Mersey Care NHS
NHS Foundation Trust

TRUST-WIDE NON-CLINICAL DOCUMENT

CORPORATE POLICY & PROCEDURE FOR THE REPORTING, MANAGEMENT AND REVIEW OF ADVERSE INCIDENTS

(including serious untoward incidents and near misses)

Policy Number:	**SA03**
Scope of this Document:	**All Staff**
Recommending Committee:	**Patient Safety Committee**
Approving Committee:	**Executive Committee**
Date Ratified:	**March 2016**
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Lead Executive Director:	**Executive Director of Nursing**
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2016 – Version 1.1

Quality, recovery and wellbeing at the heart of everything we do

Mersey Care NHS Trust

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CORPORATE POLICY & PROCEDURE FOR THE REPORTING, MANAGEMENT AND REVIEW OF ADVERSE INCIDENTS

Further information about this document:

Document name	**CORPORATE POLICY & PROCEDURE FOR THE REPORTING, MANAGEMENT AND REVIEW OF ADVERSE INCIDENTS (SA03)**
Document summary	Mersey Care NHS Trust is committed to enhancing the safety and security of its staff, service users and carers by ensuring that it has valid systems to report and learn from adverse events. The management of adverse incidents is set out in this policy and procedure, SA03, it has been written to meet national and local guidelines including those from the National Patient Safety Agency (NPSA), NHS Litigation Authority (NHSLA) and Clinical Commissioning Group (CCG), as the lead Commissioner. The effective management of adverse incidents is an integral part of the way the Trust meets its duty to minimise the risk to its service users, carers, staff and visitors, with the aim of maintaining their health and safety. This Policy has been developed to provide a systematic approach to maintaining compliance with all guidance on this topic area. This is an updated corporate policy and procedure and has been consulted upon widely, both internally and externally. Changes to the existing policy and procedure were required to reflect the amended structures and workforce of the organisation and the latest guidance published by the NHS England. Its aim is to ensure that there is a well governed, structured and systematic approach to the reporting, logging, review, of incidents with an associated high standard for the ratification of incident reports and implementation of action plans. The objectives of the policy include: - • That staff will know how and when to report an adverse incident. • Guidance will be available for staff regarding the actions that should be taken following the occurrence of an incident, to prevent a further similar incident occurring or minimise the consequences of such incidents in the future. • That a thorough examination of Serious and Untoward Incidents will take place with the aim of learning how systems and processes can be changed to reduce future harm being caused. • Individuals involved or affected by incidents will be actively engaged in the incident review process as per the Department of Health's policy of Being Open. • That data on the level and type of reporting and associated harm experienced can be accessed easily by clinical and managerial staff so that they can monitor for trends and implement appropriate safety measures. • The Trust Board and its Executive Directors will be made aware of risk issues related to the management of adverse incidents. This Policy is applicable to all staff throughout the Trust and those engaged with it including contractors who work on behalf of the Trust whose activities give rise to incidents occurring.

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To be read in conjunction with	▪ Policy and Procedure for the Management of Complaints and Concerns (SA06) • Being Open Policy (SA13) • Policy and Procedure for the Reporting Management and Investigation of Claims (SA05) • Health and Safety and Wellbeing Policy (SA07) • Risk Management Policy and Strategy (SA02) • Policy for the Recognition, prevention and therapeutic management of Aggression and Violence (SD 18) • Policy For Safeguarding Vulnerable Adults From Abuse (SD17) • Procedure for the Systematic Approach to the Analysis and Learning from Incidents, Complaints and Claims (SA32) • Policy and Procedure for Reviewing And Implementing The Recommendations of National Confidential Enquiries/ Inquiries (SA33) • Support / Information available to staff following their involvement in Complaints, Claims, Incidents and Inquests (Guidance Document) • Major incident plan (SA31) • South Sefton Community Division guidance for the Management of Incidents
This document can be made available in a range of alternative formats including various languages, large print and braille etc	

Version Control:

		Version History:
2016 – Version 1	Corporate Document Review Group	March 2016
2016 – Version 1.1	Acquisition Steering Group	June 2016

SUPPORTING STATEMENTS

This document should be read in conjunction
with the following statements:

SAFEGUARDING IS EVERYBODY'S BUSINESS

All Mersey Care NHS Trust employees have a statutory duty to safeguard and promote the welfare of children and vulnerable adults, including:

- being alert to the possibility of child/vulnerable adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child/vulnerable adult;
- knowing how to deal with a disclosure or allegation of child/adult abuse;
- undertaking training as appropriate for their role and keeping themselves updated;
- being aware of and following the local policies and procedures they need to follow if they have a child/vulnerable adult concern;
- ensuring appropriate advice and support is accessed either from managers, *Safeguarding Ambassadors* or the trust's safeguarding team;
- participating in multi-agency working to safeguard the child or vulnerable adult (if appropriate to your role);
- ensuring contemporaneous records are kept at all times and record keeping is in strict adherence to Mersey Care NHS Trust policy and procedures and professional guidelines. Roles, responsibilities and accountabilities, will differ depending on the post you hold within the organisation;
- ensuring that all staff and their managers discuss and record any safeguarding issues that arise at each supervision session

EQUALITY AND HUMAN RIGHTS

Mersey Care NHS Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, gender, race, religion or belief, sexual orientation and transgender. The Equality Act also requires regard to socio-economic factors including pregnancy /maternity and marriage/civil partnership.

The trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role as a major employer. The trust believes that all people have the right to be treated with dignity and respect and is committed to the elimination of unfair and unlawful discriminatory practices.

Mersey Care NHS Trust also is aware of its legal duties under the Human Rights Act 1998. Section 6 of the Human Rights Act requires all public authorities to uphold and promote Human Rights in everything they do. It is unlawful for a public authority to perform any act which contravenes the Human Rights Act.

Mersey Care NHS Trust is committed to carrying out its functions and service delivery in line the with a Human Rights based approach and the FREDA principles of **F**airness, **R**espect, **E**quality **D**ignity, and **A**utonomy

Contents

1. PURPOSE AND RATIONALE

1.1 This document explains: -

- why the policy is necessary (rationale)
- to whom it applies and where and when it should be applied (scope)
- the underlying beliefs upon which the policy is based (principles)
- the standards to be achieved (policy)
- how the policy standards will be met through working practices (procedure)

This policy and its implementation has been reviewed following its initial launch in June 2003 and alterations made following discussions with clinicians, service users, carers, managers and external stakeholders to ensure continuous improvement of the process. This policy and procedure will be further developed and amended as per Trust guidelines.

1.2 **Rationale**

The reporting of adverse incidents is a key and fundamental aspect of the Trust's approach to enhancing the safety of service users, carers and staff. A comprehensive adverse incident reporting system acts as an on going method for identifying risks and thereby aids both reactive and proactive risk management: -

- Reactive in terms of managing the situation and preventing further damage/incidents occurring.
- Proactive in identifying actions that can be done to prevent a further adverse incident occurring, or minimise the consequence of such incidents in the future.
- Failure to report incidents, or under reporting of near misses, could lead to adverse incidents recurring, which may result in injury to service users, carers or staff.

The management of adverse incidents needs to ensure that learning is facilitated and achieved. Systems need to be in place to give staff, service users and carers the opportunity to critically evaluate practice and learn from adverse incidents that may occur.

The purpose of this policy and procedure is to ensure the prompt and effective reporting and management of all adverse incidents. It establishes a framework for: -

- Defining and classifying all adverse incidents.
- Reporting effectively all adverse incidents internally and to its partner agencies i.e. NHS England, CCG, National Reporting and Learning System and Counter Fraud and Security Management Services.
- Ensuring a thorough examination of adverse incidents takes place by those staff involved.
- Bringing incidents to the attention of the Division.
- Enabling staff, service users, their families and carers to express their feelings regarding incidents, being involved in the review process and receiving feedback on the reports findings. (Duty of Candour)
- Ensuring that recommendations made following an SIRI review are implemented and are used to direct work to enhance service provision and that delays in completing these are noted, understood and removed.
- Ensuring lessons are learnt and action plans are in place to address weaknesses

and prevent further occurrences of adverse incidents.

Mersey Care NHS Trust will be performance managed by the North West NHS England, Specialist Commissioners and Clinical Commissioning Groups with regards to the reporting and reviewing of Serious Incident Requiring Investigation (SIRI).

The Trust Board will receive regular reports on all incidents reported to StEIS and the progress made with reviewing and learning from their investigations.

The purpose of this policy and procedure is not to apportion blame in relation to any individual but to achieve the purpose set out above. However, should negligence be identified through the review process, this will need to be addressed appropriately. Any disciplinary procedures/investigations will be undertaken separately from the review of the incident.

This policy and procedure is intended to be compliant with the European Convention on Human Rights where possible and insofar as it is applicable.

2. OUTCOME FOCUSED AIMS AND OBJECTIVES

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

- In an **Open and transparent** manner , for example Staff, service users, their relatives and carers should, where appropriate, be given the opportunity to critically appraise incidents that have arisen and the outcomes of the review that has taken place.
- With future **prevention** as a key aim, a culture of learning required in order for the Trust to develop and improve the way care is organised and delivered.
- In an **Objective** style
- In a **Timely and responsive** way
- **Based on systems** as opposed to seeking to lay individual blame.
- **Proportionately** to the risks identified and outcomes experienced.
- **Collaboratively,** working closely with commissioners and other key providers**.**

2.2 All adverse incidents will be: -

- Reported using the Local Risk Management System
- Risk assessed to ensure the environment/ individuals involved are safe and secure
- Logged as appropriate within clinical records which will also be secured in relation to fatal injures
- Assessed for seriousness, and where identified appropriate senior clinicians and managers will be informed.
- Serious incidents will be investigated and if appropriate reported to performance managers and the NHS Northwest via the Strategic Executive Information System (StEIS). Guidance for the SIRI reporting criteria is in the NHS England reporting framework.
- All adverse incidents will be reviewed and approved on the Local Risk Management System in accordance with the guidelines enclosed.

2.4 Service users and carers will be empowered, where appropriate, to become involved in the investigations of serious and untoward incidents as part of the trust's adherence to Duty of Candour guidance.

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

2.6 Each Clinical Division has a system which reviews, agrees and monitors recommendations, action plans, time scales and implementation process. The Trust's Risk Management System's action planning module will be used to track completion, a report is shared with the Quality Assurance Committee bi monthly which outlines all; actions outstanding and the reasons why

3. SCOPE

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

3.2 **The policy applies to all incidents that: -**

- Occur on Trust premises.
- Occur off Trust premises but involve persons employed by the Trust whilst on Trust business.
- Involve any patient receiving care from the Trust – including joint mental health services with local authorities.
- Involve any patient who has been open to one or more Mersey Care NHS Trust services within the last 12 months
- All service user deaths
- Low level harms

4. DEFINITIONS

Serious Incident Requiring Investigation (SIRI) - Serious incidents requiring investigation were defined by the NPSA's 2010 *National Framework for Reporting and Learning from Serious Incidents Requiring Investigation* In summary, this definition describes a serious incident as an incident that occurred during NHS funded healthcare (including in the community), which resulted in one or more of the following;

- unexpected or avoidable death or severe harm of one or more patients, staff or members of the public;
- A never event - all never events are defined as serious incidents although not all never events necessarily result in severe harm or death. (See *Never Events Framework*);

- A scenario that prevents, or threatens to prevent, an organisation's ability to continue to deliver healthcare services, including data loss, property damage or incidents in population programmes like screening and immunisation where harm potentially may extend to a large population;
- allegations, or incidents, of physical abuse and sexual assault or abuse;
- loss of confidence in the service, adverse media coverage or public concern about healthcare or an organisation.

Near miss - any unintended or unexpected incident that was prevented by some form of intervention and so resulted in no harm but without the intervention may have resulted in harm to one or more patients receiving NHS funded healthcare (NPSA).

Security incident - thefts, deliberate damage to property etc.

Environmental Incident – the release of a substance (either accidentally or by malicious act) of a substance prohibited by environmental legislation or a substance released in sufficient quantities to cause environmental pollution or damage. For example, spillage of chemicals or oil, release of harmful chemicals to sewers or watercourses. A 'major environmental incident' would be one requiring the involvement of a regulatory authority due to the volume / toxicity of the substance released.

Data breaches, these should all be reported via the risk management system and graded to ascertain if they need to be reported via StEIS **,** reported to the Information Commissioner's Office (ICO) and investigated.

Never Events

In 2015 the Department of Health published updated guidance on "Never Events" for use by Trusts and commissioners.

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

5. DUTIES

Chief Executive

- Agrees the level of investigation to take place for some Serious and Untoward Incidents usually Homicides and inpatient deaths.
- Agrees a communications plan, which includes drawing up a briefing paper for the Board of Directors.
- Ensures that Level 3 Reports (Independent Investigations) into Serious and Untoward Incidents are presented to the Board and that the action plan is monitored by the Quality Assurance Committee (QAC).
- Actively supports the effective management of the Adverse Incident Management process and is ultimately accountable for its implementation.

Executive Director of Nursing and Clinical Governance

- Accountable Director for Adverse Incident Management.

- Advises the Chief Executive on the outcome of the SUI investigations and any associated risk that have been identified.
- Ensures that there is robust management of adverse incidents on a day to day basis and that a report is shard on a bi monthly basis with the Quality Assurance Committee on the number of adverse incidents reported and actions taken to prevent further similar ones occurring.

Chief Operating Officer / Associate Medical Director / Director of Operations

- Ensures risk management procedures are in place.
- Ensures local induction is in place for new staff.
- Ensures that an adequate level of investigation is conducted within the Division in accordance with this policy and procedure.
- Ensures that contact with families following serious incidents is maintained as per the Duty of Candour directives.
- Ensures as a delegated responsibility that initial service management investigation reports are verified and forwarded within the specified timescale of 3 days.
- Ensures as a delegated responsibility that divisional investigations into serious untoward incidents are conducted and completed within 65 days.
- Responsible for having systems in place which will ensure that action plans are implemented within the timeframe and reported.
- Allocates a member of staff to be the Divisional Adverse Incident lead
- Ensures that all staff in the Division are aware of and operate within the Adverse Incident Policy (SA03

Divisional Risk Lead

- Will take delegated responsibility for ensuring that the adverse incident policy is understood and implemented in the Division
- Attends and reports to the Divisional Adverse Incident /Risk Group.
- Attend the Trust Wide Patient Safety Group
- Identity gaps in the implementation of the policy and procedure and report to the Chief Operating Officer.
- Identify trends in incident reporting and plan remedial monitoring activity.
- Close incidents on the Local risk management system.
- Develop, monitor the use of and support the divisional system which ensures that every incident which occurs in the Division is reviewed, that identifies trends and highlights risks with Chief Operating Officer.

Divisional Managers /Operations Manager

- Are responsible for ensuring that all staff members are aware of and operate within the Adverse Incident Policy (SA03).
- They are responsible for notifying the Chief Operating Officer / Associate Medical Director of all serious incidents which may require reporting to external agencies.
- They are responsible for the investigation of all serious incidents within their service and providing the final report to the divisions Risk Lead.
- They are responsible for ensuring all incidents are reviewed on the local risk management system.

Director of Patient Safety

- Is responsible for the management of the Trust's adverse incident process on a day to day basis.

- Provides advice and support to Divisional Teams.
- Coordinates investigations of serious untoward incidents
- Co-ordinates and oversees the management and investigation of serious untoward incidents including the Trust inquiries.
- Supports systems of learning from serious incidents in order to reduce the risk.
- Ensures that reports submitted to the Coroner's Office are clear and factually accurate.
- Ensures that staff are supported in Coroner's inquest proceedings and other formal inquiries.
- Maintains a status report on all serious untoward incidents.
- Ensures the incident is reported to the host and commissioning CCG where appropriate.
- Ensures all incidents are entered onto the Trust risk database (local risk management systems).
- Ensures the quarterly incident trend analysis is presented to the Trust Board and its Committees. Adverse Incident Management Group and the Health & Safety Committee.
- Ensures incidents are reported to the National Reporting and Learning System (NRLS).

Risk Management System Administrators

- Once the Adverse Incidents Team become aware of an adverse incident they will: -
  - Assess if external reporting or media briefing necessary? If yes, contact the Communications Department. Report to outside agencies as required.
  - Make final grading using NRLS classification system
- Share reports/incident data as appropriate with Specialist Departments
- Quarterly report on all adverse incidents prepared for Patient Safety Committee and Chief Operating Officers
- Reports incidents of violence against staff to the Counter Fraud and Security Management Service
- Collate Division responses for the CCG Quarterly Quality Report
- Highlight any identification of clusters of incidents and share with the Director of Patient Safety.

SUI Administrator

- With the Senior Manager responsible, agree whether a serious incident investigation or reflective practice investigation is to be implemented
- Monitor the timely completion of investigation reports and liaise directly with the lead CCG regarding request for extensions etc
- Send investigation reports to the CCG / NHS England within the agreed timescales
- Monitor and update Actions Plans

Modern Matrons / Clinical Team Managers

- Modern Matrons have the responsibility for monitoring the adherence to the Adverse Incident Policy (SA03) within their service on a daily basis.
- They have responsibility for ensuring that any appropriate training associated with Adverse Incident Policy (SA03) is undertaken by nursing staff within their service.
- Modern matrons have responsibility for ensuring that all incidents are approved on the local risk management system.

Multidisciplinary Teams

- The MDT discusses the incident and care plans amended as necessary. The process, outcome and rationale for not needing further investigation following the incident should also be recorded in the case notes.
- They will become involved with Post incident investigations when required and will actively use information gained from Adverse Incidents in the management of their patients.
- Where appropriate all seventy Two Hour Reports should be undertaken via the Multi Disciplinary Team process and agreed by the consultant involved.

The staff in charge of the area where the incident has occurred

- The member of staff in charge of an area is responsible for managing any incident in line with the Adverse Incident Policy (SA03) including delegation to another, or managing the incident her/himself.
- If the incident includes a patient they must ensure that the incident is discussed during the next multidisciplinary meeting for the individual and care plans amended appropriately. Any agency or bank staff must be made aware of Trust protocol and procedures.
- Ensure members of staff involved in or discovering incident completes an incident report on the trust's Risk Management system. If a service user been involved clinical records should be completed.
- If a contractor is involved the relevant Estates Manager must be notified along with the Health & Safety Manager. All incidents involving visitors, including relatives, must also be referred to the Claims Manager.

Staff working in the area where the incident occurs

- On discovery of an adverse incident, a member of staff involved in or discovering the incident should inform the member of staff in charge of the area at the time. The member of staff in charge should then ensure that they make a contemporaneous record of events on the trust's Risk Management System. Where appropriate photographs should be taken as evidence and forwarded to the Senior Manager Responsible for inclusion in the incident report.

All Staff within Mersey Care NHS Trust

- All staff have a duty to report any incident involving themselves when it occurs on Trust premises or anywhere if they are undertaking Trust business. Staff must act in line with this policy and also report incidents they become aware of involving service users, carers, relatives, visitors, contractors or any other person involved in an incident. If a Carer raises concerns regarding an incident they have a responsibility of making certain this is reported in line with the Adverse Incident Policy (SA03).

Groups and Committees

Trust Board

The Trust Board is responsible for ensuring that the Adverse Incident Policy (SA03) is in place via its governance arrangements and that all staff working in the Trust are aware of, and operate within the policy.

Consider and approve identified Serious and Untoward Incident reports and Level 3

reports and their action plans which will be provided by the Divisions.

Quality Assurance Committee minutes will be shared with Trust Board which will include reflections on adverse incident management.

Quality Assurance Committee

Will receive high level performance reports on the occurrence of Serious and Untoward Incidents , achievement of set targets, any associated risk issues , analysis of incidents against protective characteristics and actions taken to enhance safety on a bi-monthly basis.

Patient Safety Committee

This Committee is chaired by the Senior Manager responsible for Adverse Incident management within the Trust; its members have responsibility for monitoring the effectiveness of the implementation of the Trust's Adverse Incident Policy and adherence to national guidelines. Each Division is represented by their Adverse Incident Lead. This Group will: -

- Share incident information across Divisions to share learning and risk information and monitor the actions of Divisions.
- Disseminate external inquiry information / reports and monitor the actions of Divisions
- Monitor the adherence to the trust's Adverse Incident Policy .
- Develop new initiatives regarding the management of adverse incidents

Divisional Governance

Each Division will have a forum that will oversee its management of and learning from Adverse Incidents, this Group will be chaired by its Adverse Incident Lead. It provides a vehicle to: -

- Validate all incident investigation reports.
- Monitor trends and plan remedial action to reduce occurrence.
- Monitor the completion of actions plans.
- Monitor adherence to the Trusts Adverse Incident Policy.

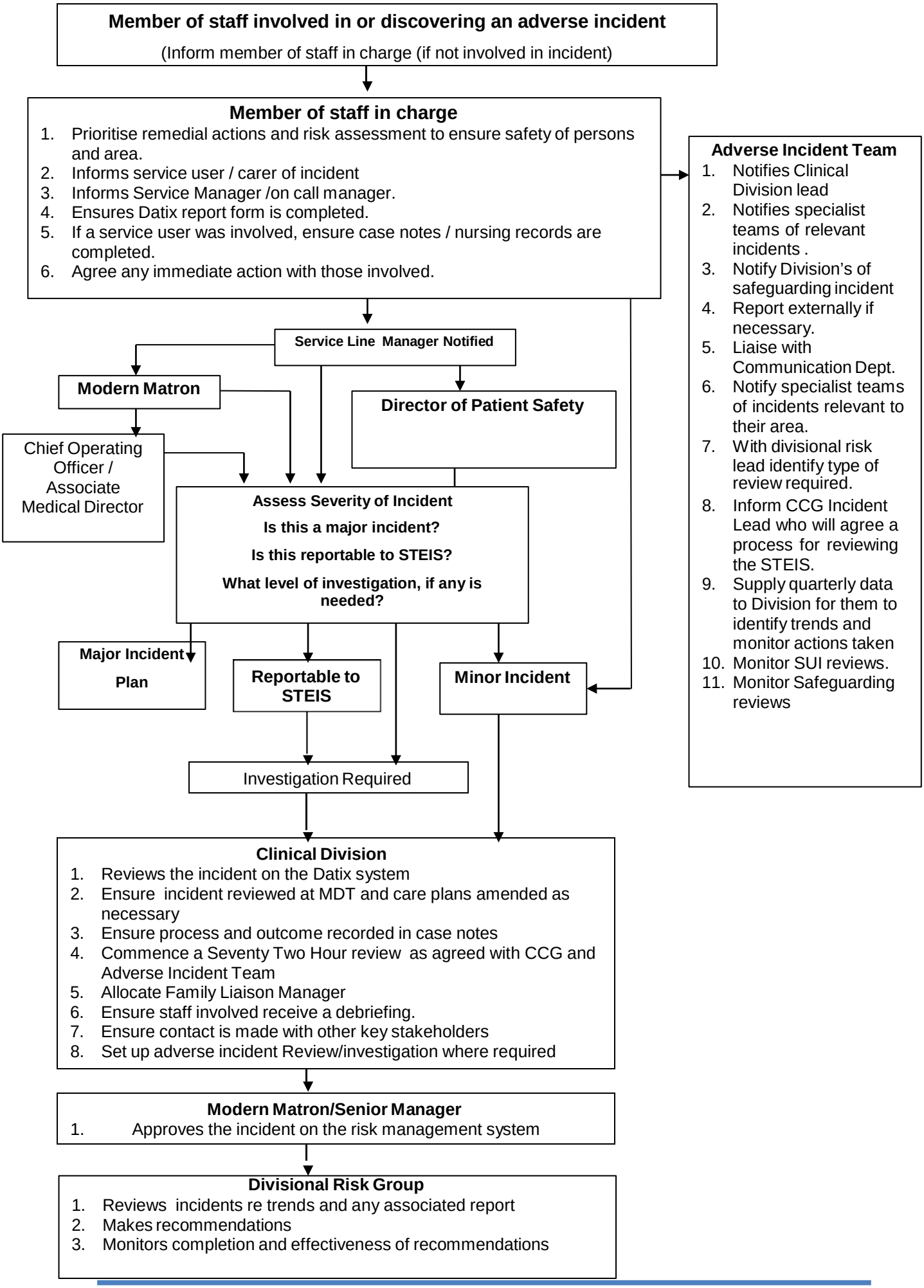
Safe from Suicide Team

- Support all investigations identified as either a suicide or a near fatal self harm
- Support members of staff charged with Duty of Candour responsibilities for families bereaved by suicide.
- Identify appropriate avenues of support or treatment for bereaved families
- Support investigation team to feedback lessons learned.
- Identify trends and implement remedial action in conjunction with local risk leads

6. PROCESS

This is a corporate procedure to be applied within Local and Secure Divisions and

Corporate Division in Mersey Care NHS Trust.


Member of staff involved in or discovering an adverse incident
(Inform member of staff in charge (if not involved in incident)
Member of staff in charge
1. Prioritise remedial actions and risk assessment to ensure safety of persons and area.
2. Informs service user / carer of incident
3. Informs Service Manager /on call manager.
4. Ensures Datix report form is completed.
5. If a service user was involved, ensure case notes / nursing records are completed.
6. Agree any immediate action with those involved.
Adverse Incident Team
1. Notifies Clinical Division lead
2. Notifies specialist teams of relevant incidents .
3. Notify Division's of safeguarding incident
4. Report externally if necessary.
5. Liaise with Communication Dept.
6. Notify specialist teams of incidents relevant to their area.
7. With divisional risk lead identify type of review required.
8. Inform CCG Incident Lead who will agree a process for reviewing the STEIS.
9. Supply quarterly data to Division for them to identify trends and monitor actions taken
10. Monitor SUI reviews.
11. Monitor Safeguarding reviews
Service Line Manager Notified
Modern Matron
Director of Patient Safety
Chief Operating Officer / Associate Medical Director
Assess Severity of Incident
Is this a major incident?
Is this reportable to STEIS?
What level of investigation, if any is needed?
Major Incident Plan
Reportable to STEIS
Minor Incident
Investigation Required
Clinical Division
1. Reviews the incident on the Datix system
2. Ensure incident reviewed at MDT and care plans amended as necessary
3. Ensure process and outcome recorded in case notes
4. Commence a Seventy Two Hour review as agreed with CCG and Adverse Incident Team
5. Allocate Family Liaison Manager
6. Ensure staff involved receive a debriefing.
7. Ensure contact is made with other key stakeholders
8. Set up adverse incident Review/investigation where required
Modern Matron/Senior Manager
1. Approves the incident on the risk management system
Divisional Risk Group
1. Reviews incidents re trends and any associated report
2. Makes recommendations
3. Monitors completion and effectiveness of recommendations

6.1 Incident Review & Approval

The Purpose of the Initial Incident Review & Approval

Each incident should be reviewed and approved by managers with knowledge or responsibility in area the incident occurred. The Division will decide who the reviewers and approvers will be. Typically a Ward manager would review an incident and the Modern Matron would approve it. However as Teams and Departments vary widely the Division has discretion to choose reviewers and approvers that meet their organisational needs.

The Purpose of the Review

The initial review is not an in depth analysis and should not be confused with a Seventy Two Hour Review or a post incident review. The initial review will ensure that the management within the Division is aware of the incident and has made a judgement about its seriousness and whether it will need further investigation and what immediate actions should be taken to maintain safety. The steps are as follows,

1. Ensure the accuracy and completeness of the report.
2. Seek updates and make corrections where information is inaccurate, missing or incomplete.
3. Grade the incident for severity using a five by five grid, Severity against likelihood.
4. Provide their view of what lead to the incident and what action has been taken or should be taken to deal with the consequences and prevent it happening again.

The Purpose of the Approval

The incident is approved to provide oversight of the adverse incident process for the Division. The approver should be checking the

1. Severity grading is appropriate
2. The actions taken are adequate
3. Decide if the issue needs to be raised further within the Division's governance structure.

Reviews should be completed within 4 days and the approval within 7 days

A reminder will be sent to the reviewers and approver for any incidents that are overdue on a weekly basis

Closing Incidents

The Division will set a closure date for the incident which will be when it is satisfied that all matters related to the incident have been dealt with. This allows an incident to be approved in terms of the immediate consequences but kept open while such things as investigations or disciplinary investigations proceed.

6.4 Informing and Involving Service Users and Carers –Family Liaison Manager

As part of Duty of Candour it is essential that the service user is informed that he/she has been involved in an incident of moderate or severe harm and asked if they would like their carer / next of kin or advocate to be informed. If the answer is yes, the Health Care Professional should liaise with the service user to decide how this is best achieved which will include the following decisions and actions , all incidents where a death has occurred will follow the directions below : -

- Can information be shared by the telephone
- Should the service user let Carers know?
- Should a Health Care Professional let Carers know immediately or can information sharing be delayed until the Carer can be seen face to face or working hours are resumed.
- Actions must be documented on the local risk management system.

If the service user does not give their permission to contact their family/carer then they should not be told unless the service user / incident meets one of the following criteria:

- The individual has been assessed as not having the capability and capacity to make the decision.
- There is a pattern of behaviour that creates risk for the carers / relatives.
- The service user is mortally / seriously injured or a high potential for further clinical deterioration exists.
- There is a pattern of the individual's behaviour escalating putting their lives at risk or that of others.

For incidents where moderate and severe harm/.death has occurred and a decision has been made to inform carers / relatives / significant others, the following should be undertaken: -

- Within 48 hours of the incident being notified to the Service allocate a Family Liaison Manager who will take the lead for informing the carers / relatives personally verbally (whenever practicable) and then ensure that a follow up letter as per Duty of Candour guidance is sent to the carer /service user. (see below)

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- Where any media briefings are made or information is shared with individuals (staff, service users/carers, and other professionals) a record of information provided should be included in the incident file.

- A follow up letter must be written by the senior manager responsible within 10 days of the incident being notified to the Service. This letter should contain (where appropriate):-
    - The Trust's Condolences.
    - Clarification of those who have already contacted the Carers / Relatives.
    - Process for review and the desire to involve family / carers in the review and how this will be done.
    - Confirm name and role of Family Liaison Manager who has responsibility for ensuring that the Relative / Carers / Service User receive a copy of the report and can comment on it and have access to on-going support (where appropriate).

Further information re Duty of Candour and the Being Open Policy can be found at Appendix

6.5 Reporting to StEIS and the Investigation of Serious and Untoward Incidents

All potential SUIs should be reported to the Director of Patient Safety and on to the local risk management system, immediately. The Director of Patient Safety or his delegate will formally confirm with the local risk management system administrator if the incident warrants reporting to StEIS.

The local risk management system Administrator will report the incident to StEIS and send a briefing to the relevant Corporate and Divisional managers, within 48 hours (excluding weekends and Bank Holidays).

The Director of Patient Safety will liaise with the Communications Department if there is the possibility of the incident attracting adverse media coverage.

Serious and untoward incidents will be allocated an investigation level, both by the CCG and Trust; any difference in opinion will be discussed and an agreement will be made.

Once the level has been confirmed, the Divisional Risk Lead in association with the Adverse Incident Team will allocate a Review Team and set Terms of Reference.

The SUI Administrator will also update relevant commissioners and NHS England / CCG / Specialist Commissioners. This update will consist of further clarification of details of the incident and how the review process is to be organised.

All incidents will be assessed by members of the Adverse Incident Team to ensure that reporting to external agencies takes place.

The Communications Department will ensure all communications are completed within the required time-scales and issue any press/media briefings in conjunction with the Communications Department of the lead commissioners where necessary. The Communications Department will check with the relevant Senior Manager for the service to ensure that carers and relatives have been informed, where appropriate, before any contact is made with the press/media.

Trust Safeguarding Lead to liaise with relevant local authority to agree single investigatory process if possible, with safeguarding expertise to be included within the panel and/or investigatory process.

A information brief should be shared with all Executive Directors following all Serious and Untoward Incidents as well as those whilst not meeting the threshold for StEIS did have a potential for causing serious harm such as fire incidents .

6.6 Role of the Incident Manager and Incident File

Once the occurrence of a Serious and Untoward Incident has been identified the Division must identify an individual who will take the role of Incident Manager. During out of hours this will be the Silver on Call for that Division who will then hand over any actions to the Chief Operating Officer at the end of their period of duty. The Chief Operating Officer will allocate an individual to be the Incident Manager who will: -

- Ensure that a safety check is undertaken / complete the safety check to assure the

Division that other service users are not at risks from clinical or care deficits.

- Develop an initial timeline of the event, which can be incorporated into the safety check.
- Take the lead in ensuring that family / Carers are informed of the incident and provided with initial information.
- Communicate with external agencies as appropriate i.e. police.
- Communicate with internal colleagues to ensure that key staff are aware of the incident and any developments - i.e. Gold on call, Chief Operating Officer, Lead for Patient Safety.
- In the case of a death, ensure that the notes are collected and kept in a secure area.
- Liaise with the Senior Manager for the Department to ensure that support for staff and other service user affected is provided as required.
- Once a Lead Reviewer has been allocated share updated information on the incident with them.
- Document all actions taken within an Incident file, information collated will include: -
    - Date and time incident occurred
    - Date and time , when informed of the incident
    - Date and time family / carers were informed and content of conversation
    - Contacts with internal and external agencies, staff
    - Directions given to colleagues
    - Immediate effect of the incident on staff and service users
    - Immediate actions taken – i.e. amend staffing levels, inform police etc.

The incident file should be kept updated for as long as activities which are being undertaken can be linked with the active management of the incident. Once completed it should be kept by the Division as evidence of the actions taken during the incident.

6.7 Investigating Incidents

As stated above all incidents will be reviewed and approved on the local risk management system. In addition further investigation and reporting to external bodies may be appropriate depending on the severity or type of the incident. The types of investigations for incidents are as follows : -

Initial Safety Check - Reflective Practice Review - 72 hours

This system has been developed by the Trust to be used by the local Team to identify the chronology of the incident and identify initial causes of concerns and remedial actions that are required. The Team Manager and lead clinician should: -

- Collate the information on the incident - what happened, when and how.
- Develop a time line of the incident.
- Invite staff involved in the care of the individual to share the information they have.
- Highlight any gaps in practice.
- Identify key types of treatment being provided such medication regime.
- Identify remedial action involved and implement.
- Must be signed off as accurate and valid by lead Consultant Psychiatrist and Acute Care /Community Lead.

- Share with Divisional Managers.

Level 1 – Concise investigation

This level of investigation can be used for incidents that have resulted in low or moderate harm to the service user.

- Most commonly used for incidents, claims, complaints or concerns that resulted in low or moderate harm to the patient.
- Also useful as an executive summary to communicate findings from full, comprehensive or independent investigation reports, following actual or potential 'severe harm or death' outcomes.
- Commonly involves completion of a summary or one page structured template.
- Includes the essentials of a thorough and credible investigation, conducted in the briefest terms.
- Involves a select number of RCA tools (e.g. timeline, 5 why's, contributory factors framework).
- Conducted by one or more people (with a multidisciplinary approach if more than one investigator).
- Should include person(s) with knowledge of RCA, human error and effective solutions development.
- If a patient is directly affected, they / relative / carer must be given the opportunity to be involved.
- Includes plans for shared learning – locally and/or nationally as appropriate.

Level 2 – Comprehensive investigation

- Commonly conducted for actual or potential 'severe harm or death outcomes from incidents, claims, complaints or concerns.
- Conducted to a high level of detail, including all elements of a thorough and credible investigation.
- Includes use of appropriate analytical tools (e.g. tabular timeline, contributory factors framework, change analysis, barrier analysis).
- Normally conducted by a multidisciplinary Team, or involves experts / expert opinion/independent advice or specialist investigator(s).
- Conducted by staff not involved in the incident, locality or Division in which it occurred..
- Led by person(s) experienced and/or trained in RCA, human error and effective solutions development.
- Includes patient/relative/carer involvement and should include an offer to patient / relative / carer of links to independent representation or advocacy services.
- May require management of the media via the organisation's Communications Department.
- Includes robust recommendations for shared learning, locally and/or nationally as appropriate.
- Includes a full report with an executive summary and appendices.

Chief Officers Investigation

This review will be conducted as per the comprehensive review but will be conducted when: -

- The incident is of a high public interest.
- Service users of the Trust have been involved in an alleged Never Event.
- The incident involved the death of a service user whilst they were an inpatient.
- The Incident involves a service user within 72 hours of discharge from an Inpatient Unit / Under Stepped up care or within 1 month of discharge from CMHT to primary care- where cause of death is deemed likely to be suicide.

The Chief Executive will agree the terms of reference for the incidents including the panel convened to facilitate the review, which will: -

- Be chaired by an Executive Level member of staff.
- Have an independent / external representative.
- Have a service user/ carer representative.
- Members will be representative of the professionals involved in the care delivery.
- Be supported by an Administrator.
- The panel should not exceed more than six individuals.
- Be Supported by Safe from Suicide team (where appropriate)

The report will be formally validated by the Trust Board.

Level 3 - Independent Investigation

NHS England on behalf of the Department of Health has a statutory responsibility to consider whether they should commission an independent review into certain serious and untoward incidents. HSG(94)27: Guidance on the discharge of mentally disordered people and their continuing care in the community and investigation of adverse events in mental health services provides guidance to the cases that should be considered and the scope of such a review. The NPSA clarify that: -

- Reviews must be commissioned and conducted by those independent to the provider service and organisation involved.
- Commonly considered for incidents of high public interest or attracting media attention.

The Trust will allocate a Senior Manager to coordinate the Trust's response with the aim of ensuring that the external team receive all information on a timely basis and all staff involved are supported appropriately.

Role of Service Users and Carers as Investigators

The Trust has provided Root Cause Analysis training to a small group of service users and Carers in order that they can actively participate in all levels of Incident reviews. They will have full access to all clinical records and take part in all aspects of the review process including the writing of the report, interviewing staff, service users, and carer's external agencies. Service users and carers as part of this role will: -

- Have an allocated mentor who they will see on at least a quarterly basis.
- Attend bi monthly Supervision/ Team meetings.
- Return all confidential material to the Trust for disposal.
- Keep all confidential material safely.

All Chief Officer Investigations investigations will have a trained service user carer representative on the panel and as many level two reviews as possible. Lead reviewers and Panel Chairs will offer support and guidance to participating service users and if any concerns are apparent share these with the Director of Patient Safety.

6.8 Completion within Timescales

The Trust has 60 days (excluding weekends and bank holidays) to complete a Serious and Untoward incident review from the time that the incident has been recognised and reported externally via StEIS. Extensions to this date can be negotiated with the commissioning CCG and or the NHS England but the rationale provided would need to reflect the complexity of the case, unexpected complications with evidence gathering or involvement with external agencies, rather than poor management of the review process. It is important that investigations are completed on time as: -

- Delays can disrupt the flow and availability of evidence and make accurate investigation difficult
- Service users and Carers need to receive information about what happened, why and how in a timely manner to help them achieve resolution.
- The findings of reviews need to be shared with services so that improvement to practice can be made quickly in order to enhance the safety and quality of service provision.
- The Trust is performance managed on the completion of investigations within the allocated 60 days target.

6.9 Issues that may delay an investigation

The involvement of the Police, Environmental Regulators, Safeguarding systems and / or Disciplinary procedure are likely to delay the commencement and / or completion of a serious and untoward incident review. All of the above can take priority over the Trust incident review. Negotiation with the above Agencies / Departments can occur to identify if parallel review can take place to ensure that clinical systems are checked and safely maintained. The Trust can organise a meeting with the Police and Health & Safety Executive under the Memorandum of Understanding. This process will allow the co-ordination of the work of the three organisations to take place and information shared.

Where a safeguarding investigation is involved Director of Patient Safety should liaise with the Trust Safeguarding Lead plus the Trust Named Nurse, (if safeguarding children issues are apparent), who will liaise with the relevant Local Authority to ascertain if separate or joint investigations are appropriate.

Where the incident involves the serious and or fatal injury of a member of staff, service user or member of the public, the Memorandum of Understanding between the Police, Health and Safety Executive and the NHS should be implemented. This will provide a vehicle for the engaged organisations to plan and share the management of the investigation process. The Director of Patient Safety will support the Executive

Director of Nursing in the operation of this process.

It is important that a review process can be actioned in a manner that allows for safety issues to be reviewed with minimum delay. Where a police or safeguarding investigation will delay the Trust investigation the lead Investigator should inform the SUI Administrator / Director of Patient Safety who should in turn notify the CCG Trust of the delay where appropriate.

6.10 Incident Investigation Process

Root Cause Analysis

The Adverse Incident investigation process, by definition, is the health and social care services response to an adverse incident to facilitate organisational learning and to establish what, if any, changes are needed to systems, services, practice, resource allocation, the environment of the care or other contributory factors. The investigation, whilst basing its actions around the incident, needs to ensure that their actions are functionally separate from any concurrent or subsequent disciplinary proceedings, which may be necessary. Any litigation which ensues is separate from the investigation process and should be referred to the Claims Manager. Investigations will be sensitive to the timing of any coroner's inquest. Delay in receipt of the Coroners verdict may not however, be a reason for delay in setting up and conducting an investigation. It is important though that information obtained is shared with the Coroners Office as requested.

The purpose of the Adverse Incident Investigation is to explore the circumstances resulting in the incident, and to establish what, if any, lessons arising need to be incorporated into practice in order to prevent or minimise a reoccurrence of the incident. This includes not only areas of weakness but also areas of good practice that should be shared across the organisation. The original grading of the incident should be reviewed and if necessary the grading amended.

The Lead Investigator should ensure that the post incident investigation process is commenced within 2 working days of the incident for inpatient areas and 5 working days for community areas. The Adverse Incident Investigation should be seen as a process rather than a one-off meeting. In some cases an initial meeting may be enough to complete the investigation process but more time may be needed in other cases.

Information should be gathered prior to the initial meeting to support the process. Particular consideration should be paid to gathering information from service users and carers. Service users, relatives and carers should also be asked whether they have any particular concerns, and these should be addressed during the investigation.

The Lead Investigator must ensure that the process involves all relevant members of the MDT, staff who were involved in the incident and any member of staff with specialist knowledge considered appropriate e.g. the Head of Risk & Resilience, or the Adverse Incidents Manager etc. Secretarial support should be provided from within the Division.

In some cases it may be appropriate to involve other external agencies in the investigation process. The Lead Investigator is responsible for identifying and involving

any external stakeholders necessary to identify the root cause of the incident (for example, voluntary agencies involved in the care of an individual in an incident in the community or contractors involved in the installation of a collapsed roof). The Lead Investigator should ensure that information is sought from these agencies without compromising confidentiality. Where information sharing is essential or confidentiality cannot be maintained, the Lead Investigator must seek advice from the Trust's Caldicott Guardian.

During the Incident investigation an analytical approach should be adopted using a Root Cause Analysis model. Training in this style of approach is provided by Trust for band six and above staff of all disciplines.

The report and action plan of the Post Incident Investigation should be structured in a standard format.

The Lead Investigator should ensure that the relevant staff, service users, relatives and carers are given an opportunity to check the information they have contributed to the report for factual accuracy.

The Lead Investigator should then forward the report to the Divisional Risk Lead. This should happen within 60 working days of the initial reporting of the incident.

Where this is not possible within 60 working days, an extension will need to be requested from the Director of Patient Safety who will liaise with the Lead CCG.

The Divisional Risk Management Group should develop a provisional action plan including time-scales and accountabilities based upon the findings of the Post Incident Investigation.

Practices, systems or other issues which the Investigation Team feel require immediate attention should be reported urgently to the commissioning service manager so that remedial action can then be put in place.

The Trust actively supports the use of the Incident Decision Tree as it promotes a fair and consistent approach to staff . The use of this tool is taught on the Trust's RCA course.

A ratified copy of the report should be sent to the Commissioners and NHS England (where necessary) within 60 working days of the initial report of the incident. The Divisional Risk Management Group will also monitor the implementation of action plans as well as communicating issues that relate to the wider organisation.

6.11 Timetable for SUI Investigations (Working Days)

Once the decision is taken that an incident is to be reviewed then the following timetable should apply by: -

- Day 1: Lead Reviewer to be appointed by the Senior Manager for the service.
- Day 2: An update to be given to the Adverse Incidents Team including terms of

reference for the review.

- Day 20 : An update to be given / requested from the Divisional Risk Lead / SUI Administrator of whether the report will be completed on time. If difficulties are being experienced in the completion of the review either: -

  - Remedial action should be put in place to ensure timely completion
  - Extension from the CCG can be requested by The SUI Administrator, these are though only given in specific situations such as sickness of interviewees, investigators, involvement of the police etc.
- Day 30 Completed chronology should be shared with staff involved in giving evidence , staff should be given seven days to respond .
- Day 40 share initial findings with clinical /service team to engage them in making recommendations.
- Day 45: Completed report to be submitted to the Senior Manager of the service.
- Day 48: Action Plan completed.
- Day 50: completed report to be submitted to be ratified by Divisional Adverse Incident Group or Trust Wide Group.
- Day 52 any required amendments/clarifications requested from the author.
- Day 60: Report to be submitted to the NHS England (StEIS), the CCG and the file closed by the SUI Administrator.
- Day 60: A letter of acknowledgement to be sent to the people involved in the report.

If the report is delayed then an update on progress to be given to each Divisional Meeting highlighting reason and progress.

A report on delays to be supplied to each Quality Assurance Committee meeting.

6.12

Nomination and Responsibilities of Investigators

- Data form for suicide/ attempted suicide to be completed by safe from suicide team

- The division's Risk Lead is responsible coordinating the nomination process for reviewers to lead the Incident investigation process. They will need to link with the Associate Medical Director to ensure that a suitable clinician is allocated to the review.

- For Chief Officer's reviews the Director of Patient Safety will assist in the development of a review panel and the writing of terms of reference.

- The Lead Investigator should have completed the training provided by the Trust in undertaking advanced investigations.

- A register of trained Advanced Investigators can be accessed via each division.

- Service Manager will allocate a member of staff involved with the team to undertake a 72 hour safety check / reflective practice review. They will be

responsible for reviewing the written information available and along with the MDT discussing the care given. Any urgent safety issues must shared with the senior manager responsible so that remedial action can be put in place.

- Two investigators should be agreed for all Level one and two incident reviews. Where possible the second investigator should be from another service. One of the two investigators must have completed the advanced investigations training. This will add an increased level of objectivity, share good practice and broaden the perspectives used during the review.

- One of the members of the Review Team could also be a service user, carer or representative who has completed the advanced investigations training.

The **Lead Investigator** will have the responsibility to co-ordinate the review process and ensure that it is facilitated in accordance with this policy and procedure and that the improvement of services is the key aim. They should be at least band seven level in the organisation. They will have completed the Root Cause Analysis Training Course. Key responsibilities include: -

- To provide and facilitate a process that is conducive to learning and analysis.
- Set the agenda in association with the Director / Service Manager responsible for the Division.
- Keep the process to task and report on any delays in meeting the time-scales set.
- Write the report and clarify that the recommendations have been agreed and action plan developed with accountabilities and time-scales.
- The Lead Investigator must inform the Service Manager if they find risk issues which are not managed effectively and if they expect any delays to occur.

The **Assistant Investigator** role is to: -

- Provide support and assistance to complete the review.
- Take on board agreed and specified responsibilities during the review.
- Provide an independent viewpoint to the proceedings.
- To agree the final report.
- To contribute to the improvement of future reviews by participating in monitoring feedback exercises.
- Sharing their views with the lead investigator thus creating a learning experience for both individuals and the organisation.
- Provide specialist knowledge/skills (where appropriate), for example, Health and Safety knowledge.

Panel Members

A panel of both external and internal individuals is brought together for Chief Officers reviews **but** could be convened for a Level 2 Investigations if it was felt that a broader membership would add to the quality of the investigation process.

The panel will usually consist of three or four individuals (not including the Lead and Assistant reviewer) and will be chosen for their knowledge and experiences of the issues that have been initially identified. They will act as an advisory body. There will

always be: -

- **Service user/carer Representative** – They are full panel members but will take a specific interest in the effect the care/treatment being investigated had had on the family and individual.
- **Chair –** Chief Officers reviews will be chaired by a Board level director, executive or non executive**.** They will ensure that the review is conducted professionally, transparently and in accordance with this policy and procedure. They will lead the sharing of investigatory findings with the Trust Board and other key stakeholders. They will not usually become directly involved in the investigatory process but act as a chair to the proceeding , that is ensuring that all evidence is considered and all members are able to input to the decision making.
- **External Specialist** – Are always included in Chief Officer investigations and will offer specialist advice in their area, as well as consider the quality of service provision generally and whether it was provided to acceptable levels. Their involvement as with that of the service user/care representative will add objectivity to the process.
- **Internal Specialist** – Will offer specialist opinion and knowledge as regards to the quality of care provided. Where the incident is a suspected suicide or near fatal self harm, this will be a member of the Safe from Suicide Team.

All of the above can be involved in interviews though the key remit of a panel is to act as an advisory group which should play a key part in challenging the perspectives and views of the Lead/Assistant reviewers. The Panel will review the quality of the analysis and be active in developing recommendations. Panel members will be chosen to ensure that they have the right level of experience , specialist knowledge and professional background to cover the issues likely to be raised /explored via the investigation.

6.13 Report Writing

The report should be -;

- Be simple and easy to read;
- Have an executive summary, index and contents page and clear headings;
- Include the title of the document and state whether it is a draft or the final version;
- Include the version date, reference initials, document name, computer file path and page number in the footer;
- Disclose only relevant confidential personal information for which consent has been obtained, or if patient confidentiality should be overridden in the public interest. This should however be considered by the Caldicott Guardian and where required confirmed by legal advice.
- Include evidence and details of the methodology used for an investigation (for example timelines/cause and effect charts, brainstorming/brain writing, nominal group technique, use of a contributory factor Framework and fishbone diagrams, five whys and barrier analysis)
- Identify root causes and recommendations;
- Ensure that conclusions are evidenced and reasoned, and that recommendations are implementable (see section 4.4.2. below);
- Include a description of how patients/victims and families have been engaged in the process.

- Include a description of the support provided to patients/victims/families and staff following the incident.

6.14 Checking for Factual Accuracy

Once the Chronology has been established it is essential that this is shared with those individuals who have provided evidence to the Investigation Team. This process ensures that any analysis and recommendations formed are based on reliable and accurate information

6.15 Sharing findings with Clinical Team

The findings of the report should be shared with the team involved at the earliest possible opportunity this can be undertaken before the recommendations have been written , this will give the opportunity for staff to suggest what they think can be done to enhance safety

6.15 Action Plans

The Trust wants all recommendations to be written as outcomes as this helps managers and clinical staff develop actions that are achievable and measurable. The requirements for an action plan include the following:

- Action plans must be formulated by those who have responsibility for implementation, delivery and financial aspects of any actions (not an investigator who has nothing to do with the service although clearly their recommendations must inform the action plan);
- Every recommendation must be specific, measurable and realistic and have a clearly articulated action that follows logically from the findings of the investigation;
- Actions should be designed and targeted to significantly reduce the risk of recurrence of the incident. It must target the weaknesses in the system (i.e. the 'root causes' /most significant influencing factors) which resulted in the lapses/acts/omissions in care and treatment identified as causing or contributing towards the incident;
- A responsible person must be identified for implementation of each action point;
- There are clear deadlines for completion of actions;
- There must be a description of the form of evidence that will be available to confirm completion and also to demonstrate the impact implementation has had on reducing the risk of recurrence;
- Will be signed off and validated by Clinical Services Manager/at action planning meetings.

6.16 Sharing the Findings of incident Investigations

The Trust has a desire to be open and transparent with service users, carers and staff to ensure that those involved have the opportunity to understand what has happened and where possible why the incident occurred. Information as regards how the Trust is going to improve practice and complete recommendations will also be shared with key stakeholders.

The process will include: -

- Lead investigator and Commissioner of the investigator making an appointment to meet with staff involved and share the outline findings of the report. The full report (unless it is embargoed by the Coroner) will be left with staff so that staff can reflect further on the issues raised.

- Lead Investigator and Service Manager will offer to meet with family and carers to share the outline findings of the investigator, leaving a copy with them for further exploration. Further meetings or ways of gaining clarification are also offered. The reports are shared with the proviso that they are treated in a confidential manner as they may contain confidential information.

- Where possible service users who have incident reports written about them will be asked to give their permission to share the investigations findings with family and carers.

- If this permission is refused, legal advice will be sought as to the Trust's ability to provide information based on a public interest case. If this situation occurs a redaction of the policy may also be undertaken to keep the level of personal information shared to a minimum. If a public interest rationale is being used to share information the service user involved should be informed and shown the final version of the redacted development used.

6.17 Report Validation / Ratification

Investigation reports will go through a series of checks to ensure that they are of an acceptable standard, see diagram below and contribute to the governance of the organisation. Reports will be assessed using criteria agreed with the Lead CCG any gaps will be highlighted and amendments requested. The level of the investigation undertaken will effect whether scrutiny is facilitated by internal and or external processes: -

- Level 1 Reports – Validated internally by the clinical division and externally by CCG
- Level 2 - Validated internally by the clinical division and externally by CCG / NHS England.
- Chief Officers Report- validated internally by the Trust Board (checked for accuracy and clinical validity by the Clinical division)
- Level 4 - validated by the Commissioners Board after a period of checking for factual accuracy has taken place. The receiving Trust will share the findings of the document with its Trust board and validate the action plan developed in response to any recommendations made.

6.18 Recommendations from Investigations (from Complaints & StEIS)

Recommendations from all investigations are implemented by the Division involved. The quality of evidence collected and level of rag rating given to each action will be validated by the Divisional Governance framework for levels 1 and 2 incident investigation. The Quality Assurance Committee will validate all Chief Officers

Reviews and 4 action plans and evidence collated

Each Division will input all actions onto the Risk Management Database. Divisions are monitored by the Adverse Incident Team in their completion of actions plans, reminders are sent and evidence of changes requested.

Audit should be used to clarify the impact that the action is having on the safety of care and improvements to the practice desired.

Rag Rating guide: -

Red

The action has not been completed and or there is no evidence that a change to the system or identified practice has occurred.

Amber

The action has been partially or fully completed but changes to systems or practice have not been validated by auditing evidence/monitoring or occurs on an inconsistent basis.

Green

The action has been completed and there is evidence that changes to systems and or practice are in place and being undertaken on a consistent basis.

6.19 Oxford Model Events

These are sessions that are facilitated by the Division in association with the Director of Patient Safety. It is aimed at sharing either one incident or a group of similar incidents with staff. Attendees will be provided with the chronology of events and then will work on identifying the issues or concerns and actions to prevent a re-occurrence.

Staff should be invited who will be able to take learning back to their place of work and effect changes. Partner Agency staff from CCGs, Police and Social Services etc should also be invited, where issues to be raised affect their organisations. Commissioners and Performance Managers are regularly invited to ensure transparency in the way the Trust deals with and learns from incidents.

Feedback on the Service's response to the actions identified must be shared with all those who attended and implementation of the action plan monitored by the Division.

6.20 Dare to Share Events

These sessions are normally scheduled for a day and will focus on one issue that the Trust recognises as being a concern; they can be identified from within the organisation or following the publication of a national report. They will usually focus on a board topic area and not on one or two individual service users they will though where possible always be service user focussed and aimed at identifying any future changes to practice required. .

6.21 Quality Practice Alerts (QPA)

These are alerts that are shared across the organisation via electronic communication. The issues raised usually emanate from adverse incidents including safeguarding incidents, complaints or claims but not exclusively. It is important to note that this process will be used to disseminate and monitor the response to Safeguarding alerts.

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

In each case the QPA clearly states the actions that should be taken and who by. Timescales are given for feedback and the evidence of actions collated.

6.22 Cumulative Review

In order to prevent issues from being considered in isolation and common trends from being missed, investigation reports and action plans will be reviewed collectively by Trust on a six monthly basis.

A more collective approach can help to make the delivery of multiple action plans more manageable and can also help inform wider strategic aims.

6.23 News Letters

Each division will share learning from incidents via a monthly newsletter to all staff

7. CONSULTATION

This policy has been shared with staff from Divisions by Members of the Patient Safety Committee: -

- Modern Matrons
- Consultant Psychiatrists
- Legal Advisor
- Service User and Carer Complaints and Incidents Group
- Ward staff
- Community Staff

Information on issues requiring inclusion in the Policy was gained from discussion within the Trust's Incident Group.

Mersey Care NHS Trust recognises that all sections of society may experience prejudice and discrimination. This can be true in service delivery and employment. The Trust is committed to equality of opportunity and anti-discriminatory practice both in the provision of services and in our role our role as a major employer. The Trust believes that all people have the right to be treated with dignity and respect. The Trust is working towards, and is committed to the elimination of unfair and unlawful discriminatory practices. All employees have responsibility for the effective implementation of this policy. They will be made fully aware of this policy and without

exception must adhere to its requirements.

Mersey Care NHS Trust also is aware of its legal duties under the Human Rights Act 1998.

All public authorities have a legal duty to uphold and promote human rights in everything they do. It is unlawful for a public authority to perform any act which constitutes discrimination.

Mersey Care NHS Trust is committed to carrying out its functions and service delivery in line with the Human Rights principles of dignity, autonomy, respect, fairness, and equality.

8. TRAINING AND SUPPORT

The training the Trust provides on Adverse Incident includes: -

- Awareness raising sessions within Mandatory and Induction Training.
- Root Cause Analysis Training.
- Specifically tailored training for Departments and Teams –developed on request or through concerns regarding the level of reporting highlighted via trends analysis.
- Safeguarding Training

Specific detail regarding the above training and other types that is available and who it is provided for can be found in the organisational training needs analysis which is incorporated within the Learning and Development Policy.

Equality and Human Rights Analysis

Title: Policy and Procedure for the reporting and management and Review of Adverse Incidents. SA 03
Area covered: TRUST-WIDE NON-CLINICAL / TRUST-WIDE CLINICAL / DIVISIONAL / WARD BASED / SERVCE BASED POLICY

What are the intended outcomes of this work? *Include outline of objectives and function aims* The policy provides guidance to staff to ensure that they take a consistent and through approach to the reporting and management and review of Adverse incidents, taking into account the needs of staff, visitors, contractors and service users and carers throughout the process.
Who will be affected? *e.g. staff, patients, service users etc* Staff, service users, carers

Evidence
What evidence have you considered?
Disability (including learning disability)
Sex

Race *Consider and detail (including the source of any evidence) on difference ethnic groups, nationalities, Roma gypsies, Irish travellers, language barriers.*
Age *Consider and detail (including the source of any evidence) across age ranges on old and younger people. This can include safeguarding, consent and child welfare.*
Gender reassignment (including transgender) *Consider and detail (including the source of any evidence) on transgender and transsexual people. This can include issues such as privacy of data and harassment.*
Sexual orientation *Consider and detail (including the source of any evidence) on heterosexual people as well as lesbian, gay and bi-sexual people.*
Religion or belief *Consider and detail (including the source of any evidence) on people with different religions, beliefs or no belief.*
Pregnancy and maternity *Consider and detail (including the source of any evidence) on working arrangements, part-time working, infant caring responsibilities.*
Carers *Consider and detail (including the source of any evidence) on part-time working, shift-patterns, general caring responsibilities.*
Other identified groups *Consider and detail and include the source of any evidence on different socio-economic groups, area inequality, income, resident status (migrants) and other groups experiencing disadvantage and barriers to access.*
Cross Cutting *implications to more than 1 protected characteristic*

Human Rights	**Is there an impact?** **How this right could be protected?**
Right to life (Article 2)	*Use not engaged if Not applicable*
Right of freedom from inhuman and degrading treatment (Article 3)	*Use supportive of a HRBA if applicable*
Right to liberty (Article 5)	
Right to a fair trial (Article 6)	
Right to private and family life (Article 8)	
Right of freedom of religion or belief (Article 9)	
Right to freedom of expression **Note: this does not include insulting language such as racism (Article 10)**	

Right freedom from discrimination (Article 14)	

Engagement and Involvement *detail any engagement and involvement that was completed inputting this together.*

Summary of Analysis *This highlights specific areas which indicate whether the whole of the document supports the trust to meet general duties of the Equality Act 2010*
Eliminate discrimination, harassment and victimisation
Advance equality of opportunity
Promote good relations between groups

What is the overall impact?

Addressing the impact on equalities
There needs to be greater consideration re health inequalities and the impact of each individual development /change in relation to the protected characteristics and vulnerable groups

Action planning for improvement

Detail in the action plan below the challenges and opportunities you have identified. *Include here any or all of the following, based on your assessment*

- *Plans already under way or in development to address the **challenges** and **priorities** identified.*
- *Arrangements for continued engagement of stakeholders.*
- *Arrangements for continued monitoring and evaluating the policy for its impact on different groups as the policy is implemented (or pilot activity progresses)*
- *Arrangements for embedding findings of the assessment within the wider system, OGDs, other agencies, local service providers and regulatory bodies*
- *Arrangements for publishing the assessment and ensuring relevant colleagues are informed of the results*
- *Arrangements for making information accessible to staff, patients, service users and the public*
- *Arrangements to make sure the assessment contributes to reviews of DH strategic equality objectives.*

For the record

Name of persons who carried out this assessment:

Date assessment completed:

Name of responsible Director:

Date assessment was signed:

Action plan template

This part of the template is to help you develop your action plan. You might want to change the categories in the first column to reflect the actions needed for your policy.

Category	Actions	Target date	Person responsible and their area of responsibility
Monitoring			
Engagement			
Increasing accessibility			

Single Equality and Human Rights Screen

Name of Document
Policy and Procedure for the reporting and management and Review of Adverse Incidents. SA 03

Who does it relate to	Staff	√	Service Users	√	Carers	√

Area of Trust it covers
Trust wide All Clinical Business Units

Names of people completing screen (Minimum of 3)
George Sullivan
Steven Jeffery
Collette Irving

What is the purpose of policy / service change /strategy. what is your this document trying to achieve
The policy provides guidance to staff to ensure that they take a consistent and through approach to the reporting and management and review of Adverse incidents, taking into account the needs of staff, visitors, contractors and service users and carers throughout the process.

The screening of any document is completed to ensure that it does not have either a **Direct** or **Indirect** impact on any members from particular protected Equality Groups.

Equality Strand	Y	N	Reasoning
Age		X	
Disability inc Learning Disability		X	
Gender		X	
Race Inc Gypsies and travellers and Asylum Seekers		X	
Religion and Belief		X	
Sexual Orientation		X	
Transgender		X	
Cross cutting		X	
Total		0	

Accessibility

Is it clear that this document is available in other formats:	Yes √	No	comment
Other comments noted from the assessment.			

Any areas highlighted by the EIA assessors must be put into an action plan. This must record all areas noted even when it can be rectified immediately. The document with the assessment, which includes the action plan, must be available for scrutiny and be able to show:-

- What has been highlighted
- What has been done to rectify immediately
- What time frame has been agreed to rectify in the future

HUMAN RIGHTS IMPACT ASSESSMENT

Right of freedom from inhuman and degrading treatment (Article 3)	
Does this policy ensure people are treated with dignity and respect	The policy considers all adverse incidents and has reporting mechanisms identified for reporting any concerns in relation to any potential degrading or other serious incident.
Could this policy lead to degrading or inhuman treatment (eg lack of dignity in care, excessive force in restraint) How could this right be protected?	
Right to life (Article 2)	
Does this policy help protect a persons right to life?	Yes .Mersey care NHS Trust recognises that it has a legal duty to promote and protect life.
Does this policy have the potential to result in a persons loss of life?	No .
How could this right be protected?	Page 11 states that following an adverse incident that a risk assessment should be undertaken to the area can continue to be used to provide care/services.
Right to a fair trial (Article 6)	
Does this policy support the right to a fair trial?	
Does this policy threaten the right to a fair trial? (eg no appeals process)	No.
How could this right be protected?	
Right to liberty (Article 5)	
Does this policy support the right to liberty?	No issues identified.
Does this policy restrict the right to liberty?	
Is the restriction prescribed by law?	

Right to private and family life (Article 8)	
Does this policy support a persons right to private and family life	No issues identified.
Does this policy have the potential to restrict the right to private and family life	
How could this right be protected?	
Is it prescribed by law?	
Is it necessary?	
Is it proportionate?	
Right to freedom of expression Note: this does not include insulting language such as racism (Article 10)	
Does this policy support a persons ability to express opinions and share information	Not considered to be any consideration in this policy.
Does this policy interfere with a person's ability to express opinions and share information?	
Is it in pursuit of legitimate aim?	
Is it prescribed by law?	
Is it necessary?	
Is it proportionate?	
Right of freedom of religion or belief (Article 9)	
Does this policy support a person's right to freedom of religion or belief?	No issues identified.
Does this policy interfere with a person's right to freedom of religion or beliefs? (eg prevention of a person practising their religion Is it in pursuit of legitimate aim? Is it prescribed by law? Is it necessary? Is it proportionate?	
Right freedom from discrimination (Article 14)	
If you have identified an impact, will this discriminate against anyone group in particular? No .	

Is the Document:-

Compliant	yes	y/n
Non compliant - With actions immediately taken		y/n
Action Plan completed	yes	y/n
Full Impact Assessment Required	no	

Lead Assessor_____George Sullivan_____
Date_____06/June/2011_____

ACTION PLAN

Age	Impact Noted	Action Required	Action Taken	Date to be completed.
Disability	No Consideration of service users with a learning disability or mild cognitive impairment.	See comment below in box race.		
Gender				
Race	No consideration of supporting services users who do not speak English.	On page 19 -In the paragraph that begins with the words' The lead investigator must ensure that the process involves all relevant members of the MDT - Need to consider that the investigator may need to ensure that if a person they are interviewing does not speak English that the investigator ensures that they contact an interpreter - or an advocate which is most appropriate in the case of learning disabilities.		

Religion and Belief				
Sexual Orientation				
Transgender				

Cross cutting	Need to identify if there are any equality/discrimination issues/patterns in relation to incidents.	Mat need to widen the categories in relation to the equality strands not already included such as Trans/disability. In relation to page 36 In relation to category A + B+ C for instance where is states Sexual , racial and gender harassment - There needs to be some level of monitoring around the equality strands/protected characteristics with a regular analysis for each CBU linking into the Datix system. Steve Morgan to contact Meryl Cuzak re requirements.		
Human Rights	The policy should have the Trust equality and human rights statement included. This so staff are aware of their responsibilities in relation to human rights.	Add Equality and human rights statement.		

9. SUPPORTING DOCUMENTS

BS ISO/IEC 17799:2000 BS 7799-1:2000 *Code of practice for information security management.*

BS 7799-2:2002 *Information security management systems — Specification with guidance for use.*

Mersey Care NHS Trust (2003) Mersey Care NHS Trust Major incident plan

Mersey Care NHS Trust (2004) Fire Safety Policy

Mersey Care NHS Trust (2003) Health, Safety and Welfare Policy

Mersey Care NHS Trust (2011) Environmental Policy

Mersey Care NHS Trust (2007) Waste Management Policy

Mersey Care NHS Trust (2003) Policy on staff concerns at work about patient care or matters of business probity/conduct (whistleblowing)

National Health Service Executive (1994) *Guidance on the discharge of mentally disordered people and their continuing care in the community* HSG (94)27

National Health Service Litigation Authority (2002) *Clinical Negligence Scheme for Trusts: Clinical Risk Management Standards*

National Patient Safety Agency (2001) *Doing Less Harm: Improving the Safety and Quality of Care Through Reporting, Analysing and Learning from Adverse Incidents Involving NHS Patients – Key Requirements for Health Care Providers* Department of Health, London

BS ISO/IEC 17799:2000 BS 7799-1:2000 *Code of practice for information security management.*

NHS England Framework for reporting and Learning from Serious Incidents (2015)

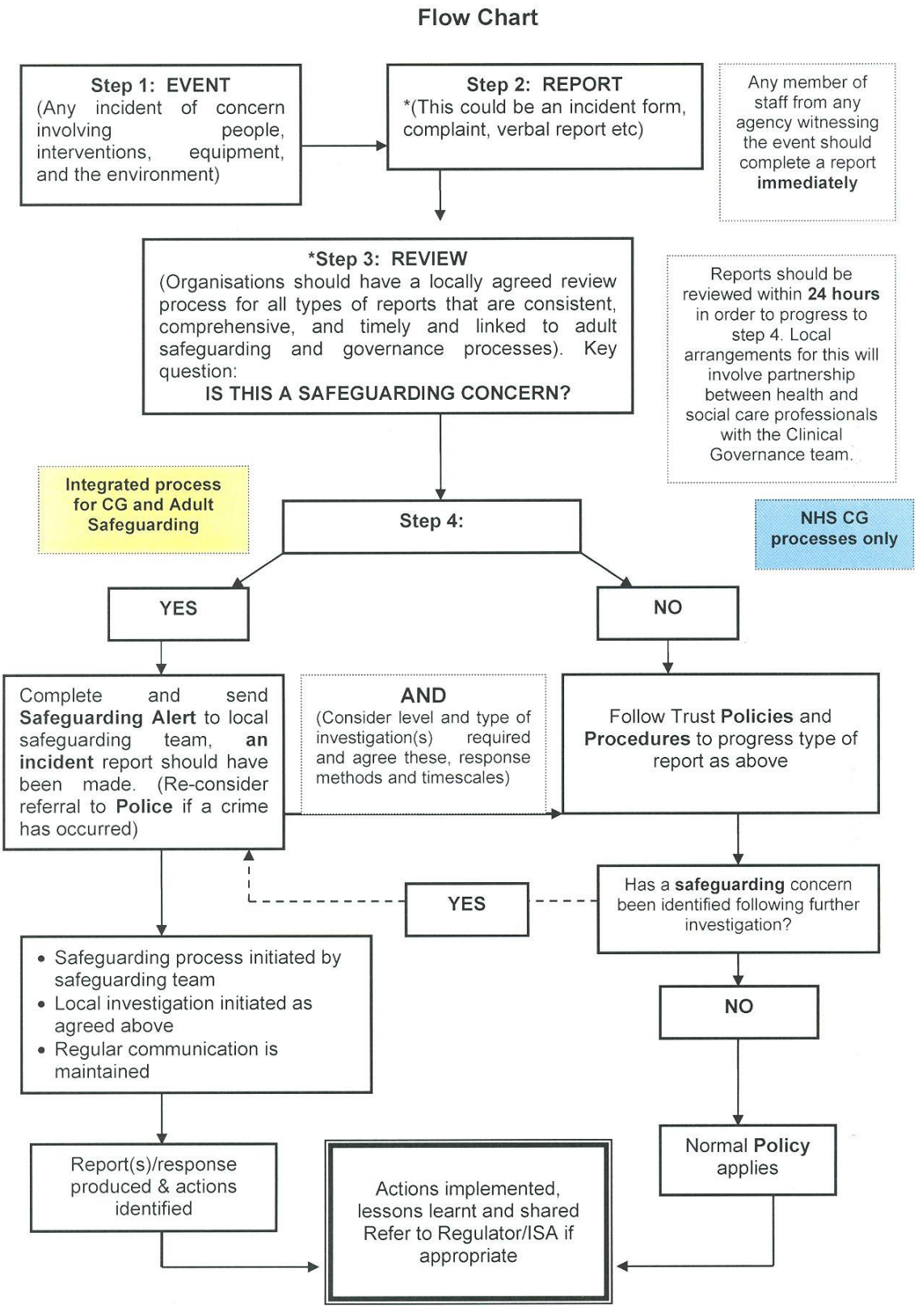
Add open and honest DOC

.

10. APPENDICES

Appendix 1 does not belong with AI

Clinical Governance and Adult Safeguarding- An Integrated Process



Appendix 2

MANAGING THE PATIENT SAFETY INCIDENT
IN ACCORDANCE WITH BEING OPEN

1. INCIDENT DETECTION

1.1 Introduction

The Being Open process begins with the recognition that the service user has suffered moderate harm, severe harm or has died, as a result of adverse incident.

1.2 Detection

An adverse incident may be identified by:-

- A member of staff at the time of the incident;
- A member of staff retrospectively when an unexpected outcome is detected;
- A service user/carer may express their concern or dissatisfaction with the service user's healthcare either at the time of the incident or retrospectively;
- Other sources such as detection by other service user, visitors, non-clinical staff or the service user's General Practitioner.

1.3 Prioritizing Action

As soon as a patient safety incident is identified, the primary objective is to provide appropriate treatment and care and the prevention of further harm. The Trust upon identifying a patient safety incident will ensure that the processes for reporting, investigating and analysing the causes of incidents (RCA) will be implemented, including the principles of acknowledgement and apology.

1.4 Criminal or Intentional Unsafe Act

The Trust acknowledges that patient safety incidents are almost always unintentional. However, following an incident investigation it may be determined or suspected that harm is a result of a criminal or intentional unsafe act.

In such instances where this concern becomes apparent the lead for the RCA investigation team / Service Director will notify the Executive Director of Service Development and Delivery.

2. INITIATING THE BEING OPEN PROCESS

2.1

- The Line Manager in association with the Director of Patient Safety will identify who will be the most appropriate individuals to contact the family. This individual will be chosen based on experience and skill in this area.

- A letter will also be sent that advises the service user/carer on the

investigation processes and clarifies who will be the Lead Reviewer. It will confirm that they are very welcome to provide their views and given information as to how they can do this.

- A phone call or personal contact will also be made within the first 48 hours of the incident.

- Ensure there is a consistent approach by all team members around discussions with the service user/carers.

- The Line Manager / Team Leader will identify immediate support needs for the healthcare staff involved.

The RCA Investigation Team will meet with the respective Multi Disciplinary Team / Line Manager as soon as possible after the event to:-

- Establish the basic clinical and other facts.

- Assess the incident to determine the level of immediate response.

- Consider the appropriateness of engaging service user support at this early stage. This may include the provision of support being provided via:-

  - PALS

  - Advocacy Service

  - A Multi Disciplinary Team member

  - Psychological Care and Intervention

2.2. Initial Assessment to Determine Level of Response

The Line manager and their Team should use the matrix overleaf to identify the actions that should be undertaken.

3. TIMING

The initial Being Open discussion with the service user/carer will occur as soon as possible after recognition of the patient safety incident and no later than 10 days following the incident. The Multi Disciplinary Team and the RCA Investigation Team will consider the most appropriate timing of this discussion considering:-

- Clinical condition of the service user;

- Availability of key staff involved in the incident and in the Being Open process;

- Availability of the service user and/or their family;

- Availability of support staff, for example a translator or independent advocate, if required;

- Service user/carer preference *(in terms of when and where the meeting take place and which Healthcare Professional leads the discussion);*

- Privacy and comfort of the service user/carers

- Arranging the meeting in a sensitive location, usually in the home of the service user/carer.

4. CHOOSING THE INDIVIDUAL TO COMMUNICATE WITH THE SERVICE USER AND/OR THEIR CARERS

4.1 The Healthcare Professional who informs the Service User/Carer about the Incident and proposed review process – Service Representative (Being Open)

The person nominated to undertake this role can be the service user's Consultant Psychiatrist and/or a senior experienced member of the Multi Disciplinary Team. It can also be a Line Manager or staff member external to the Service. The nominated person will have received training in communication of patient safety incidents and the principles of Being Open. The nominated person where possible will be:-

- Be known to, and trusted by, the service user/carer;

- Have a good grasp of the facts relevant to the incident;

- Be senior and have sufficient experience and expertise in relation to the type of patient safety incident to be credible;

- Have good interpersonal skills, including being able to communicate with service users/carers in a way they can understand;

- Be willing and able to offer, an apology (on behalf of the Trust), re-assurance and feedback to service users/carers;

- Be able to maintain a medium to long term relationship with the service users and/or their carers, where possible, and to provide continued support and information;

- Be culturally aware and informed about the specific needs of the service users and/or their carers.

4.2 Use of a Substitute Healthcare Professional for the Being Open Discussion

There may be circumstances when the nominated person who usually lead the Being Open discussion is unable to attend, on these occasions it will be appropriate to delegate this responsibility to an appropriate trained Deputy. The nominated Deputy will be of equivalent experience and expertise.

4.3 Assistance with the Initial Being Open Discussion

The nominated person communicating information about a patient safety incident

will be able to nominate a colleague to assist them with the meeting. Ideally this will be someone with experience or training in communication and Being Open procedures.

4.4 Consultation with the Patient Regarding the Healthcare Professional Leading the Being Open Discussion

If for any reason it becomes clear during the initial discussion that the service user would prefer to speak to a different Healthcare Professional, the service user/carer's wishes will be respected. A Deputy with whom the service user/carer are satisfied will be provided.

4.5 Responsibilities of Junior Healthcare Professionals

Junior staff or those in training should not lead the Being Open process except when all of the following criteria have been considered:-

- The incident resulted in low harm only;
- They have expressed a wish to be involved in the discussion with the service users/carers;
- The senior Healthcare Professional responsible for the care is present for support;
- The service user/carer agree.

Where a junior Healthcare Professional who has been involved in a safety incident asks to be involved in the Being Open discussion, it is important they are accompanied and supported by a senior team member. It is unacceptable for junior staff to communicate patient safety information along or to be delegated the responsibility to lead a Being Open discussion unless they volunteer and their involvement takes place inappropriate circumstances *(i.e. they have received appropriate training, direct support and mentorship for this role).*

4.6 Involving Healthcare Staff who Make Mistakes

Some patient safety incidents resulting in moderate harm, severe harm or death will result from errors made by healthcare staff while caring for service users. In these circumstances the member[s] of staff involved should NOT initially participate in the Being Open discussion with the service users and/or their carers. Where staff, who have made an error, wish to meet the service user/carer, this should be considered. If this is deemed appropriate, support should be offered to the member of staff. Where it is felt not to be appropriate due to levels of hostility, emotional state of the staff member, a personal letter of apology can be sent.

The same principles apply where the service user/carer demand/request to see the staff. Managers in association with the Director of Patient Safety should make the decision based on the best interests of the service user/carer who require closure and the needs and safety of the member of staff. Where considered appropriate, the meeting should be planned carefully, the staff member accompanied and the focus maintained on the apology as an explanation will be

or will have been provided via an incident review. If a meeting is not felt to be appropriate then as stated a letter of apology can be sent. The relatives will need to have an explanation of why a meeting cannot t be facilitated by a senior manager.

5. CONTENT OF THE INITIAL BEING OPEN DISCUSSION WITH THE SERVICE USER AND/OR THEIR CARERS

5.1 The service users and/or their carers will be advised of the identity and role of all people attending the Being Open discussion before it take place. This allows them the opportunity to state their own preference. They will be informed of who their service link will be (Being Open Representative) and their role in: -

- Providing a link with the Review Team and process.
- Gaining external support where requested.
- Providing initial information as it is known and appropriate.

It is likely to be appropriate, where possible, for the Lead Reviewer to attend the initial meeting with the Service Representative. It is also good practice in cases where a death has occurred for a senior Clinician / Manager to attend. Where a homicide is the incident being managed, a senior manager will be the Being Open Representative.

5.2 There should be an expression of genuine sympathy, regret and an apology for the harm or distress that has occurred. The commitment to truthfulness and clarity of communication, jargon free, timely, factual and an open manner of delivery will be underpinning principles of how the discussion is delivered by the healthcare staff.

5.3 The facts that are known about the adverse incident will be agreed by the Multi Disciplinary Team / Service, prior to meeting with the service users/carers. It should be made clear to the service users/carers that new facts may emerge as the incident investigation proceeds.

5.4 The service users/carers understanding of what happened will be taken into consideration, as well as any questions they may have.

5.5 There will be consideration and formal record made of the service users/carers' views and concerns, and demonstration that these are being heard and taken seriously.

5.6 Appropriate language and terminology will be used when speaking to service users and/or their carers. For example, using the terms 'patient safety incidents or adverse event may be at best meaningless and at worst insulting to service users/carers. If a service users/carers first language is not English, it is important to consider their language needs - if they would like the Being Open discussion to be in their preferred language the Trust will make arrangements for appropriate interpreter services.

5.7 An explanation will be given about the next stages in the incident investigation process and, where appropriate, any resulting recommendations and action plans.

5.8 Information on the possible short and long term effects of the incident *(if known)*

will be shared. The latter may have to be delayed to a subsequent meeting when the effects/outcomes are known.

5.9 An offer of practical and emotional support will be made to the service users/carers by signposting them to appropriate support agencies as offering more direct assistance in the first instance, e.g. PALS, Advocacy, Psychological Services.

5.10 Information about the service user and the incident will not normally be disclosed to third parties without consent.

5.11 It is recognised that service user/carers may be anxious, angry and frustrated even when the Being Open discussions are conducted appropriately.

5.12 It is essential that the following does **not** occur:-

- Speculation;
- Attribution of blame;
- Denial of responsibility;
- Provision of conflicting information from different individuals

5.13 The initial Being Open discussion is the first part of an ongoing communication process. Many of the points raised here will be expanded upon in subsequent meetings with the service user/carer.

6. NOTIFICATION

6.1 Family and Carers

Every effort must be made to notify family and carers when a serious patient safety incident has occurred as soon as possible after the event and no later than 10 days after the incident has been reported. The Manager who initially receives the report *(Matron/Duty Manager)* will take responsibility for ensuring that this happens.

Initial contact should be attempted by telephone *(where available)* and efforts maintained until contact established.

- This will be followed up in writing by the Line Manager of the area where the incident occurred on the next working day.
- Copies of any completed investigation/review reports should also be provided within 10 days of completion.

6.2 National Reporting and Learning System (NRLS)

There is a requirement to report all patient safety incidents through the National Patient Safety Agency's (NPSA) NRLS. However, this will not be done until the incident investigation has been completed and the lessons learnt identified by the organisation. The Trust, however, may consider discussing such incidents with

NPSA patient Safety Advisor as appropriate.

6.3 Each Service will take responsibility for informing their Commissioners and Agencies such as the Mental Health Act Commission. The Trust's DATIX Manager will share information with the Strategic Health Authority (SHA) via the use of the national reporting system STEIS. The Commissioners and SHA will be kept informed of the review process and receive a copy of the completed review document.

The Director of Patient Safety will meet quarterly with the SHA to monitor progress with all incident reviews and safety measures put in place.

7. INVOLVEMENT / LIAISON WITH CRIMINAL JUSTICE SERVICES

7.1 Some incidents that involve mentally ill service users will require the intervention of the Police and Crown Prosecution Service. The Trust will share information with the Police as is allowed under the Data Protection Act Section 29.

It is important that where a homicide or suspicious death is the incident, the Police should be asked if it is acceptable for the Trust to continue with its investigation process. A senior manager should act as the Trust Liaison Officer and negotiate with the Police; Terms of Reference for an incident review that would not impede a Police investigation but would aid learning from a health care perspective.

7.2 The Trust will facilitate Memorandum of Understanding meetings in accordance with national guidance where the incident requires Police involvement and may be of interest to the Health and Safety Executive. The Trust will be represented by a manager at Director's level and will share information with other Agencies as required under the Terms of Reference.

Appendix 3

Mersey Care NHS
NHS Trust

Introduction to Family Liaison Manager Role

The role of the Family Liaison Manager has been developed to provide you with a person who is able to provide you with support and information at this very difficult and emotional time of your lives. Their remit is specifically about helping you to understand the processes that we use to review the care and treatment provided by the Trust. They will though be able to help you access information regarding other processes that may occur at this time such as the Coroners Inquest. You can contact them on the numbers below; they will also contact you during the review process to keep you updated on its progress. The completion of such reviews can be complex and it is important you are kept to up to date, that you are able to in put into its work and have an opportunity to see the findings.

The key role of any review is to try and find out from a health care perspective what happened and give answers to as many of your questions as possible. The Family Liaison manager has a key role in making sure that you understand how, why and what we do to achieve this. They are not directly involved in the review and therefore can focus on helping meet your individual needs.

The key roles of the Family Liaison Manager are -;

- To act as a link between the service user / family / friends involved and the review team
- To explain how the review process will work, who will be seen, who will be involved and how long it will take.
- To explain how the review will be used, who it will be shared with and how it's quality is checked
- To update you on progress, give reasons for any delays and ensure you feel as involved as possible.
- To link you with support agencies that you feel may be of help.
- To keep in regular contact with you or as agreed with you.
- To link with other agencies potentially involved such as the police and coroners office with the aim of ensuring that clear communication exists between these agencies to help provide you with unambiguous and accurate information at all times.
- To represent the Trust in all aspects of our work with you and to seek help and guidance from senior colleagues and specialists where you request this or they feel it necessary.
- To do their very best to ensure that your confidentially is maintained at all times