)	Eclipse
	Recovery Near You (Pitt St)	Eclipse
	Enterprise	Eclipse
	Aquarius	Eclipse
Foston Hall	CAMEO	Secure Email
HMP Birmingham	Primary Care Team (B3, Ward 1)	Eclipse
SIAS	Aquarius	Eclipse
	Str8 Up	Eclipse
	Welcome	Eclipse
	The Bridge	Eclipse
PFI	AMEY	Eclipse
	Cofely	Eclipse

10.1.3 **Appendix 1C: Eclipse User Guides**

All user guides for Eclipse Modules are available on the home page of the Eclipse system. The guides could also be accessed by clicking **here**.

10.2 Appendix 2: Management of Incidents

10.2.1 Appendix 2A: Additional guidance on management of incidents

The focus of managing an incident should always be to reduce risks of further harm, and reoccurrence. The following guidance sets out in further detail key issues which may be considered.

1 Injuries

1.1 In the event of an injury to any person involved in Health and Social Care activities or on health and social care premises, the priority is to manage the situation safely and ensure that no further harm can occur.

1.2 Arrangements must then be made for the injured person to receive appropriate first aid/medical attention. If the injured person is a member of staff and the injury is minor, a First Aider should be contacted. If the injured person is a service user, a doctor should be contacted. In some circumstances, a "crash call" or a 999 emergency call may be required.

1.3 For Trust staff, certain injuries, such as inoculation incidents, bites and scratches must also be reported immediately via telephone to the Occupational Health Department, in accordance with the Inoculation Policy. If the injury occurs out of hours, the injured person must report to the nearest Accident & Emergency Department.

1.4 Non-Trust personnel incurring an injury should be strongly advised and assisted, if appropriate, to make an appointment to see their GP. If they are not registered with a GP, they should have assistance in attending the nearest Accident & Emergency Department.

1.5 Certain injuries are notifiable to the Health & Safety Executive. The Health and Safety Team will inform the Health & Safety Executive under RIDDOR, using Form F2508 or by e-mail to the Incident Contact Centre .(See Appendix 5)

1.6 In the event of a notifiable disease the HSE must be informed by the Health and Safety Team using Form F2508a or by an email to the Incident Contact Centre.(See Appendix 5)

2. Police Involvement

2.1 In certain circumstances, it may be necessary to notify the police of an incident, e.g. serious physical assault, service user absconsion, theft, deliberate fire setting, trespass or if a claim to the Criminal Injuries Compensation Authority may be made.

2.2 When a service user has committed an aggressive act, the clinical team needs to consider whether or not the police should be notified. In the event of actual physical assault all such cases must be reported to the Police (see Prevention & Management of Violence Policy). The Trust's Local Security Management Specialist (LSMS) should be notified of all cases involving assault to Trust staff and these will be reported to NHS Protect via SIRS (uploaded from Eclipse).

2.3 The Trust's LSMS is in post to support staff who are victims of a physical assault and to monitor and support police investigations into such matters.

Where a physical assault occurs, full details of the incident including police incident / crime number and the name

3. Fire

3.1 The Trust Fire Safety Policy and local Fire Procedures must be adhered to at all times, particularly in regard to calling the Fire Service and raising the alarm. Details of all fire setting incidents must be reported immediately to the Trust Risk & Safety Department. The Service development manager and the Head of Estates/Facilities Management must also be alerted (on-call arrangements apply out of hours).

3.2 For more detail, staff can refer to the Fire Safety Policy.

4. Security

4.1 In the event of a missing or absconded service user, the Missing Patients Policy must be followed.

4.2 The Trust's Local Security Management Specialist (LSMS) should be advised of serious security breaches as soon as is practicable depending on the seriousness of the incident and availability of the LSMS.

4.3 For further detail, staff can refer to the Security Management Policy.

4.4 In the event of an incident in which relates to the security of service user information, the Information Governance Lead must be informed who will then advise the Trust's Caldicott Guardian and where appropriate the Information Commissioner.

5. Infection & Notifiable Diseases

5.1 All incidents of infection (suspected or confirmed) must be reported to the Infection Control team and other providers e.g. Occupational Health department in line with overarching policy for Infection Control.

5.2 Where an individual (staff or service user) contracts an infection or condition, the Trust Infection Control team and health provider is to be contacted.

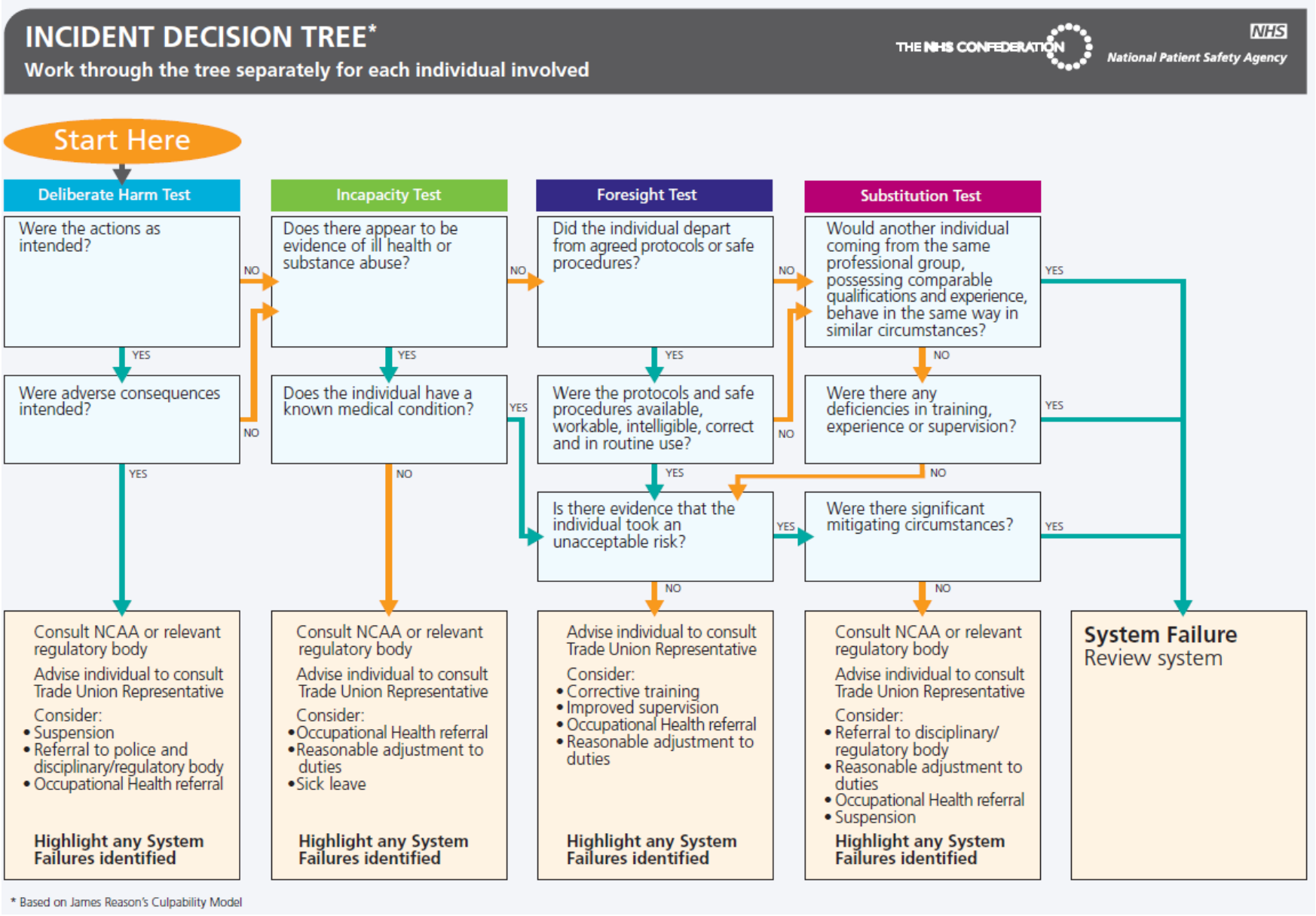
5.3 In the event of an infectious outbreak, the Infection Control team will notify Public Health England in addition to SI process instigated by the Head of Investigations.

5.4 Certain conditions are reportable to the Health & Safety Executive. In this event the HSE must be informed in line with Health and Safety policy.

6. Untoward Incidents involving medical devices

6.1 Estates and Facilities must also be notified and the Health & Safety Team must notify the MHRA (see Appendix 5).

10.2.2 **Appendix 2B: Incident Decision Tree**



10.3 Appendix 3: Serious incidents Criteria

NHS England Serious Incidents Framework 2015/2016 sets out the below circumstances in which a Serious Incident must be declared:

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

  - Unexpected or avoidable death of one or more people. This includes
    - suicide/self-inflicted death; and
    - homicide by a person in receipt of mental health care within the recent past (usually 6 months);

  - 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), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS funded care caused/contributed towards the incident (see Part One; sections 1.3 and 1.5 of the Serious Incidents Framework for further information).

- A Never Event - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death. See Never Events Policy and Framework for the national definition and further information;

- 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

Additional BSMHFT criteria:

- All deaths of service users in receipt of services or notified deaths of service users discharged within 6 months, where BSMHFT was the most recent primary care provider.

- A near miss that is based on an assessment of risk that considers: an assessment of risk that considers:

  - The likelihood of the incident occurring again if current systems/process remain unchanged; and
  - The potential for harm to staff, patients, and the organisation should the incident occur again.

- Escape / absconsion from a Medium Secure Facility (including failure to return from section 17 leave)
- Absconsion (excluding failure to return from leave) of service users under section
  - All absconsions will require an absconsion questionnaire to be completed on Eclipse as part of the management signoff.
- 16 – 18 year old admission to an adult bed
- Outbreaks or incidents of infection resulting in avoidable transmission.
- Grade 3 or 4 pressure ulcer (excluding those occurring within 3 days of admission / transfer from other healthcare facility – the transferring facility should be informed that the reporting responsibility lies with them in these instances) Ischaemic wounds in diabetic patients should not be confused with pressure ulcers. Contact the Tissue Viability Nurse for clarification if required.
- HMP Birmingham - Deaths in Custody and Deaths within 7 days of discharge from HMP Birmingham Healthcare and Deaths occurring whilst on release under temporary licence (RUTL) from HM Prison Birmingham.

10.4 Appendix 4: Review Grades for Serious Incidents

Review Grade	Review Type	When	Internal Timescale	External Timescale	STEIS Reportable	Example(s)
Grade 1	Senior clinical management review	Death from -Natural causes (except inpatient death) -Accidental e.g. RTA -Victim of homicide where the perpetrator is not associated with the Trust Detained patient found to be missing from ward (excluding PICU/Secure Services)	14 days	N/A	No	Community patient dies from cancer.
Grade 2	Non commissioners reportable Concise internal investigation	An incident or near miss where is an opportunity for significant learning that does not meet commissioner reportable criteria.	4 weeks	N/A	No	Sectioned patient found to be missing from the ward/PICU and is not involved in further incident whilst AWOL In-patient dies from natural causes whilst on ward. Failure to communicate discharge plans between teams led to a near miss.
Grade 3	Commissioner reportable senior clinical management review	A commissioner reportable incident that does not require a full internal investigation.	48 hours for Admission of <18	48 hours for Admission of <18	Yes	Admission of an under 18 to an adult ward
Grade 4	Concise internal investigation	Serious incidents meeting Serious Incident criteria, appendix 3 provides fuller explanation.	4 weeks	60 working days	Yes	• Suspected suicide of a community patient • Assaults resulting in serious harm. • Patient self-harms resulting in surgery. • Unencrypted memory stick containing patient information is stolen from Trust premises. • A patient fall that results in a fracture.

Review Grade	Review Type	When	Internal Timescale	External Timescale	STEIS Reportable	Example(s)
Grade 5	Comprehensive internal investigation	A serious incident that requires a panel approach for the investigation and is likely to result in a Grade 6 independent investigation.	8 weeks	60 working days	Yes	• In-patient commits suicide
Grade 6	Independent investigation	An independent investigation commissioned by external agency e.g. NHS England or the Executive team.	6 months	6 months from the date of investigation	Yes	A reinvestigation of a grade 5 review. Patient with an open episode of care (or recently discharge within 6 months) is the suspected perpetrator of a homicide.

10.5 Appendix 5: Additional Notifications requirements

Who to Notify	When	How	Primary Trust Policy (monitoring & audit)	By Who	Internal Notifications
HM Coroner & General Practitioner	Sudden and/or unnatural deaths / All deaths of inpatients	Direct telephone contact	R&S 02 The Reporting, Management and Learning from Incidents	Doctor	Legal Department
Health & Safety Executive (HSE)	Incidents notifiable under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR)	Online through HSE website - web form	R&S 16 Health & Safety	Health & Safety Team	Health & Safety Team
Medicines and Healthcare Related Products Agency (MHRA)	Suspected adverse reactions to medicines	Through the Yellow Cards System	C 06 Medicines Code	Clinicians / Healthcare workers	Pharmacy
Medicines and Healthcare Related Products Agency (MHRA)	Incidents relating to medical devices under MHRA/2007/001	Through MHRA website	C 06 Medicines Code	Clinicians / Healthcare workers	Health & Safety Team
Birmingham City Council / Solihull City Council (Environmental Health)	Confirmed reports of food poisoning	Direct telephone contact	IC 01 Infection Prevention and Overarching Policy & IC 01 – Annex H Outbreak of Infection Policy	Infection Control Team	Associate Director of AHP's and Physical Health & Wellbeing
Public Health England (PHE)	The recognition of a single case of infection with a novel or uncommon pathogen. All outbreaks and clusters of communicable diseases in the hospital (including	Direct telephone contact	IC 01 Infection Prevention and Overarching Policy & IC 01 – Annex H Outbreak of Infection Policy	Infection Control Team	Director of Nursing

Who to Notify	When	How	Primary Trust Policy (monitoring & audit)	By Who	Internal Notifications
	periods of increased incidence for C. Difficile)				
NHS Estates	Fire incidents	Annually through ERIC system	R&S 15 Fire Safety	Health & Safety Officers / Fire Advisor	
Care Quality Commission (CQC)	Absconsions from PICUs and Secure units where the patient has been detained under a hospital order.	Through CQC website	C37 Missing Patient	Nurse in Charge / Ward Manager	Mental Health Act Administrators
Care Quality Commission (CQC)	Deaths where the patient has been detained under a hospital order.	Through CQC website	R&S 02 The Reporting, Management and Learning from Incidents	Nurse in Charge / Ward Manager	Mental Health Act Administrators
Care Quality Commission (CQC)	Certain deaths of people using the service	Via National Reporting & Learning System (NRLS)	R&S 02 The Reporting, Management and Learning from Incidents	Governance Intelligence Team	
Care Quality Commission (CQC)	Allegations of abuse	Via National Reporting & Learning System (NRLS)	R&S 02 The Reporting, Management and Learning from Incidents	Governance Intelligence Team	Safeguarding Team
Care Quality Commission (CQC)	Events that stop or may stop the service running safely or properly	Via National Reporting & Learning System (NRLS)	R&S 02 The Reporting, Management and Learning from Incidents	Governance Intelligence Team	
Care Quality Commission (CQC)	Serious injuries to people who use the activity	Via National Reporting & Learning System (NRLS)	R&S 02 The Reporting, Management and Learning from Incidents	Governance Intelligence Team	

Who to Notify	When	How	Primary Trust Policy (monitoring & audit)	By Who	Internal Notifications
National Confidential Enquiry into Suicide & Homicide	Suicides or Homicides committed by a patient or discharged patient.	Professor Louis Appleby PO Box 86, Manchester, M29 2EF	CG 14 NICE Guidance and National Confidential Inquiries	Head of Investigations	
NHS Protect	Any incident of the following • Bribery • Corruption • Criminal Damage • Fraud • Theft • Violence, harassment, abuse and anti-social behaviour	Through the Security Incident Reporting System (SIRS)	R&S 02 The Reporting, Management and Learning from Incidents	Governance Intelligence Team	Local Security Management Specialist (LSMS)
NHS Commissioning Board Special Health Authority (formerly NPSA)	Unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving NHS-funded healthcare.	Through National Reporting and Learning System (NRLS)	R&S 02 The Reporting, Management and Learning from Incidents	Governance Intelligence Team	
Commissioning Groups - Birmingham Cross City - WMSCT - NCG - BDAAT / SDAAT - SS Cluster	Incidents that are identified as serious in alignment with the Trust Incident Reporting & management Policy	Through the Strategic Executive Information System (STEIS)	R&S 02 The Reporting, Management and Learning from Incidents	Investigations Team	
Information Commissioner's Office (ICO) Via Connecting for Health	All Information Governance incidents reported on Eclipse which meet a Level 2 final score	On the ICO Security breach notification form	R&S 02 The Reporting, Management and Learning from Incidents	Information Governance Lead	

10.6 Appendix 6: Never Events (NHS England 2015/16)

Never Events are defined by the Department of Health as 'serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers'.

The list of never events has been updated as part of the Never Events Policy and Framework published by NHS England 2015/2016. The list of never events is accessible by following the link below:-

https://www.england.nhs.uk/wp-content/uploads/2015/03/never-evnts-list-15-16.pdf