The Reporting, Management & Learning from Incidents Policy

POLICY NUMBER & CATEGORY	**RS 02**	**Risk & Safety**
VERSION NO & DATE	**5**	**May 2018**
RATIFYING COMMITTEE	**Clinical Governance Committee**	
DATE RATIFIED	**August 2018**	
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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.

What do I need to know

We have included the following practice guidance notes to support staff with this policy

- **How to report, manage & learn from incidents (RS02-PGN-01)**
- **Supporting staff involved in an incident (RS02-PGN-02)**
- **How to investigate (RS02-PGN-03)**

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 within 7 days for untoward incidents and 72 hours for serious incident 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 implement a local learning from incidents process in line with practice guidance (RS02-PGN-01).
- 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, family/carers and service users 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. **Practice Guidance notes "How to report, manage and learn from incidents (RS02-PGN-01)** identifies timeframes for incidents management and learning.

2.6 Managers should feedback actions and comments following an incident to the initial reporter of the incident; this is a mandatory requirement on Eclipse.

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 Where a serious incident has been identified there will be an independent Serious Incident Review lead identified to undertake investigation in line with

the national Serious Incidents Framework, please refer to section 3.3.13 for further details on the management of serious incidents.

2.9 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.

2.10 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 NHS Improvement 'A Just Culture Guide' (**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.

2.11 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 As outlined in the NHS England – Serious Incident Framework, serious incidents are events in healthcare 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

3.1.2.3 Whilst not all incidents would qualify as commissioner reportable serious incidents, we recognise that there may be opportunities for learning by applying the serious investigations methodology for such cases. These cases will be identified will be identified as internal serious incidents and will follow a similar process to commissioner reportable cases with the exception of external reporting.

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 in line with NHS Improvement 'A just culture guide'. (**Appendix 2B).**

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, alternatively a member of staff can contact the Trust Freedom to Speak Up Guardian to raise concerns. Should the Dear John or Freedom to Speak Up process identify any quality/safety issues then an incident should be reported on Eclipse sensitively so learning could take place in an open and transparent way.

3.3 Management of incidents

3.3.1 Immediate response to an incident

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

3.3.3 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.

3.3.4 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.

3.3.5 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.

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

3.3.7 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 go home, management must be advised of this action. Other individuals should also be offered support where appropriate.

3.3.8 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.

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

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

3.3.10.1 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.

3.3.10.2 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. 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 contact with the relevant person is required within 10 working days (Refer to the Duty of Candour policy (C25)).

3.3.10.3 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.

3.3.10.4 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).

3.3.11 **Standards for Supporting Staff**

3.3.11.1 The Trust acknowledges that staff may find being involved in an incident to be stressful and recognises that it is therefore important that staff

are appropriately supported. This applies to all staff, including bank, agency and locum workers, volunteers and those on work experience. Please refer to **Practice Guidance notes "Supporting staff involved in an incident (RS02-PGN-02)**.

3.3.12 **Untoward Incidents Management Process**

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

3.3.12.2 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 7 days of the incident being reported.

3.3.12.3 Please refer to **Practice Guidance notes "How to report, manage and learn from incidents (RS02-PGN-01)** for further guidance.

3.3.13 **Serious incidents Management Process**

3.3.13.1 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.

3.3.13.2 Please refer to **Practice Guidance notes "How to report, manage and learn from incidents (RS02-PGN-01)** for further guidance.

3.3.13.3 **Assessing whether an incident is a Serious Incident**

3.3.13.3.1 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.

3.3.13.3.2 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.

3.3.13.3.3 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.

3.3.13.4 **Grading of serious incidents and Learning from Deaths**

3.3.13.4.1 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.

3.3.13.4.2 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).

3.3.13.5 **Allocation of review leads**

3.3.13.5.1 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.

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

3.3.13.6 **The Investigation process**

3.3.13.6.1 Once a review lead has been allocated an incident will be reviewed using the principles of the Serious Incident Framework (NHS England, 2015). Please refer to **Practice Guidance notes "How to investigate (RS02-PGN-03)** incident' for further guidance.

3.3.13.7 **Quality assurance of serious incidents investigations**

3.3.13.7.1 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.

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

3.3.13.7.3 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.

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

3.3.13.8 **Independent investigations**

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

3.3.13.8.2 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.

3.3.13.8.3 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

3.3.13.8.4 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

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

3.4 Learning from Incidents

3.4.1 In an organisation as complex and diverse as Birmingham and Solihull Mental Health NHS Foundation Trust, it is inevitable that the organisation will experience a large number of incidents ranging from near miss, no harm

activity to the most serious. It is only thorough a robust learning process, can an organisation really learn and improve the quality and safety of the care it delivers. Assurance and effectiveness will be sourced through local and trust clinical governance. Please refer to **Practice Guidance notes "How to report, manage and learn from incidents (RS02-PGN-01).**

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.
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 sign off untoward incidents within 7 days • To complete management reports for serious incidents within 72 hours • 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.
Learning from Deaths Group	• To assign final avoidability score on deaths that have undergone a root cause analysis investigation.
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) • 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	14/05/2018
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 2018

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
NRLS reporting (including CQC notification via NRLS)	Head of Governance Intelligence	Organisation Patient Safety Report	Bi-annually	Trust Clinical Governance Committee
Deaths of Detained patients	Head of Compliance	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 Practice Guidance Notes

10.1.1 **How to report, manage & learn from incidents (RS02-PGN-01)**

The Reporting, Management & Learning from Incidents Policy Practice Guidance Note

How to report, manage & learn from incidents?

Date Issued	Planned Review	PGN No:
Issue 1 – April 2018	April 2020	RS02-PGN-01
Author / Designation	Haider Al-Delfi – Head of Governance Intelligence	
Responsible Officer / Designation	Haider Al-Delfi – Head of Governance Intelligence	

Content

What do I need to know	
• Report incidents on **Eclipse** within 1 working day. Ensure the record is accurate, complete and factual.	All
• The more incidents are reported, the more information is available about what is going wrong, and the more action can be taken to improve quality and safety of care	All
• Utilise incidents data on the Black Hole and from within RiO to learn from incidents and to inform clinical practice.	All
• Sign off untoward incidents within 7 days	Managers
• Complete serious incidents management reports within 72 hours	Managers
• Utilise NHS Improvement 'A just culture guide' to treat staff fairly after incidents.	Managers
• Embed a robust local review process within regular team meetings to learn from incidents and to influence practice.	Managers
• Promote a learning culture within your team to engage staff and improve services.	Managers
• Contact the Governance Intelligence Team for support and feedback	All

Introduction

Responding appropriately when things go wrong in healthcare is a key part of the way that the NHS can continually improve the safety of the services we provide to our patients. We know that healthcare systems and processes can have weaknesses that can lead to errors occurring and, tragically, these errors sometimes have serious consequences for our patients, staff, services users and / or the reputation of the organisations involved themselves. It is therefore incumbent on us all to continually strive to reduce the occurrence of avoidable harm.

Over the last decade the NHS has made significant progress in developing a standardised way of recognising, reporting and investigating when things go wrong and a key part of this is the way the system responds to serious incidents.

Dr. Mike Durkin – National Director of Patient Safety – NHS England, NHS England Serious Incident Framework (March, 2015).

Birmingham and Solihull Mental Health NHS Foundation Trust (the Trust / BSMHFT) has adopted the principles of the National Patient Safety Agency's "Seven Steps to Patient Safety" and embedded them into day to day practice.

Within "Seven Steps to Patient Safety", it concludes that in respect of reporting:

> *"Research has shown that the more incidents are reported, the more information is available about what is going wrong, and the more action can be taken to make healthcare safer. That is why it is important that all staff, both clinical and non-clinical, have the confidence and knowledge to report all patient safety incidents. Analysis at a national level will enable service-wide action where patterns, clusters or trends reveal the scope to reduce risk or prevent recurrence for future patients."*

The Trust has a responsibility to manage all its incident activity in a timely manner, which will include communicating incident activity with external agencies.

This Practice Guidance Note (PGN) is written to inform all employees of the reporting, management and learning mechanisms in place within the Trust.

Whilst the above may imply that incidents are solely directed to clinical practice, it must be highlighted that this is a Trust-wide Practice Guidance Note and will also include all incidents which occur in non-clinical settings, in essence the principles of "Seven steps to patient safety", are of utmost importance to all who work in a healthcare setting.

1 How to report an Incident?

All staff must **report** untoward incidents, near misses and serious incident on Eclipse (BSMHFT incident reporting and management system) **within 1 working day**. When the incident has been stabilised, ensure the incident is reported on Eclipse as soon as is practicable (click here to access Eclipse).

The following requirements are of paramount importance when reporting on Eclipse:

- Accuracy of information;
- Record only fact not opinion;
- Complete all the appropriate sections, many sections on the form are mandatory, so will need to be completed before the form can be submitted;
- Help sections have been provided by each section to aid with completion.

Be aware of your responsibilities for incidents that meet the criteria for notification to external organisations as defined in **Appendix 5** of the policy.

Incident forms in draft format, also known as “Save for Later”, must be completed by reporters within 7 days of initial entry, this is to ensure timely capturing of information and improved data quality. If after 7 days the incident remains in “Save for Later” status, the Governance Intelligence Team will deactivate the incident and communicate the change to the relevant operational team where known.

The Governance Intelligence Team can support you in this process (click here for team contact details). A short training package is available on BSMHFT e-learning zone.

2 How to Manage an Incident?

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

- Ensure the safety of all affected by the incident and provide emergency / life-saving care if required;
- Ensure the safety of the environment, in the most serious of incidents; this will need to be kept secure to aid with potential criminal investigations;
- Ensure any equipment involved in an incident is retained in a safe area for further examination / inspection.

- Offer support where required, this is further explained in Practice Guidance Note, RS02–PGN-02 'Supporting Staff involved in an Incident';

- Escalate to Point of Contact or Senior / On-Call Manager as appropriate.

It is the Manager's responsibility to ensure that appropriate action has been taken to address the incident, to identify local learning lessons and to 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 7 days** for untoward incidents **and within 72 hours for serious incidents**. 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 contact with the relevant person is required within 10 working days.

Where further information becomes available after signoff the manager should update the eclipse form and attach any relevant documents. Alternatively, the manager should contact the Governance Intelligence Team to update the incident.

The nature of the incident will directly impact on the follow up action, for example a serious incident of unexpected death in community setting will have immediate actions through the Duty of Candour process, supporting families, carers and staff to come to terms with the loss, and supporting any agencies that are currently involved to understand the circumstances. However, if there has been an in-patient unexpected death a greater level of support may be required due to ongoing Police, Health and Safety Executive and Care Quality Commission investigations.

Where an incident highlights concerns around practice/performance this should be managed through existing Human Resources policies. The NHS improvement 'A just culture guide' could be utilised to establish further clarity, see Appendix 2B in the policy.

Further guidance on managing incidents with injury, police involvement, fire, security, infection & notifiable diseases and medical devices is available in appendix 2A .

3 Learning from incidents and near misses

In an organisation as complex and diverse as Birmingham and Solihull Mental Health NHS Foundation Trust, it is inevitable that the organisation will experience a large number of incidents ranging from near miss, no harm activity to the most serious. It is only thorough a robust learning process, can an organisation really learn and improve the quality and safety of the care it delivers.

When activity is reported, in line with Trust Policies, the learning from incidents occurs at different stages depending on the context and severity of incidents. This Practice Guidance Note gives an indication of the processes existing at BSMHFT to support learning from incidents and near misses within 24 hours, 7 days, 1 month, 1-3 months and annually.

Learning within 24 hours

As incidents are reported on Eclipse (BSMHFT Incidents Reporting and Management System), automatic email notifications are distributed to managers and subject matter experts. Furthermore, incidents are displayed within patients' RiO records approximately 5 minutes from the time initially reported. This enables clinicians to have timely access to incidents data to inform risk management and care planning activities.

Within the first 24 hours, systems will have been stabilised, an assessment will have been carried out of whether there is a need to urgently communicate across the Trust, to inform other services of the risk of the incident re-occurring. There may be a consideration of creating a new risk through the risk management processes of the Trust. For any serious incident the relevant management team is required to complete an initial management report on Eclipse within 72 hours, this indicates what they have done, who they have supported, how our responsibilities under Duty of Candour have been fulfilled. This report is sent to the Investigations team and electronic notifications are distributed to operational colleagues so they are fully briefed about the incident.

As part of immediate actions managers in partnership with the Governance Team of the Trust, can decide that it is important to cascade an outcome of the incident to other areas and teams. Examples of these alerts:

- Any new type of illicit substance / New Psychoactive Substance that is currently circulating and the risks they pose;
- Any new type of ligature risk following a self-harm episode, with advice / guidance and support;
- Issues in relation to clinical practice following the review of an incident or number of incidents;
- Clarification to Clinical Teams about standards and practice where it is found that clinical standards have not been complied with i.e. observation, seclusion etc.;
- Standardisation of incident collection, in order to inform other agencies of risks such as ambulance delays etc.

Learning within 7 days

It is the Manager's responsibility to ensure that appropriate actions have been identified / undertaken by the local management team and lessons learned and outstanding actions have been documented on Eclipse management form in line with the timeframes identified in Section 3 of this PGN. Management comments are displayed within RiO approximately 5 minutes after the record is updated.

Managers should have a robust 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.

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

Every Monday the Trust's serious incidents, complaints and complex clinical issues are discussed by the Executive Team at the Executive Team weekly meeting.

Clinical governance facilitators are notified of all incidents for their area(s) and all trust-wide completed Serious Incidents Reviews on daily basis to gain better insight of local practice and to contribute towards improving local reporting culture, quality of care and safety.

The Trust Serious Incidents Group meets on weekly basis to review completed serious incidents reviews. Recommendations arising from Serious Incident reviews are 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.

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

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

Learning within 1 month

The routine reporting of incidents allows for trends and patterns to be identified through the analysis of the information. The Black Hole enables local services to review and learn from incidents data across different timeframes and organisational hierarchy. Team specific Black Hole reports are circulated to operational team managers on monthly basis.

Individual teams and service area to utilise the Black Hole information to allow monthly reflection and a discussion around trends acknowledging that the detail and outcomes of ongoing investigations may not be known at this stage.

Serious incidents investigations will be well underway, with teams considering local learning after reflection, at any point in this learning process alerts and safety messages can be cascaded in the organisation.

Monthly reports are produced by the Governance Intelligence Team from incidents data to support learning in the organisation and to provide assurance to commissioners (e.g. Commissioner's Clinical Quality Review Group (CQRG) monthly incidents reports)

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.

Learning within 1-3 months

Clinical governance facilitators provide local clinical governance committees with a quarterly incidents report highlighting trends and areas of learning for services.

Completed serious incidents reviews are reviewed on monthly basis at local clinical governance committees or equivalent local forums to agree and monitor progress on actions.

A learning lessons bulletin and short series of videos "It Takes 3" is shared on quarterly basis to cascade learning from incidents and investigations.

Incidents data contribute towards the Integrated Quality Report for consideration at various Trust committees. The Integrated Quality Report identifies areas for themed analysis and where further more detailed analysis is required. This is part of the wider management of risk where incidents are reviewed in conjunction with complaints, claims and PALS issues in order to identify weaknesses, patterns and themes and implications for practice thereby minimising reoccurrences and improving safety.

Further quarterly reports are produced by the Governance Intelligence Team from incidents data to support learning in the organisation and to provide assurance to commissioners (e.g. Mental Health Legislation Committee Quarterly report, Infection Prevention Partnership Committee report etc.)

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

Learning annually

The Trust considers its activity in line with national data such as the National Reporting Learning System every 6 months and the NHS benchmarking network reports as they are published.

The Trust reflects on its incident activity in its annual quality account received by all members of the Trust, to review the culture of reporting. This allows for independent scrutiny from external stakeholders.

All of the above information and learning that takes place at every level, allows the external Commissioners to be assured that we have robust

systems in place for reflection and learning to utilise this learning to inform the necessary improvements to quality and safety of care.

Acknowledgment

This practice guidance has been developed following local and national discussions with colleagues across the NHS. Special thanks to Northumberland Tyne and Wear NHS FT for contributing towards this PGN.

10.1.2 **Supporting staff involved in an incident (RS02-PGN-02)**

The Reporting, Management & Learning from Incidents Policy Practice Guidance Note

Supporting Staff Involved in an Incident

Date Issued	Planned Review	PGN No:
Issue 1 – April 2018	April 2020	RS02-PGN-02
Author / Designation	Samantha Munbodh – Head of Investigations	
Responsible Officer / Designation	Samantha Munbodh – Head of Investigations	

Content

1. Introduction

1.1 Birmingham and Solihull Mental Health Foundation Trust (the Trust / BSMHFT), values its staff and as such wants to ensure support is available to those following traumatic or stressful incidents.

1.2 As outlined in the NHS England – Serious Incident Framework (March, 2015):

"It is important to recognise that serious incidents can have a significant impact on any staff who were involved or may have witnessed the incident. Like victims and families staff may want to know what happened and why, and what can be done to prevent the incident happening again."

1.3 Post incident supporting is about creating space and time for reflection, ventilation of feelings and sharing of concerns or anxieties.

2. Scope

2.1 This Practice Guidance Note applies to all staff employed by the Trust, either directly or as part of a contracted service.

3. Support for Staff

3.1 The Trust will be supportive to all staff who have been involved (directly or indirectly) in an adverse / critical incident within the work place and aim to reduce where possible and practicable the impact of such incidents on the staff members wellbeing. The primary aim of this guidance is to signpost staff to the appropriate support when they have been exposed to incidents that have the potential to have an on-going impact upon their health and wellbeing.

4 Accessing Support

4.1 Line Managers, Team Leaders, Heads of Service and Clinical Nurse Managers have a responsibility to identify if an individual staff member requires specialist support. The level and type of support should be identified through discussion with the staff member concerned. (See Appendix 1).

5. Impact on Staff

5.1 All staff should be given the opportunity to choose what level of support would be of most benefit to them through support and discussion with their Line Manager / Team Lead.

5.2 The level of support required may vary and this will be dependent on the severity of the incident and whether or not the staff member was directly involved.

6. Levels of Support Available for Staff

6.1 Level 1 – Local
Because of their qualifications and experience, many of the staff within the Trust have the required competencies and skills to enable them to provide support to colleagues post incident.

6.1.2 At a local level (for example, at ward or team level) a staff support session can be held. This type of local support is usually facilitated by a Ward Manager or Team Leader as soon as is reasonably practicable following the incident occurring.

6.1.3 The support session should allow all those involved in the process to be able to reflect on the incident, vent their feelings, and discuss the events as a group or team in an open and non-judgemental environment.

6.1.4 Staff need to be aware that following a critical incident there will be a period of time where staff may experience a range of emotions and consequent changes in behaviour. Within the support process staff must be reassured that this is a normal reaction to what may be an abnormal incident and that most people start on a process of “self-repair”.

6.1.5 Support can also be offered to staff on an individual basis if that is preferred. This can be facilitated by the Ward Manager or Team Leader.

6.2 Level 2 – Local with Additional Specialist Support

6.2.1 Following an initial staff support session where a Manager has concerns a further follow up meeting might be required.

6.2.2 The Ward or Team Manager can request additional support for this follow up meeting from a suitable competent practitioner, for example Senior Clinical Nurse, Psychologist, Safeguarding Practitioner, Pharmacist, Security Specialist.

6.2.3 The post Incident Review Meeting would involve all members affected by the incident facilitating opportunity to consider how staff members are feeling about and coping with the after affects. Staff may also consider whether any additional types of support would be helpful.

6.2.4 In line with current practice and research this type of meeting would normally take place within 3 – 4 weeks post incident and the evidence would suggest that the follow up meeting should not take place within 7 days of the incident.

6.3 Level 3 – Formal Support

6.3.1 Where more formal support is required the Manager may need to refer the individual to the Occupational Health Provider. Line Managers, Team Leaders and Service Leads should pay attention to the behaviour and wellbeing of all staff following a critical incident and if concerned may make a referral to the Occupational Health Provider at any time.

7 Range of Staff Support Mechanisms

7.1 In addition to the above, there is a range of support mechanisms that can be accessed in the Trust. This can be done by line management referral or self-referral (see Appendix 1).

8 Support for Staff who are required to Give Evidence in Court

8.1 It is recognised that having to prepare witness statements and appear in court to give evidence can be both anxiety provoking and stressful for staff.

8.2 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.

8.3 Staff will be accompanied to the appropriate court and de-briefed following the conclusion of the case.

8.4 Additional support in relation to these processes for staff can be obtained through the Head of Investigations and the Head of Governance as well as the legal team

Appendix 1

ADDITIONAL HEALTH AND WELLBEING RESOURCES AND SUPPORT

1. Key Contacts

- **PAM Occupational Health**

  E-mail: birmingham.clinic@people-am.com
  Tel: 0121 227 7117

- **Needle Stick Helpline**

  24/7 helpline Number - **0330 660 0365**.

- **HR Advice and Support –HR Operations Team**

- **Governance advice and support (inc. Eclipse) Ext 1061 (Governance Team)**

- **Resuscitation and First Aid Contact Details**

- **PAM Assist** 0800 882 4102

2. Wellbeing Resources and Support

- **Occupational Health Support (OHIO)**

  Managers can make referrals to the Occupational Health Service by clicking the following link: https://www.ohiosystems.co.uk/.

- **Access free Physiotherapy Support through Occupational Health (PHIL service)**

- **Employee Assistance Programme (counselling and confidential 24/7 support) 0800 882 4102**

- **Online Employee Assistance Support (PAM Assist)**

  There's useful information on PAM Assist's online resource. You can listen to podcasts, sign up to newsletters and access secure and confidential e-mail counselling by logging on to the PAM Assist site and joining the online service: http://login.pamassist.co.uk/

- **Health Manager –Online Wellbeing Portal and App**

  Health Manager (provided by our Occupational Health provider PAM) is a free and confidential online health & wellbeing resource that offers a combination of personally tailored programmes and general health information and support.

- **Health and Wellbeing Workshops/Health Promotion Sessions/Health Checks**

  A range of Health Promotions sessions and workshops including Know your Numbers clinics have been set up across the Trust. For further information please contact the HR team.

- **Access to Mental Health First Aid Training, Mindfulness and various Mental Wellbeing Support via Recovery College**

- **Access to various gyms and sports facilities and various discounts available to staff**

3. Trust Policies and Procedures

The Reporting, Management & Learning from Incidents Policy
Risk Management Policy
Health and Safety Policy
Management of Stress Policy and Guidance
Security Management Policy
Prevention and Management of Violence Policy
Police Interventions Policy
All Trust Policies and Procedures

10.1.3 **How to investigate (RS02-PGN-03)**

The Reporting, Management & Learning from Incidents Policy Practice Guidance Note

How to Investigate

Date Issued	Planned Review	PGN No:
Issue 1 – April 2018	April 2020	RS02-PGN-03
Author / Designation	Samantha Munbodh – Head of Investigations	
Responsible Officer / Designation	Samantha Munbodh – Head of Investigations	

Content

1. Introduction

The purpose of this procedure is to establish a clear framework for conducting investigations and to ensure such investigations are undertaken in a manner consistent both with the rights of those who may be involved and the need to establish the facts accurately and expeditiously.

2. Investigation Process for Serious Incidents

2.1 Allocation of Review Lead

On behalf of the Executive Director of Nursing the Head of Investigations will allocate an Investigating Officer who will complete the Serious Incident Review, the Investigations Officer, will have undertaken serious incident review training and be independent from the service. The report will be completed on the Trust template, within 40 days of the incident and shared with the Clinical Director, before submission to the Serious Incident Team.

All Investigations are conducted in a manner

- Demonstrably supportive
- Blame free atmosphere
- Listening, learning and improving.
- Information on progress

2.2 Gathering and Mapping

Identifying what information is needed and how this will be obtained (interviewing people, mapping services, reviewing notes). Unless there are clear exceptional reasons, the Investigation Officer should inform the patient/client and their family/next of kin of the investigation, and ask if they wish to provide relevant information to the enquiry or contribute to the terms of reference. The letters in Appendix 1 and 2 can be used to support this process.

At all stages sensitivity and tact will be practiced with appropriate support available for anyone providing information into the incident.

During and after this phase there will be a consideration regarding what went wrong (the problems, service delivery problems, care delivery problems) information.

Mapping a time line using the tabular timeline should also enable the identification of good practice and key problem areas in the sequence of events. Identifying issues to explore

During the chronology mapping further “why” questions will be raised. The Five Whys is a technique to help you to drill down into a particular issue through the various layers of cause to find the fundamental cause of the problem”

2.3 Analysing Information

At this stage the Investigations Officer, reviews the collated information and agrees the priority problems identified. Now the lead starts to analyse the problems to identify the underlying problems known as contributing factors. Consideration is then given to which are the root causes/fundamental issues to be addressed, this can be identified by using the 5 whys technique (Appendix3).

2.4 Recommendations

Recommendations are developed that will help prevent another safety incident

Recommendations will be tested/assessed for their ability to provide robust solutions to existing problems.

3. Report content

As outlined in the NHS England – Serious Incident Framework (March, 2015) the report should:

- Be simple and easy to read;
- Have an executive summary, index and contents page and clear headings;
- Include the title of the document and state whether it is a draft or the final version;
- Include the version date, reference initials, document name, computer file path and page number in the footer;
- Disclose only relevant confidential personal information for which consent has been obtained, or if patient confidentiality should be overridden in the public interest. This should, however, be considered by the Caldicott Guardian and where required confirmed by legal advice;
- Include evidence and details of the methodology used for an investigation;
- Identify root causes and recommendations;
- Ensure that conclusions are evidenced and reasoned, and that recommendations are implementable;
- Include a description of how patients / victims and families have been engaged in the process;
- Include a description of the support provided to patients / victims / families and staff following the incident.

Appendix 1

Date

PRIVATE & CONFIDENTIAL

xxxxxx
xxxxxxxxxxxxxxx
xxxxxxxxxx
xxxxxxxxxxx
xxx xxx

Dear xxx xxxxxxxxxxxx

I am writing to you in my capacity as (insert title) on behalf of Birmingham and Solihull Mental Health Foundation Trust regarding the incident involving (insert name).

I am sorry for any distress caused as a result of the incident and I would like to apologise for intruding at this difficult time.

Or

I would like to offer my sincere condolences to you for the tragic loss of (insert name) and I would like to apologise for intruding at this difficult time.

I have been asked to conduct an internal review into the incident as I am independent from the service area, the purpose of my letter is to make you aware of the process I will follow:-

- Find out what happened, when and how
- Look into the care that was offered to you / patient name to ensure that it meets expected standards, identifying any areas of notable good practice
- Look for learning points and improvements so we can care for you/others better
- Find out if there are things we could do differently in the future
- Produce a report of my findings as part of the review process, which makes realistic recommendations to address learning points
- Provide a consistent means of sharing learning from the incident

As part of this review I would like to ask if you and / or your family would like to meet with me (and *insert name & job title* who is jointly investigating the incident if applicable) you are welcome to bring someone with you for support. I will be contacting you within xxxx days via telephone / letter to arrange this.

It may be too soon for you to feel able to discuss the events with me, which I fully understand, however, if you change your mind at any time or have any questions about (insert name) care please contact the investigations team.

If you feel able to be involved please contact me by telephone or letter - details as above. If you do have any other concerns or questions please feel free to contact the Customer Relations team, their contact details are:

Tel: 0800 953 0045
Available from 8am to 8pm Monday to Friday – excluding bank holidays
Email: bsmhft.customerrelations@nhs.net

I look forward to hearing from you in due course, however if you have any questions or queries in the meantime please do not hesitate to contact me.

Yours Sincerely

Appendix 2

Dear xxxxxxxxxxx

I have been appointed as the Review Lead for an incident relating to the patient with the RIO number XXXX, as part of this review and I am required to look into this patient's death/care and the months leading up to this. To help me do this I would like to meet with you to gain clarity on a few details.

I understand that this may be a difficult time for you, please be assured that my meeting with you is to collect information surrounding the incident and not to make any judgements.
Part of my role also includes producing a report to highlight areas of best practice, areas for improvement and areas that we may need to raise awareness of, which you will have sight of before it is submitted.

Please could you let me know your availability for the following dates/times:

- ??
- ??
- ??
- ??

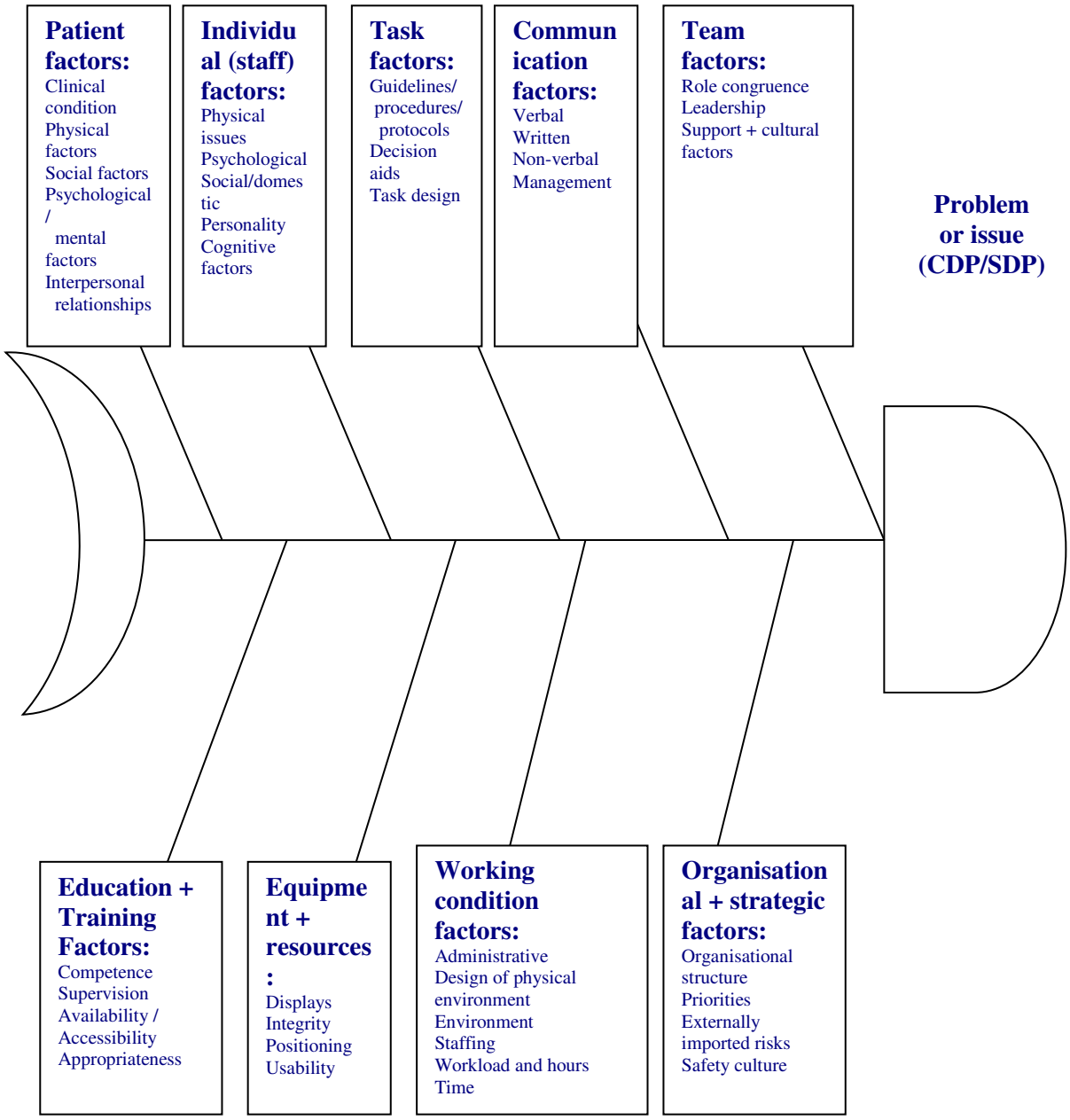
In preparation for this meeting it would be helpful if you refreshed yourself with the clinical documentation. The meeting should take no longer than xx. If you would feel more comfortable to have someone with you during the meeting you are more than welcome to invite a work colleague or union representative along.

If at any point during the meeting you would like to take a break, you are not sure of any questions or would like me to re-phrase anything then please do not hesitate to ask.

With best wishes.

Review Lead

Appendix 3


Patient factors:
Clinical condition
Physical factors
Social factors
Psychological / mental factors
Interpersonal relationships
Individual (staff) factors:
Physical issues
Psychological
Social/domestic
Personality
Cognitive factors
Task factors:
Guidelines/ procedures/ protocols
Decision aids
Task design
Communication factors:
Verbal
Written
Non-verbal
Management
Team factors:
Role congruence
Leadership
Support + cultural factors
Problem or issue (CDP/SDP)
Education + Training Factors:
Competence
Supervision
Availability / Accessibility
Appropriateness
Equipment + resources:
Displays
Integrity
Positioning
Usability
Working condition factors:
Administrative
Design of physical environment
Environment
Staffing
Workload and hours
Time
Organisational + strategic factors:
Organisational structure
Priorities
Externally imported risks
Safety culture

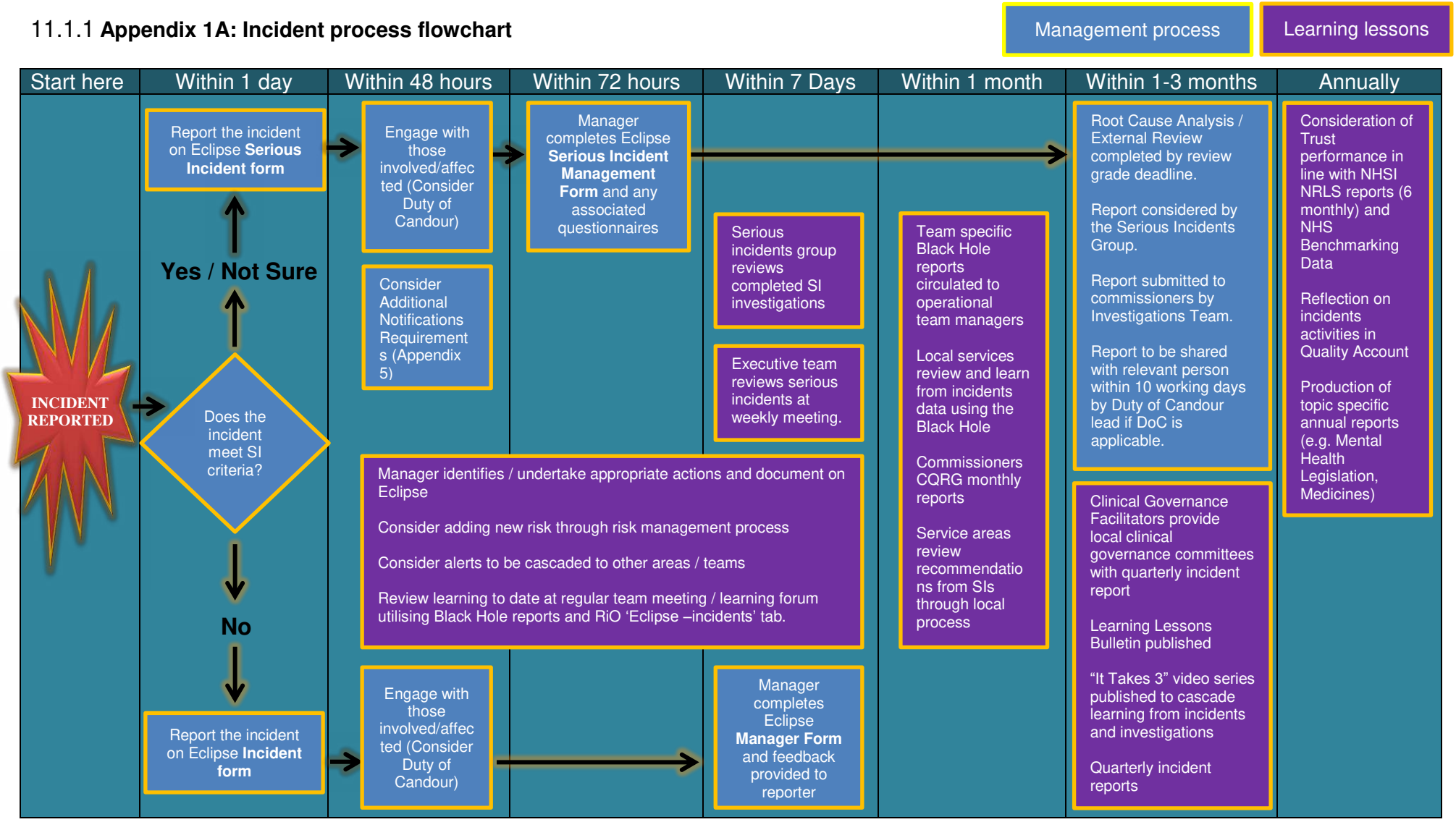
11 APPENDICES

Updates to appendices and Practice Guidance Notes 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.

11.1 Appendix 1: Incident reporting process & procedure guidance

11.1.1 Appendix 1A: Incident process flowchart



11.1.2 **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

11.1.3 **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**.

11.2 Appendix 2: Management of Incidents

11.2.1 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.

4.5 All information governance incidents must be reported immediately via Eclipse as the Trust only has 72 hours from the point of being aware the incident has occurred to determine if the incident is reportable to the Information Commissioner's Office. Failure to do so could result in the Trust being issued with a fine.

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).

11.2.2 **Appendix 2B: NHS Improvement 'A Just Culture Guide'**

A just culture guide

Supporting consistent, constructive and fair evaluation of the actions of staff involved in patient safety incidents

This guide supports a conversation between managers about whether a staff member involved in a patient safety incident requires specific individual support or intervention to work safely. Action singling out an individual is rarely appropriate - most patient safety issues have deeper causes and require wider action.

The actions of staff involved in an incident should **not** automatically be examined using this *just culture guide*, but it can be useful if the investigation of an incident begins to suggest a concern about an individual action. The guide highlights important principles that need to be considered before formal management action is directed at an individual staff member.

An important part of a just culture is being able to explain the approach that will be taken if an incident occurs. A just culture guide can be used by all parties to explain how they will respond to incidents, as a reference point for organisational HR and incident reporting policies, and as a communication tool to help staff, patients and families understand how the appropriate response to a member of staff involved in an incident can and should differ according to the circumstances in which an error was made. As well as protecting staff from unfair targeting, using the guide helps protect patients by removing the tendency to treat wider patient safety issues as individual issues.

Please note:

- **A just culture guide** is not a replacement for an investigation of a patient safety incident. Only a full investigation can identify the underlying causes that need to be acted on to reduce the risk of future incidents.
- **A just culture guide** can be used at any point of an investigation, but the guide may need to be revisited as more information becomes available.
- **A just culture guide** does not replace HR advice and should be used in conjunction with organisational policy.
- **The guide** can only be used to take one action (or failure to act) through the guide at a time. If multiple actions are involved in an incident they must be considered separately.

Start here - Q1. deliberate harm test

1a. Was there any intention to cause harm?

→ **Yes** → **Recommendation:** Follow organisational guidance for appropriate management action. This could involve: contact relevant regulatory bodies, suspension of staff, and referral to police and disciplinary processes. Wider investigation is still needed to understand how and why patients were not protected from the actions of the individual. → END HERE

No go to next question - **Q2. health test**

2a. Are there indications of substance abuse?

→ **Yes** → **Recommendation:** Follow organisational substance abuse at work guidance. Wider investigation is still needed to understand if substance abuse could have been recognised and addressed earlier. → END HERE

2b. Are there indications of physical ill health?

2c. Are there indications of mental ill health?

→ **Yes** → **Recommendation:** Follow organisational guidance for health issues affecting work, which is likely to include occupational health referral. Wider investigation is still needed to understand if health issues could have been recognised and addressed earlier. → END HERE

if **No to all** go to next question - **Q3. foresight test**

3a. Are there agreed protocols/accepted practice in place that apply to the action/omission in question?

3b. Were the protocols/accepted practice workable and in routine use?

3c. Did the individual knowingly depart from these protocols?

→ **If No to any** → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. → END HERE

if **Yes to all** go to next question - **Q4. substitution test**

4a. Are there indications that other individuals from the same peer group, with comparable experience and qualifications, would behave in the same way in similar circumstances?

4b. Was the individual missed out when relevant training was provided to their peer group?

4c. Did more senior members of the team fail to provide supervision that normally should be provided?

→ **If Yes to any** → **Recommendation:** Action singling out the individual is unlikely to be appropriate; the patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. These actions may include, but not be limited to, the individual. → END HERE

if **No to all** go to next question - **Q5. mitigating circumstances**

5a. Were there any significant mitigating circumstances?

→ **Yes** → **Recommendation:** Action directed at the individual may not be appropriate; follow organisational guidance, which is likely to include senior HR advice on what degree of mitigation applies. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. → END HERE

if **No**

Recommendation: Follow organisational guidance for appropriate management action. This could involve individual training, performance management, competency assessments, changes to role or increased supervision, and may require relevant regulatory bodies to be contacted, staff suspension and disciplinary processes. The patient safety incident investigation should indicate the wider actions needed to improve safety for future patients. → END HERE

11.3 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. These will be considering in line with the "Learning from Deaths" policy.

- 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 (excluding failure to return from section 17 leave unless in forensic setting)
- 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.

11.4 Appendix 4: Review Grades for Serious Incidents

Review Grade	Review Type	When	Internal Timescale	External Timescale	STEIS Reportable	Example(s)
Grade 1	local 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	72 hours management report	N/A	No	Community patient dies from cancer. These cases will be subject to "Learning from Deaths" and "Serious Incidents" triage and subsequent process.
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	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.	6 weeks	60 working days	Yes	• Suspected suicide of a community patient • Assaults resulting in serious harm. • Patient self-harms resulting in surgery. • Level 2 IG incidents as per IG lead guidance. • A patient fall that results in a fracture that required overnight stay for treatment.
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.	6 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.

11.5 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	Managers	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 periods of increased	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
	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	
National Confidential	Suicides or Homicides	Professor Louis	CG 14 NICE Guidance	Head of Investigati	

Who to Notify	When	How	Primary Trust Policy (monitoring & audit)	By Who	Internal Notifications
Enquiry into Suicide & Homicide	committed by a patient or discharged patient.	Appleby PO Box 86, Manchester, M29 2EF	and National Confidential Inquiries	ons	
NHS Improvement NRLS Team	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 meets the reporting criteria within NHS Digital's Guide to the Notification of Data Security and Protection Incidents. Any incident which meets the criteria set by NHS Digital must be reported within 72 hours of the Trust being made aware of the incident.	The incident reporting function in NHS Digital Data Security and Protection Toolkit	R&S 02 The Reporting, Management and Learning from Incidents	Information Governance Lead	

11.6 Appendix 6: Never Events (NHS England 2018)

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 2018. The list of never events is accessible by following the link below:-

https://improvement.nhs.uk/documents/2266/Never_Events_list_2018_FINAL_v5.pdf

11.7 Appendix 7 – Equality Impact Assessment Form

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 Investigations**
Division		**Service Area**	**Governance**
Date Started	**10/8/17**	**Date completed**	**10/8/17**
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. • 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. 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 by the National Serious Incident Framework			
Who will benefit from the proposal?			
All patients, families and staff			
Impacts on different Personal Protected Characteristics –*:*			

This policy has no negative impact on any personal protective characteristics, it aims to promote involvement with all involved.				
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				
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				
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				
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				
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				
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 in to pregnancy and maternity?				
Race or Ethnicity				

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				
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				
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				
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				
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**

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 hr.support@bsmhft.nhs.uk. 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.