SERIOUS INCIDENT POLICY

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Contents

1. Policy Statement

1.1 Responding appropriately when things go wrong in healthcare is a key part of the way that the NHS can continually improve the safety of the services we provide to our patients.

Serious Incident (SI) recognition and investigation underpins a basic component of the Risk Management Framework for North Staffordshire Combined Healthcare NHS Trust (NSCHT).

The Trust wishes to ensure that when a serious incident occurs:

- There are robust and systematic measures in place for safeguarding service users, carers' staff, the public, property, NHS resources and reputation.
- The organisation learns from adverse events and in doing so prevents further harm.

This policy provides frontline staff and Managers with guidance in the management of Serious Incidents. The Trust is committed to ensuring a robust, pro-active, safety culture in which incidents are seen to be a valuable opportunity for learning and improving services.

NSCHT is committed to delivering a quality service and embraces the ethos of a "fair blame culture" based on the core belief that the immediate organisational response to a Serious Incident should be of seeking to learn; where staff are able to report serious incidents in a supportive honest and open environment without fear of a punitive response. The Trust acknowledges the vital importance of robust systems and processes for ensuring that the underlying causes of an incident are not simply attributed to the actions of those individuals involved but must ensure exploration of all factors which may have potentially contributed to the root causes of the incident including policies, systems, processes and culture. The Trust will however, consider disciplinary procedures where appropriate.

2. Scope

2.1 This policy applies to all Health and Social Care Staff working within NSCHT, including those employed on a bank, agency or locum basis.

The Policy will be applied universally across all services so as to ensure consistency of approach in respect to the identification, investigation and learning from Serious Incidents.

3. Purpose

3.1 This Policy has been developed to provide a framework to assist Directors, Heads of Directorate and staff to understand their responsibilities and accountability when serious incidents occur, how these are reported,

investigated and managed by the Trust and are in line with national standards (NHS England Serious Incident Framework).

This will:

- Assist staff to identify potential and actual serious incidents.
- Ensure that the Trust executes its responsibility under the Duty of Candour
- Assist staff in taking action to prevent reoccurrence or further harm
- Ensure that all staff have appropriate guidance and support in investigating and learning from serious incidents.
- Ensure that robust governance arrangements regarding identification, learning, actions and trends arising from serious incidents are identified

4. Definition

For the purpose of this policy a Serious Incident is defined as being distinguished from all other incidents by the criteria issued by NHS England (Serious Incident Framework. Revised March 2015). In broad terms, serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare.

4.1 Whilst there is no definitive list of events/incidents that constitute a serious incident; the following section sets out the circumstances in which a serious incident must be declared.

Serious incidents in the NHS include:

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

- A Never Event - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death.
- An incident (or series of incidents) that prevent, or threatens to prevent an organisation's ability to continue to deliver an acceptable quality of healthcare services.

4.2 Never Events

Never Events are a particular type of serious incident that meet all of the following criteria:

- They are **wholly preventable**, where guidance or safety recommendations that strong systemic protective barriers are available **at a national level, and should** have been implemented by all healthcare providers.
- Each Never Event type **has the potential to cause serious patient harm or death**. However, serious harm or death is not required to have happened as a result of a specific incident occurrence for that incident to be categorised as a Never Event.
- There is evidence that the category of Never Event **has occurred in the past**, for example through reports to the National Reporting and Learning System (NRLS, and a risk of reoccurrence remains.
- **Occurrence of the Never Event is easily recognised and clearly defined** – this requirement helps minimise disputes around classification, and ensures focus on learning and improving patient safety.

Should a Never Event occur, the Exec on call must be notified immediately, in order to determine if immediate escalation to the Commissioner on call is required.

Further guidance and information can be found at http://www.dh.gov.uk/publications

5. Equality and Diversity Statement

5.1 This procedure should be applied equally to all employees ensuring there is no discrimination on the grounds of age, disability, race, ethnicity, gender, sexual orientation, religion, belief, offending background, trade union activities, family circumstance or domestic/care arrangement.

6. Responsibilities

6.1 Trust Board

The Trust Board has overall responsibility for Governance including safe clinical and non-clinical practice. The Board will ensure that effective management systems are in place to achieve high standards, the provision of mandatory reports to the Board including minutes of sub-committee meetings.

6.2 Chief Executive (CEO)

The Chief Executive has overall responsibility for patient safety and risk management within the Trust. The CEO will be responsible for ensuring that the Board, Chairman and Non-Executive Directors are kept informed as appropriate. The CEO will liaise with the Communications Department should media involvement arise following a Serious Incident.

6.3 Medical Director

- Will act as a Board Member with responsibility for overseeing the reporting and investigation of SIs within the Trust Directorates. Be responsible for ensuring that the CEO is kept fully informed about any SI investigation and for reporting the details of SIs to the relevant governance committees and the Trust Board
- Will hold responsibility for final agreement to submit completed investigations and action plans to commissioners for approval and closure.
- Will give due consideration to wider business and or communication implications arising from SI's and commission further action reasonably practicable to minimising the risk of further serious incidents from occurring.
- Will take responsibility for ensuring accountability and delivery of actions arising from serious incidents.

6.4 Clinical Safety Improvement Group (CSIG)

The group will monitor the on-going progress of all SI's via monthly meetings. Monitoring will include:

- All investigations approved for closure in the preceding month
- Updated progression on all open investigations including any agreed extension timescale.
- Emerging trends and themes from incidents and investigations. Synopsis of
- all new SI's reported since the previous meeting.
- Receive feedback on completed investigations including lessons learned and recommendations.
- Receive Directorate reports on status and progress of action plans arising from SI investigations.
- Ensure that any Serious Incidents involving the complaints or safeguarding processes are facilitated via a strategy meeting.
- Consider the contents of quarterly status reports on performance of completion of investigation, trend analysis and lessons learned.

6.5 Head of Directorate and Clinical Director

- Will commission the investigation and delegate responsibility in their absence
- Will ensure that the next of kin is contacted and offered the opportunity to meet with a senior member of trust staff. This should be the Head of Directorate and Clinical Director or designated senior clinician/manager.

- Will set the investigation Terms of Reference with the Directorate Governance Lead
- Will receive regular updates on progress and findings from the investigation from the Governance Lead.
- Will have joint responsibility for approving the investigation report and action plan (where appropriate) for final sign off agreement by the Medical Director, ensuring delegation of this function in their absence
- The Clinical Director will be responsible for commissioning, overseeing and agreeing completion of Action Plans relating to investigations
- The Clinical Director will be responsible for facilitating and sending out a letter of condolence to the identified next of kin in cases of Sudden and Unexpected Death. The HoD/CD will personally contact the next of kin in order to offer a direct face-to-face meeting with the HoD/CD or designated senior clinician/manager.

6.6 Directorate Governance Lead

- Will request and ensure that a 72 hour briefing note (appendix 19.3) is completed by the Service/Team Leader in which the incident has occurred ensuring that any risks have been identified and remedial actions implemented.
- Will forward the 72 hour briefing to the Patient and Organisational Safety Department.
- Will have responsibility for identifying an Investigating Officer within three working days of the incident being identified to undertake an SI investigation (with assistance from the Patient and Organisational Safety Department) ensuring that appointed officers are independent of the service area where the incident occurred.
- Will ensure that the appointed Investigating Officer is in receipt of the Terms of Reference set out for the investigation in accordance with NPSA guidance investigation level and the timescales and milestones for completion.
- Ensure that each completed investigation, (including an action plan, where required) is submitted to commissioners within the 60 day timescale. Where investigations are forecast to exceed the agreed timescale; Governance Leads will inform the Patient and Organisation Safety Team (POST) at the earliest opportunity, in order that possible extensions to the investigation time scales may be negotiated with Commissioners.
- Will report progress and status of action plans at the Clinical Safety Improvement Group ensuring that a programme of audit is implemented to ensure implementation of action plans and record measurable outcomes.
- Will support feedback of Investigation progress to the commissioner/Provider SI Sub Group.
- Ensure that the appointed Investigating Officer is in receipt of all relevant information relating to the incident including completed incident form, incident investigation form and briefing note.

6.7 Patient and Organisational Safety Team (POST)

- Will ensure that all Serious Incident are entered on to the STEIS (Strategic Executive Information System) database in accordance with contractually agreed timescales and update the database with progress until agreement for closure of the incident is agreed by Commissioners.
- Inform the Commissioning Quality and Risk Lead of the SI by email within two working days of notification of the incident.
- Ensure that an Executive Summary of all new SI's is completed and circulated to Executive Directors, Non-Executive Directors, Head of Directorate, Clinical Director and Directorate Governance Lead within 1 working day of the incident reported on to STEIS.
- Circulate the 72 hour briefing report to the Directorate Governance Lead and Head of Directorate.
- Assist the Governance Lead in providing the Investigating Officer with all relevant information relating to the incident including completed incident form, incident investigation form and briefing note.
- Meet monthly with the Commissioner Quality and Risk Lead to update on progress of open SI's and agree actions arising from the meeting.
- Submit anonymised investigation report to Commissioner Quality and Risk
- Lead on agreement of the Medical Director and Directorate Clinical Director.
- Provide weekly status reports on all open SI's to the Executive Directors Provide a monthly status report on all open SI's to CSIG.
- Provide advice, support and expertise on all aspects of the SI investigation process to the Investigating Officers.
- Liaise with the Coroner's Office on all matters relating to information sharing in respect of sudden unexpected deaths.
- Escalate any issues relating to timescale compliance in the first instance to the Directorate Governance Lead.
- In circumstances in which the Governance Lead has been unable to resolve any timescale issues, the Patient and Organisational Safety Department will escalate to the Medical Director.
- Will coordinate, advertise promote and co-facilitate learning events on a monthly basis across the Trust including external invitation.
- Inform the Staff Support and Counselling Department of all relevant reported serious incidents.
- Produce a detailed quarterly report to the Trust Board on serious incident statistics, themes, trends and lessons learnt.

6.8 The Investigating Officer

- Will be registered on the Trust list of Root Cause Analysis trained Investigators or will have been identified as part of their personal development plan to undertake Root Cause Analysis training but will assist in the investigation under the supervision of an investigator trained in RCA investigation.
- Undertake the assigned investigation utilising a Root Cause Analysis approach and in accordance with the agreed Terms of Reference, levels

and scope of the investigation and within the timescales set out by the Directorate Governance Lead.

- Will maintain close liaison with the Patient and Organisational Safety Team providing information/updates as specified in the timescales identified ensuring that any concerns that arise during the course of the investigation are escalated to the Directorate Governance Lead and the Patient and Organisational Safety Team.
- Will ensure that the Team Leader of the service in which the investigation relates to is aware of the scope, level and Terms of Reference of the investigation and ensure that progress and any findings of the investigation are communicated in a sensitive and timely manner. The Investigating Officer will be responsible for sharing the completed investigation report following final agreement for Commissioner submission by the Executive Director with the team/individuals involved.
- Will be supported by the Patient and Organisational Safety Team in undertaking a lessons learnt event relating to the investigation undertaken.
- Will not be involved within the Service Area where the Incident has occurred

6.9 The Complaints Manager

- Will liaise with the Patient and Organisational Safety Team regarding any complaint indicating requirement for a Serious Incident Investigation in accordance with NPSA guidance and ensure cohesive communication to monitor trends arising from complaints and Serious Incidents.

6.10 The Safeguarding Lead

- Will liaise with the Patient and Organisational Safety Team regarding any Safeguarding Incident indicating requirement for Serious Incident Investigation in accordance with NPSA guidance and ensure cohesive communication to monitor trends arising from safeguarding incidents and Serious Incidents.
- Will ensure that as part of the Section 75 agreement with North Staffordshire, SI's that relate to the social care functions will be reported to Staffordshire County Council's Head of Safeguarding.

6.11 Ward/Service Area Managers

- Will ensure that an incident form is completed on the Trust Safeguard Incident Reporting System within 24 hours of the incident occurring. http://sid/divisions/CorpServices/TrustBoard/Trust%20Policies/5.01%20Incident%20Reporting%20Policy.pdf
- Will ensure that on confirmation of a Serious Incident requiring investigation, a
- 72 hour briefing note is completed and submitted immediately on completion to the Patient and Organisational Safety Team (19.3, 72 Hour Briefing Note) ensuring that immediate actions and lessons learned are identified and implemented to reduce recurrence.
- Will be responsible for the collaborative working with the Directorate

- Governance Lead to ensure that an action plan is produced; incorporating recommendations of the SI investigation and within the specified timescales as set out in the Terms of Reference.
- Will ensure that, in the case of reported death, that all patient records held in the department are sealed and delivered in person to the Health Records Department, ensuring that a final entry into the most recent patient record to reflect the incident, closure of the notes and transportation to the Health Records Department, ensuring that the GENYSIS note tracking system is completed.

6.12 Roles and responsibilities of all staff

- All staff have a responsibility for risk management and for reporting incidents. All incidents will be reported via the electronic Trust Safeguard Incident Reporting System within 24 hours of the incident occurring or the identification that an incident has occurred.
- Serious Incidents require further attention in respect of the process required; staff reporting SIs must inform their Line Manager immediately (in hours) or the DSN (out of hours). They must ensure that the electronic incident report is completed within 24 hours (as detailed above).

7 Being Open

7.1

- Promoting a culture of openness is a prerequisite to improving patient safety and the quality of healthcare systems. It involves explaining and apologising to a patient/carers that has been harmed or involved in an incident as a result of their healthcare treatment. It ensures communication is open, honest and occurs as soon as possible following an incident. It encompasses communication between healthcare organisations, healthcare teams and patients and/or their carers.

- The relevant information is contained within Trust policy 4.40 “Being Open Policy incorporating Duty of Candour”; this policy is based on guidance produced by the National Patient Safety Agency (NPSA) in2009 as is known as The Being Open Framework.

- Since the introduction of the Being Open Framework a clause has been added to the National Health Service (NHS) standard contract formally introducing ‘Duty of Candour’. From November 2014 a regulatory duty has been imposed by the Health and Social Care Regulations and is now part of the Care Quality Commission registration requirements.

- It is important to recognise that patients, relatives and/or carers can be adversely affected by a Serious Incident. They may have questions about what has happened and should have access to appropriate support and information, such as discussion/explanation and should be supported by the most appropriate senior person. Being Open when things go wrong is an essential element within ensuring effective partnerships between

patients and the organisation. The National Health Service Litigation Authority (NHSLA) strongly advocates professionals to be honest and transparent with patients and their relatives.

- The NHSLA state "that it is both natural and desirable to sympathise and express sorrow or regret of the harm caused" such an expression would not constitute an admission of liability. In addition it is noted that many patients and relatives often ask for a detailed explanation of the circumstances surrounding an incident, therefore it would be deemed 'good practice' to provide the facts. Such openness can often prevent incidents from becoming formal complaint and litigation claims.

- In all SI reviews, the patient, relatives, and/or carers should be consulted at the beginning of the investigation to help set the Terms of Reference and have met with the Investigating Officer to go through the final report with the opportunity to make comments. Staff are advised that further guidance can be found via the Trusts Intranet Being Open Policy 4.40 http://sid/divisions/CorpServices/TrustBoard/Trust%20Policies/Being%20Open.pdf

8 Local Process for Reporting and Responding to a Serious Incident

8.1 The Team/Service Manager for the area in which the incidents occurs will consider the severity of the incident with reference to this policy guidance on categorisation of a Serious Incident. On identifiable of a Serious Incident requiring investigation, the individual will:

- Conduct an immediate assessment of the situation and take any remedial action as necessary.
- Complete a 72 hour Briefing note (appendix 19.3) and forward to the Directorate
- Governance Lead and Patient and Organisational Safety team on completion.
- Inform their Line Manager by telephone.
- Inform the Patient and Organisational Safety Team via telephone in hours. Inform the Duty Senior Nurse via bleep out of hours.
- Complete a Safeguard Incident Report within 24 hours of the incident occurring however, completion of the incident form should be completed as soon after the incident as is practicable.
- The Patient and Organisational Safety Team will immediately inform the Executive
- Team, Head of Directorate, Clinical Director and Directorate Governance Lead via email and Safeguarding Lead where indicated.
- The Patient and Organisational Safety Team will record the incident on STEIS and inform the Commissioner Quality and Risk Manager within 2 working days of notification of the incident.

9 Making Statements

9.1 Employees must be informed at the outset of any formal incident investigation process that they may be called to provide a statement detailing their action/s and decision making surrounding the event itself. The employee should be advised of their right to seek advice and assistance from their trade union before making their formal response. The employee must also be informed that their statement may be used in other investigations relating to the SI such as disciplinary processes or external reviews.

10 Securing Records

10.1 The Patient and Organisational Safety Team will ensure that all available notes held on an individual will be identified by the Trust Genesys note tracking system and requested to be forwarded to the Medical Records Department for electronic scanning to enable the investigation process to commence.

11 Supporting Staff

11.1 The information provided in this section is applicable to all members of staff who have been affected by a Serious Incident occurrence.

11.2 Immediate Support

The Line Manager will be responsible for identifying the need for immediate support for individual staff or teams; considering the welfare of any staff member involved in a Serious Incident, paying regard to psychological trauma or stress.

11.3 On-going Support

Where a member of staff is affected by a Serious Incident the appropriate Line Manager will ensure liaison between themselves and the staff member and consider referral or encourage self-referral to the Occupational Health Service or the Staff Support and Counselling Service.

11.4 The Staff Support and Counselling Service will be informed of all serious incidents by the Patient and Organisational Team.

12 Disciplinary Process

12.1 The principle of “fair blame” will apply to all investigations, that is, individual responsibility for individual actions. The SI investigation process should never be utilised as part of a disciplinary process; HR processes regarding disciplinary action in relation to SIs may be considered if one or more of the following apply

- There is a breach of criminal law

- Professional misconduct has been identified
- There are repeated, unsafe occurrences in relation to the same individual
- In the view of the Trust or professional body, the action causing the incident was not acceptable practice
- There is evidence that attempts were made to conceal the incident or tamper with any evidence.

13 Complaints Process

13.1 It should be noted that, in the course of undertaking an SI investigation, if a complaint about service, practice or performance is identified, this must be highlighted immediately and the complaints process followed.

14 Process by which to raise concerns

14.1 Any member of staff may, at one time or another, have concerns about what is happening at work. Usually, such concerns are easily resolved by the individual discussing them with their line manager.

14.2 Guidance to staff to raise concerns if unable to resolve at a local/Line Manger level is available via the Whistleblowing policy document held on the Trust intranet. (Whistleblowing policy 3.09)

15 Monitoring

Overall responsibility for the SI investigation process lies with the Directorate Management team to which the SI belongs.

15.1 The Clinical Safety Improvement Group has a standing agenda item for open serious incidents and will be updated by the Directorate Governance Lead or representative of the Governance Lead at each meeting and will reflect actions arising from the meeting via the meeting action monitoring schedule.

15.2 Minutes of the Clinical Safety Improvement Group will be available to the Quality Committee and will be submitted in a summary report to the committee. Minutes of the Quality committee meeting will be included in the monthly Trust Board meeting.
Executive Directors will receive weekly synopses of all open SI's with progress statement update each week.

15.3 The Performance Team will monitor compliance with external timescale reporting and closure via liaison with the Patient and Organisational Safety Department and via STEIS in accordance with the agreed Provider/Commissioner contract.

15.4 Action plans arising from investigations will be agreed and written by the

Directorate Governance Lead and the relevant team leader/ward manager and agreed at Directorate level prior to submission with the SI report. Each action plan will have an identified person who is responsible for delivering the action.

15.5 Directorate Governance Leads will be responsible for tracking progress implementation and impact upon practice of action plans and will provide a monthly update on action plan progress to CSIG as a standing agenda item. Once completed the Governance Lead is responsible for forwarding the completed action plan to the Patient and Organisational Safety Team for uploading onto the Trust SI database.

15.6 A report detailing serious incident statistics, trends and themes will be submitted to the Trust Board on a quarterly basis by the Head of Patient and Organisational Safety, in addition to a monthly summary of SI's reported since the previous meeting.

15.7 This policy will be reviewed 3 yearly or earlier the event of any new SHA/DH directives. Compliance with this policy will be monitored through the mechanisms detailed in the table below. Where compliance is deemed to be insufficient and the assurance provided is limited an action plan will be developed to address the gaps; progress against the action plan will be monitored at the specified group / committee

Minimum requirement to be monitored	Process / Method	Responsible individual / group / committee	Frequency of monitoring	Responsible individual / group / committee for review of results	Responsible group / committee for monitoring action plan
Duties	File audit	Pt and Organisational Safety Department	6 monthly	Pt and Organisational Safety Department	Clinical Safety Improvement Group
How all serious incidents are reported, internally and externally	File audit	Pt and Organisational Safety Department	6 monthly	Pt and Organisational Safety Department	Clinical Safety Improvement Group
How staff can raise concerns, for example whistleblowing, open disclosure, etc	Annual report to audit committee	Trust board secretary	Annual	Audit committee	Audit committee
How the organisation trains staff, in line with the training needs analysis	RCA trained Investigating Officers General principles of Serious Incident recognition	Pt and Organisational Safety Department Pt and Organisational Safety Department	Annual Via core required training analysis monthly	Serious Incident Lead Business Managers	Serious Incident Lead Business Managers
Different levels of investigation appropriate to the severity of the event	File audit	Pt and Organisational Safety Department	6 monthly	Pt and Organisational Safety Department	Clinical Safety Improvement Group
How the organisation shares safety lessons with internal and external stakeholders	Audit of monthly learning event attendance register Audit of Strategic Executive Information System(STEIS) database	Pt and Organisational Safety Department Pt and Organisational Safety Department	6 monthly 6 monthly	Pt and Organisational Safety Department Pt and Organisational Safety Department	Clinical Safety Improvement Group Clinical Safety Improvement Group

Minimum requirement to be monitored	Process / Method	Responsible individual / group / committee	Frequency of monitoring	Responsible individual / group / committee for review of results	Responsible group / committee for monitoring action
How action plans are followed up	Delivering Health database audit	Directorate Governance Lead	6 monthly	Clinical Safety Improvement Group	Quality and Governance Committee
How incidents, complaints and claims are analysed	Quality and Governance Development Plan Monthly report to CSIG	Performance Management Team Directorate Governance Leads	6 monthly Monthly	Quality and Governance Committee Clinical Safety Improvement Group	Quality and Governance Committee Clinical Safety Improvement Group
How this information is combined to provide a risk profile for the organisation	Risk Management report	Performance Management Team	Quarterly	Quality and Governance Committee	Quality and Governance Committee
A report template which includes qualitative and quantitative analysis	Integrated Quality Report	Performance Management Team	Quarterly	Quality and Governance Committee	Quality and Governance Committee
How this information will be shared with relevant individuals or groups	Integrated Quality Report	Performance Management Team	Quarterly	Directorate Management meeting	Directorate Management meeting
Timescales for the previous 5 minimum requirements	Copy of reports and minutes	Trust Board secretary	Annual	Quality and Governance Committee	Quality and Governance Committee

16 Analysis

16.1 The Clinical Safety Improvement Group will review all open serious incidents on a monthly basis ensuring that any concerns or actions to be taken arising from serious incidents are recorded in the group minutes and an action monitoring schedule maintained for progress and completion of actions.

16.2 Aggregation of numbers, themes, trends and links with complaints, PALS, claims and safeguarding reports will be monitored and analysed via the Trust quarterly Integrated Quality Report which will reflect qualitative and quantitative data presented in a standard template.

The report will be facilitated by the Performance Team and be made available to the Quality Committee and Trust Board prior to submission to Commissioners. In addition the report will be presented at Directorate Management meetings and cascaded through directorate structures.

17 Learning and Change

Learning following SIs is essential, not only for the ward/team that has been directly affected by the incident, but relevance to other teams and service's across the Trust must be considered and shared

17.1 The Trust philosophy is to view feedback from Serious Incident Investigations, recommend actions arising out of investigation reports and associated actions as valuable information about the quality of the service we deliver and how we can strive to improve.

Learning from Serious Incidents to ensure that positive change occurs will be facilitated in the following ways:

- Operational Debriefing following a Serious Incident to reflect on the Serious Incident will serve as an opportunity to consider the wellbeing of the team affected and provide an opportunity to consider current systems and ensure safe systems are completed to avoid further re-occurrence of an incident. Operational Debrief should occur as soon as is practicable following the incident, ideally prior to the end of that shift. The Team/Service Manager will be responsible for ensuring this is completed.
- Psychological Debriefing following a Serious Incident will be offered by the Staff Support and Counselling Service to the affected team and individuals. Further guidance on timescales for psychological debriefing to be undertaken can be found in the Critical Incident Stress Management Policy 5.13 http://sid/divisions/CorpServices/TrustBoard/Trust%20Policies/5.13%20Critical%20Incident%20Stress%20Management%20Policy.pdf
- The Ward/Team Manager will complete a 72hour briefing note in order that timely action may be taken as required.
- Investigating Officer feedback to the ward/service area team to inform on the

findings of the investigation, reflecting on notable practice, lessons learned, root cause and any recommendations following Executive Director agreement for submission to Commissioners.

- Ward/service area completion of an action plan in conjunction with the Directorate Governance Lead in response to investigation recommendations to ensure initial local ownership and improvement to ensure safe practice.
- Bi-Monthly learning lessons events where an anonymised single case study/investigate or a collection of investigations with common themes are presented to a multidisciplinary invited audience. This can include GP, Commissioner, UHNS and any other external parties as appropriate. Attendance will be recorded and entered onto the OLM database.

- An anonymised summary report of each serious incident investigation will be produced by the Investigating Officer and will form a standing agenda item on service line monthly meeting. Summary reports will be available to all staff as part of an on-going learning process and will be made available via the Trust intranet.

18 Procedure for Commissioning Thematic Reviews of Serious Incidents

In cases where there is evidence that the incident is part of an unusual or trend or where the circumstances or consequences of the incident are exceptionally serious there may need to instigate a wider investigation or themed review. A thematic review may be undertaken as an internal process or identified as requiring external involvement.

- The Medical Director will be responsible for commissioning of all serious incident related thematic reviews.
- The Directorate Clinical Director will be responsible for identifying the scope and developing the terms of reference of the review and for the appointment of the review team
- The Terms of Reference will be agreed by the Medical Director and shared with the Executive Director Team
- The Head of Patient and Organisational Safety will be part of the team and responsible for supporting the review team with the data required to complete the thematic review within the timescales agreed within the Terms of Reference
- The Identified Lead Reviewer will be responsible for providing two weekly updates to the Clinical Director and Head of Directorate on progress of the review, identifying at the earliest opportunity where themes have been identified and mitigating actions are required to preserve patient safety
- The Clinical Director will be responsible for briefing the Medical Director on a regular basis
- The Clinical Safety Improvement Group will have a standing agenda item for Thematic Review updates and will operationally support the review
- The Clinical Director will be responsible for providing review updates to the Quality Committee

- The Clinical Director is responsible for ensuring that the final draft report has met the agreed Terms of Reference and clearly identifies a conclusion with recommendations and actions
- The report will be approved by the Medical Director and Quality Committee
- Final reports will be presented to the Clinical Safety Improvement Group and Quality Committee and where appropriate key findings will be shared via the Learning Lessons monthly bulletin
- Serious Incident Thematic Reviews will be shared with the Clinical Commissioning Group via the Clinical Quality Review Meeting (CQRM) following the approval of Quality Committee.

19 Training

19.1 A register of Investigating Officers trained in Root Cause Analysis Investigation to National Patient Safety Agency (NPSA) standard will be held on an electronic database by the Patient and Organisational Safety and Complaints Teams.

19.2 The principle of Serious Incident identification and investigation and Being Open Policy principles will be cascaded via Corporate Induction, Trust Mandatory Training days

19.3 Root Cause Analysis training is a once only training course required by investigating officers. RCA training needs will be identified as part of the TNA process annually and where additional RCA courses are deemed to be required a strategic training plan will be submitted to fund this provision. PDR processes will reflect individual objectives relating to Investigating Officer training and should be incorporated in to all Band 7 and 8 objectives

20. Mortality Surveillance

In December 2016, the Care Quality Commission published a report[1] in which it found that learning from deaths was not being given sufficient priority in some organisations and consequently valuable opportunities for improvements were being missed. This report was followed in March 2017 when the National Quality Board published *National Guidance on Learning from Deaths*. The guidance states that Trusts should ensure that governance arrangements include, facilitate and give due focus to the review, investigation and reporting of deaths. This includes those deaths that are determined 'more than likely than not' to have resulted from problems in healthcare.

Trusts should publish quarterly mortality surveillance reports in order to share and act upon any learning derived from the investigation process. Trusts should support and engage bereaved families and carers, recognising their insights as a vital source of learning.

[1] Learning, candour and Accountability: A review of the way NHS trusts review and investigate the deaths of patients in England. CQC December 2016

20.1Scope

There are three levels of scrutiny that can be applied when someone dies.

- Death Certification: In England, deaths by natural causes can be certified by the attending doctor. Doctors are encouraged to report any death to the coroner where they cannot readily certify the death as being due to natural causes.
- Case Record Review: Some deaths should be subject to further review, looking at the care provided to the deceased as recorded in their clinical notes in order to identify any learning.
- Investigation: Trusts may decide that some deaths warrant an investigation and should be guided by the circumstances for investigation in the Serious Incident Framework. Some deaths will be investigated by other agents, notably the coroner.

The trust will continue to use the Serious Incident (SI) Policy framework to investigate the unexpected deaths/suspected suicides of people in receipt of services or who have been in receipt of services with the previous 12 months.

All inpatient deaths will be managed via the SI policy.

The trust will review all inpatient and community deaths of people with a Learning Disability, utilising the LeDeR review process once this is published. This process will be facilitated by the Local Clinical Commissioning Group. Until LeDeR is available the trust will use a Structured Judgement Review; this is the methodology for use in relation to adult acute inpatient deaths and allows reviewers to score a death as having a more than 50% chance of having been avoidable when this judgement is made in relation to the care provided by the trust conducting the review. The trust Ulysses incident reporting module requires that people with a Learning Disability are identified. This will allow the trust Patient and Organisational Safety Team to monitor the Learning Disability teams' compliance with the review requirements.

Physical and mental health are closely linked. People with severe mental illness (SMI) are at risk of dying on average 15 to 20 years earlier than other people[2] In the event of deaths which do not meet the criteria for SI investigation i.e. people who die from an alcohol related death or people with SMI who die from natural causes, the trust will complete case reviews. For Mental Health trusts there is no requirement to use the Structured Judgement Review, nevertheless there is a requirement to consider potential factors for premature death and factors relating to the increased risk of complications for those people with physical health and SMI co-morbidities. In relation to this requirement, there is currently no single agreed definition of which conditions/criteria would constitute SMI. The term is generally restricted to the psychoses, including schizophrenia, bipolar disorder, delusional disorder, unipolar depressive psychosis and schizoaffective disorder.

20.2 Review Process

The trust will review deaths according to the criteria set out below.

Deaths to be investigated under the Serious Incident Policy:

[2] The Five Year Forward View for Mental Health. NHS England 2016

- All unexpected deaths/suspected suicides of people open to mental health services or open to mental health services within the previous 12 months
- All unexpected deaths/suspected suicides of people open to substance misuse services where the death is suspected to be drug related

Deaths to be investigated using a case review process:

- Deaths of people open to mental health services, where the person has a diagnosis of Serious Mental Illness and has died at an age which may be reasonably considered to be premature.
- Deaths of people open to Substance Misuse Services, where alcohol abuse is considered to be a factor.

Due to the small number of deaths meeting the case review process criteria, the trust will select at random up to 5 deaths per quarter for review using this process.

20.3 Engagement with bereaved families

Engagement with bereaved families will be managed as per the Serious Incident Policy (see main SI policy, section 6.5)

20.4 Roles and responsibilities in relation to mortality surveillance

a. Trust Board

- The Medical Director, as **Patient Safety Director**, is responsible for the learning from deaths agenda.
- The Non-Executive Director Chair of the Quality Committee is responsible for oversight of the process.
- Ensure that case reviews and investigations are completed to a high quality.
- Ensure that mortality reporting is robustly reported and that learning from investigations is regularly reported to the board. This report will be discussed at the open section of the Trust Board.
- Ensure that learning from investigations is reported in the Annual Quality Account.
- Share relevant learning across organisations where the insight gained could be useful.
- Ensure that there are sufficient numbers of staff trained in the investigation and case review methodology and that they have protected time as part of their contracted hours to review and investigate deaths.
- Offer timely, compassionate and meaningful engagement with bereaved families and carers, in relation to all stages of responding to a death.
- Independent investigation will be carried out when warranted.

b. The Non-Executive Director will:

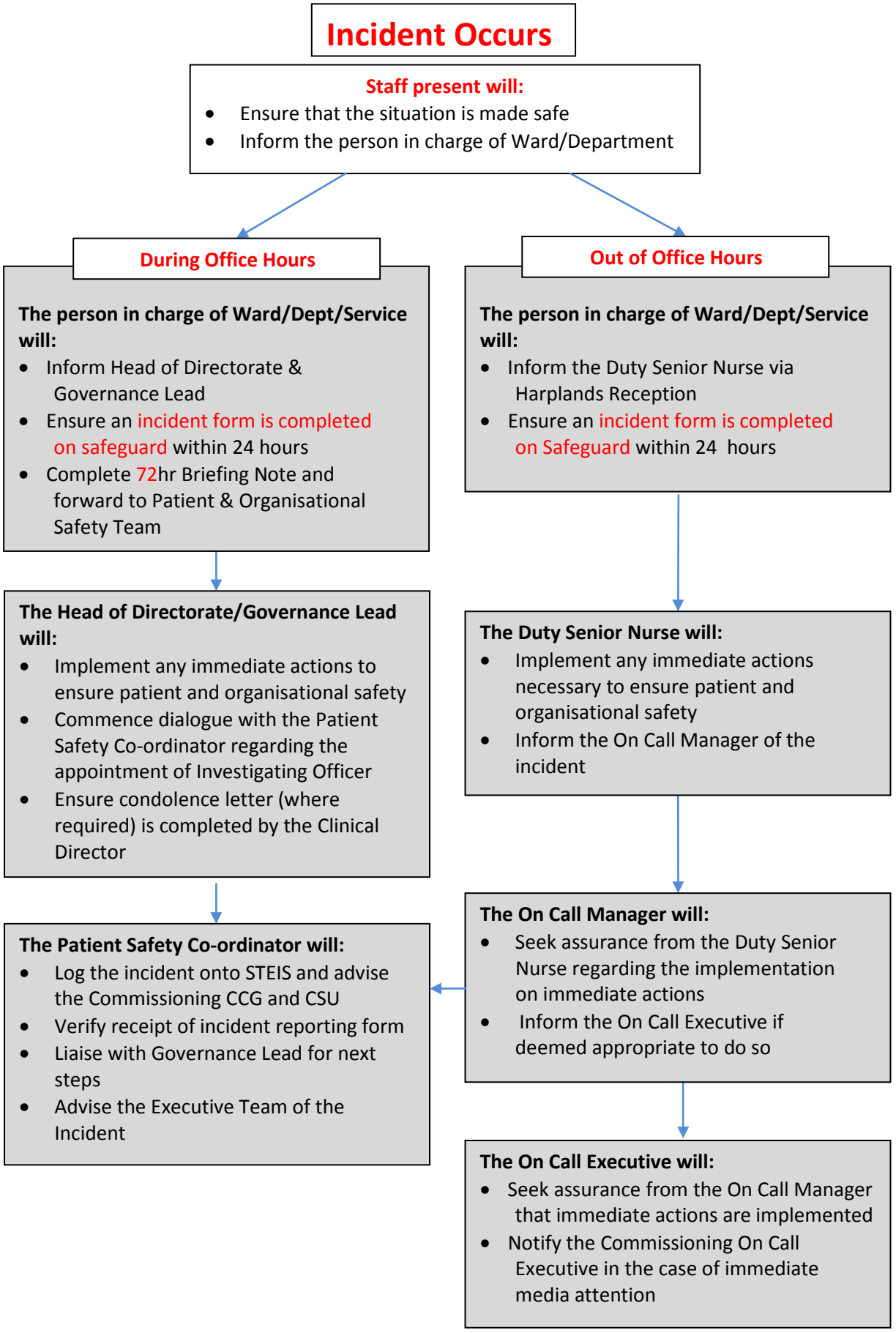
- Understand the review process to ensure that the process used is robust and can withstand scrutiny.
- Champion quality improvement that lead to actions that improve patient safety
- Assure published information accurately and fairly reflects the Trust's approach and challenges

c. The Patient and Organisational Safety Team (P+OS Team) will:

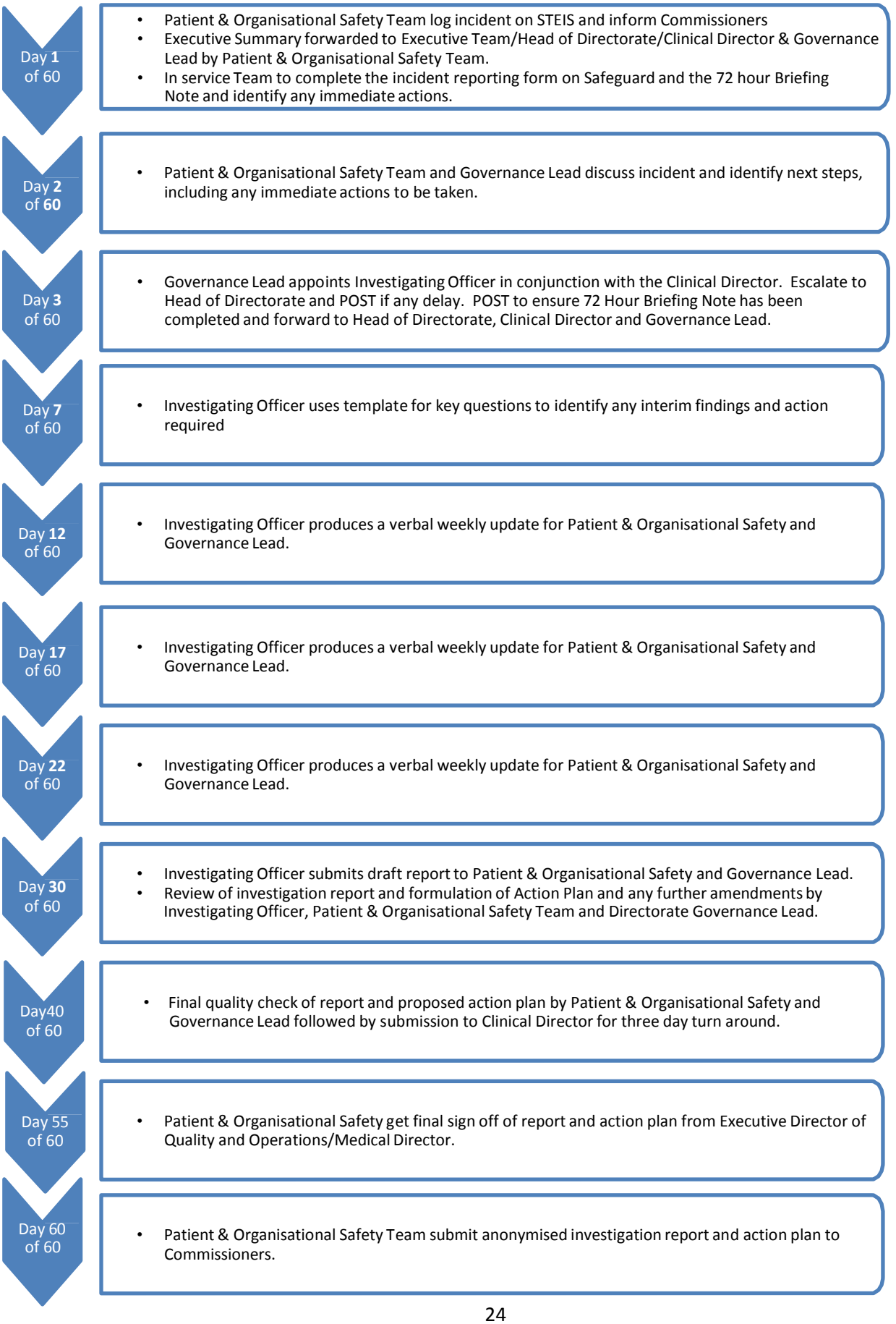
- Receive a monthly report of all people who are open to services and who have been deceased during the previous month; this information will be provided by the trust performance team.
- Cross reference the above report with the P+OS Team database of unexpected deaths meeting Serious Incident Criteria, the trust incident reporting system and any notifications received from HM Coroner's Office.
- Liaise with HM Coroner's Office regarding a cause of death for all deaths reported via the trust incident reporting system.
- Identify any deaths which require further investigation and inform the relevant directorate, who will be responsible for appointing an Investigating Officer and completing the investigation.
- Produce a quarterly report for Quality Committee regarding the number of deaths of people known to the trust.
- Ensure that all learning from deaths is shared across the trust clinical teams.
- Coordinate the case review process, which will be chaired by the medical director, selecting 5 deaths at random per quarter.
- Share mortality surveillance data with commissioners through the Clinical Safety Improvement Group with additional assurance provided through the Clinical Quality Review Meeting.

21. Appendices

21.1 Serious Incident Responsibilities Flowchart



21.2 Investigation Timescales in Working Days



21.3 Serious Incident 72 Hour Briefing Report

North Staffordshire Combined Healthcare NHS
NHS Trust

72 Hour Briefing Note: Appendix 19.3 Serious Incident Policy

This briefing note will be requested by the Patient and Organisational Safety Team (POST) on confirmation that a serious incident investigation is required and will be completed by the Care Coordinator or nominated other
The briefing aims to outline the circumstances of the incident including a timeline of the incident occurring.
The briefing will assist the Patient and Organisational Safety Team in agreeing actions as necessary and will assist the Investigating Officer to complete the investigation accurately and in a timely manner.
If you have any queries regarding the completion of this form, please contact the team on the following extensions; FN 2161, 2096, 2080.

SERIOUS INCIDENT LOG DETAILS **Patient and Organisational Safety Team will complete the questions marked red)**

STEIS DETAILS	
STEIS number	
STEIS category	
Date reported on to STEIS	
Date reported to Commissioners	

INVESTIGATING OFFICER (IO) INFORMATION	
Date IO appointed	
IO name	
IO details	
Directorate	
Team name	
Base	
Contact number	
Email address	

INCIDENT INFORMATION	
Incident form number	
Actual date of incident	
Date incident reported to POST	
Type	
Cause Group	
Cause	
Incident details	

TEAM INVOLVED	
Directorate	
Service Line	

Team	
Team Base	
Team contact number	
Team Manager	

PATIENT DETAILS	
Name	
NHS number	
Date of Birth	
Gender	
Ethnicity	
Address	
Next of Kin/Nearest Relative	
Designated contact (if different from above)	
Is the NOK/Identified contact aware of this incident?	

MENTAL HEALTH DETAILS					
Diagnosis					
CPA status (standard or enhanced)					
Date of last CPA review					
Was patient subject to DOLS?	No		Yes		
MHA status (if applicable)					
Care Coordinator					
Named Nurse (if applicable)					
Consultant Psychiatrist					
Current medication					
Details of current risk assessment and care plan					
Last review of risk assessment					
Last scheduled appointment date					
Did the patient attend the last appointment?					
If the patient did not attend, please record the action taken					
Does the patient have a history of not attending?					
Does the patient have a history of poor engagement?					
Is there an electronic plan in place in cases of DNA?					
Is there a designated person and contact no recorded in case of DNA?					
Please detail any recent substance misuse history					
Is the patient involved in					

substance misuse services (including Aquarius/CRI)?	
If yes to the above, please give name and contact details	
Is the patient attending appointments with any other provider of mental health services?	
Are there any recent or current safeguarding concerns?	
Any recent incidents reported via the incident reporting system?	

PHYSICAL HEALTH DETAILS	
Details of any known physical health conditions	
Details of any known medications for physical health	
Any recent deterioration in physical health	
Recent Acute Hospital admission for physical condition	

TIMELINE OF EVENTS LEADING TO THE INCIDENT (the timeline should only relate to circumstances relevant to this incident and not a chronology of the patients history with services):	
Date (and time if relevant)	
Event	
Date (and time if relevant)	
Event	
Date (and time if relevant)	
Event	
Date (and time if relevant)	
Event	
Date (and time if relevant)	
Event	
Date (and time if relevant)	
Event	

(Copy and paste to create additional boxes if required)

PERSON COMPLETING THIS FORM	
Name	
Team	
Contact number	
Email address	
Date completed	

PLEASE RETURN THIS BRIEFING BY EMAIL TO THE FOLLOWING
JacquelineL.Wilshaw@northstaffs.nhs.uk JoannaL.Milgate@northstaffs.nhs.uk LesleyP.Whittaker@northstaffs.nhs.uk Rosanna.Melnik@northstaffs.nhs.uk