

Incident Policy

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8.1	May 2016	Chris Kitchener, Associate Director of Governance & Risk Management	Revised	Revised to include: Duty of Candour Changes to national SI framework including investigation timescales Changes to incident team structure
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Introduction

- 1.1 The Trust is committed to providing a safe environment for its staff, service users and visitors as well as delivering high standards of care. It acknowledges that sometimes, in the course of providing healthcare, incidents can occur, some of which may have serious consequences for a service users, their carers, families, staff and the public. In cases, even where human error is involved, incident investigation may reveal other related organisational failings which need to be addressed.
- 1.2 The Trust positively encourages open and honest reporting of risks, hazards and incidents. Equally it recognises that being involved in an adverse incident can be a difficult and stressful time for staff concerned. The Trust takes its responsibility seriously and has developed further guidance that focuses on learning and quality. It is not the policy of the Trust to use the reporting of an incident itself to attribute blame to any individual.
- 1.3 The Trust is committed to promoting a culture of openness, and has adopted the Being Open principles. Further guidance on communication in line with Being Open and Duty of Candour principles is set out in Appendices F and G.
- 1.4 Actual or potential media interest should be handled in accordance with the Trust's Media Policy. All inquiries should be directed to the Trust's Associate Director of Communications, who will liaise with the media and staff.

2.0 Purpose

- 2.1 This policy defines the roles and responsibilities of staff in relation to the processes for reporting, managing, and investigating incidents and the approach to learning lessons and preventing recurrence.
- 2.2 This policy provides guidance that ensures:
 - Incidents are managed effectively and immediate action/learning takes place
 - Staff follow the correct procedures when an incident occurs
 - Investigations are conducted in a timely manner and are of high quality
 - The Trust learns from incidents to improve the safety and quality of services
 - Staff, service users, their carers and families and members of the public are provided with appropriate support throughout the process

3.0 Definitions

Definitions of terms used within this policy. The following list is a guide only and not exhaustive.

- 3.1 Incident
"Incident" is used in this policy to refer to any event which gives rise to, or has the potential to, produce unexpected or unwanted effects involving the safety of service users, staff, visitors on Trust premises or employed by the Trust, or loss or damage to property, records or equipment which are on Trust premises or belong to the Trust. This includes accidents, clinical incidents, deaths, security breaches, violence, and any other category of event which does or could result in harm. It also includes failures of medical or other equipment.
- 3.2 Hazard
A hazard is a situation or state of affairs which gives rise to the likelihood of harm, loss or damage as described under 'Serious Incident' below, whether or not any incident has so far occurred.

3.3 Near Miss

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

3.4 Major Incident

The term Major Incident is defined as, 'a significant event, which demands a response beyond the routine, resulting from uncontrolled developments in the operation of the establishment or transient work activity' (HSE)

The event may either cause, or have potential to cause, either:

- Multiple serious injuries, cases of ill health (either immediate or delayed), or loss of life,

or

- Serious disruption or extensive damage to property, inside or outside the establishment

In the case of a major incident, the Trust Emergency Management Plan should be followed in the first instance.

3.5 Serious Incident

The NPSA defines a serious incident (SI) 'something out of the ordinary or unexpected, with the potential to cause harm, and /or likely to attract public and media interest'.

The term covers incidents/near misses which generally meet the criteria as severe or catastrophic under the standard rating scales agreed by the Trust. For the Trust, Serious Incidents will include – but are not restricted to – incidents and near misses of the following types:

- Incidents resulting in unexpected death that involve Trust service users, staff or visitors to the Trust
- All deaths within secure settings, deaths of people subject to the Mental Health Act, or equivalent legal restrictions
- Incidents which acutely jeopardise the well-being of Trust service users, staff or visitors to the Trust
- Serious violent incidents involving Trust services users, staff or members of the public
- Incidents with a significant impact on the safety and well-being of children and pregnant women
- Large scale theft or fraud
- Cases where major litigation is expected involving Trust service users or staff
- Major health risk, e.g. infection outbreak
- Serious damage to Trust property, e.g. through fire or criminal activity
- Any incident which is likely to produce significant legal, media or reputation implications for the Trust.

3.6 Patient Death

All patient deaths, irrespective of cause must be reported on Datix. The cause of a patient death is not always known to the Trust at the time of occurrence. The Trust will often have to await the outcome of a post-mortem and in rare cases, toxicology investigation for the cause of death to be established. However it is important that all relevant managers are notified (via completion of a Datix report) of a death when it occurs to allow any remedial or immediate action to be initiated.

3.7 Manager

Throughout this policy, the term manager is used to refer to the person with first line management responsibility for a team or department at the time when an incident takes place.

3.8 Staff

The term staff is used in this policy to refer to all individuals employed by East London NHS Foundation Trust ("the Trust") and Individuals employed by the other organisations, including partner NHS organisations, Local Authorities, contractors or temporary staffing agencies, whilst they are involved in the provision of care to service users under the management of a Trust clinical team, or undertaking other work on behalf of or under the aegis of the Trust.

4.0 **Duties**

4.1 The Trust Board

The Trust Board provides the strategic leadership to promote and develop the Trust's safety culture. This includes responsibility for effective risk management within the Trust, and to ensure that the Trust complies with its statutory obligations.

4.2 The Chief Executive

The Chief Executive is ultimately responsible for ensuring that the Trust is compliance with the Health and Safety at Work Act 1974 and associated legislation.

4.3 The Medical Director

The Medical Director is accountable for the implementation of this policy and will report to the Trust Board on matters relating to it.

4.4 The Governance & Risk Management Department

The Governance & Risk Management Department, led by the Associate Director of Governance & Risk Management, is responsible for the day-to-day implementation and monitoring of this policy.

4.5 Directors and senior clinicians/managers

Directors and senior clinicians/managers in each service area are responsible for implementation of this policy in their service area.

In particular, managers are responsible for:

- Ensuring that all staff within their department or team are familiar with this policy and have been given guidance on the process for reporting incidents.
- Ensuring that temporary or agency staff are given guidance on the need to report incidents and the process for doing so, as part of their local induction.
- Ensuring that any person whom they may delegate to take charge of the Team or Department is familiar with this policy, as part of their induction.
- Ensuring that action is taken to contain an incident and to minimise harm
- Communication with staff and services users, their carers and families, and the provision of appropriate support.

4.6 Staff

All staff will follow the procedures outlined in this policy. In the event of an incident involving staff not directly employed by the Trust, guidance will be given on these procedures from appropriate Trust managers.

Under the Health & Safety at Work Act 1974, it is the responsibility of individual employees at every level to take care of their own health and Safety at work and that of others who may be affected by their acts at work, and to co-operate with management in complying with health and safety obligations, particularly by reporting any defects, risks or potential hazards.. Staff are aware that, they must

cooperate with all review or investigation that the Trust decides to undertake. This is in accordance with various NHS and professional codes of conduct and Trust Policy.

4.7 Service Users and carers

It is the policy of the Trust to encourage service users and carers to report incidents. Details on how service users can raise concerns or report incidents is included in the Inpatient Welcome Pack available on the wards.

5.0 **Incident management**

The immediate responsibility for managing an incident falls to the most senior person on duty in the area, at the time the incident occurs or is reported for the first time.

That individual is responsible for:

- Ensuring those directly involved in the incident receive the immediate care and assistance required to minimise any injury, or psychological trauma
- Assessing the situation and deciding on the appropriate response

The following factors should be taken into account to determine necessary action:

- The extent of harm caused and the immediate first aid and support needed to the injured or traumatised
- The adequacy of the immediate nursing, medical and management response, and the need for specialist advice/support
- The safety of the situation and the potential for further harm
- The need to inform service users, carers and relatives
- The need to inform external agencies (i.e. Police)
- The need to escalate the response to senior management
- The need to support service users, staff and others affected by the incident.

When the incident is an actual or suspected SI, the manager should liaise with senior management and the Associate Director of Governance & Risk Management to:

- Ensure any additional immediate or remedial action required is taken
- Secure all relevant records
- Arrange for statements to be taken
- Ensure that arrangements are in place for additional support (including debriefing and counselling) and communication

Further guidance on post-incident support is set out below.

6.0 **Supporting People Affected by an Incident**

All incidents where a member of staff or patient has been deliberately injured will be reported to the police.

6.1 Supporting Service Users

The team responsible for providing care to the service user at the time of the incident will continue to provide support in most circumstances. Where this is not possible, another team will be identified to take over this responsibility.

6.2 Supporting Staff

- All staff affected by an incident will receive support and advice from their line manager.
- It is the responsibility of the immediate line manager and the service manager of the directorate to ensure that a debriefing meeting is offered following a serious incident.
- The Associate Director of Governance & Risk Management will provide guidance and/or additional support with debriefing meetings as well as providing support to individual staff who may need it, as part of the investigation process.
- Staff should report all incidents of actual or threatened violence and aggression as reflected in the Trust Policy for the Recognition, Prevention and Management of Violence and Aggression.
- As part of the debriefing process the line manager must ensure that all staff are aware of how to seek additional support.
- If the staff member is experiencing difficulties associated with the incident then a referral to Occupational Health services should be made by the line manager.
- All staff that are required to attend for interview as part of a serious incident review will be sent an invitation letter containing the terms of reference of the review, an outline of the investigation process and details of how to access additional support from the Employee Assistance Programme
- The Trust has an 'Employee Assistance Programme' in place. The scheme is a 24hr, 7 days a week, free and confidential support service available to all Trust employees.
- Support to staff including debriefing meetings should be documented on the electronic incident report form as part of the managers' sign off and in the 48 Hour Report and Serious Incident Review Report.

6.3 Supporting Families and Carers

- The Trust operates Being Open and Duty of Candour Policies which stipulates that Families and Carers must be notified when a related service user is involved or affected by an serious incident, within the context of confidentiality as outlined in Appendices F and G. Further guidance on making contact with bereaved families is given under the 'Responding to deaths' section
- The care team will continue to maintain contact with the relative or family member as necessary and appropriate. In some circumstances, it will not be appropriate for the team to continue with this contact.
- The Trust will make every effort to contact families of a victim who have been affected by the actions of a service user.

7.0 **Incident reporting**

Immediate action to be taken following an incident:

Any member of staff present when an incident is discovered must take immediate action to reduce further risk and in maintaining safety, ensure that their own safety is not compromised.

Once the immediate situation has been addressed, it is the responsibility of all members of staff to bring any incident or near miss to the attention of their manager or the most senior person on duty in the area (e.g. team leader or ward manager).

An incident report must be completed as soon as possible.

Where there are two or more teams involved in a service user's care, the team identifying the incident will be responsible for reporting on Datix.

Guidance for staff on how to report incidents is set out in Appendix A.

It is the responsibility of the line manager to review reported incidents. An automatic notification will be sent to their inbox informing them that an incident report has been submitted by a member of his or her staff. As soon as practical, the manager must review the incident with rest of the team in order to identify the root causes and remedial actions that need to be taken to prevent similar incidents from occurring.

The Governance & Risk Management Department is responsible for ensuring that all relevant internal and external parties are informed of incidents. This is set out in Appendix B.

The Datix Risk Management System is used to facilitate reporting, and internal alerting takes place via Datix email notifications.

When the incident is potentially a serious incident, the Medical Director or nominated person will request a 48 hour report. The fundamental purpose of the report is to obtain further information about the nature of an incident, the seriousness of the consequences, the remedial action taken, the learning that has taken place and any need for further investigation and sharing of learning across the Trust. The report is used to aid the grading of incidents for further investigation and to inform the scope of any subsequent investigation.

Grade 3 and 4 pressure ulcers automatically trigger a 48 hour report managed by the locality.

7.1 External reporting

The Associate Director of Governance & Risk Management is responsible for ensuring all relevant agencies are notified.

- Reporting to Commissioners

When an incident occurs the Commissioning authority must be notified within 48 hours of the incident being reported via the Department of Health's StEIS reporting system.

The Trust must provide a 72 hour report within three days of the incident being identified.

- Reporting to CQC

The Trust will notify the Care Quality Commission (CQC) of all serious incidents relating to the death of a detained patient and Absence without Leave within 72hrs of the incident being reported in accordance to their reporting requirements.

<http://www.cqc.org.uk/organisations-we-regulate/mental-health-services/mental-health-act-guidance/mental-health-act-notifi>

- RIDDOR Reporting

The Trust has an obligation to report serious work-place accidents, occupational diseases and specified dangerous occurrences (near misses) to the Health and Safety Executive (HSE) in accordance to the Reporting of Injuries, Diseases and Dangerous Occurrences Regulation 1995 (RIDDOR).

The Governance & Risk Management department will identify such incidents via Datix and make the necessary escalation to the HSE. All RIDDOR report and receipt notifications will be attached to Datix.

For a full list of RIDDOR reportable incidents see:

<http://www.hse.gov.uk/riddor/index.htm>

- [Reporting Faulty Medical Devices to the Medical and Healthcare Regulatory Agency \(MHRA\)](#)

The Medicines and Healthcare products Regulatory Agency (MHRA) is the executive agency of the Department of Health charged with protecting and promoting public health and patient safety by ensuring that medicines, healthcare products and medical equipment meet appropriate standards of safety, quality, performance and effectiveness, and that they are used safely.

Where a medical equipment or device has not met this product standard or is deemed faulty, the Trust will notify MHRA via the online Adverse Incident Centre (AIC) reporting database. A record of the notification will be kept on Datix. In some circumstances, the Trust may find it appropriate to carry out a serious incident review, and put in place corrective actions to reduce the risk of recurrence.

The Agency will sometimes issue a Medical Device Alert (MDA) warning of hazardous products, potential safety issues or unsafe procedures, and providing relevant advice.

For all MHRA reporting, please refer to:

<http://www.mhra.gov.uk/#page=DynamicListMedicines>

- [Reporting to the National Reporting and Learning System \(NRLS\)](#)

All patient safety related incidents will be uploaded to NRLS at least monthly, via Datix NRLS upload. <http://www.nrls.npsa.nhs.uk/report-a-patient-safety-incident/>

- [Involving the Police and Criminal Justice Service in a Criminal Incidents that Affects a Health Body](#)

The Police, Crime Prosecution Service and the NHS have jointly agreed a process for managing and reducing violence and antisocial behaviour in the NHS. The National Memorandum of Understanding (Tackling violence and antisocial behaviour in the NHS; Joint Working Agreement between the Association of Chief Police Officers, the Crown Prosecution Service and NHS Protect) sets out arrangement for best practice of joint working between the 3 agencies. It is expected that all NHS organisation adopt the core guidance of this memorandum and build it into any local policy or arrangement.

http://www.nhsbsa.nhs.uk/Documents/SecurityManagement/Joint_Working_Agreement_between_ACPO_CPS_NHS_Protect.pdf

The Local Security Management Specialist will aim to ensure that all security related crime that affects the Trust are reported to the police, including offences involving NHS staff, patients or visitors, offences involving property or other offences committed on Trust premises.

8.0 Incident investigation

The level of investigation for any incident will depend on the decision of the grading panel. The Medical Director has overall responsibility for the grading of incidents.

8.1 Incident Grading

A serious incident grading is decided at the daily grading meeting.

8.2 Guidance on the Severity of Incidents.

The Guidance on severity grading of incident key will assist the grading panel to reach a decision on the appropriate grading of an incident.





8.3 NPSA Incident Risk Rating Matrix

	Likelihood (B)				
Likelihood score	1	2	3	4	5
Severity (A) ↓	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

Table 3 Risk scoring = consequence x likelihood (A x B)

Note: the above table can be adapted to meet the needs of the individual trust.

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

	1 - 3	Low risk
	4 - 6	Moderate risk
	8 - 12	High risk
	15 - 25	Extreme risk

The Serious Incident Reviewer is responsible for setting the risk rating of all serious Incidents.

The incident is graded by the severity and likelihood of reoccurrence in the Trust. The incident potential severity and likelihood of reoccurrence, is rated on a scale of 1 to 5. The risk rating is the sum of potential severity and the likelihood of reoccurrence at that severity, with a total of 25 being the highest risk rating possible. Refer to the table below.

The levels of investigation used within the Trust are as follows:

- Comprehensive panel led (Level 1a) serious incident – panel investigation lead by an independent reviewer and a co-reviewer from a different Directorate to that where the incident took place
- Comprehensive corporate led (Level 1b) serious incident – investigation lead by either a corporate SI reviewer or a Directorate reviewer plus a co-reviewer from the Directorate where the incident took place
- Concise (Level 2) local review – managed locally by the Directorate, with an action plan
- Level 3 Local resolution – no formal review required

The investigation process depends on the level of investigation that is assigned. The Trust has developed protocols for each level of investigation, which set out the process in detail, and provides clear guidance for staff involved. These are set out in Appendix H and are:

- Protocol for the Conduct and Approval of Panel led SI Investigations
- Protocol for the Conduct and Approval of Corporate SI Investigations
- Concise Local Clinical Review Protocol
- Level 3 Local Resolution Protocol.

The time frame for completing a serious incident investigation is set by the NPSA.

Comprehensive reviews):- a maximum of 60 days for the Trust to complete and forward the report to the responsible commissioner.

In addition, some types of incidents require different types of investigation, including:

- Safeguarding Adult incidents that are subject to Safeguarding Adult investigations
- Safeguarding Children incidents that are subject to the Serious Case Review process
- Information loss incidents
- Some cases of Homicide may be subject to a Domestic Homicide Review. (Domestic Violence, Crime and Victims Act 2004)
<http://www.homeoffice.gov.uk/crime/violence-against-women-girls/domestic-homicide-reviews/>

Protocols for these investigations have also been developed and are set out in Appendices J, K and L

All investigations will be conducted using Root Cause Analysis (RCA) principles and methods, which are incorporated into the protocols and report templates.

All investigations will be recorded and monitored by the Governance & Risk Management Department through the Datix Risk Management system.

In some situations, the investigation process will be complicated by other factors, such as:

- The need to conduct a joint investigation with other NHS Trusts, local authorities or other agencies
- The incident being subject to a Coroner's Inquest, investigation by the Police, Health & Safety Executive or other external agency
- The incident being subject to a complaint or legal claim
- Staff being subject to a HR investigation relating to the incident
- The possibility of the incident being subject to independent investigation under HSJ 94(67)

In any of these circumstances the Governance & Risk Management Department will liaise with relevant staff and external agencies in order to ensure that correct procedures are followed.

Incidents involving homicide or other serious incidents may be subject to independent investigation under HSJ 94(67). Independent investigations are commissioned by NHS London and the responsibility for conducting the investigation does not fall to the Trust. The Governance & Risk Management Department will coordinate the Trust's liaison with the independent investigation. A protocol has been developed and is included in Appendix J.

Action Plan implementation

Where there are recommendations made from an SI investigation, the directorate responsible for the care will develop action plans against the recommendations. Action plans for Trust wide recommendation will be agreed by the Medical Director and confirmed at the SI Committee

Comprehensive panel led action plans are monitored centrally by the Governance & Risk Management Department. corporate led and concise investigation action plans are monitored by the relevant Directorate.

9.0 Learning from incidents

The Medical Director has overall responsibility for ensuring that learning from incidents takes place. Quality Committee monitors learning from incidents.

All the protocols and templates used for incidents, regardless of grade, ensure that causes of incidents, and action taken, are systematically recorded. The data should aid the facilitation of analysis of levels of reporting, trends and hotspots.

The whole system of reporting and investigating incidents is designed to improve the quality and safety of services. To do this, it is important that learning is well defined and understood, and capable of being measured. The Trust categorises learning in four levels and defines it as follows:

Level:	How learning takes place:	Examples of learning:
Individual	Reflective practice	Improved Individual performance/development
Team	Reflective practice/Case-study discussion Promoting learning from other areas	Improved team performance indicators Changes to environment, practice etc
Service/directorate	Governance committee(s) review of incidents Promoting learning from other areas	Changes to functioning/management of services Improved service/directorate performance indicators
Trust	Trust Board/committee(s) review of incidents Promoting learning from other areas/external sources	Changes to Trust policy/training Commissioning of service reviews/additional resources Improved Trust performance indicators

To promote the learning set out above, the following processes will take place:

9.1 Individual

- Incidents to be discussed as part of staff supervision
- Healthcare Governance and Medicines Safety Alerts to be made available to all staff

9.2 Team

- Teams (through local governance forums or otherwise) review incidents that have taken place in their area, and learning set out in newsletters and other briefings
- Feedback sessions following SI investigations

9.3 Service/Directorate

- Governance Committee(s) to review incidents on a regular basis, and individual SI reports, as well as reports from individual teams
- Monitoring of progress against action plans
- Promoting of learning and best practice through links between directorate and corporate healthcare governance structures and staff
- Regular mandatory learning lessons seminars to include the review of a serious incident from another Directorate

9.4 Trust

- Trust Board/Committee(s) to review incidents on a regular basis, and individual SI reports
- Monitoring of progress against action plans
- Promoting of learning and best practice through links between directorate and corporate healthcare governance structures and staff
- Incorporation of learning from incidents into relevant training courses
- Service/policy/training reviews to take findings from incident investigations into account
- Review of external reports/investigations
- Dissemination of safety alerts
- Trust-wide learning lessons seminars
- Clinical Audit programme
- Implementation of research findings
- Attendance at relevant external meetings (i.e. Local Safeguarding Children Boards, NHS London meetings etc)

10.0 **Thematic reviews**

A thematic review may be commissioned when the Trust identifies common features to a number of serious incidents. Common features may include similar location, similar means of harm, similar teams or services. The goal of a thematic review is to enable wider systemic learning from incidents, and to ensure that commonalities between individual incidents and investigations are identified and addressed.

The aim of the formal thematic review meeting is to identify common themes, make recommendations as to future actions to address risks identified and to ensure learning can take place.

A thematic review may be undertaken when:

- Three similar incidents occur in one Directorate
- A cluster of similar incidents are identified in one team
- Three rare occurrences of an incident happen across several Directorates

A thematic review will be identified and commissioned by the Chief Medical Officer, other Executive Director or by the chair of the incident review grading panel. The review will be undertaken by a reviewer or panel identified by the Chief Medical Officer or delegate. The Associate Director of Governance & Risk Management will provide the reviewer/panel with Terms of Reference and methodology for the review and will identify the cases to be included.

The findings of the thematic review will be tabled at Part 2 of the Quality Committee and will be shared with other agencies / Commissioners as appropriate.

11.0 **Responding to deaths**

Whilst the incident policy sets out standards and processes for managing incidents including when a death occurs, the National Quality Board contains specific requirements in its 'National guidance on learning from deaths'. The following points

therefore specifically set out how the Trust responds to the deaths of patients who die under their management and care

11.1 Incident reporting and investigation process

- All deaths reported on Datix will be screened daily by the Chief Nurse, Chief Medical Officer or delegate and closed (no further action required) or identified for review (48 hour report) and the decision recorded on Datix.
- 48 hour reports will be screened at the daily grading panel and closed or identified for serious incident review following the national Serious Incident Framework
- Where deaths are reported on a clinical system but not on Datix the service will be asked to retrospectively report as an incident to enable screening to take place
- Where a patient is not under the care of the Trust at the time of death but another agency raises concern this will be discussed at the weekly grading meeting and a decision made on investigation or closure

11.2 Case record review

- The Mortality Review Panel will meet monthly to specifically review the following deaths:
 - Patients who received palliative / end of life care within the last six months of their life
 - Patients who received non palliative / end of life care within the last six months of their life
 - Infant mortalities
 - Fast track community health patients
 - Patients not seen within the last six months of their lives and not recorded on Datix
- The Panel will decide which deaths are subject to an in depth case record review, to be undertaken by a clinician not involved in the patient's care. These will be selected where:
 - Bereaved families, carers or staff raise significant concern about the quality of care
 - The patient has a learning disability (through the LeDeR process)
 - An alarm has been raised (e.g. through CQC)
 - Patients are not expected to die
-

11.3 Reporting deaths

- Service directors are immediately responsible for alerting commissioners and other agencies (social care, police etc) when a serious incident occurs
- The corporate incident team is responsible for reporting deaths on StEIS that meet the serious incident framework threshold
- The Director of Corporate Planning is responsible for reporting deaths of detained patients to CQC
- The Associate Director of Legal Affairs is responsible for liaising with the Coroner when a death occurs
- The lead reviewer is responsible for making contact with agencies involved in the patient's care

11.4 Complaints

- If a complaint is received about a death that has not been subject to investigation this will be discussed at the weekly grading panel and a decision made on whether to commission an investigation in addition to treating as a complaint

11.5 Learning disability deaths

- All learning disability deaths will be reported to the Learning Disabilities Mortality Review Programme (LeDeR). These will be automatically flagged to the weekly grading panel where a decision will be made on further investigation via the incident investigation process. LeDeR reviews will be commissioned by the relevant commissioner

11.6 Support for bereaved families, carers and staff involved

- On notification of a death immediate contact will be made by a senior manager of the service where the care took place, offering condolences, support and practical advice including how to obtain legal advice or the support of an advocate
- Contact will be maintained when appropriate according to the wishes of the family / carer
- Service / clinical directors will ensure staff are given support in the event of the death of a patient known to them
- In the case of an investigation the lead reviewer will make early contact with the family, offering support and asking how they wish to be involved
- The lead reviewer will make regular contact with the family including making arrangements to feed back the findings of the review
- The lead reviewer will have a no-blame ethos, ensuring that staff are supported through the investigation process

11.0 Monitoring

The implementation of this policy will be monitored by the following:

- Incident Reporting rates (as compared to NRLS benchmark data)
- Timeliness of 48 hour reporting
- Timeliness of investigations
- Number of outstanding action plans/recommendations
- Trust Board review of the annual Incident Report, including analysis of learning that has taken place
- Internal audit/NHSLA review of Incident Policy/procedures

12.0 References:

1. *Department of Health (2000). An Organization with a Memory.*
2. *National Patient Safety Agency (NPSA) Seven Steps to Patient Safety.*
3. *Health and Safety Executive (HSE) The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR), HSE Books.*
4. *NHSLA Risk Management Standards 2010-11*
5. *NHS London Serious Incident Procedures August 2009*
6. *National Patient Safety Agency (NPSA) National Framework for Reporting and Learning from Serious Incidents Requiring Investigation (Winter 2010)*
7. *National Patient Safety Agency (2009) Being Open: Communicating Patient Safety Incidents with Patients and their Carers.*
8. *Department of Health (2015; revised 2017) Working Together to Safeguard Children: A guide to inter-agency working to safeguard and promote the welfare of children, Chapter 4: Serious Case Reviews*

10. Department of Health (2014) *The Care Act : Safeguarding Adults.*

11. Department of Health (2010) *Clinical Governance and Adult Safeguarding, An Integrated Process*

12. *Memorandum of Understanding Investigating patient safety incidents involving unexpected death or serious harm: a protocol for liaison and effective communications between the NHS, Association of Chief Police Officers and HSE; Guidelines for the NHS In support of the Memorandum of Understanding*

13. *National guidance on learning from deaths, National Quality Board March 2017*

13.0 Appendices:

- A Incident Reporting Guide
- B ELFT Serious Incident Management Process
- C Guidance on Severity of Grading of Incidents
- D 48hr Report Level 2 Reviews
- E Risk Rating Matrix
- F Being Open Guidance
- G Level 1a Serious Incident Review Procedure
- H Level 1b Serious Incident Review Procedure
- I Level 3 Incident Review Procedure
- J Protocol for the Coordination of Independent Investigations
- K Safeguarding Adults Reporting Procedure
- L Guidance on Reporting and Reviewing Incidents Involving Children or Affecting Young People or Pregnant Women.
- M Local Safeguarding Children Board (LSCB) Serious Case Review (SCR) Process
- N Guidance for the informing of families/Carers of Patient Safety Incident.
- O Thematic review template

Appendix A

Incident Reporting Guide

1. What is an incident?

An incident is any event which gives rise to, or has the potential to, produce unexpected or unwanted effects involving the safety of service users, staff, families / carers, visitors on Trust premises or employed by the Trust, members of the public (where affected by the actions of service users), loss or damage to property, records or equipment which are on Trust premises or belong to the Trust. It includes accidents, clinical incidents, security breaches, violence, and any other event which does or could result in harm or damage.

These may include incidents of violence and aggression, accidents and injuries, errors and omissions, data loss and breaches of confidentiality, absence without leave and breaches of Mental Health law etc.

Please see the full list of incident categories on the Governance & Risk Management pages of the intranet, or appended to the Trust Incident Policy, for a more comprehensive list.

2. Why report incidents

Incident Reporting:

- Allows individuals, teams, Directorates and the Trust to learn from incidents and improve the quality and safety of the services. The Trust encourages staff to report every incident and near miss that takes place. Incident reporting has been increasing year on year, and the Trust is continuing to work hard to improve reporting.
- Helps ensure that everyone who needs to know that an incident, or near miss, has happened knows. This means appropriate remedial action is taken, and appropriate support is available to service users, staff, visitors and others who are involved. It also facilitates appropriate follow up, such as police involvement.
- Enables the appropriate level of investigation into incidents to take place, for the Trust to learn from adverse events, and improve the quality and safety of its services.

3. Who reports incidents?

Any Trust employee who can provide the necessary details of an incident can complete an incident form. It is recommended that new or inexperienced staff initially do so under the supervision of more experienced colleagues. An individual does not need to have been directly involved in an incident to report it, however they must be able to give accurate and comprehensive information.

It is the responsibility of the individual or the team/ward identifying the incident to ensure that it is reported on Datix.

4. How to report an incident?

- The incident form is accessed via the Trust intranet. Click on the quick link on the home page
- Reporters do not need to log in or have a password but should have a Trust email account

- Most of the form entails choosing from drop-down menus. Some choices may bring up some additional sections of the form. Guidance notes are featured throughout the form where necessary
- All mandatory sections are marked with a red asterisk. It is not possible to submit the form without completing mandatory sections
- Where appropriate, users will be asked to provide details of the individuals involved in the incident. Always choose the patient involved in the incident first, not the reporter or witnesses
- Where more than one person is involved, identify the main person. Where a service user attacks another identify the perpetrator as the main person involved then the victim
- To avoid any potential breach of confidentiality, person identifiable information (names, phone numbers, addresses etc.) is only recorded where it is specifically requested, **not** in any free text boxes where initials should be used
- There are boxes to record the lead up to an incident, a description of the incident itself, and the actions taken to manage the incident (antecedent – behaviour - consequence)
- To ensure the appropriate response to an incident and so learning can be taken from it, it is vital that the incident is categorised accurately. Contact the Governance & Risk Management department if advice is required
- Once the report is completed click on submit

Good incident reports aid improvement, and are:

Factual – do not state opinions, stick to facts.

Accurate – ensure that the incident type/category and directorate/site is accurate and include a clear description of what the actual incident is

Comprehensive – to allow decisions to be made quickly and alleviate for a further information request

Timely – ensure that the reporting time limits are adhered to.

5. When to report an incident?

All incidents and near misses should be reported as soon as possible.

Immediate remedial action is often likely to take priority over completion of an incident report. In the event of a 'serious incident' (as defined by Trust Policy) it is expected that an incident report will be submitted within two **hours** of the incident taking place, although the incident is may be reported in person/by phone in the first instance.

All other incidents should be reported as soon as possible, always within **24 hours** of the incident taking place or 24 hours of becoming aware of the incident..

6. What happens once an incident is reported?

- **Acknowledgement** – every incident form submitted generates an automated acknowledgement. Every report is read and fed into the Trust's learning processes, as outlined below.
- **Notification** - every incident report is automatically forwarded to those who need to know about it. As a minimum this will include:
 - PIN/Team leader
 - Consultant
 - Matron and Borough Nurse (in-patient)
 - Service manager (community)
 - Service Director
 - Clinical Director

It is vital that the correct information about people, ward/service, site, and consultant of the service user involved is included in the Datix report.

In addition some categories of incident will be forwarded to Trust Leads in that area, or those with particular responsibility for following up or supporting people involved in certain types of incident, for example Health and Safety incidents are followed up by the Health, Safety and Security Manager, Infection control incidents are followed up by the Lead Nurse for Infection Control. It is therefore vital that incidents are categorised accurately so that this follow up and support can be delivered

- **Manager's sign off** – all incident reports require sign off by the manager of the service submitting the form. This sign off should take place within 48 hrs of the incident being reported.

The sign off process ensures the quality, accuracy and completeness of incident reports. It also provides additional information about the causes and management of incidents that can then be used to learn, and to improve the quality and safety of services.

Sign off provides assurance that managers are aware of incidents that have taken place, and are in a position to ensure that the incident has been managed, those involved have been appropriately supported and appropriate action plans formulated.

Managers should also use the incident reports to facilitate learning at local governance or reflective practice groups.

- **Grading of severity** – after the manager has signed off an incident, all incidents are then reviewed within the Governance & Risk Management Department and assigned a severity grading that equates to the level of review required.

- **Grading Incidents**

All incidents are assessed daily by the incident team. When it is thought that an incident may meet the criteria of a 'serious incident' the Governance & Risk Management Department will liaise with the Medical Director who may request a 48 hour report.

All 48 hour reports are reviewed by a 'Grading Panel' of senior staff to reach a final decision.

Quick and accurate grading facilitates the review process by which learning and improvement takes place.

- **Incidents Grading**

- Level 1a Serious Incident – panel investigation lead by an independent reviewer and a co-reviewer from a different Directorate to that where the incident took place
- Level 1b Serious Incident – panel investigation lead by either a corporate SI reviewer or a Directorate reviewer plus a co-reviewer from the Directorate where the incident took place
- Level 2 Local review – managed locally by the Directorate
- Level 3 Local resolution – no formal review required

- **Governance** – Data and information collected from incident reports and subsequent reviews feed into the Trust's Governance processes to help monitor and improve the quality and safety of our services.

All staff are involved in the governance process, and learning from incidents takes place at all levels across the Trust. Individuals, teams and Directorates review and draw learning and actions for improvement from incidents that take place in their locality.

Trust incident reporting data is analysed by the Governance & Risk Management Department and disseminated to key Trust Groups and Committees. Directorates should manage their own incident reporting data via dashboards.

All Serious Incident Review reports will, where appropriate, identify areas of learning and have an associated action plan for addressing those issues. As well as feedback to individuals/teams involved in serious incidents, all SI reviews are reviewed by senior staff from across the Trust to ensure that issues are shared where appropriate, across the Trust. Issues arising from SI reviews are analysed by the Governance & Risk Management Department to identify key themes to help identify priorities and co-ordinate improvement work.

The Trust runs quarterly learning seminars to share some of the important lessons learnt from Serious Incident Reviews and promote discussion of the issues.

7. Additional information

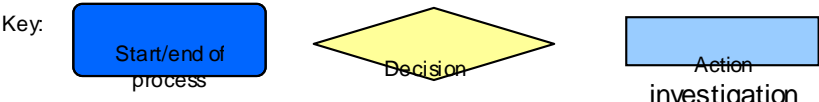
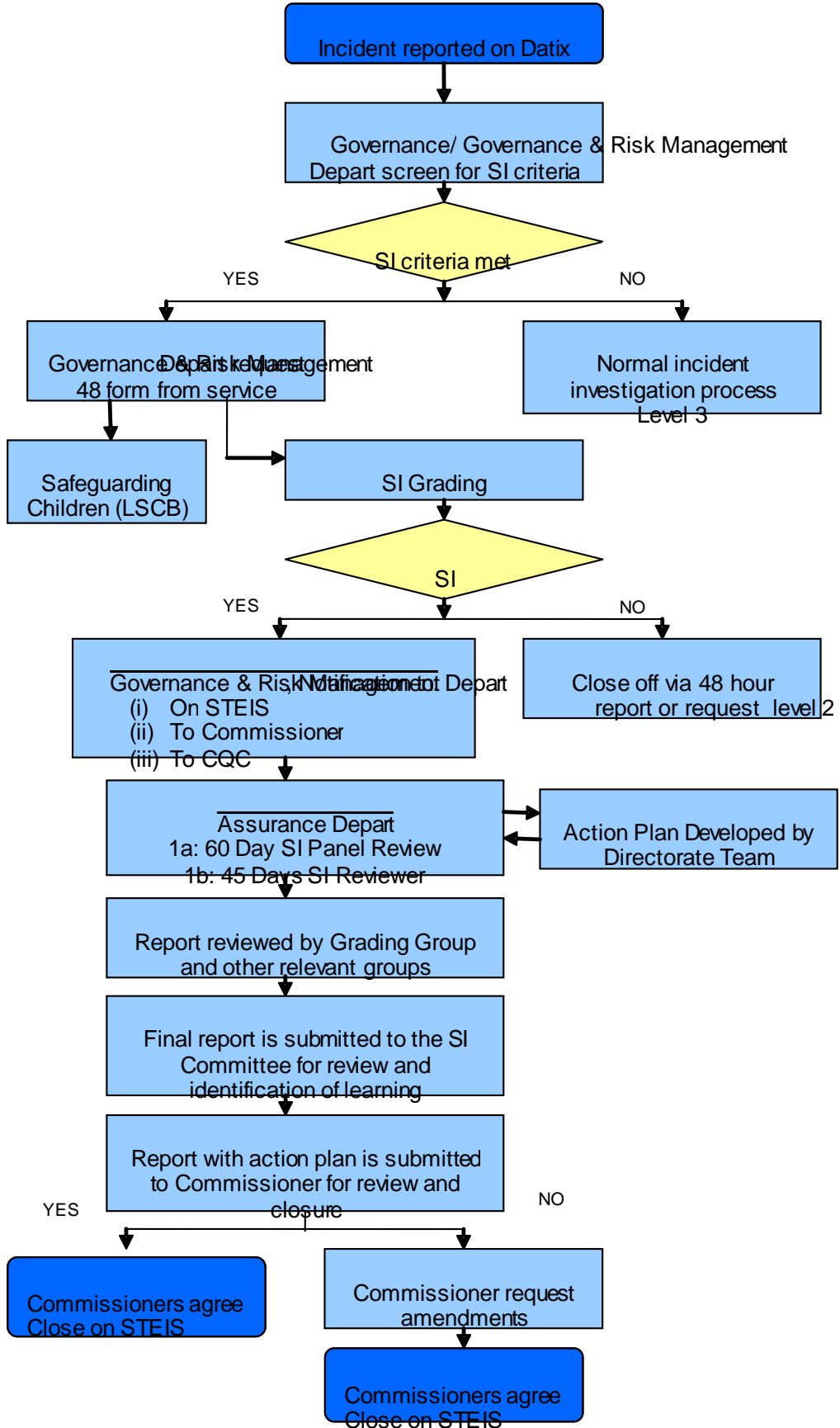
For more incident reporting data, feedback and information around learning from incidents please speak to your local governance lead or go to the Governance & Risk Management pages of the intranet.

The Governance & Risk Management Department is available to support all aspects of the incident process; reporting, review and learning. Please do not hesitate to contact them by phone or email if you would like to discuss any part of the process, or need any practical support, help or guidance.

Email incident.reporting@elft.nhs.uk

Appendix B

ELFT SI Management Process



Guidance on the severity grading of incidents

These examples are for guidance only; it is not an exhaustive list. The overall context, nature and impact of an incident must always be taken into consideration in the grading process to identify whether initial learning can be identified. In particular issues of safeguarding children or vulnerable adults should be taken into account where appropriate, and guidance may be sought from the relevant Trust leads in such circumstances. Repetition of similar incidents of lesser severity may lead to the need for a review of those incidents at a higher level of severity. Near misses – An event that potentially could have led to actual harm/loss/injury at any level- should always be reported and its severity grading according to what there might have happened and what learning can be identified to prevent similar incidents reoccurring.

When a severity of level 1 or 2 is suspected a 48 hr report will always be requested by the Medical Director, or nominated deputy, to inform final grading. Expert advice should always be sought when there is any uncertainty about grading of severity.

Incident Category	Incident Severity/Investigation Level			
	Level 3 – Locally Resolved	Level 2 – Local Review	Level 1b – Serious Incident Review	Level 1a – Serious Incident Review
Violence and Aggression				
Threatening Behaviour	Minor agitation or swearing	Damage to property	Threats to kill or maim where imminent risk is perceived	Possession of a firearm
	Invasion of personal space	Possession of a weapon fashioned by a service user (e.g. sharpened toothbrush) or bladed article	Possession of a weapon fashioned by a service user (e.g. sharpened toothbrush) or bladed article with intent	Serious threat to kill or maim with demonstrable intent, staff feeling in imminent danger of the above
Bullying and/or Harassment	Bullying and/or harassment that has been satisfactorily managed/dealt with	Persistent bullying and/or harassment causing distress to the victim	Persistent severe bullying and/or harassment with aggravating factors (e.g. racist, sexist or homophobic)	
Verbal Attack	Verbal aggression where no intent to cause distress or harm is detected, or where it is non-directed	Verbal aggression with serious threat to harm or damage where imminent risk is perceived	Threats to kill or maim where imminent risk is perceived	Serious threat to kill or maim with demonstrable intent, staff feeling in imminent danger of the above
Physical Attack	Pushing and shoving, pinching, slapping or hitting with no use of implements or weapons and no injuries, or minor injuries treatable with first aid, caused	Assault using implements or weapons and / or causing injury requiring some hospital treatment (but not as an in-patient)	Serious assault causing significant injury requiring hospital treatment as an in-patient	<ul style="list-style-type: none"> Assault causing life threatening injuries Homicide
Sexual Aggression	Inappropriate sexual behaviour and/or comments	Inappropriate sexual behaviour and/or comments with perceived immediate threat	Sexual assault, serious sexual harassment or physical contact with intent to molest	Rape and very serious sexual assault
Hostage-taking	N/A	N/A	Hostage situation resolved without harm to the single victim	Hostage situation involving multiple victims and or physical harm to the victim(s)
Allegation of Assault or Abuse (perpetrated by staff)	Advice to be taken from all appropriate sources (e.g. safeguarding adults lead, safeguarding children lead, senior management and/ or service director, HR representative) before	Advice to be taken from all appropriate sources (e.g. safeguarding adults lead, safeguarding children lead, senior management and/ or service Director, HR	Advice to be taken from all appropriate sources (e.g. safeguarding adults lead, safeguarding children lead, senior management and/ or service Director, HR	Advice to be taken from all appropriate sources (e.g. safeguarding adults lead, safeguarding children lead, senior management and/ or service Director, HR

	decision on grading is taken	representative) before decision on grading is taken	representative) before decision on grading is taken	representative) before decision on grading is taken
Incident Category	Incident Severity/Investigation Level			
	Level 3 – Locally Resolved	Level 2 – Local Review	Level 1b – Serious Incident Review	Level 1a – Serious Incident Review
Harm to Self	Self harm with no evidence of intent, no injury, or very minor injuries treatable with first aid, sustained (through design)	<ul style="list-style-type: none"> Self harm with significant injury requiring hospital treatment but not admission Attempted Suicide - community Suicide of service user out of contact with services for over 12 months 	<ul style="list-style-type: none"> Serious self harm resulting in hospital admission Attempted Suicide – in-patient Community Suicide 	In-patient Suicide (including absconded service users)
Unexpected Death	N/A	Deaths of service users where there are no suspicious circumstances	Unexplained deaths of service users	Deaths of service users where there is evidence that aspects of their care and treatment may have contributed to death
Physical Health Issue	<ul style="list-style-type: none"> Grade 1 pressure sore Admitted with pressure sore from another area Refusing food and fluids Refusing high priority physical medication e.g. diabetes /insulin 	<ul style="list-style-type: none"> Grade 2 pressure sore obtained in ELFT Discharged from hospital and returned with same within 48 hours Refusing food and fluids and clinically compromised but no admission Refusing insulin and BM very high Long delays for primary or acute referrals 	<ul style="list-style-type: none"> Grade 3 pressure sore or above Admission to acute hospital with dehydration from ELFT ward Admission to acute hospital collapsed secondary to medication Admitted to A&E or ACU due to refusing medication 	Any admission from ELFT to ITU
Abscond and Absence Without Leave	<ul style="list-style-type: none"> Absconds/AWOL of informal service users Absconds /AWOL of service users detained under section (without restriction order) on 	<ul style="list-style-type: none"> Absconds /AWOL of service users detained under section, with restriction order, on 'general' wards 	Service user detained in conditions of medium security absconds from, or fails to return from, leave. An immediate risk to self or others	Detained service user absconds from within the perimeter of a medium secure unit.

	'general' wards	<ul style="list-style-type: none"> Absconds/AWOL from conditions of low security Service user detained in conditions of medium security absconds from, or fails to return from, leave. No immediate risk to self or others identified. 	is identified.	
Service user (clinical) Falls	Where the slip, trip or fall resulted in harm that required first aid, extra observation or review of medication.	Where the slip, trip or fall resulted in harm that required medical attention.	Where the slip, trip or fall resulted in harm that required medical attention in A&E or acute hospitalisation. Possibly causing a dislocation or fracture.	Where death was the direct result of a slip, trip or fall.
Medication	Incorrect medicine prescribed or dispensed or selected for administration but not administered.	Prescribing, dispensing or administration error but with no or minor effect.	Prescribing, dispensing or administration error with moderate adverse effects.	Prescribing, dispensing or administration error resulting in serious harm or death.
Substance misuse	Discovery of alcohol or illicit drugs in service user's possession and/or evidence of consumption, but with no immediate risk to self or others apparent	Possession or consumption of alcohol or illicit drugs leading to intoxication and risk posed to self or others	As level 2 but with more serious risk to self or others; overdose requiring medical intervention, risk to others through aggression (see aggression section) or supplying others with alcohol and/or illicit drugs	Death or life threatening situation arising from the use of alcohol and/or illicit drugs, including suspected overdose
Health and Safety	<ul style="list-style-type: none"> Near miss Accident with no injury or loss 	Minor injury inflicted requiring first aid	Injury inflicted requiring medical attention and further treatment	Life threatening injury or death
Fire	Fire alarm activated due to burnt food or smoking with no damage caused	<ul style="list-style-type: none"> Fire in one room with some damage but no injury Repeated smoking related fire alarms with apparent access to ignition source 	<ul style="list-style-type: none"> Fire exceeding one room and or requiring evacuation of a ward Fire causing injury 	Fire causing widespread damage to and/or evacuation of an entire inpatient unit or community team base
Infection control	<ul style="list-style-type: none"> Isolated incident of lapse in cleanliness 	Outbreak of a notifiable illness	Serious harm to individual or impairment of the ability of a service to function as a result	N/A

	<ul style="list-style-type: none"> Isolated incidence of notifiable illness 		of an outbreak or lapse in standards of cleanliness/ infection control	
Information governance, confidentiality, and records management	No significant reflection on any individual or body. Media interest very unlikely. Minor breach of confidentiality. Only a single individual affected	<ul style="list-style-type: none"> Damage to an individual's reputation. Possible media interest e.g. celebrity involved. Potentially serious breach. Less than 5 people affected or risk assessed as low e.g. files encrypted Damage to a team's reputation. Some local media interest that may not go public. Serious potential breach & risk assessed high e.g. unencrypted clinical records lost. Up to 20 people affected 	Damage to a services reputation. Low key media coverage. Serious breach of confidentiality e.g. up to 100 people affected	<ul style="list-style-type: none"> Damage to an organisation's reputation. Local media coverage. Serious breach with either particular sensitivity e.g. sexual health details, or up to 1000 people affected Damage to NHS reputation. National media coverage. Serious breach with potential for ID theft or over 1000 people affected
Mental Health Act breach	N/A	Unlawful treatment or detention – this may be escalated to level 1 depending on circumstances and consequences for the Trust and/ or individual concerned.	This may be considered in the event of more than one episode of unlawful detention taking place on one ward.	
Loss of, or damage to, property	<ul style="list-style-type: none"> Low value cost to the Trust (up to £500) Personal loss up to £100 	<ul style="list-style-type: none"> Loss to the Trust of £500 to £10,000 Personal loss of £100 to £5000 	<ul style="list-style-type: none"> Loss to the Trust of £10,000 to £40,000 Personal Loss of £5000 to £10,000 	<ul style="list-style-type: none"> Loss to the Trust of £40,000+ Personal loss of £10,000+

Appendix D

48 Hour report

The purpose of the 48 Hour Report is to:

- Prompt a review of the care provided following a patient safety incident, in addition to remedial action being taken immediately following the incident
- Highlight any gaps in the patient's care that may need addressing
- Identify any gaps or areas of risk relating to the overall care provided by the team, create recommendations and for level 2 reviews, create an action plan
- Identify gaps in knowledge or more serious risks that may require a serious incident review

48 hour reports will be requested electronically by the Governance & Risk Management Department and should be submitted electronically within 48 hours of the request.

Concise review

A Concise review may be requested where the 48 hour report does not contain enough information, there are concerns that do not meet serious incident criteria but warrant further investigation, or where an action plan is required.

Concise reviews will be requested by email together with the relevant template. This should be returned to the Governance & Risk Management Department within two weeks of the request being made.

Concise reviews will contain an action plan which should be SMART and contain both job titles and names of responsible individuals.

Appendix E

Rating Matrix (Model)

For the full *Risk matrix for risk managers*, go to www.npsa.nhs.uk

Table 1 Consequence scores (A)

Choose the most appropriate domain for the identified risk from the left hand side of the table. Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards

Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breach of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breaches in statutory duty Improvement notices Low performance rating Critical report	Multiple breaches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Table 2 Likelihood score (B)

What is the likelihood of the consequence occurring?

The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

Likelihood score	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost certain
Frequency How often might it/does it happen	This will probably never happen/recur	Do not expect it to happen/recur but it is possible it may do so	Might happen or recur occasionally	Will probably happen/recur but it is not a persisting issue	Will undoubtedly happen/recur, possibly frequently

Table 3 Risk scoring (C) = consequence x likelihood (A x B)

	Likelihood (B)				
Likelihood score	1	2	3	4	5
Consequence (A)	Rare	Unlikely	Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

For grading risk, the scores obtained from the risk matrix are assigned grades as follows

	1 - 3	Low risk
	4 - 6	Moderate risk
	8 - 12	High risk
	15 - 25	Extreme risk

Instructions for use

- 1 Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.
- 2 Use table 1 (page 13) to determine the consequence score(s) (A) for the potential adverse outcome(s) relevant to the risk being evaluated.
- 3 Use table 2 (above) to determine the likelihood score(s) (B) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.
- 4 Calculate the risk score the risk multiplying the consequence by the likelihood: A

(consequence) x B (likelihood) = C (risk score)

- 5 Identify the level at which the risk will be managed in the organisation, assign priorities for remedial action, and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings, and the organisation's risk management system. Include the risk in the organisation risk register at the appropriate level.

Appendix F

Being Open Policy

The National Patient Safety Agency (NPSA) issued a [Safer Practice Notice Being Open When Patients Are Harmed September 2005](#) requiring all NHS Trusts in England to develop a [Being Open Policy](#) by June 2006, the Trust responded by developing a Statement in Support of Being Open March 2006. This policy replaces the Trust's Statement in Support of Being Open.

Being open simply means apologising and explaining what happened to service users and/or their carers who have been involved in a patient safety incident. Apologising and explaining what has happened does not in itself constitute an admission of liability.

It also refers to the open and timely reporting of all safety incidents including near misses (no-harm incidents).

More specifically the being open process refers to a systematic consistent approach to handling the communications with service users and/or carers after a patient safety incident. Generally this involves attempting to schedule a series of meetings to provide a sincere apology for the harm experienced by the service user, and to provide facts about exactly what happened and if possible why it happened. These communications also need to extend to detailing any actions to be taken by the organisation to minimise likelihood of recurrence and the outcome of these actions.

This open effective communication with service users and carers is central to the process of identifying and dealing with errors, care/service delivery problems, or negative perceptions of the care and service provided. Evidence suggests that in taking this approach NHS organisations can mitigate the trauma suffered by service users and potentially reduce complaints and litigation. Being open also enables service/user and carer perspectives, and concerns to inform the direction and scope of any post incident investigation/review thereby assisting in the process of identifying, mitigating and where possible eliminating the root causes associated with a specific safety incidents.

In some cases harm to service user/service users may occur independent of any act or omission by healthcare staff or services. In the case of severe self-harming or suicide attempts these acts can sometimes be neither predictable nor preventable. However even in such cases the key principles of 'being open' can still be applied.

The present policy is underpinned by the Being Open Procedure a step by step guide to undertaking what the NPSA describe as a "being open discussion". The present Policy also links with the Trust's Incident Policy.

Following completion of serious incident reviews, the investigators or locality managers will offer to meet with the patient, carers/family where appropriate to provide feedback on the findings of the review.

All actions carried out as part of the Being Open process should be documented and also incorporated into the incident report, 48 Hour Report and the Serious Incident Review Report.

Appendix G

Duty of Candour Policy

Secondary care providers in England registered with the CQC are now subject to a statutory Duty of Candour. Although clinicians already have an ethical responsibility to be open and honest, the Duty of Candour is an organisational responsibility. This new regulatory requirement was introduced in November 2014 in response to the findings of the Francis Inquiry and the Berwick Review which recommended the enforcement of fundamental standards to prevent problems like those at Mid Staffordshire and Winterbourne.

The Duty of Candour applies when moderate or severe harm occurs as a result of a notifiable safety incident. It also applies to the death of an individual where the death relates to the incident rather than a natural cause or underlying condition. The Trust uses the harm fields on Datix to identify incidents falling within the scope of the Duty of Candour.

The Duty of Candour means we should be open and honest with patients or their representatives when something goes wrong that causes, or has the potential to cause moderate or severe harm, or distress. In your professional capacity you have an important role to play in making sure patients or their relatives receive a full and open explanation, an apology and appropriate support.

What is the Duty of Candour?

- A new legal duty on Trusts to inform and apologise to patients and / or their family if there have been mistakes in care that have led to moderate or severe harm, or death
- Having truthful, accurate and open discussions with the patient or their family when things go wrong to help them understand what has happened
- Apologising – verbally as soon as the incident happens and then in writing, clearly stating we are sorry for the suffering and distress caused
- Following up with the patient or their family as investigations evolve
- Documenting those communications

What the Duty of Candour is not

- An apology or explanation is not an admission of liability
- It is not about being defensive
- It is not speculation – Candour is about facts. Never speculate - agree to provide the information later

What is harm?

- Some incidents have an obvious ‘harm’ threshold – death including suicides and homicides, Grade 3 and 4 pressure ulcers
- Some are less obvious – medication incidents, violence and aggression

- When you complete an incident form you decide whether or not harm has occurred and complete the 'harm' dropdown box appropriately –the Help function on Datix provides guidance

Who should say sorry?

- A senior member of the team where the harm occurred should speak to the patient or their family as soon as possible and follow this up in writing
- The apology should include a dedicated contact in case patients or their family want to get in touch. If necessary include an explanation about next steps
- If there is a subsequent serious incident investigation, the lead SI reviewer will contact the patient or their family when the investigation commences

Where should you record your apology?

- Record the dates of your verbal and written apologies in the 'Additional information' box on Datix and on the patient's clinical record
- If it hasn't been possible to give an apology record the reason why in the 'Additional information' box
- Attach your written apology to Datix and in the patient's clinical record

Comprehensive Serious Incident Review Procedures

Administration Procedures

1. All directorates will have a sub-folder within the Governance & Risk Management Department folder (K:\Governance & Risk Management Department) and nominated key people within each directorate will have access to their directorate folder. The folders will be managed centrally by the Incident Coordinator who will ensure all investigation documents are retained within the specific investigation folders.
2. Each directorate will have access to their respective Recommendations Calendar which is designed to map out the forthcoming implementation dates (by month) for each of the recommendations, to capture the completion of action plans and to provide a hyperlink to the action plans so that the directorates can provide updates on implementation including completion.
3. All Trust wide recommendations will be updated by the Associate Director of Governance & Risk Management in consultation with the Medical Director and Director of Nursing and Quality.

Investigation Procedures

1. The Incident Review Panel will review the 48 Hour Report / Concise Report and the Medical Director or delegate will decide upon the level of further review required.
2. The Incident Review Meeting Panel will discuss and agree the terms of reference, scope of the review and think about what professional disciplinary input may be appropriate. Where this is not possible on the day, the decision must be made at the earliest opportunity.
3. The Incident Coordinator will create a new folder for the investigation in the relevant directorate sub-folder in the K Drive: Governance & Risk Management Department folder.
4. The Governance & Risk Management Department will arrange for originals of the patient/s case notes to be safely stored in the Governance & Risk Management department.
5. The Medical Director will identify a panel to carry out the investigation in conjunction with the SI Reviewer for Comprehensive Panel Led incidents. The Directorate will identify the panel for Comprehensive Corporate Led incidents.
6. The Incident Coordinator will inform the nominated panel members of the investigation.
7. The lead SI reviewer will be responsible for contacting any affected carer or family member and invite them to participate in the review if felt appropriate.
8. All electronic documents relating to the review will be stored in the individual folder which will be named using the patient initials and STEIS reference.
9. The SI Reviewer will complete the tabular timeline in most cases and circulate to the panel members prior to the first panel meeting.
10. The Incident Coordinator will liaise with the directorate leads regarding interviews.
11. The Governance & Risk Management department will be responsible for ensuring the review process is documented.
12. The SI reviewer will write the draft SI report at the end of the review and will meet with the rest of the panel to amend and agree the final draft.

13. A feedback meeting to the directorate team and the care team will take place and any suggested changes to the draft report will be considered by the investigation panel.
14. The report and directorate action plan will be submitted for review to the Incident Review Meeting. This is attended by the Medical Director who is responsible for signing off the reports.
15. If further action or amendments are advised at the Incident Review Meeting, the SI Reviewer will ensure this is incorporated.
16. Final agreement is by the Medical Director at the Incident Review Meeting. Comprehensive corporate reviews may then be redacted and sent to Commissioners. Comprehensive panel reports require the approval of SI Committee prior to sending to Commissioners.
17. The final report and action plan is presented at SI Committee by the directorate Clinical Director
18. The Medical Director will also table comprehensive panel reports to the Board
19. Commissioners carry out a quality assurance review of all Trust SIR reports. Further amendments may be requested and if so, this will be forwarded by the Associate Director of Governance & Risk Management to the Directorate or SI Reviewer as appropriate
20. When a report is signed off, the Incident Coordinator will enter the relevant details of the action plan on the directorate's Recommendation Calendar and this will include hyperlinking to the action plan so that local directorate leads can easily update the action plan when recommendations and their action points have been completed. The directorate will need to check the calendar monthly to monitor the due dates of action points.
21. The Associate Director of Governance & Risk Management will be responsible for monitoring the implementation of Trustwide recommendations by liaising with the relevant Trustwide leads, Medical Director and Director of Nursing and Quality.
22. The report and action plan will be disseminated to all the relevant managers and committees via the directorate leads.
23. The SI Reviewer will arrange to feedback the findings of the review to the patient and/or their carers where this has been agreed or requested and is appropriate and they will be given a copy of the Executive Summary.
24. The incident coordinator will ensure all documentation relating to the review is scanned and stored on the relevant K drive including emails, letters, interview notes and paper case notes. This list is not exhaustive

Appendix I

Level 3 Incident Review Procedures

Level 3 incidents are low level incidents that have been reported on Datix that do not meet the criteria for a serious incident review or concise review. Level 3 incidents are locally resolved within the team/service.

Learning from incidents

All teams/services should review level 3 incidents and discuss them at their local governance forums as part of the learning process.

Review Procedures

1. Level 3 reviews are undertaken at a team level and documented on Datix.
2. All managers responsible for a team or a department have a Datix login which enables them to access and view incident reports relating to their area.
3. The Datix system will send an email notification to the manager's inbox when a member of their staff has submitted a Datix report.
4. The manager will review incidents with the team, identify any root causes, undertake any necessary remedial action and record these on Datix as part of the signing off process.
5. Where serious issues are identified, immediate escalation to relevant trust managers should take place.
6. The manager is responsible for making sure that the staff, patient, and relatives are supported in accordance with the Trust's Being Open Policy

Learning from Incidents

The Trust expects that all teams and directorates will regularly review level 3 incidents and present them at relevant meetings and forum to promote shared learning.

Protocol for the Coordination of Independent Investigations

1. Introduction

This protocol is intended to describe, and to clarify, the process for the coordination of independent investigations from the point of such an investigation being commissioned right through to the sign off of the resulting action plan as fully implemented.

The main objectives of the protocol are to ensure that:

- Independent Investigation Panels are properly supported in their role
- Trust staff receive appropriate support and advice
- Good communication takes place between all parties
- Recommendations are implemented in a timely and effective manner
- Risk to the Trust's reputation is minimised

The protocol is based on current Trust Incident Reporting and Management Policy and current implementation, monitoring and oversight practices, which in turn are informed by guidance from the National Patient Safety Agency (NPSA), NHS London and our Primary Care Trusts (PCTs). As such this protocol will be subject to regular review under the direction of the Quality Committee.

2. Responsibilities

The Medical Director is the Board lead for SIs, including independent investigations.

The Associate Director of Governance & Risk Management has overall responsibility for coordination of independent investigations, and will be supported by the Incident Coordinator.

The Quality Committee is the committee with overall responsibility for monitoring the management of SIs and for ensuring that learning takes place from all incidents.

The SI Committee receives independent investigation reports on behalf of the Trust Board, and provides a summary report to the Trust Board.

The Trust Board receives reports from the SI Committee on each independent investigation, and also receives a monthly status report on independent inquiries.

3. Criteria for Independent Investigations

NHS London / East of England has responsibility for commissioning independent investigations which meet the following nationally agreed criteria:

- When a homicide has been committed by a person who is or has been under the care, i.e. subject to care programme approach, of specialist mental health services in the six months prior to the event
- When it is necessary to comply with the State's obligations under Article 2 of the European Convention on Human Rights. Whenever a State agent is, or may be, responsible for a death, there is an obligation on the State to carry out an effective investigation. This means that the investigation should be independent, reasonably prompt, provide a sufficient element of public scrutiny and involve the next of kin to an appropriate extent
- Where the SHA determines that an adverse event warrants independent investigation, for example if there is concern that an event may represent significant systemic service failure, such as a cluster of Suicides.

Independent investigations should be completed within 6 months of them being commissioned.

4. Commissioning the investigation

The decision to commission an independent investigation by NHS London / East of England will normally be taken after receipt of the Trust's internal SI investigation report (and in the case of homicides, after the conclusion of criminal proceedings).

NHS London / East of England will consider the quality of the Trust's internal investigation when determining the scope and process for the independent investigation.

5. Support and communication systems

At the outset of the Trust's internal investigation, and on its conclusion, staff should be informed of the possibility of an independent investigation being commissioned, and given information to describe the process for independent investigations.

When the Trust is notified that an independent investigation is being commissioned, the Associate Director of Governance & Risk Management will inform all relevant staff/managers.

The Associate Director of Governance & Risk Management and the relevant Borough/Service & Clinical Director will discuss the support to be put in place for staff, including the need for specialist external advice. Advice will be taken from the Associate Director of Legal Affairs.

The exact nature of support to be put in place will vary according to the nature and scope of the independent investigation, and the circumstances of the particular incident. It may include some of the following:

- A briefing meeting at the outset of the investigation
- Provision of written information outlining the process
- Support in statement writing and at interviews
- Access to local managers/professional leads/executive directors
- Access to unions and professional bodies
- Access to the Employee Assistance Programme and occupational health services
- Individual meetings as appropriate (i.e. on receipt of Scott letters)
- A meeting prior to publication of the report

The independent investigation team have responsibility for contacting the perpetrator, their family and the victim's family and involving them throughout their inquiry.

The progress of all independent investigations will be monitored by the Quality Committee and Trust Board on a monthly basis.

The Associate Director of Governance & Risk Management will keep all relevant parties informed of progress and developments throughout the duration of the process.

6. Initiating, conducting and supporting the investigation

At the outset of the investigation, NHS London / East of England will arrange a meeting with all stakeholders to agree timescales, ground rules, sharing of information and terms of reference.

The Associate Director of Governance & Risk Management will be the Trust's lead contact for the investigation manager, and will ensure that all requests for documentation, meetings and other evidence is supplied in a timely manner.

The investigation manager will be requested to send any correspondence to individual staff (i.e. requests for interviews or Salmon letters) through the Associate Director of Governance & Risk Management, so that appropriate support can be put in place for staff.

7. Receipt of the draft report

The Trust will be provided with a copy of the draft report and asked to respond to matters of factual accuracy.

If there are any individual members of staff that are criticised in the report, they will be given Salmon (warning) letters and have the opportunity to respond to the investigation panel. As stated above, these letters should be sent via the Associate Director of Governance, who will ensure that they are communicated to the member of staff in an appropriate way (letters will be delivered in a sealed envelope). A meeting will normally be held with the member of staff to support them during this stage of the process.

The Trust will receive a final draft, and will be requested to prepare an action plan in response to recommendations made (which are relevant to the Trust). This will be led by the Associate Director of Governance & Risk Management, in conjunction with the Chief Executive, Director of Nursing, Medical Director, Borough/Service and Clinical Director, and any other relevant staff.

The Trust's response will be approved by the Medical Director.

The final draft report and action plan will be submitted to the Quality Committee and SI Committee, and communicated to all members of staff interviewed during the investigation.

The role of the Quality Committee is a forum to highlight themes and trends within all SI reports, and a means of ensuring the Trust has an overview of those issues and that work is being done to address them, and to share and disseminate learning across the Trust. The role of the SI Committee is to receive independent investigation reports on behalf of the Trust Board.

The action plan will be incorporated into the Trust's register of action plans arising from independent investigations, which is maintained by the Incident Coordinator.

8. Publication

NHS London / East of England will determine how the report will be published. This is done by a grading system, and could include one or more of the following:

- Public launch event

- Press release
- Noted at NHS London / East of England Board meeting
- Placed on NHS London / East of England website

The Trust's Associate Director of Communications is responsible for developing and implementing a media strategy for each independent inquiry, including informing all relevant parties. This will normally be done in conjunction with NHS London / East of England, commissioners and other partners.

The Director of Governance is responsible for informing Monitor, the Care Quality Commission and other relevant agencies

The independent investigation report will be submitted to the Trust Board following its publication.

9. Implementing the action plan and monitoring implementation

The responsibility for monitoring the implementation of all action points lies with the Quality Committee.

The SI Committee will be provided with reports in order for it to scrutinise progress on behalf of the Trust Board.

10. Signing off the completed action plan

The completed action plan will be signed off by the Quality Committee and reported to the SI Committee.

11. Archiving

All documentation relating to independent investigations must be safely stored in order to comply with record keeping and information governance standards.

Electronic versions of all reports and action plans (and other documentation) should be linked to the relevant incident report on Datix, with a backup stored in the Governance & Risk Management Department K drive.

Appendix K

Safeguarding Adults Incident Reporting Procedure

The procedure to be followed in relation to reporting a Safeguarding Adult concern is as follows:

1. Staff to consider if an urgent police response is required
2. Suspected safeguarding issue indicated on Datix incident form and reviewed by the safeguarding team
3. The person raising the concern completes a Safeguarding concern form and sends to the Local Authority Safeguarding Adult Team and attach to Datix
4. Record safety management plan in clinical record.
5. The Local Authority Safeguarding Team provides a decision on the concern raised to them. That decision might range from a recommendation to hold a safeguarding strategy meeting to requiring ELFT to carry out a Section 42 Enquiry.

Following this, the Trust may commission a formal review. The general process to be followed is as follows:

Trust Serious Incident Review

1. The Trust will commission the Serious Incident Review in line with this policy.
2. The Trust will implement recommendations and share the outcome of the review with the Local Authority Safeguarding Adult Team .
3. The local Adult Safeguarding Board will consider if it meets the criteria for a Safeguarding Adult Review (SAR).

Local Authority Safeguarding Adult Review

1. The Local Authority Safeguarding Team will commission an Adult Safeguarding Review in line with their local procedures when an adult in its area with care and support needs dies as a result of abuse or neglect, whether known or suspected, and there are concerns that partners agencies could have worked more effectively to protect the adult. SABS will also arrange a SAR if an adult with care and support needs, in its area has not died, but the SAB knows or suspects that the adult has experiences serious abuse or neglect.
2. The Trust SI review will be included as part of the review process and meetings will involve Trust staff.
3. The SAR report will be published and recommendations communicated to the trust from the Local Safeguarding Board.

Janette Clark

Associate Director for Safeguarding Adults

Appendix L

Guidance on Reporting and Reviewing Incidents Involving or Affecting Children, Young People or Pregnant Women

Introduction

The Trust has a duty to safeguard and promote the welfare of children (including unborn children) and one way of doing this is to ensure that children directly or indirectly affected by incidents are followed up and supported. The Trust's Safeguarding Children Team (SCT) collates information about how children are affected by incidents and is involved in serious incident investigations or serious case reviews that affect children.

Incident Reporting Form

The Trust Incident Reporting Form has sections on children and pregnant women. These should be completed if:

- A child was the subject of an incident;
- A child's parent/carer was subject of an incident even if the child was not there;
- A pregnant woman was subject of an incident or may have been affected;
- Action to safeguard a child was necessary.

Some Examples of Incidents Involving Children

- Patient causes injury or death to own or other children.
- Suicide of patient who has children living with them or elsewhere.
- Suicide of child or adolescent patient.
- Homicide by child or adolescent patient.
- Patient causes damage to child's home.
- Patient is arrested and he/she has children.
- Patient with children is killed or seriously injured by another person.

This list is not exhaustive.

What Happens Next?

Once the Governance & Risk Management Department has received an incident report form they will check for mention of children or pregnant women. Sometimes children are mentioned in the text even when the sections on children have not been filled in.

Relevant forms are forwarded to the Associate Director for Safeguarding Children. If necessary one of the SCT will phone the worker or manager named on the form to discuss how children have been considered and supported if necessary.

If any action is agreed the worker and the SCT member will each record this. There may be further discussions over a period until no further action is necessary.

The SCT member will email the Incident Co-ordinator a summary of their findings. Some incidents will become subject to further review as determined by the Medical Director and the Grading Panel or a Local Safeguarding Children Board.

If the incident involves the death or serious injury of, or homicide by, a child or young person under 18 the case will be considered by a Local Safeguarding Children Board (LSCB) to determine whether it meets the criteria for a multi-agency review. (see later section). In such cases, the Trust will await the decision of the LSCB before starting any internal review and will notify NHS London / East of England to this effect. The SCT will liaise between the Trust and the LSCB.

Local Management Review or Clinical Review

In cases affecting children or pregnant women the reviewer will consult the SCT at the outset to check whether they have already followed up the incident and have any initial information regarding the welfare of children to share. The SCT may also be consulted during the process as necessary to ensure relevant issues are taken into account.

Serious Incident Corporate Comprehensive Review

In cases affecting children or pregnant women the reviewer/s will consult the SCT at the outset and during the process as necessary to ensure relevant issues are taken into account.

Serious Incident Corporate Panel Led Review

In cases affecting children or pregnant women the SCT will provide one of the Panel members or be involved in preliminary discussions with the Panel as necessary. In addition if Local Authority Children's Social Care had a role with the family concerned, they may be invited to provide a member of the Panel so that a joint review of practice can be carried out. This is with the aim of joint learning and improving inter-agency working for the benefit of children and their parents/carers.

Local Safeguarding Children Board Serious Case Reviews

Very occasionally one of the Local Safeguarding Children Boards (of which the Trust is a member) may decide that a case meets the criteria for a Serious Case Review (as set out in Government Statutory Guidance Working Together, 2010). If such a case involves the Trust each agency carries out an internal review and produces an Individual Management Report (IMR). A Trust panel will be appointed which will include a member of the SCT who is responsible for writing the report and attending LSCB meetings. The report will be signed off by the Trust Lead Director for Safeguarding Children. The LSCB will also convene a multi-agency Serious Case Review Panel with representation by a senior officer from the Trust.

The Trust must use templates for chronologies, reports and action plans as required by the LSCB.

The LSCB will appoint an independent overview author to produce an overview report taking account of all the submitted IMRs. Each health agency has to submit its IMR to the local Designated Nurse for Safeguarding Children who is required to produce a Health Overview report.

The SCT will work closely with the Governance & Risk Management Department to ensure that there is a co-ordinated process for carrying out the review and meeting the needs of LSCB and Trust systems. Any reports arising from such investigations will be sent to the Strategic Health Authority and the Government Department responsible for safeguarding children issues.

LSCBs also have the power to carry out a local multi-agency case review for cases which do not meet the national criteria but there is felt to be significant potential for local inter-agency learning. In such cases the LSCB is not required to appoint an independent overview author nor submit reports to the Government.

Standard Terms of Reference for Serious Incident Reviews where Service Users have Children or are pregnant

Where there is a serious incident where the service user has children or is pregnant, the Medical Director will consider inclusion of the following Terms of Reference:

- The consideration given to the emotional and physical needs of the children/unborn child prior to and at the time of the incident and subsequently
- The consideration given to the impact of the patient's mental health on the patient's parenting capacity
- The interface between all relevant adult and children's agencies prior to the incident and subsequently
- The quality of record keeping and information sharing between agencies
- Any legal and procedural issues affecting the sharing of information

Queries

Queries about the process of following up incidents affecting children should be made to:

Jan Pearson, Associate Director for Safeguarding Children

Jan.pearson@elft.nhs.uk

Office: 020 7655 4136

Mob: 07971 664232

Appendix M

Local Safeguarding Children Board (LSCB)

Serious Case Review (SCR) Process

One of the roles of an LSCB is to review cases where children have died unexpectedly. The criteria are set out in Working Together to Safeguard Children, HM Government 2010.

Each LSCB has a Serious Case Review Committee to lead on this. The members are from Local Authority Children and Young Peoples' Services (which includes Children's Social Care and Education), the PCT commissioners, Metropolitan Police, Probation, ELFT and the relevant local Hospital Trust.

The LSCB is a statutory multi-agency partnership board of which ELFT is a member and an equal partner. LSCBs were set up under the Children Act 2004.

The Associate Director for Safeguarding Children and other senior officers represent the Trust on each LSCB Executive Board and Serious Case Review Committee in the three local boroughs and she and colleagues also sit on other committees – e.g. those responsible for training, policy and procedures, audit, monitoring and so on. It is important for operational managers to be involved in LSCB work in order to forge stronger local strategic and operational links between the Trust and the LSCBs.

Soon after an incident involving the death of, or serious injury to, a child/ren, the case is taken to the Safeguarding Children Board's Serious Case Review Committee where it is agreed whether the criteria for an SCR are met. The LSCB then has four months in which to produce a multi-agency Overview Serious Case Review Report which is submitted to the Government.

Each agency has to produce a chronology and an Individual Management Review (IMR) using templates required by the LSCB. For the Trust this is equivalent to an SI report. In many of the other agencies their safeguarding children lead carries out the review single-handedly whereas the Trust uses the SI panel process which is thorough but also time-consuming and labour intensive.

Independent Overview Report authors are appointed by the LSCB to collate all the chronologies and findings from the individual agency reports (IMRs) and as well as including each agency's recommendations add their own reflections and conclusions on inter-agency working and draft some recommendations for the LSCB as a whole.

The Trust's Safeguarding Children Team provides a member for all IMR panels and are responsible for writing the agency's report. They also liaise between the Trust and the LSCB. In addition the panel may invite a representative from the LSCB/Children's Social Care to assist the panel.

The IMR is submitted to the Trust Board for approval and to the LSCB Serious Case Review Committee

The Action Plans arising from SCRs are monitored by the Trust's Safeguarding Committee as well as the relevant multi-Trust Health Child Protection Clinical Governance Committee and LSCB.

Appendix N

Process for Handling Data Security and Protection Incidents (Confidentiality Incidents)

1.0 Introduction

- 1.2 A data security and protection incident (confidentiality incident) is one leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, personal data, transmitted, stored or otherwise processed - GDPR Article 4(12)
- 1.3 Personal data is 'any information relating to an identified or identifiable living individual'.
- 1.4 Notifiable breaches to regulatory authorities are those likely to result in a high risk to the rights and freedoms of individuals.
- 1.3 These definitions apply irrespective of the media involved and include loss of electronic media and paper records.
- 1.4 Events / breaches which have a significant impact on the continuity of essential services under the Security of Network Information Systems (NIS) Directive are also reportable in the same way as any other data breach.
- 1.5 Breach reporting is mandatory for all organisations.

2.0 Purpose

- 2.1 This process ensures:
- The management of confidentiality incidents conform to the processes and procedures set out for managing Serious Incidents (SIs) across the Trust
 - There is a consistent approach to evaluating confidentiality SIs
 - All staff know how and to whom they should report and escalate suspected or actual confidentiality incidents
 - Early reports of confidentiality breaches are sufficient to decide appropriate escalation, notification and communication to interested parties
 - Appropriate action is taken to prevent damage to patients, staff and Trust reputation
 - For those meeting the threshold of an SI, all aspects of a confidentiality breach are fully explored and 'lessons learned' identified, communicated and acted on
- 2.2 This process also applies in principle to 'near misses'.

3.0 Initial Reporting of Confidentiality Breaches

- 3.1 All suspected confidentiality breaches should be reported on Datix as soon as they occur or when they become known.
- 3.2 Breaches involving loss of ICT services (including loss of mobile phones, Smartcards etc) should be reported in the first instance to the ICT service desk for resolution.
- 3.3 Individuals should seek the advice of the Data Protection Officer or information governance team prior to completion if clarity or advice is required on the type of incident.

4.0 Managing the Incident

- 4.1 All confidentiality incidents will be managed in accordance with the high level confidentiality incidents flowchart attached at Appendix N.1.
- 4.3 When the threshold initially appears met, or if further information is required to enable a decision, the DPO will seek a 48 hour report via the incident team. The DPO will also provide a clear list of questions based on information governance principles. Where there is no doubt the incident meets the severity for external reporting and time is crucial (ie weekends, bank holidays), the DPO or nominated delegate will report directly via the Data Security & Protection Toolkit to comply with the 72 timescale for reporting without waiting for the 48 hour report.
- 4.4 On receipt of the 48 hour report, the DPO will make the decision regarding the need for a serious incident investigation, seeking the advice of the SIRO or Caldicott Guardian as appropriate.
- 4.2 The decision will be dependent on the guidance provided by NHS Digital's 'Guidance to the notification of data security & protection incidents'. This establishes whether the confidentiality breach meets the threshold for reporting to the Information Commissioner's Office. This will depend on the adverse effect and likelihood values:
 - The significance of the breach, according to the impact on the individual, graded on a scale of one to five (one being the lowest and five the highest)
 - The likelihood of serious consequences occurring, according to the impact on the individual, graded on a scale of one to five (one being a non-occurrence and five indicating it has occurred)
 - The vulnerability of a group of individuals affected (automatically generating a score of two unless the incident is contained)
 - The sensitivity of the information (if it is a special category of data)

4.3 Likelihood of an adverse effect

No.	Likelihood	Description
1	Not occurred	Absolute certainty there can be no adverse effect
2	Not likely or any incident involving vulnerable groups even if no adverse effect	Where there is no evidence to prove no adverse effect has occurred this must be selected

3	Likely	Likely there will be an adverse effect arising from the breach
4	Highly likely	Almost certain that at some point in the future an adverse effect will happen
5	Occurred	Reported occurrence of an adverse effect arising from the breach

4.4 Potential severity of an adverse effect

No.	Effect	Description
1	No adverse effect	Absolute certainty there can be no adverse effect
2	Potentially some minor adverse effect or any incident involving vulnerable groups even if no adverse effect occurred	Where there is no evidence to prove no adverse effect has occurred this must be selected
3	Potentially some adverse effect	Likely there will be some adverse effect arising from the breach
4	Potentially pain and suffering / financial loss	Reported suffering and decline in health, or financial detriment
5	Death / catastrophic event	Death or catastrophic occurrence

4.5 Breach assessment grid

Severity (Impact)	Catastrophic	5	5	10	15 20 25 DHSC & ICO		
	Serious	4	4	8	12 16 20		
	Adverse	3	3	6	9 12 15 ICO		
	Minor	2	2	4	6 8 10		
	No adverse effect	1	1	2	3	4	5
			1	2	3	4	5
			Not Occurred	Not Likely	Likely	Highly Likely	Occurred
			Likelihood that citizens' rights have been affected (harm)				

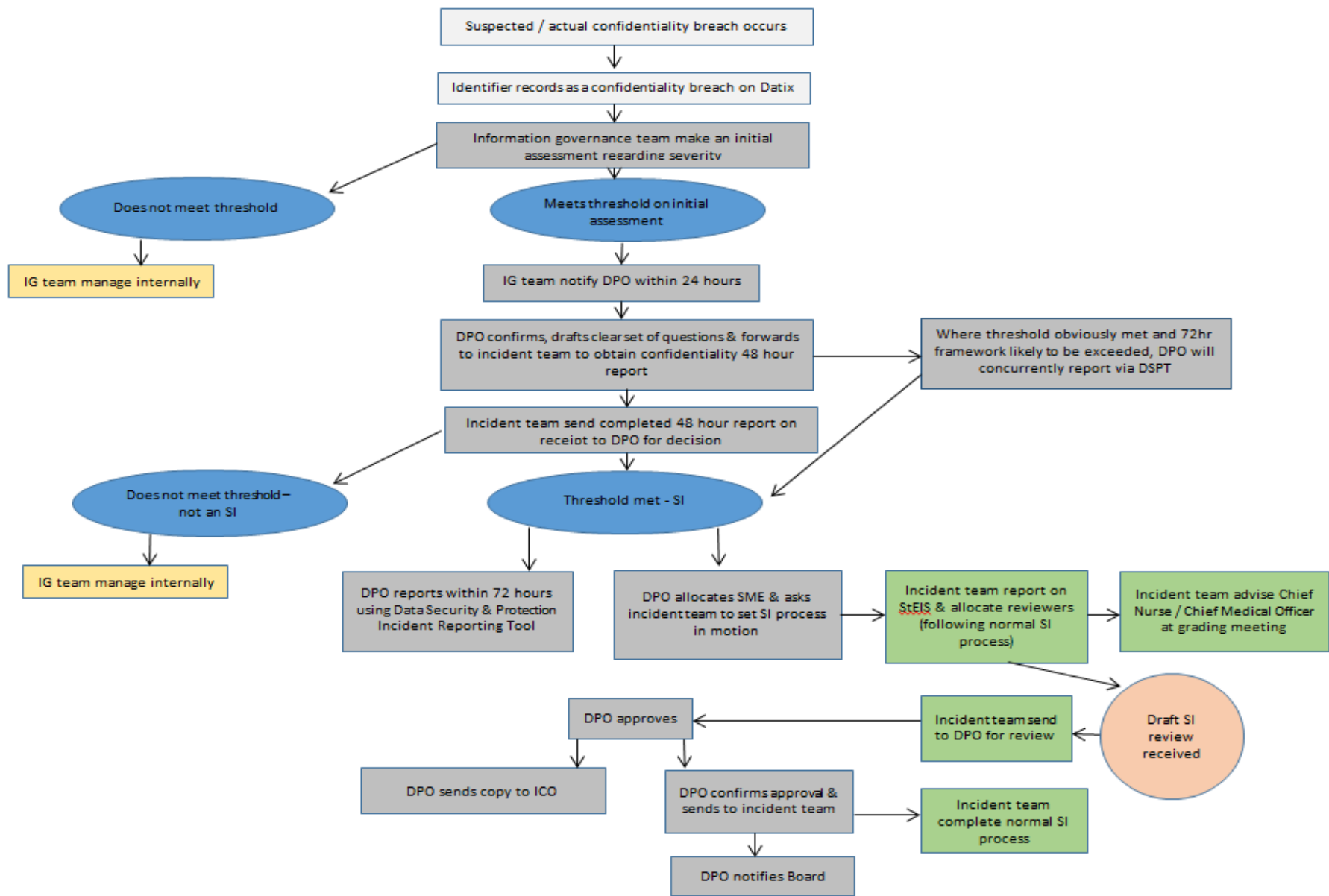
4.5 Yellow breaches are reportable to the ICO whilst red breaches are reportable to the ICO and the NHS Digital Data Security Centre (the latter within 24 hours).

4.4 Under the following circumstances notification to the Information Commissioner's Office may not be necessary:

- Encryption – personal data protected by encryption

- Trusted partner – there is a level of assurance that the recipient will not read / access the data, will comply with instructions to delete / return it, not take any further action with it etc
 - Cancelling the effect of a breach – where we can null the effect of the breach
- 4.5 When the Trust is aware the threshold is met (i.e. this has been confirmed by the DPO) the breach will be reported via the Data Security & Protection Incident Reporting Tool to the Information Commissioner’s Office (ICO) within 72 hours (this is taken to mean as soon as practicable during weekends and bank holidays). The NHS Digital Data Security Centre will also be informed where appropriate. See also 4.3 regarding incidents obviously meeting the threshold where the 72 hour framework is likely to be breached.
- 4.6 The DPO will advise the SIRO when an incident is reported to the ICO.
- 4.7 Concurrently the Incidents & Complaints Manager will set the process for investigation in motion following the national framework for managing serious incidents.
- 4.8 The DPO will identify an information governance subject matter expert to support a confidentiality serious incident investigation.
- 4.9 The DPO will approve confidentiality SI investigations prior to formal approval at SI Committee and submission to Commissioners.
- 4.10 The DPO will send completed investigations to the ICO
- 4.11 Completed investigations will be submitted to the Board.
- 4.12 Lessons learned from confidentiality incidents will be widely disseminated to mitigate against the recurrence of future incidents.
- 4.0 Communication of a personal data breach to the data subject**
- 4.1 Individuals must be advised when a confidentiality breach occurs that is likely to result in a high risk to their rights and freedoms (ie their expectation to have their information kept safely and securely and used appropriately). This is the responsibility of the Directorate where the incident took place.
- 4.2 Individuals must be given:
- A description of the breach
 - A description of the likely consequences
 - A description of the measures taken / proposed to be taken
 - Contact details of an individual from whom further information can be obtained
- 4.3 The Data Protection Officer will advise on a case by case basis when communication is necessary.

I



Thematic review of <insert title>

Date of review <insert date>

<Review panel names>

Introduction / executive summary of purpose <state why – three similar incidents in one Directorate, cluster of similar incidents in one team, three rare occurrences across several Directorates>

Terms of reference <scope, locations covered etc>

Methodology < literature review (complaints, SI reviews, incident reports), systems interrogation (clinical system, Datix), stakeholder consultation, interviews, policies / procedures>

Overview of incidents

Common themes / results of thematic review

Specific issues (including recommendations / conclusions for each)

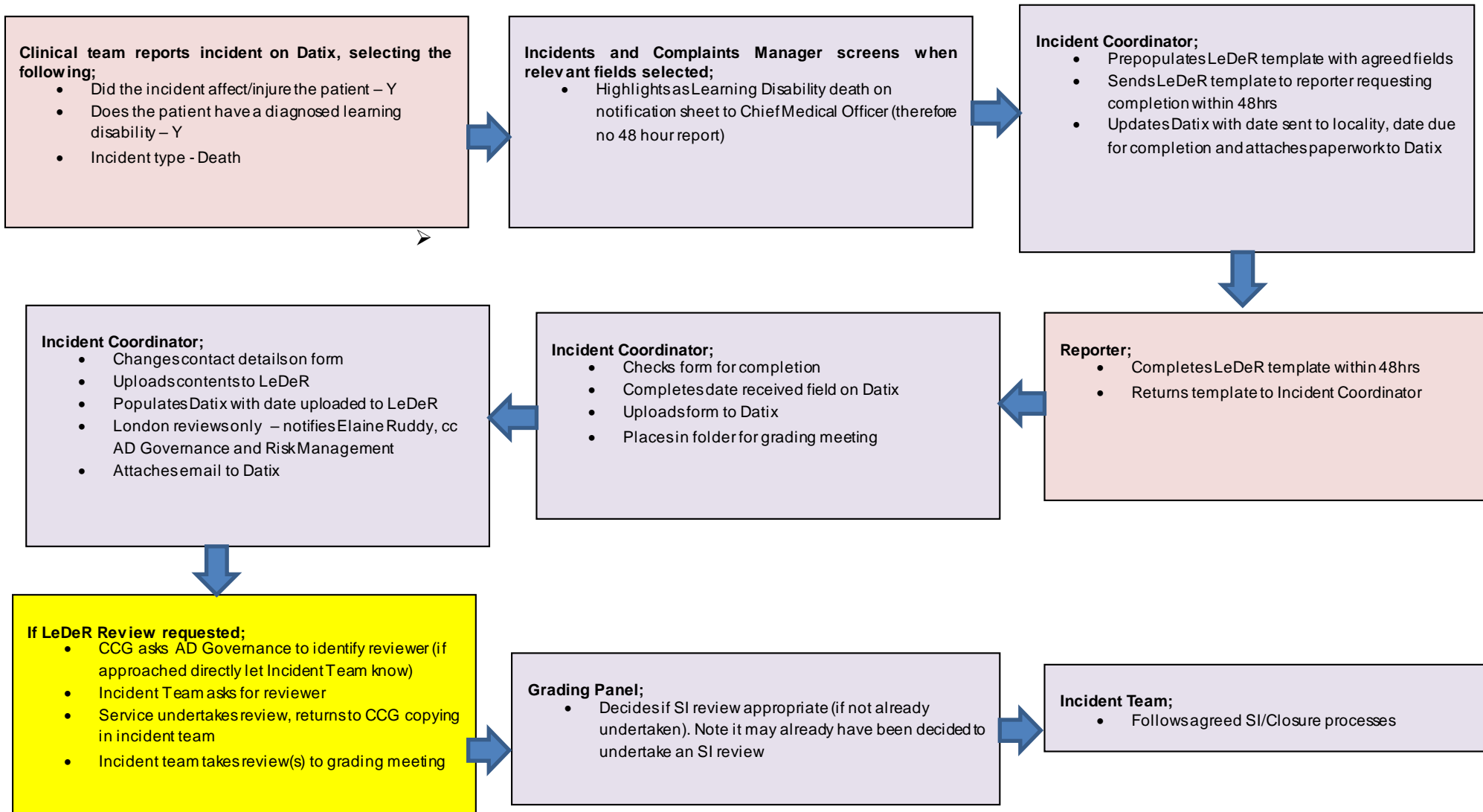
Learning

Conclusion and recommendations

Action plan

Appendices

Appendix P. LeDeR Flowchart



Governance & Risk Management Team -

Grading Panel;

- Decides if SI review appropriate

September 2017

