Policy Number	SA03

COVID-19 DOCUMENT CHANGE FORM

NHS Mersey Care NHS Foundation Trust
Community and Mental Health Services

In light of the COVID-19 outbreak it has been necessary to make temporary changes to this Policy Document. Therefore when reading the policy document please take account of the changes highlighted in Part B and C of this form.

PART A – INFORMATION ABOUT THIS POLICY DOCUMENT

Policy Name	**Reporting, Management, Review and Learning from Incidents**				**Reference No**	**SA03**	
Executive Lead *(Trust-wide policies)*	**Executive Medical Director**						
Chief Operational Officer *(Clinical Division policies)*							
Policy Document *(Tick only one)*	Trust-wide (Board approved)	☒	Trust-wide (Executive Director approved)	☐	Secure & Specialist Learning Disabilities Division	☐	
	Community Division	☐	Local Division	☐			
Type of Policy *(Tick only one)*	Clinical Policy	☐	Non-clinical Policy	☒			
Clinical Policy Only *(Tick only one)*	Minor Change *(Not referred to the Clinical Cell)*	☐	Major Change *(Referred to Clinical Cell, then to SCG for approval)*	☒			
Approving Body *(Tick only one)*	Board of Directors	☒	COVID-19 Strategic Coordination Group	☐	Community Division Tactical Coordination Group	☐	
	Corporate Division Tactical Coordination Group	☐	Local Division Tactical Coordination Group	☐	Secure & Specialist LD Division Tactical Coordination Group	☐	

PART B – CHANGES TO THE POLICY DOCUMENT

Section / Paragraph No	Outline of the information that has been amended in this policy document
Section 7 plus Appendices 3, 4 & 5	In respect of the process for the management of Serious Incidents as outlined in this policy, temporary arrangements will be put in place for the management of Serious Incidents whilst the trust's COVID-19 governance arrangements for policy documents are in place. This means that: • all Full Serious Incident Reviews are to be suspended and placed on hold (with the agreement of NHS Liverpool CCG and other commissioners) • the trust will continue to identify those incidents that may meet the requirements for a Full Serious Incident Review and will undertake an Initial (72-hour) Incident Reviews for all Serious Incidents • all Serious Incidents will continue to be logged on the Strategic Executive Information System (StEIS) as required by NHS England's Serious Incident Framework

PART C – RATIONALE FOR CHANGES

Please explain why this document needs to be amended during the COVID-19 outbreak
It is recognised that the trust will be facing a range of capacity issues, including in respect of those clinical staff who usually undertake the learning reviews into serious incidents, as a result of staff absence and the redeployment of clinical staff from corporate to clinical areas. The intention of this temporary change to the normal process for the management of incidents is to emphasise, during the COVID-19 outbreak, the continuing need to report, review and learn from incidents in order to maintain patient safety and staff safety / well-being. …./ continued

Policy Number	SA03

COVID-19 DOCUMENT CHANGE FORM

These temporary arrangements will still allow:

- through the maintenance of the Initial (72-hour) Review Process, for the immediate learning from incidents so that actions may to be identified and implemented as appropriate (the duty of candour process also remains unchanged)
- for the trust to continue to establish if any themes or trends arise
- for incidents to be recorded, so that Full Serious Incident Reviews (as required) may be undertaken once these temporary arrangements in response to COVID-19 are revoked
- for the trust to respond to incidents using an open, transparent and just and learning approach to the management of incidents

As the trust's Board of Directors is responsible for approving the *Reporting, Management, Review and Learning from Incidents (SA03)* policy, the COVID-19 Strategic Coordinating Group considered these temporary changes and has recommended them to the Board of Directors for approval. These temporary arrangements will be kept under review by the trust.

PART D – APPROVAL (for completion by officer loading policy document onto intranet / website)

Date Referred to the Clinical Cell *(Clinical Policies only)*	
Date Referred by the Clinical Cell to the SCG *(Clinical Policies only)*	
Date Approved by the Approving Body	Board of Directors – 17 April 2020
Date Circulated to Relevant Staff	17 April 2020
Date Published on the Divisional Intranet / Trust Website	17 April 2020

Note – the Approving Body to send this form to the appropriate divisional officer (for divisional policies) or the Corporate Governance Team (for trust-wide policies) who will be responsible for adding this form to the front of the existing policy and then uploading these onto the intranet / trust website.

CORRESPONDENCE FROM LIVERPOOL CCG (dated 18 MARCH 2020)

The CCG expects all serious incidents / never events to be reported in the usual way via StEIS. However, following submission of internally approved 72 hour reviews (within 5 working days, wherever possible); RCAs may be undertaken once the crisis is stood down. We will then work with you to agree revised submission dates and possibly use a thematic or other approach, where appropriate for outstanding investigations. For any RCAs currently underway; please let us know via the sui.management@nhs.net account if you are unable to submit on time and we will approach in the same way as any newly reported serious incidents. There remains no changes to NHSE/I advice around serious incidents at present.

As a minimum requirement in terms of the 72 hour reviews, please can we ask you to include the following information for assurance that a robust review has taken place; with evidence of mitigating actions implemented and any immediate lessons learnt and shared to prevent a reoccurrence. This will also assist our decision regarding whether the incident meets the reporting requirements of the Serious Incident Framework, or if it can be stepped down.

NHS
Mersey Care
NHS Foundation Trust

Community and Mental Health Services

TRUST-WIDE POLICY DOCUMENT

REPORTING, MANAGEMENT, REVIEW AND LEARNING FROM INCIDENTS

(including near misses, serious incidents and never events)

Policy Number:	**SA03**
Scope of Document:	**All Staff**
Recommeding Committee	**Strategic Patient Safety & Improvement Group**
Approving Committee:	**Board of Directors**
Date Approved:	**26 February 2020**
Next Review Date (by):	**31 January 2021**
Version Number:	**2020 Version 3**
Lead Executive Director:	**Executive Medical Director**
Lead Author(s):	**Director of Patient Safety**

TRUST-WIDE POLICY DOCUMENT

2020 – Version 3

Striving for perfect care and a just culture

TRUST-WIDE POLICY DOCUMENT

REPORTING, MANAGEMENT, REVIEW AND LEARNING FROM INCIDENTS

Further information about this document:

Document name	**Reporting, Management, Review and Learning from Incidents (SA03)**
Document summary	The effective management of 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.
Author(s) Contact(s) for further information about this document	Dr Panchu Xavier Director of Patient Safety Telephone: 0151 471 2210 Email: panchu.xavier@merseycare.nhs.uk
Published by Copies of this document are available from the Author(s) and via the Trust's website	Mersey Care NHS Foundation Trust Trust Offices, V7 Building Kings Business Park Prescot, Merseyside, L34 1PJ Trust's Website www.merseycare.nhs.uk
To be read in conjunction with	Risk Management Strategy (SA02) Reporting, Management and Investigation of Claims (SA05) Management of Complaints /Concerns (SA 06) Health and Safety and Welfare Policy (SA07) Being Open including Duty of Candour Policy (SA13) Policy for the Recognition, prevention and therapeutic management of Aggression and Violence (SD 18) Policy For Safeguarding Adults From Abuse (SD17) Learning from Deaths Policy (SA 45) Major Incident Plan (IPR 00)
This document can be made available in a range of alternative formats including various languages, large print and braille etc	

Version Control:

		Version History:
2015 – Version 1	Board of Directors'	2015
2017 – Version 1.1	LCH Update	July 2017
2017 – Version 2	Policy Group	October 2017
2017 – Version 2	Board of Directors	November 2017
2020 – Version 3	Board of Directors	February 2020

SUPPORTING STATEMENTS – this document should be read in conjunction with the following statements:

SAFEGUARDING IS EVERYBODY'S BUSINESS

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

- being alert to the possibility of child / adult abuse and neglect through their observation of abuse, or by professional judgement made as a result of information gathered about the child / 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 / 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 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 Foundation 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 Foundation Trust recognises that some sections of society experience prejudice and discrimination. The Equality Act 2010 specifically recognises the *protected characteristics* of age, disability, sex, race, religion and belief (or lack thereof), sexual orientation, gender reassignment, pregnancy and maternity and marital and civil partnership status. The Equality Act also requires regard to socio-economic factors.

The trust is committed to promoting and advancing equality and removing and reducing discrimination and harassment and fostering good relations between people that hold a protected characteristic and those that do not 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 Foundation 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 Foundation 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

In the policies section of the www.merseycare.nhs.uk

- Learning Review Report Template for Serious Incident Reports
- Equality and Human Rights Analysis for this policy

1 PURPOSE AND RATIONALE

1.1 **Purpose** – to explain the roles, responsibilities and process for identifying, reviewing and learning from incidents to allow the organisation to take prompt and effective measures to improve patient safety and experience, working to achieve zero harm and within a Just and Learning environment for its staff.

1.2 This policy provides guidance that ensures:

a) incidents are managed effectively and immediate action/learning takes place;

b) staff follow the correct procedures when an incident occurs;

c) investigations are conducted in a timely manner and are of high quality;

d) the Trust learns from incidents to improve the safety and experience of patients/service users and quality of services;

e) staff, patients/service users, their carers and families and members of the public are provided with appropriate support throughout the process.

1.3 **Rationale** - the Trust is committed to providing a safe environment for its patients/service users, staff and visitors as well as delivering high standards of care. It acknowledges that sometimes, in the course of providing healthcare, incidents can occur, some of which may have serious consequences for a patients/service users, their carers, families, staff and the public. In cases, even where care does not go as planned, incident review may reveal other related systemic concerns which need to be addressed.

1.4 The Trust positively encourages open and honest reporting of risks, hazards and incidents. Equally it recognises that being involved in an incident can be a difficult and stressful time for staff concerned. The Trust takes its responsibility seriously and has developed further guidance that focuses on learning and quality.

1.5 It is not the policy of the Trust to use the reporting of an incident itself to attribute blame to any individual. A Just and Learning Culture can be seen as an environment where we put equal emphasis on accountability and learning, staff are encouraged to report and learn from incidents to understand when things go well as well as responding when things do not go as planned. The Trust acknowledges that our staff work within complex systems with many factors influencing the likelihood of challenges occurring and the principles and practice associated with a restorative culture are set out in the microsite on the Trust intranet home page. http://sharepoint.merseycare.nhs.uk/sites/JustLearningCulture/SitePages/home.aspx

1.6 The Trust is committed to promoting a culture of openness, and has adopted Being Open principles. Further guidance on communication in line with Being Open and Duty of Candour principles is set out in Policy SA13.

1.7 The Trust intends to have a clearly described process for reporting, review and learning from incidents which allows for patient safety/experience to be sustained, future risks to be managed and the Trust to be able to meet its contractual and legal obligations for reviews as designated by the NHS England's Serious Incident

Framework 2015.

2 OUTCOME FOCUSED AIMS AND OBJECTIVES

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

a) in an **open and transparent** manner, for example staff, patients / service users, their relatives and carers should, where appropriate, be involved in review that has taken place;

b) with future **prevention** as a key aim, a culture of learning required in order for the Trust to develop and improve the way care is organised and delivered;

c) in an **objective** style;

d) in a **timely and responsive** way;

e) **based on systems** as opposed to seeking to lay individual blame;

f) **proportionately** to the risks identified and outcomes experienced;

g) **collaboratively**, working closely with commissioners and other key providers.

2.2 Incidents will be:

a) reported using the Local Risk Management System;

b) risk assessed to ensure the individuals/environment involved are safe and secure;

c) recorded as appropriate within clinical records;

d) assessed for both harm and impact, and where identified as serious, appropriate senior clinicians and managers will be informed;

e) serious incidents meeting the reporting criteria will be reported to NHS England via the Strategic Executive Information System (StEIS);

f) all incidents will be reviewed and approved on the Local Risk Management System in accordance with the guidelines enclosed.

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

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

2.5 Each Clinical Division will have a system which allows for the review and monitoring of incidents including serious incidents. This will include processes to provide assurance on the timeliness and quality of any incident reviews, to provide consensus and monitoring of recommendations, this includes time scales and

implementation of improvement plans. The Trust's Risk Management System's action planning module will be used to track completion.

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:

a) occur on Trust premises;

b) occur off Trust premises but involve persons employed by the Trust whilst on Trust business;

c) involve any patient receiving care from the Trust – including, for example, joint mental health services with local authorities;

d) involve any patient who has been open to one or more Mersey Care NHS Foundation Trust services within the last 12 months;

e) all service user deaths;

f) occur where services are shared with other provider organisations.

4 DEFINITIONS

4.1 See Appendix 1 for Glossary of Terms

5 DUTIES

5.1 **Chief Executive** – includes:

a) as "Accountable Officer" for the Trust, being responsible for ensuring sufficient resources are in place to ensure the effective reporting, recording, review to allow for learning from incidents;

b) delegating the day to day responsibility for establishing and monitoring the implementation of this policy to the Executive Medical Director.

5.2 **Executive Medical Director** – includes:

a) being Accountable Director for incident management and learning reviews;

b) advising the Chief Executive on the outcome of the serious incident learning reviews and any associated risks that have been identified;

c) ensuring that there is robust management of incidents on a day-to-day basis and that reporting on incidents and learning themes are identified and improvement plans devised to prevent further harm.

5.3 **Senior Managers** - includes:

a) all Trust Directors, Chief Operating Officers and Deputies, Associate Directors, Heads of Service and Senior Managers having responsibility for the management of incidents within the areas of their remit and control and systems are in place to ensure that this is fully operationalized;

b) it is the responsibility of senior mangers to ensure a feedback/ communication loop about changes made in response to reported errors, near misses and incidents and ensure learning that is gained from the review process. Ultimately the aim is to ensure incidents do not happen again and the learning is fully implemented and monitored as part of the Trust and divisional governance requirements.

5.4 **Divisional Governance Leads** – includes:

a) taking delegated responsibility for ensuring that the incident policy is understood and implemented in the Division;

b) attending and reports to the Divisional Safety Huddles;

c) attending the Trust Wide Strategic Patient Safety and Improvement Group;

d) identifying gaps in the implementation of the policy and procedure and report to the Chief Operating Officer;

e) identifying trends in incident reporting and plan remedial monitoring activity;

f) developing, monitoring the use of and supporting the divisional system which ensures that every incident which occurs in the Division is reviewed, that identifies trends and highlights risks with the relevant Chief Operating Officer.

5.5 **Divisional Managers / Operations Managers** – are responsible for:

a) ensuring that all staff members are aware of and operate within the Incident Policy (SA03);

b) notifying the Chief Operating Officer / Clinical Director of all serious incidents which may require reporting to external agencies;

c) ensuring the investigation of all serious incidents within their service and providing the final report to the divisions Governance Lead;

d) ensuring all incidents are reviewed on the local risk management system.

5.6 **Director of Patient Safety / Associate Director of Patient Safety** – includes:

a) responsibility for the management of the arrangements of the Trust's incident process on a day-to-day basis;

b) providing advice and support to Divisional Teams;

c) coordinating investigations of serious incidents;

d) coordinating and overseeing the management and investigation of serious incidents including the Trust Chief Executive and external inquiries;

e) supporting systems of learning from serious incidents in order to reduce risk;

f) ensuring that reports submitted to the Coroner's Office are clear and factually accurate;

g) ensuring that staff are supported in Coroner's inquest proceedings and other formal inquiries;

h) maintaining a status report on all serious incidents;

i) ensuring the incident is reported to the host and commissioning CCG where appropriate;

j) ensuring all incidents are entered onto the Trust's risk database (local risk management systems);

k) ensuring incident trend analysis is presented to the Board of Directors and its Committees;

l) ensuring a bi-monthly Safety Report and annual report on serious incident management are prepared for the Board of Directors and the Board Committee overseeing quality issues;

m) ensuring that there is a system in place to allow for accurate and timely upload of incidents to the National Reporting and Learning System (NRLS).

n) to monitor human rights issues that emanate from incidents

5.7 **Patient Safety Team** – includes

a) where the Incident Team become aware of an adverse incident they will:

i) engage the Division to ensure that the incident is given prompt review,

ii) ensure that final grading of harm and category using NRLS classification system is correctly selected for upload to the NRLS;

b) sharing reports / incident data as appropriate with Specialist Departments;

c) preparing reporting and maintain dashboards on all incidents for the Strategic Patient Safety & Improvement Group and Chief Operating Officers;

d) reporting incidents of violence against staff to the Counter Fraud and Security Management Service;

e) highlighting any identification of clusters of incidents and share with the Director of Patient Safety'

f) monitoring the timely completion of learning reviews and liaise directly with the lead Clinical Commissioning Group (CCG) regarding request for extensions etc.;

g) sending learning review reports to the CCG / NHS England within the agreed timescales;

h) monitoring Actions Plans for updates as required;

i) collating the overarching Trust data and quality indicator information for reporting to commissioners with the Director of Patient Safety.

5.8 **Patient Safety Lead** – will

a) support the implementation of the Duty of Candour (DoC) process;

b) ensure that processes are in place so that all incidents that meet the criteria for DoC are shared with the family as per national guidance;

c) accompany reviewers to share the report and support those taking on the role of Family Liaison Manager to do this;

d) provide training for those undertaking the Family Liaison manager role;

e) provide DoC information for the annual report to the Board of Directors and its Board Committee overseeing quality;

5.9 **Modern Matrons / Service Line Leads** – have responsibility for:

a) monitoring the adherence to the Incident Policy (SA03) within their service on a daily basis;

b) ensuring that any appropriate training associated with Incident Policy (SA03) is undertaken by nursing staff within their service;

c) ensuring that all incidents are approved on the local risk management system;

d) ensuring that reviewers selected to participate in a serious incident learning review are able to fulfil this role.

5.10 **Multidisciplinary Teams (MDTs)** – includes:

a) discussing the incident and care plans should be amended as necessary. The process, outcome and rationale for those incidents not needing further review should be recorded in case notes;

b) being involved with post incident reviews when required and will actively use information gained from incidents in the management of their patients; and

c) where appropriate all 72 Hour Reports should be undertaken via the MDT process and agreed by the responsible clinician/consultant involved in the care.

5.11 **The staff in charge of the area where the incident has occurred** – includes

a) the member of staff in charge of an area is responsible for managing any incident in line with the Incident Policy (SA03) including delegation to another, or managing the incident her/himself;

b) if the incident concerns a patient, ensuring that the incident is discussed during the next MDT meeting or Safety Huddle and care plans amended appropriately;

c) ensuring that any agency or bank staff must be made aware of Trust protocol and procedures in respect of reporting incidents;

d) ensuring members of staff involved in or discovering incident completes an incident report on the Trust's Risk Management system. If a patient/service

user been involved this should also be documented within the healthcare records;

e) ensuring that the level of harm and risk rating is accurately selected for any incident reviewed;

f) ensuring that 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.

5.12 **Staff working in the area where the incident occurs** – includes:

a) on discovery of an 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;

b) where appropriate photographs should be taken as evidence and forwarded to the Senior Manager responsible for inclusion in the incident report.

5.13 **All Staff within Mersey Care NHS Foundation Trust** – includes:

a) All staff having a duty to report any incident involving themselves when it occurs on Trust premises or anywhere if they are undertaking Trust business;

b) acting in line with this policy and also report incidents they become aware of involving patients/service users, carers, relatives, visitors, contractors or any other person involved in an incident;

c) if a Carer raises concerns regarding an incident, all staff have a responsibility of making certain this is reported in line with the Incident Policy (SA03);

d) ensuring that they include the level of harm that occurred as a result of any incident and the risk relating to that incident on the Trust's Risk Management System;

e) participating in any learning review at request.

6 REPORTING AND OVERSIGHT

6.1 **Board of Directors** is responsible for:

a) ensuring that the 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;

b) considering and approving identified Serious Incident learning and Level 3 learning reports and their action plans which will be provided by the Division;

c) receiving the minutes of the Board Committee overseeing quality will be shared with Board of Directors which will include reflections on adverse incident management.

6.2 The **Board Committee overseeing Quality Issues** is responsible for:

a) receiving and scrutinizing an annual report on the occurrences of and

management of incidents which will include an analysis of protected characteristics;

b) receiving and scrutinizing high level performance reports on the occurrence of Serious 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.

6.3 The **Strategic Patient Safety and Improvement Group** is chaired by the Director of Patient Safety for the Trust; its members have responsibility for monitoring the effectiveness of the implementation of the Trust's Incident Policy and adherence to national guidelines. The Group has been established to provide assurance to the Board Committee overseeing quality that patient safety in the Trust is of the highest standard. In discharging its responsibilities, the Group will assure itself of Trust wide approaches to:

a) planning and driving continuous improvement in patient and staff safety;

b) identifying, sharing and ensuring delivery of best-practice;

c) ensuring that required standards and safety goals are achieved;

d) identifying risks to the quality of care.

6.4 Each Division is represented by their senior management and Governance Lead. This Group will be responsible for:

a) sharing learning and risk information;

b) reporting on progress against improvement initiatives and actions associated with learning from adverse events;

c) disseminating high level enquiry reports for benchmarking practice and monitor actions associated with gap analysis;

d) monitoring adherence to the Trust's Incident Policy in relation to serious incidents;

e) monitoring the effect of adverse incidents on human rights issues and factors contributing to incidents related to breaches of human rights;

f) monitoring incidents associated with people from BAME and protected characteristics.

6.5 Each **Clinical Division** will have the ***divisional governance forum*** in place to oversee the division's management of and learning from incidents to provide a means to:

a) validate all incident investigation reports;

b) monitor trends and plan remedial action to reduce occurrence;

c) monitor the completion of action and improvement plans;

d) monitor adherence to the Trust's Incident Policy.

7 PROCESS

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

a) Appendix 2 overall process for review and learning from incidents

b) Appendix 3 initial reporting, review and escalation of incidents

c) Appendix 4 early review of serious incidents (72 hour review process)

d) Appendix 5 review allocation and level of review

e) Appendix 6 dissemination of learning

8 TRAINING

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

a) Guidance on SharePoint on completion of incident reporting forms;

b) awareness raising sessions within Induction and update training;

c) systemic serious incident learning review training;

d) specifically tailored training for Departments and Teams – developed on request or through concerns regarding the level of reporting highlighted via trends analysis.

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

9 MONITORING

9.1 The implementation of this policy and the Trust's adherence to local and national standards will be monitored both internally and externally. Local oversight is outlined in Section 6 above.

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

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

10 SUPPORTING DOCUMENTS

10.1 This policy is supporting by a ***Learning Review Report Template*** for use by staff completing a ***Serious Incident Report*** as part of the Root Clause Analysis. The template, together with the **Equality and Human Rights Analysis**, can be found in the policies section of the Trust's website (**www.merseycare.nhs.uk**) under the listing for this policy – SA03.

10.2 In addition each of the flow diagrams shown in Appendices 2 to 5 of this policy have been attached as separate documents on the website for convenience and shown as

a) SA03 – Appendix 2 – Overall Process for Incident Management

b) SA03 – Appendix 3 – Initial Incident Review

c) SA03 – Appendix 4 – 72 Hour Review Process

d) SA03 – Appendix 5 – Review Allocation and Level of Review

e) SA03 – Learning Review Report Template

f) SA03 – Equality and Human Rights Analysis.

APPENDIX 1 - GLOSSARY OF TERMS

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

Hazard – A hazard is a situation or state of affairs which gives rise to the likelihood of harm, loss or damage as described under 'Serious Incident' below, whether or not any incident has so far occurred.

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

Major Incident - The term Major Incident is defined as, 'a significant event, which demands a response beyond the routine, resulting from uncontrolled developments in the operation of the establishment or transient work activity' (HSE). The event may either cause, or have potential to cause, either:

- Multiple serious injuries, cases of ill health (either immediate or delayed), or loss of life, **or**
- Serious disruption or extensive damage to property, inside or outside the establishment

In the case of a major incident, the Trust Major Incident Plan (IRP00) should be followed in the first instance. The Major Incident Plan is available in the policies section of the Trust's website (**www.merseycare.nhs.uk**).

Serious Incident - The NPSA defined a serious incident (SI) 'something out of the ordinary or unexpected, with the potential to cause harm, and /or likely to attract public and media interest' (2011). **https://improvement.nhs.uk/resources/serious-incident-framework/**

The term covers incidents/near misses which generally meet the criteria as severe or catastrophic under the standard rating scales agreed by the Trust.

- For the Trust, Serious Incidents will include – but are not restricted to – incidents and near misses of the following types:
- Incidents resulting in unexpected death that involve Trust service users, staff or visitors to the Trust
- All deaths within secure settings, deaths of people subject to the Mental Health Act, or equivalent legal restrictions
- Incidents which acutely jeopardise the well-being of Trust service users, staff or visitors to the Trust
- Serious violent incidents involving Trust services users, staff or members of the public
- Incidents with a significant impact on the safety and well-being of children
- Large scale theft or fraud
- Cases where major litigation is expected involving Trust service users or staff

- Major health risk, e.g. infection outbreak
- Serious damage to Trust property, e.g. through fire or criminal activity
- Any incident whereby the delivery of a service is significantly affected
- Any incident which is likely to produce significant legal, media or reputation implications for the Trust.

Never Event - Never Events are serious incidents that are entirely preventable because guidance or safety recommendations providing strong systemic protective barriers are available at a national level, and should have been implemented by all healthcare providers. A link to the national guidance is below **https://improvement.nhs.uk/documents/2265/Revised_Never_Events_policy_and_framework_FINAL.pdf**

Patient Death - All patient deaths, irrespective of cause must be reported on the relevant Risk management system as per the Learning from Deaths Policy (SA45) - available in the policies section of the Trust's website (**www.merseycare.nhs.uk**).

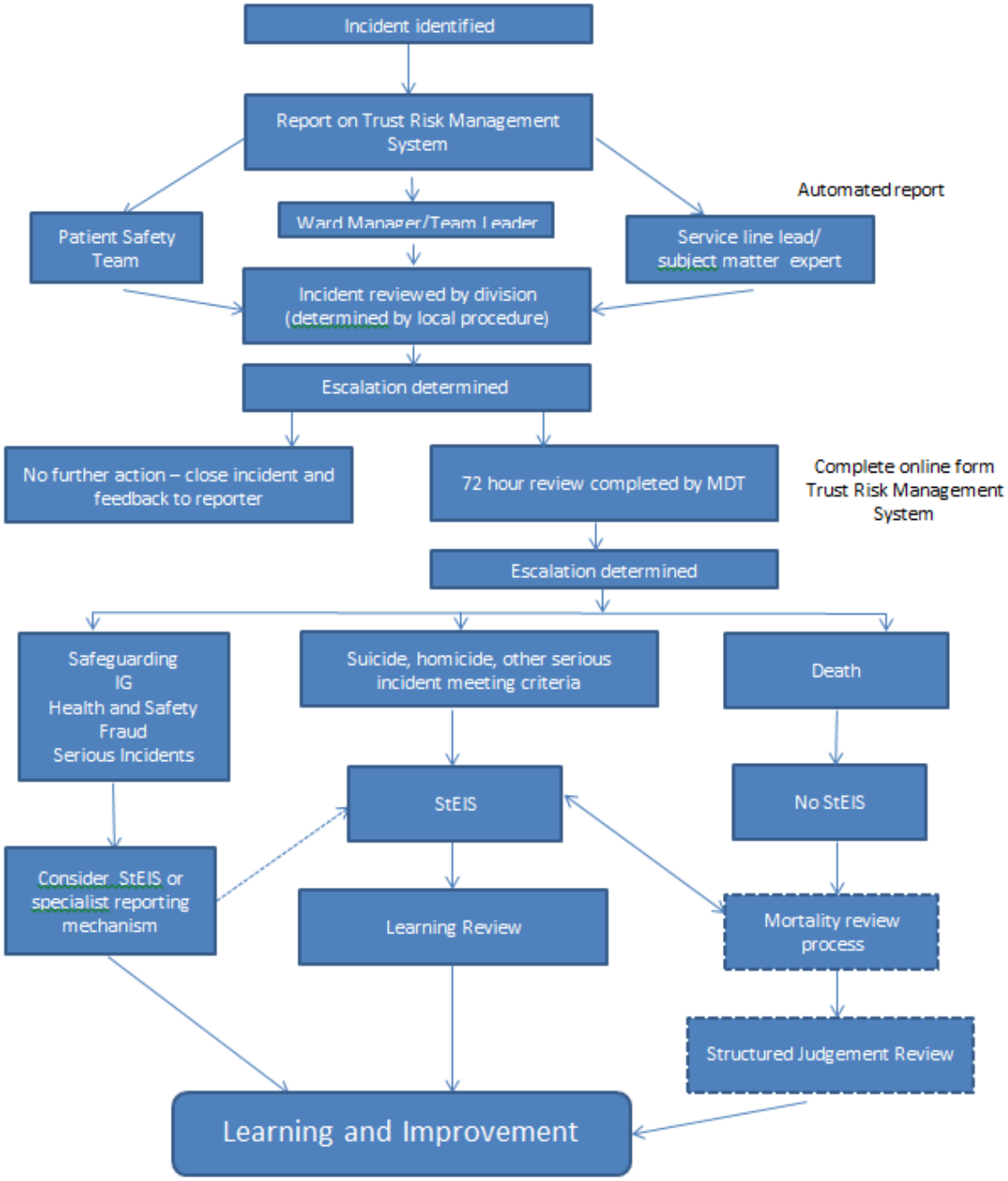
The cause of a patient death is not always known to the Trust at the time of occurrence. The Trust will often have to await the outcome of a post-mortem and in rare cases, toxicology investigation for the cause of death to be established. However it is important that all relevant managers are notified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

Harm - Levels of harm are set out in the National Reporting and Learning Service guidance on reporting patient safety incidents. Click on the link below **https://improvement.nhs.uk/documents/1673/NRLS_Degree_of_harm_FAQs_-_final_v1.1.pdf**

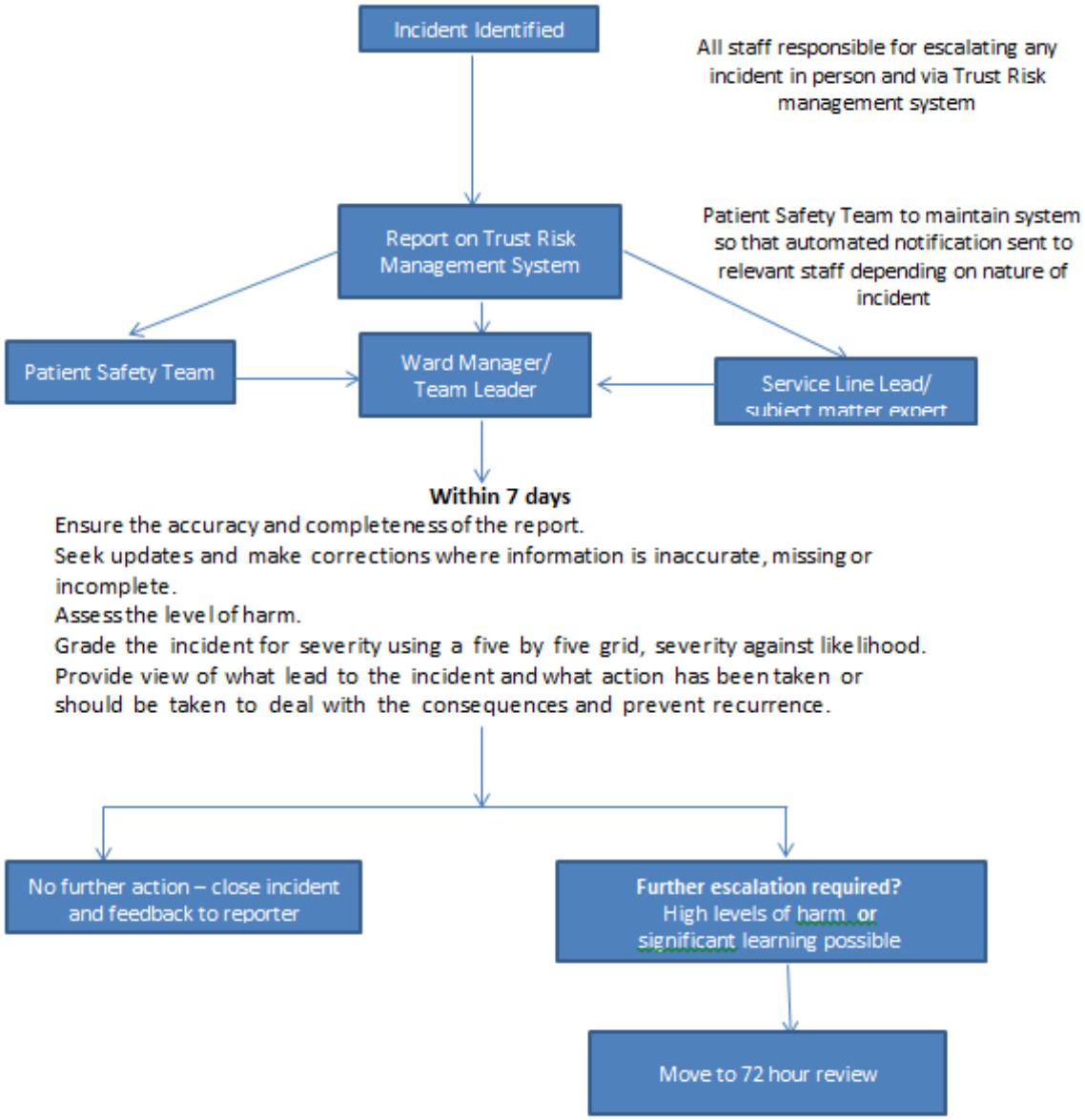
Duty of Candour - Duty of Candour applies to patient safety incidents that occur during care provided and that result in moderate harm, severe harm or death. There is a legal duty to inform and apologise to patients if their care has not gone as planned and this has led to significant harm. The Trust's Being Open (including Duty of Candour) Policy (SA13) is available in the policies section of the Trust's website (**www.merseycare.nhs.uk**).

Levels of review - The National Serious Incident Framework notes that the nature, severity and complexity of serious incidents varies on a case-by-case basis and that therefore the level of response should be dependent on and proportionate to the circumstances of each specific incident. **https://improvement.nhs.uk/documents/920/serious-incidnt-framwrk.pdf**

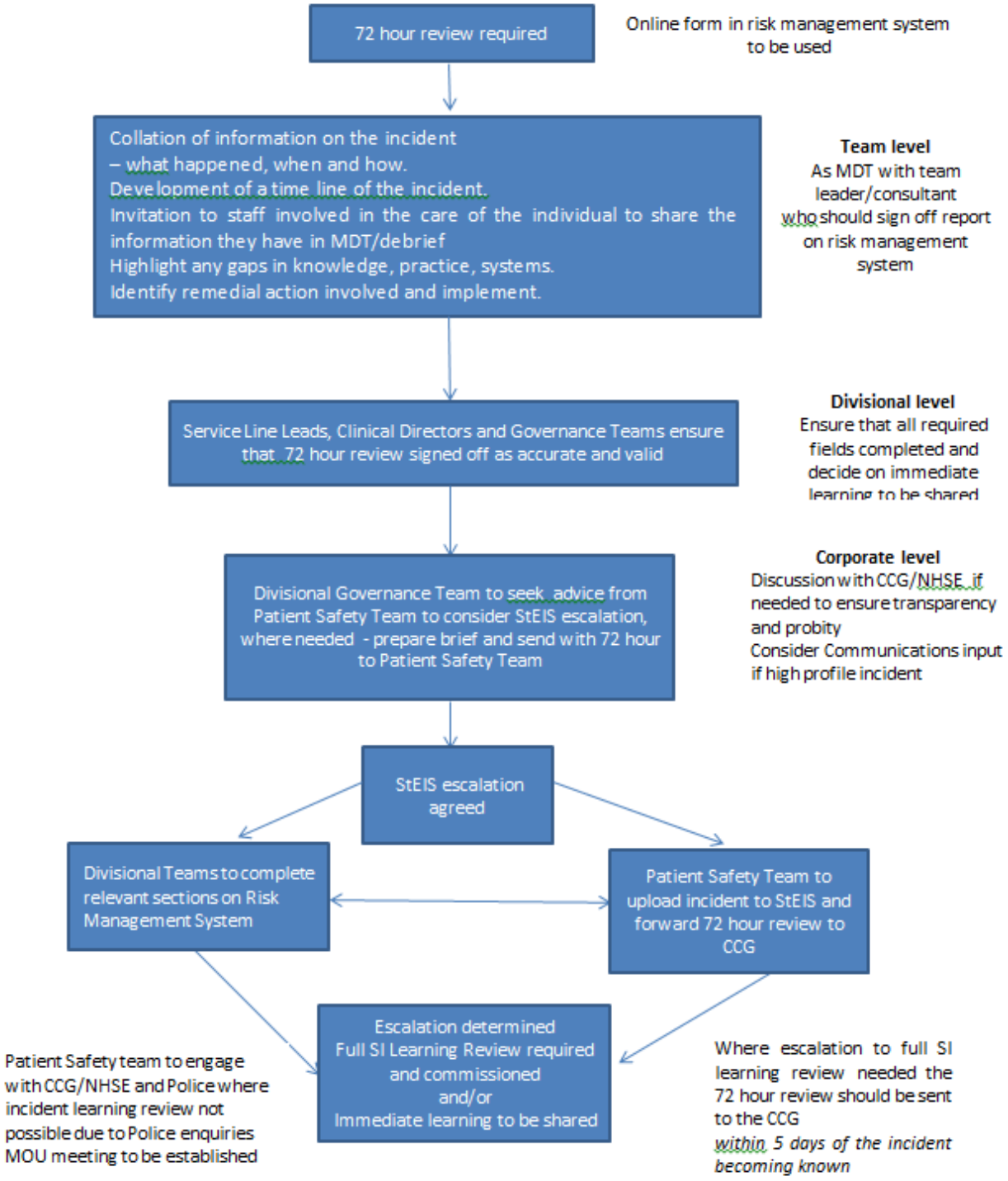
APPENDIX 2 – OVERALL PROCESS FOR INCIDENT MANAGEMENT



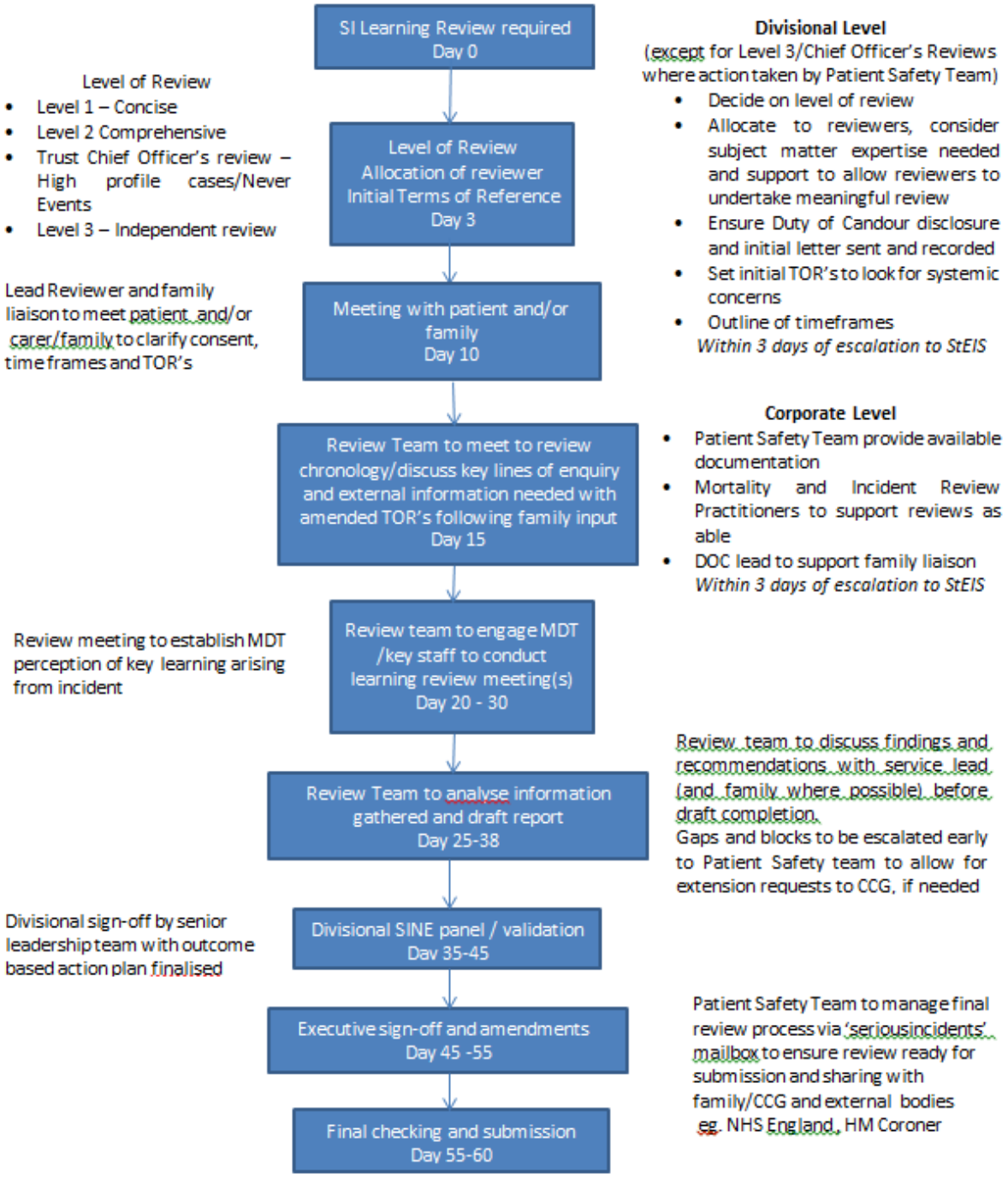
APPENDIX 3 - INITIAL INCIDENT REVIEW



APPENDIX 4 - 72 HR REVIEW PROCESS



APPENDIX 5 REVIEW ALLOCATION AND LEVEL OF REVIEW



APPENDIX 6 - LEARNING FROM REVIEWS

Immediate Sharing of learning with the 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 contribute to actions to enhance patient safety and experience.

Action Plans - Action plans should only be drafted in relation to actions not already underway as part of any divisional or Trust-wide improvement plan. Recommendations should be written as outcomes as this helps managers and clinical staff to develop actions that are achievable and measurable. The requirements for an action plan include the following: -

a) be formulated by those who have responsibility for implementation, delivery and financial aspects of any actions (rather than a reviewer unconnected to the service although clearly their recommendations must inform the action plan);
b) every recommendation is specific, measurable and realistic and have a clearly articulated action that follows logically from the findings of the review;
c) actions that are designed and targeted to significantly reduce the risk of recurrence of the incident. It must target the systemic weaknesses or most significant influencing factors which resulted in or contributed to the incident;
d) an identified owner – these will usually be the service line lead / senior manager for the area in which the incident occurred;
e) an identified responsible person for implementation of each action point;
f) clear deadlines for completion of actions;
g) 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;
h) signed off and validated via Divisional governance processes.
i) have clarity on the action required where human rights issues have been identified.

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

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 review 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 patient/ service user involved should be informed and shown the final version of the redacted development used.

Sharing of Learning – alternative methods

Learning Review Events – Oxford Model/Dare to Share - The Oxford Model involves sessions that are facilitated by the clinical divisions and can be supported by the Patient Safety team. The details of either one incident or a group of similar incidents are shared with staff who will then work on identifying the issues or concerns and recommendations to prevent reoccurrence.

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 may also be invited, where issues to be raised affect their organisations.

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

Dare to share events sessions are normally scheduled for a day and will focus on one issue that the Trust recognises as being a concern; this 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 individual patient/service users histories. They will though where possible always be service user focussed and aimed at identifying any future changes to practice required.

Quality Practice Alerts (QPA) - These are alerts regarding a patient safety or Trust business related matters that are shared across the organisation via electronic communication. The issues raised can emanate from any category of incident including those arsing from safeguarding concerns, complaints or claims. 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, Risk Manager and the staff member requesting the dissemination. It is important that QPAs are targeted at the most influential and appropriate audience.

In each case the QPA must clearly state the actions that should be taken and whom by. Timescales are given for feedback and the evidence of actions collated. Consideration should always be given to how a persons human rights will be maintained where QPAs are suggesting restrictions or might affect those with a protected characteristic.

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

Improvement plans allow for an aggregated approach which can help to make the delivery of multiple elements of action plans more manageable and can also help underpin wider strategic aims.

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

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