Birmingham and Solihull Mental Health NHS Foundation Trust

The Reporting, Management & Learning from Incidents Policy

Policy number and category	**RS02**	**Risk & Safety**
Version number and date	**6**	**October 2021**
Ratifying committee or executive director	**Clinical Governance Committee**	
Date ratified	**December 2021**	
Next anticipated review	**December 2024**	
Executive director	**Executive Director of Quality and Safety (Chief Nurse)**	
Policy lead	**Head of Patient Safety**	
Policy author *(if different from above)*	**As above**	
Exec Sign off Signature (electronic)		
Disclosable under Freedom of Information Act 2000	**Yes**	

Policy context

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 and their actions.

Policy requirement (see Section 2)

The Trust endorses the principles of being open and transparent when things do not go as expected.
This policy is based on the seven key principles of incident management outlined by NHS England's Serious Incident Framework (March 2015) that all incidents must be managed in an open and transparent manner, for example:

a) staff, patients / service users, their relatives and carers should, where appropriate, be involved in review that has taken place;
b) with future prevention as a key aim, a culture of learning required in order for the Trust to develop and improve the way care is organised and delivered;
c) in an objective style;
d) in a timely and responsive way;
e) based on systems as opposed to seeking to lay individual blame;
f) proportionately to the risks identified and outcomes experienced;
g) collaboratively, working closely with commissioners and other key providers.

2.2 Incidents will be:

h) reported using the Local Risk Management System; eclipse
i) risk assessed to ensure the individuals/environment involved are safe and
j) secure;
k) recorded as appropriate within clinical records;
l) assessed for both harm and impact, and where identified as serious, appropriate senior clinicians and managers will be informed;
m) serious incidents meeting the reporting criteria will be reported to NHS England via the Strategic Executive Information System (StEIS);
n) all incidents will be reviewed and approved on the Local Risk Management System in accordance with the guidelines enclosed.

2.3 Patients / service users and carers will be empowered, where appropriate and according to their wishes, to become involved in the investigations of serious incidents as part of the Trust's adherence to the principle of involvement within the National Patient Safety Strategy and Duty of Candour requirements.

2.4 All staff directly involved in incidents be supported appropriately and will be provided with the opportunity to reflect on and learn from the incident in a non-judgemental and open environment as part of the review process.

2.5 Each Clinical Division will have a system which allows for the review and monitoring of incidents including serious incidents. This will include processes to provide assurance on the timeliness and quality of any incident reviews, to provide consensus and monitoring of recommendations, this includes time scales
The Trust's Risk Management System's action planning module will be used to track completion

Contents

1. Introduction

1.1 Rationale (Why)

Birmingham and Solihull Mental Health Trust, hereafter referred to as the Trust is committed to providing high standards of care for our patients and service users. It acknowledges that sometimes, in the course of providing healthcare, incidents can occur, some of which have serious consequences for patients/service users their carers, families, staff and the public.

The Trust actively encourages open and honest reporting of risk, hazards, and incidents and to speak up when things go wrong. Equally it recognises that being involved in an incident can be a difficult and stressful time for staff concerned. The Trust takes it responsibility seriously and has developed guidance that focuses on supporting staff.

It is not the policy of the Trust to use the reporting of an incident itself to attribute blame to any individual. A Just and Learning Culture can be seen as an environment where we put equal emphasis on accountability and learning, staff are encouraged to report and learn from incidents to understand when things go well as well as responding when things do not go as planned. Further information on Just Culture can be found here **https://www.england.nhs.uk/patient-safety/a-just-culture-guide**.

The Trust is committed to promoting a culture of openness and has adopted Being Open principles when working with patients and families. Further guidance on communication in line with Being Open and Duty of Candour is outlined in Policy the Duty of Candour Policy C25. More detail can be found here **www.gov.uk/government/publications/nhs-screening-programmes-duty-of-candour/duty-of-candour**

The aim of this policy is to ensure that incidents are managed effectively, and immediate action/learning takes place.

1.2 Scope (Where, When, Who)

This policy applies to all staff (including HMP Birmingham) whether they are employed by the Trust permanently, temporarily through an agency or bank arrangement, are students on placement, are party to joint working arrangements or are contractors delivering services on the Trusts behalf.

An incident is defined as any event or circumstance that could have or did lead to unintended or unexpected harm, loss or damage relating to service users, members of staff, the public, and the environment or Trust property. Incidents that did lead to harm is referred to as adverse events. Incidents that did not lead to harm but could have are referred to as 'near misses' (adapted from: National Patient Safety Agency, 2001).

This policy applies to all incidents that:

a) Occur on Trust premises;
b) Occur off Trust premises but involve persons employed by the Trust whilst on Trust business;
c) Involve any patient receiving care from the Trust
d) Involve any patient who has been open to BSMHFT in the last 6 months;

e) All service user deaths within 6 months of discharge; expected and unexpected including HMP Deaths in Custody within 7 days of discharge from HMP Birmingham Healthcare and Deaths occurring whilst on release under temporary licence (RUTL) from HM Prison Birmingham." Further details on the reporting of deaths can be found in the Learning from Deaths Policy (C58)
f) Occur where services are shared with another provider organisation

2. The policy:

2.1 This policy is based on the seven key principles of incident management as outlined by NHS England's Serious Incident Framework (March 2015) that all incidents must be managed:

a) in an open and transparent manner, for example staff, patients / service users, their relatives and carers should, where appropriate, be involved in review that has taken place;
b) with future prevention as a key aim, a culture of learning required in order for the Trust to develop and improve the way care is organised and delivered;
c) in an objective style;
d) in a timely and responsive way;
e) based on systems as opposed to seeking to lay individual blame;
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e) serious incidents meeting the reporting criteria will be reported to NHS England via the Strategic Executive Information System (StEIS);

2.3 Patients / service users and carers will be empowered, where appropriate and according to their wishes, to become involved in the investigations of serious incidents as part of the Trust's adherence to the principle of involvement within the National Patient Safety Strategy and Duty of Candour requirements.

2.4 All staff involved in incidents will be supported emotionally according to their need. To be provided with the opportunity to reflect on and learn from the incident in a non-judgemental and open environment as part of the review process.

2.5 Each Clinical Division will have a system which allows for the review and monitoring of incidents including serious incidents. This will include processes to provide assurance on the timeliness and quality of any incident reviews, to provide consensus and monitoring of recommendations, this includes time scales and implementation of improvement plans. The Trust's Risk Management System's Action Planning module will be used to track completion of actions.

3. The procedure

3.1 When an incident is identified, immediate action must be taken by staff to ensure that:

- The area and any persons (including patients, staff and the public) affected by the incident are safe
- Prompt and appropriate clinical care provision is provided to prevent further harm
- A debrief session is held as soon after the event as possible to allow staff the opportunity to reflect on the situation and explore how it has made them feel. The exact nature of the support mechanisms used will be dependent on the type and severity of the incident and the needs of the individuals involved, managers must consider what support staff may require. The manager/person in charge should consider actions to protect the individual's wellbeing at all times. Further guidance on how to support staff following an incident can be found: **http://connect/corporate/humanresources/healthandwellbeing/wellbeingsupportandresources/Pages/Post-Incident-Support.aspx**
- The local management team are verbally informed of the incident.
- Depending upon the circumstances of the incident consideration should also be given to the incidents occurring "out of hours" and escalation to the senior manager on-call
- Any immediate safety concerns are shared across other areas of the organisation at the earliest opportunity

3.2 All incidents (including near misses) must be reported using the Trust reporting electronic system called Eclipse. Eclipse can be accessed via the "Home" page of the internal intranet site.

3.3 The Eclipse login is the same as your computer login (if single sign on is enabled you will be logged in automatically). A "How to Guide "on how to log an incident is available on the Eclipse system homepage.

3.4 Incidents should be reported within 24 hours of knowledge that they have occurred. In some situations, staff may not be aware that an incident has occurred until an unexpected outcome is detected sometime later. In such cases the incident should be reported retrospectively.

3.5 The incident report should be completed by staff who have been made aware of the incident by third parties, were involved in, witnessed or experienced the incident. It is the responsibility of all staff to ensure that incidents are reported to enable timely learning and to prevent recurrence.

3.6 There are two reporting options available, Serious Incident and Untoward Incident. There is no definitive list of incidents that should be declared as Serious Incidents and each incident must be considered on a case-by-case basis.

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 events which affect patients directly and include events which may indirectly impact patient safety or an organisation's ability to deliver on-going healthcare or systemic failings of an assurance system. There are however, certain incidents which must be declared as a Serious Incident and these are set out in the NHS England Serious Incident Framework (2015) **https://www.england.nhs.uk/patient-safety/serious-incident-framework/** When a death has been reported and does not meet the requirements of a serious incidents review, it will be considered under the Learning from Deaths policy (C58).

3.7 The severity of an incident will be determined using the NHS England – Degree of Harm (**https://www.england.nhs.uk/wp-content/uploads/2019/10/NRLS_Degree_of_harm_FAQs_-_final_v1.1.pdf**) and validated by the Governance Intelligence team. The statutory requirement to fulfil Duty of Candour must be considered for all patient safety incidents where there has been moderate harm or above to the service user/patient. Further detail can be found in the Duty of Candour Policy (C25)

3.8 The Trust acknowledges that not all staff feel psychologically safe to report incidents. Eclipse does accommodate anonymous reporting and assurance is given that details are not identifiable. If an incident is extremely sensitive and/or the reporter wishes to raise the issue through alternative routes, Freedom to Speak Up Guardians are available. You can contact one of the Speak Up Guardians directly in confidence via email bsmhft.speakup@nhs.net or phoning 0121 301 3940.

3.9 Once an incident has been reported the system will generate and send an automatic e-mail notification to the relevant staff, including subject matter experts. If the names of staff within a position change, we ask that you notify the Eclipse Team at **bsmhft.eclipse@nhs.net**. Certain incidents must be reported directly to the CQC. Incidents falling into this category will be identified and reported via the Regulatory and Compliance team. Staff with queries relating to this should contact the team direct. Following an information governance breach the Trust has 72 hrs from the point of being made aware of the incident to determine if the incident is reportable to the Information Commissioner's Office. Failure to the do this will result in financial penalty for the Trust.

3.10 The processes to be followed in relation to reporting, reviewing and learning from incidents are outlined in appendices 2 – 6 as follows

- Appendix 2 Incident Management Overall Process.
- Appendix 3 Initial reporting, review and escalation of incidents
- Appendix 4 Early review of Serious Incidents (72-hour review process)
- Appendix 5 Review allocation and level of review
- Appendix 6 Action Planning Module

- Appendix 7 Dissemination of Learning

3.11 The Trust will provide training related to incident reporting and learning review including:

a) Guidance on Eclipse on the completion of incident reporting forms;
b) Awareness raising sessions within Inductions along with update training;
c) Specifically tailored training for Departments and Teams – developed on request or through concerns regarding the level of reporting highlighted via trends analysis.
d) Training for Managers on how to sign-off incidents

3.12 The Trust will also provide training on Just and Learning Culture as a core element of promoting a patient safety culture

4. Responsibilities

Post(s)	Responsibilities	Ref
All Staff		
Chief Executive	Holds overall accountability for clinical and non-clinical risk, which includes the reporting and management of incidents	
Executive for Quality and Safety (Chief Nurse)	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.	
Service, Clinical and Corporate Directors	a) All Senior Managers to have responsibility for the management of incidents within the areas of their remit and control. Systems are in place to ensure that this is fully operationalised; b) it is the responsibility of senior managers to ensure a feedback/ communication loop about changes made in response to reported errors, near misses and incident & learning that is gained from the review process. c) Ultimately the aim is to ensure incidents do not happen again and the learning is fully implemented and monitored as part of the Trust and divisional governance requirements.	
Service Managers/Clinical Nurse Manager	a) To understand incident trends in their portfolio to aid decision making and resource allocation. b) To encourage/support Ward/Team Managers to promote a local learning	

	culture through improved incident reporting and local learning processes. c) To ensure appropriate support is in place for staff, service users and families/carers following incidents.	
Policy Lead	a) Responsibility for the management of the arrangements of the Trust's incident process on a day-to-day basis; b) Providing advice and support to Service Areas; c) coordinating and overseeing the investigations of serious incidents; d) supporting systems of learning from serious incidents to reduce risk; e) maintaining a status report on all serious incidents; f) ensuring the incident is reported to the host and commissioning CCG where appropriate; g) ensuring all incidents are entered onto the Trust's risk database (local risk management systems); h) ensuring incident trend analysis is presented to the Board of Directors and its Committees; i) ensuring a monthly Safety Report and annual report on serious incident management are prepared for the Board of Directors and the Board Committee overseeing quality issues; j) ensuring that there is a system in place to allow for accurate and timely upload of incidents to the National Reporting and Learning System (NRLS).	
Trust Board	The Trust Board has ultimate responsibility for risk management. It is responsible for engendering through its leadership the development of a strong learning culture. The Board has a leader acting as Director for Quality and Safety (Chief Nurse) who takes responsibility for the management of incidents and is responsible for oversight of progress.	
Integrated Quality Committee	This Board reporting Committee is responsible for receiving and reviewing reports on performance on incidents and identified trends and providing assurance to the Trust Board	

5. Development and Consultation process

Consultation summary		
Date policy issued for consultation	**October 2021**	
Number of versions produced for consultation	**1**	
Committees / meetings where policy formally discussed	**Date(s)**	
Where received	**Summary of feedback**	**Actions / Response**

*(*Add rows as necessary)*

6. Reference documents

- National Patient Safety Agency- NRLS 7 Steps to patient safety in mental health
- NRLS guidance documentation
- Learning from Deaths Policy (C58)
- Duty of Candour Policy (25)
- NHS England Just Culture Guide
- NHS England Serious Incident Framework (2015)

7. Bibliography

We wish to thank NHS Mersey Care for their inspiration and support

8. Glossary

Incident - "Incident" is used in this policy to refer to any event which gives rise to, or has the potential to, produce unexpected or unwanted effects involving the safety of service users, staff, visitors on Trust premises or employed by the Trust, or loss or damage to property, records or equipment which are on Trust premises or belong to the Trust. This includes accidents, clinical incidents, deaths, security breaches, violence, and any other category of event which does or could result in harm. It also includes failures of medical or other equipment.

Near Miss - A near miss is any occurrence where the effects of which were narrowly avoided due to luck or skilful management. For the purpose of this policy, the term ''incident'' includes near misses.

Major Incident - The term Major Incident is defined as, 'a significant event, which demands

a response beyond the routine, resulting from uncontrolled developments in the operation of the establishment or transient work activity' (HSE). The event may either cause, or have potential to cause, either:

- Multiple serious injuries, cases of ill health (either immediate or delayed), or loss of life, or
- Serious disruption or extensive damage to property, inside or outside the establishment In the case of a major incident, the Trust Major Incident Plan (IRP00) should be followed in the first instance. The Major Incident Plan is available in the policies section of the Trust intranet.

Never Event - Never Events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level and should have been implemented by all healthcare providers. A link to the national guidance is below

https://www.england.nhs.uk/publication/never-events/

9. Audit and assurance

The implementation of this policy and the Trust's adherence to local and national standards will be monitored both internally and externally

9.2 The Trust is externally held to account via contractual arrangements by BSOL CCG and NHS Specialist Commissioners on its management of incidents. This includes ongoing assessment and feedback on the quality and timeliness of serious incident learning review reports on an ongoing basis

9.3 The level of incident reporting in the Trust is monitored via the National, Reporting and Learning System (NRLS), which reports nationally on an annual basis the number of patient safety incidents that are reported within each NHS Trust. The Trust will use benchmarking data arising from this to monitor its safety culture within the organisation.

10. Appendices

Equality Analysis Screening Form

A word version of this document can be found on the HR support pages on Connect
http://connect/corporate/humanresources/managementsupport/Pages/default.aspx

Title of Proposal	Amendment to the Reporting, Management and Learning from Incidents Policy		
Person Completing this proposal	Samantha Munbodh	**Role or title**	Head of Patient Safety
Division	Governance	**Service Area**	Corporate
Date Started	27 September 2021	**Date completed**	27 September 2021

Main purpose and aims of the proposal and how it fits in with the wider strategic aims and objectives of the organisation.

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.

The purpose of the policy is to ensure that internally

- There is a clear understanding of what an incident or near miss is.
- Staff are supported appropriately when they are involved in an incident
- How to report an incident on Eclipse, the Trust Risk Management System,
- 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.

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 by the National Serious Incident Framework

Who will benefit from the proposal?

All patients, families and staff

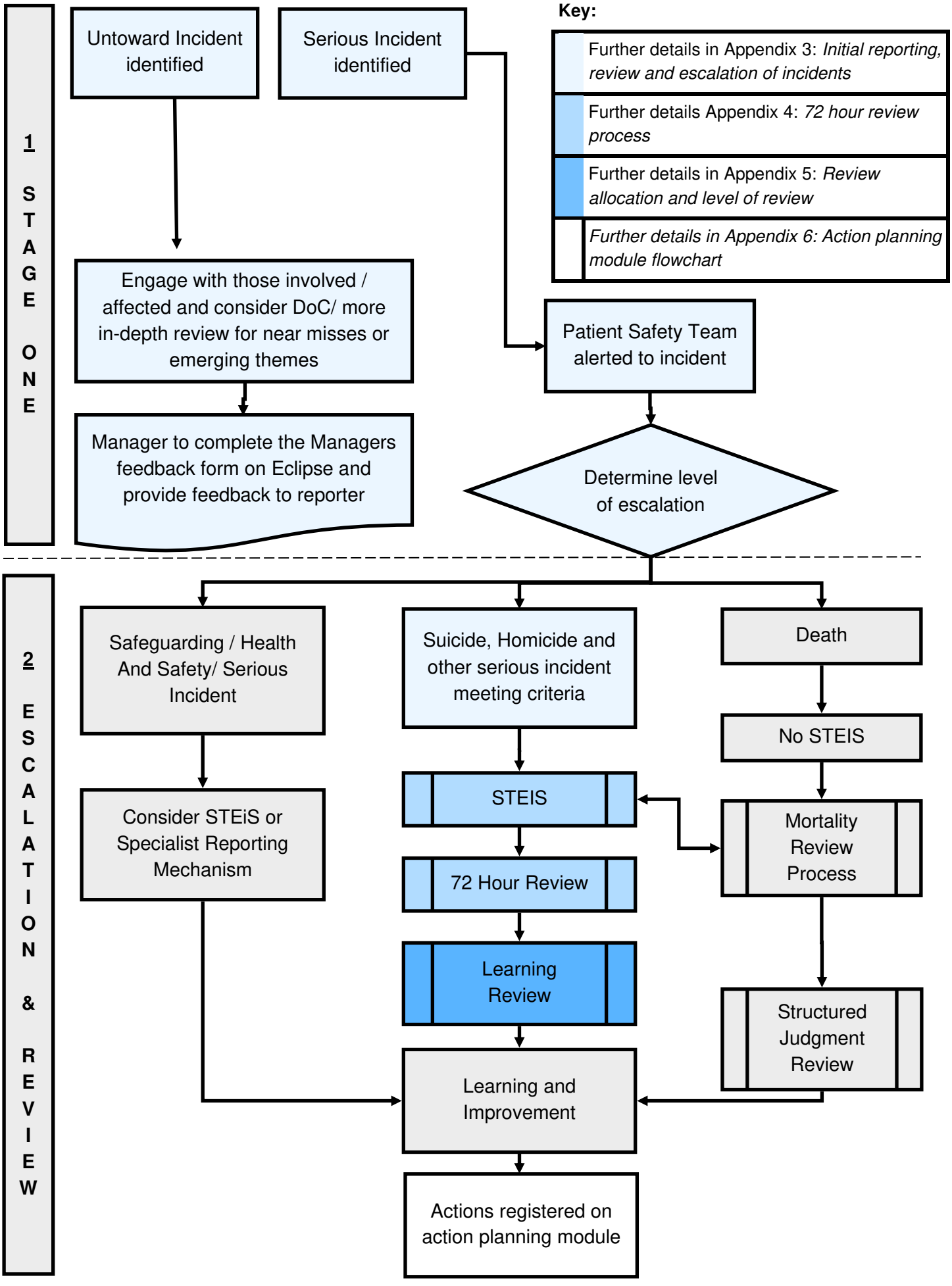
Impacts on different Personal Protected Characteristics – *Helpful Questions:*				
This policy has no negative impact on any personal protective characteristics, it aims to promote involvement and fair treatment				*Promote good community relations?* *Promote positive attitudes towards disabled people?* *Consider more favourable treatment of disabled people?* *Promote involvement and consultation?* *Protect and promote human rights?*
Please click in the relevant impact box or leave blank if you feel there is no particular impact.				
Personal Protected Characteristic	**No/Minimum Impact**	**Negative Impact**	**Positive Impact**	**Please list details or evidence of why there might be a positive, negative or no impact on protected characteristics.**
Age			X	
Including children and people over 65 Is it easy for someone of any age to find out about your service or access your proposal? Are you able to justify the legal or lawful reasons when your service excludes certain age groups				
Disability			X	
Including those with physical or sensory impairments, those with learning disabilities and those with mental health issues Do you currently monitor who has a disability so that you know how well your service is being used by people with a disability? Are you making reasonable adjustment to meet the needs of the staff, service users, carers and families?				
Gender			X	
This can include male and female or someone who has completed the gender reassignment process from one sex to another Do you have flexible working arrangements for either sex? Is it easier for either men or women to access your proposal?				
Marriage or Civil Partnerships			X	
People who are in a Civil Partnerships must be treated equally to married couples on a wide range of legal matters Are the documents and information provided for your service reflecting the appropriate terminology for marriage and civil partnerships?				
Pregnancy or Maternity			X	
This includes women having a baby and women just after they have had a baby Does your service accommodate the needs of expectant and post-natal mothers both as staff and service users? Can your service treat staff and patients with dignity and respect relation into pregnancy and maternity?				

Race or Ethnicity			X	
Including Gypsy or Roma people, Irish people, those of mixed heritage, asylum seekers and refugees What training does staff have to respond to the cultural needs of different ethnic groups? What arrangements are in place to communicate with people who do not have English as a first language?				
Religion or Belief			X	
Including humanists and non-believers Is there easy access to a prayer or quiet room to your service delivery area? When organising events – Do you take necessary steps to make sure that spiritual requirements are met?				
Sexual Orientation			X	
Including gay men, lesbians and bisexual people Does your service use visual images that could be people from any background or are the images mainly heterosexual couples? Does staff in your workplace feel comfortable about being 'out' or would office culture make them feel this might not be a good idea?				
Transgender or Gender Reassignment			X	
This will include people who are in the process of or in a care pathway changing from one gender to another Have you considered the possible needs of transgender staff and service users in the development of your proposal or service?				
Human Rights			X	
Affecting someone's right to Life, Dignity and Respect? Caring for other people or protecting them from danger? The detention of an individual inadvertently or placing someone in a humiliating situation or position?				
If a negative or disproportionate impact has been identified in any of the key areas would this difference be illegal / unlawful? I.e., Would it be discriminatory under anti-discrimination legislation. (The Equality Act 2010, Human Rights Act 1998)				

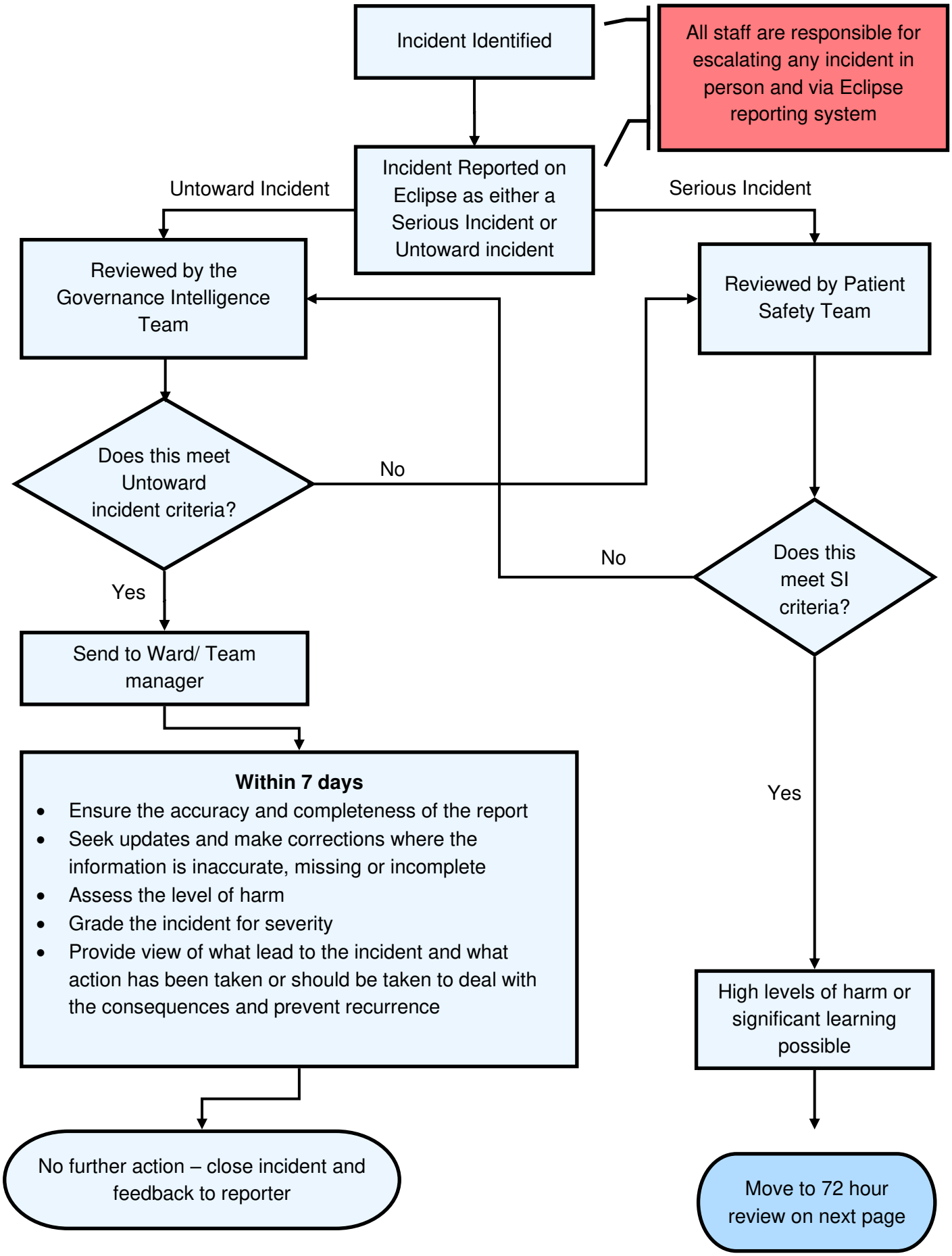
	Yes	**No**		
What do you consider the level of negative impact to be?	**High Impact**	**Medium Impact**	**Low Impact**	**No Impact**
				X

If the impact could be discriminatory in law, please contact the **Equality and Diversity Lead** immediately to determine the next course of action. If the negative impact is high a Full Equality Analysis will be required. If you are unsure how to answer the above questions, or if you have assessed the impact as medium, please seek further guidance from the **Equality and Diversity Lead** before proceeding. If the proposal does not have a negative impact or the impact is considered low, reasonable or justifiable, then please complete the rest of the form below with any required redial actions, and forward to the **Equality and Diversity Lead.**
Action Planning:
How could you minimise or remove any negative impact identified even if this is of low significance?
How will any impact or planned actions be monitored and reviewed?
How will you promote equal opportunity and advance equality by sharing good practice to have a positive impact other people as a result of their personal protected characteristic.
Please save and keep one copy and then send a copy with a copy of the proposal to the Senior Equality and Diversity Lead at **bsmhft.hr@nhs.net** . The results will then be published on the Trust's website. Please ensure that any resulting actions are incorporated into Divisional or Service planning and monitored on a regular basis.

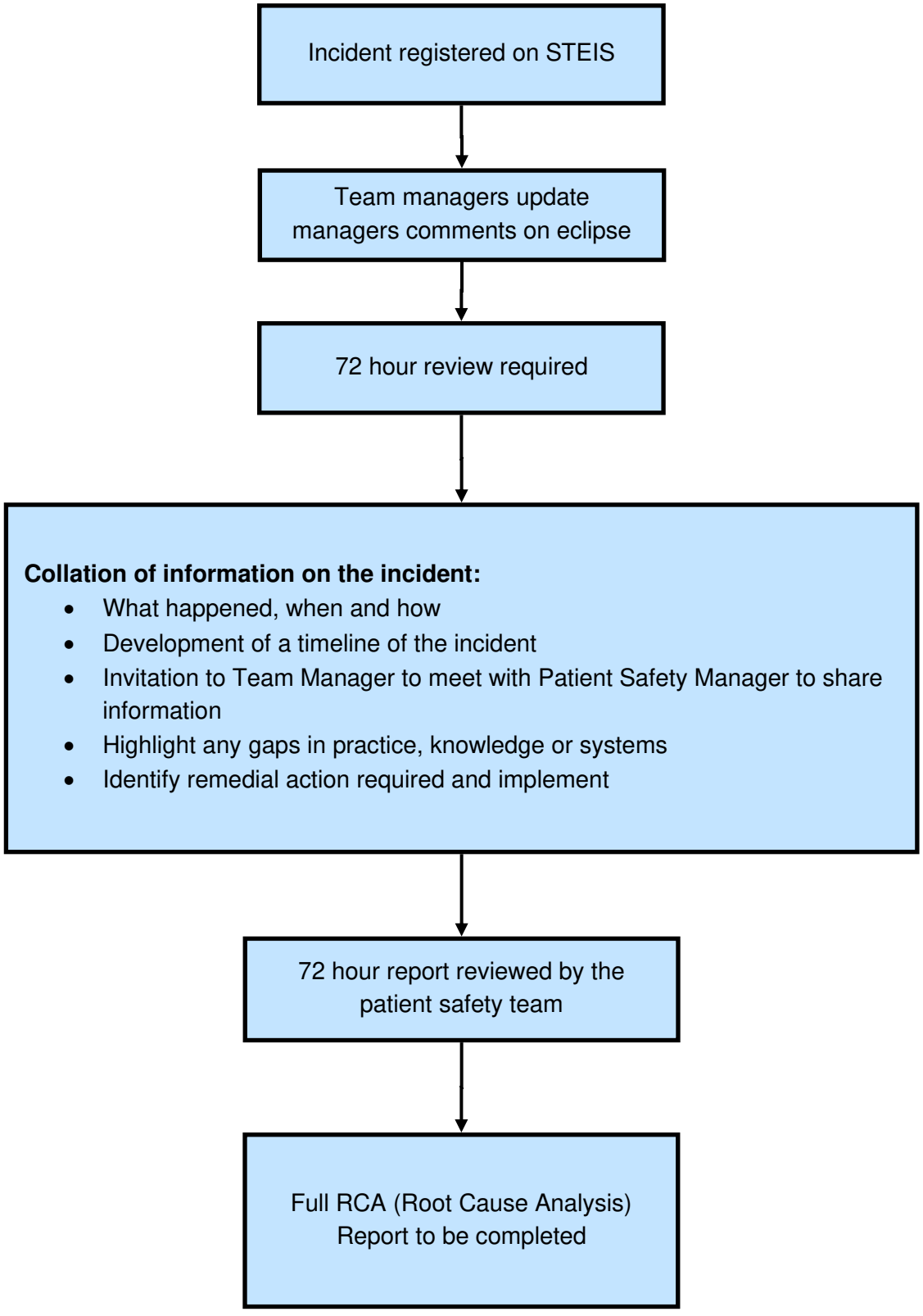
Incident Management Overall Process



Initial reporting, review, and escalation of incidents

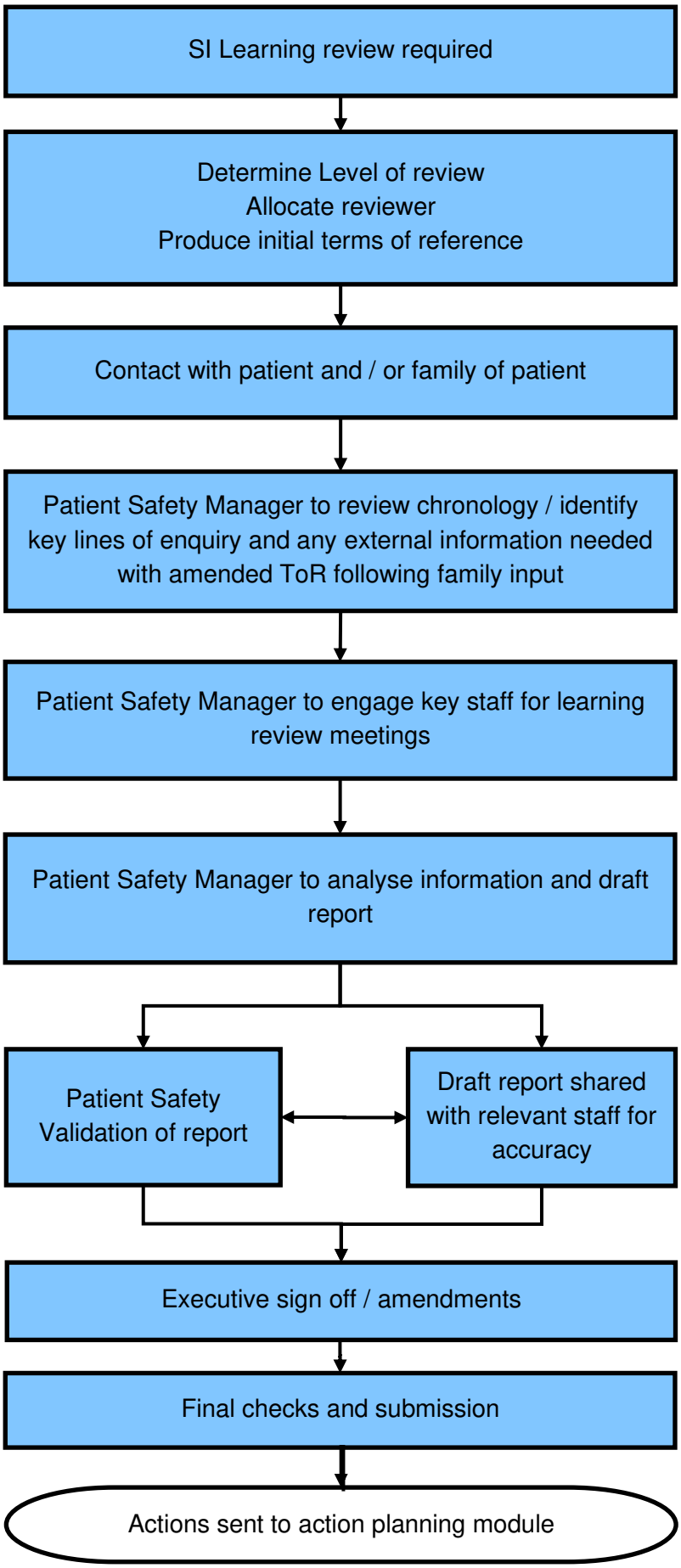


72 hour review process

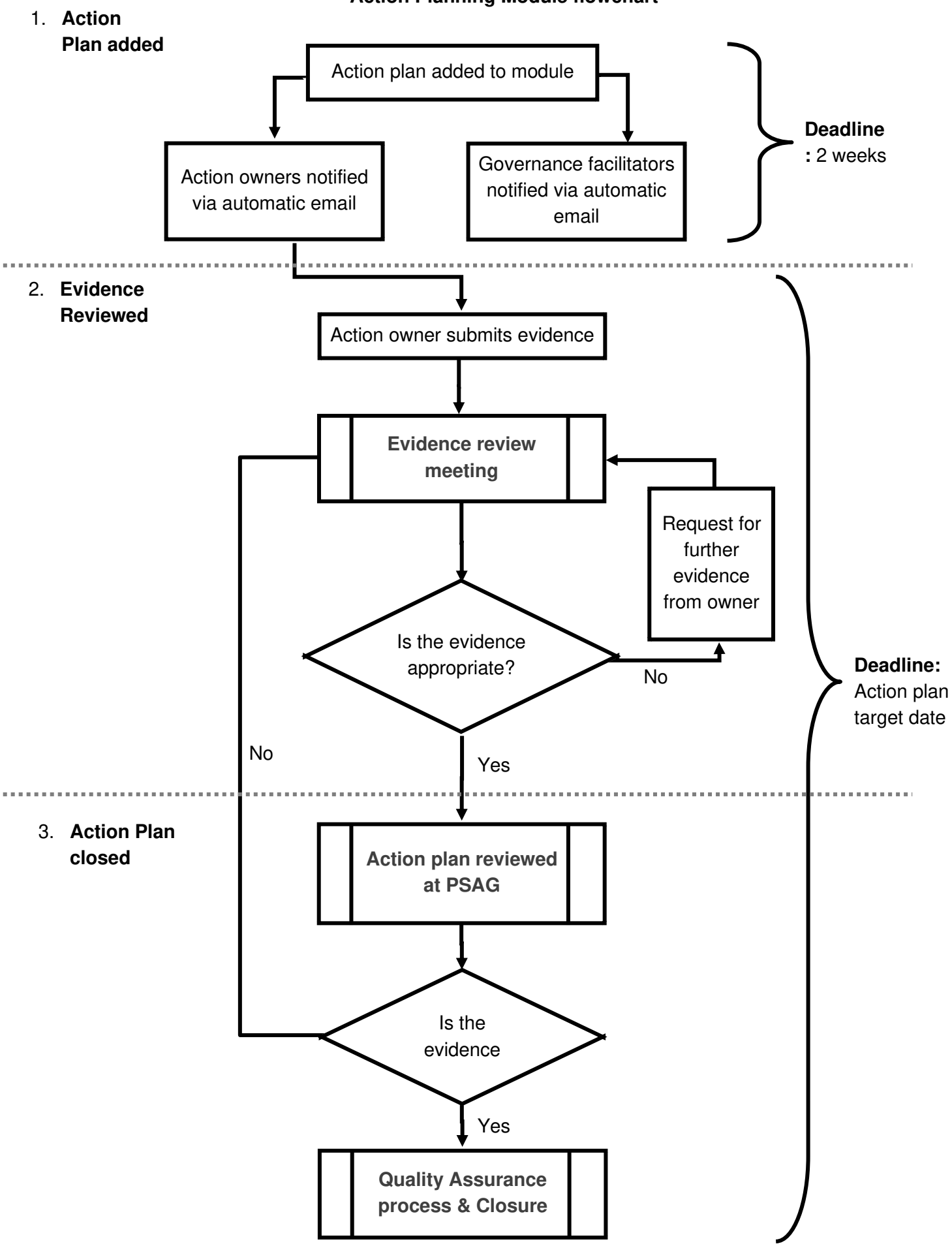


Appendix 5

Review allocation and level of review



Action Planning Module flowchart



Appendix 7

Dissemination of learning

The Trust has a commitment to organisational and local learning.

Themes and Trends - the Black Hole within the eclipse system on the trust intranet site (Connect) provides interactive reports for teams and service areas to learn from incident data. The information on the Black Hole is updated daily and provides staff with in-depth incidents analysis to support learning**.**

Sharing of learning from a Serious Incident - The findings of the report should be shared with the team involved at the earliest possible opportunity this can be undertaken before the recommendations have been written, this will give the opportunity for staff to contribute to actions to enhance patient safety and experience.

Sharing the Findings of incident Investigations - The Trust has a desire to be open and transparent with patients/service users, carers and staff to ensure that those involved have the opportunity to understand what has happened and where possible why the incident occurred. Information regarding how the Trust is going to improve practice and complete recommendations will also be shared with key stakeholders. Confidentiality of information shared by patients/service users should be maintained and reports will only be shared with family and carers with their permission, where this is possible to be obtained.

Sharing of Learning – alternative methods

Reflective practice – To help learn from experience the Trust actively encourages reflective practice, whether this is individually or as a group. To help do this in a structured way Gibbs (1988) Reflective Cycle "Learning by Doing" is highly recommended**.**

Kitchen Table/ Dare to Share – Value based learning / Kitchen Tables – Value based learning involves sessions that are facilitated by the Patient Safety team. A Kitchen Table event is where people can talk openly and honestly, without judgment and above all be listened to. Informal discussions will take place around what is important to staff about keeping people safe and whether they have any suggestions on how patient safety can be improved within the Trust. The details of either one incident or a group of similar incidents are shared with staff who will then work on identifying the issues or concerns and recommendations to prevent reoccurrence.

Quality Practice Alerts (QPA) - These are alerts regarding a patient safety or Trust business related matters that are shared across the organisation via electronic communication. The issues raised can emanate from any category of incident including those arsing from safeguarding concerns, complaints or claims.

Any member of staff can request that a QPA is shared. The sharing of the alert is considered by the Patient Safety Advisory Group and the staff member requesting the dissemination. It is important that QPAs are targeted at the most influential and appropriate audience.

In each case the QPA must clearly state the actions that should be taken and whom by. Timescales are given for feedback and the evidence of actions collated. Consideration should always be given to how

a person's human rights will be maintained where QPAs are suggesting restrictions or might affect those with a protected characteristic.

Equality Impact - In order to prevent the further enhancement of health inequalities we must monitor and understand the impact on service user and staff populations, this means regularly interrogating the data to understand where disproportionate impact may occur across staff and service users. This data is to be used regularly to inform and challenge service and pathway development and recurring disproportionate impact escalated.

Quarterly Bulletin – The Patient Safety Team will share learning from incidents via a quarterly newsletter to all staff

It Takes 3 - Basic details of an incident review can be captured and shared during opportunities in clinical practice such as Safety Huddles. These briefings are designed to allow for succinct delivery of the learning arising from a review to allow for assimilation to practice