Oxford Health
NHS Foundation Trust

Policy control document

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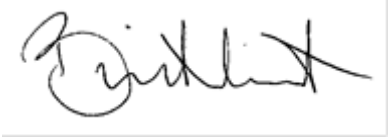
Policy title	**Policy for reporting and learning from incidents and deaths**
Policy code	**RMHS1**
Author(s) (name and title/role)	**Jane Kershaw, Head of Quality Governance**

Approval history	
Name of committee	**Date**
Integarted Governance Committee	**25th January 2012**
Safety Quality Sub-Committee	**July 2015**
Quality Committee	**17th July 2015**
Safety Quality Sub-Committee	**September 2017**
Policy reviewed by author as fit for purpose and signed off by Chief Nurse (see summary of Revisions)	*Date of approval for current version* 9th February 2024

Date of next review	31st August 2024

Signature following desktop review by Head of Quality Governance.

Chair of approving committee Britta Klinck

Signature 

Title Chief Nurse

Date 9th February 2024

All policies are copy controlled. When a revision is issued previous versions will be withdrawn. An electronic copy with be posted on the Trust Intranet for information.

Change control

Number of pages (excluding appendices): 12
Summary of revisions: February 2024: Jane Kershaw (Head of Patient Safety) is completing a revision of the policy to incorporate recent changes to national incident reporting and investigation the policy and confirmed it remains fit for purpose in the meantime. New review date approved by Chief Nurse Policy was reviewed in March 2021 and it is still fit for purpose and meets current national requirements. Internal team emails and external website links have been updated. However national changes are expected with the new NHSE&I Patient Safety Incident Response Framework due to be published and rolled out from April 2022. The policy will be reviewed and amended once the details of the new framework are finalised.

Policy title Policy for Reporting and Learning from Incidents and Deaths including Serious Incidents (SI)

Policy code RMHS01

Version 5
Date of approval 9th February 2024

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Appendices

1. Purpose

This policy sets out the processes and expectations for the reporting, review and learning from all incidents and deaths including those which require an investigation under the serious incident framework. The policy is closely aligned to two other Trust policies; CP23 focused on supporting staff to care for people at the end of their life and on the process of verifying a death, and CORP24 which describes the Trust's standards for informing and involving patients and their families/ carers following an incident or death. The national requirements behind the policy are listed in Appendix 9.
All incidents or serious near misses involving patients, visitors or staff involving physical harm, psychological harm or damage to Trust property should be reported on the Trust's electronic incident management system. The majority of incidents which occur will involve little or no harm/ injury to patients or staff however we can often learn the most from these incidents. When an incident or unexpected death occurs, it is critical that the immediate safety of any patient, family member, staff member and/ or member of public is reviewed, and support is offered. For child deaths this is managed through the multi-agency rapid response process.

The timely identification and reporting of incidents, near misses and deaths is essential to the Trust having an open culture focused on systematic learning to minimise risk and to improve the safety of care provided. The Trust uses a standardised risk matrix to grade all incidents and deaths (in scope) based on severity and likelihood that incident could reoccur, see Appendix 2 for more details. As part of national learning across England and Wales the Trust reports patient safety incidents to the National Reporting and Learning System (NRLS) (Appendix 4) and serious work related incidents to staff to the Health and Safety Executive (Appendix 5).

For those incidents or deaths where the potential for learning is so great a heightened level of response is required and an investigation under the serious incident framework will be carried out. The definition of a serious incident is in Appendix 7 and the national criteria and requirements for serious incident investigations can be found at https://improvement.nhs.uk/resources/serious-incident-framework/

During an investigation the Trust is committed to ensure the process:

- Is fair and equitable
- Involves patients and their families to the extent they wish
- Focuses on learning when things went wrong and improving practice
- Focuses on identifying root causes and underlying system factors

Serious incident investigations are not undertaken to hold individual staff to account or to determine a cause of death. If the actions of a member of staff show reckless intent, failure to follow Trust policy or acting outside their professional boundaries the appropriate HR process will be referred to and started.

This document should be read in conjunction with the following key policies;

- Being Open and Duty of Candour (CORP24)
- Concerns, Complaints and Compliments (CP38)
- Safeguarding Children (CP14)
- Safeguarding Vulnerable Adults (CP25)
- Clinical management of patient deaths at end of life and guidelines on verification of a death (CP23)

2. Support for staff, patients and families

Involvement in or witnessing an incident or death may cause distress to staff, patients, their families and members of the public.

2.1 Staff

Should staff be involved in a stressful or traumatic event such as a complaint, an incident or death it is important to access appropriate support from a line manager and other resources within and outside the Trust at the time needed. If an incident or death happens out of normal working hours and you need support, the on-call manager will be able to provide such support. The following link is to the staff support leaflet Wellbeing Matters - Search results for "staff support v6" - All Documents (sharepoint.com)., which provides details of the range of support. This includes support from the spiritual and pastoral care team, occupational health team and psychological de-briefing service.

After a serious incident or death there should be consideration by the team manager to requesting a facilitated group psychological debrief, if appropriate this should be requested via postincident.support@oxfordhealth.nhs.uk. This is an opportunity for a team to discuss what has happened, to consider the likely reactions and to identify/ provide support. This is not mandatory and is not part of the serious investigation process.

After incidents of suspected/confirmed suicide and serious self-harm multi-disciplinary clinical reviews should be held by the mental health team within two weeks. These reviews are not part of the formal incident review process but they can inform such reviews including the terms of reference. It is the team manager's responsibility to arrange a multi-disciplinary clinical review.

If a member of staff needs support during or after being involved in an internal serious incident investigation or an external investigation contact the serious incident team on 01856 902351 or at patient.safety@oxfordhealth.nhs.uk Sometimes staff are required to attend a coroner's inquest about an unexpected death to provide evidence, the Trust's legal services team will liaise with the coroner's office and support staff through the process. For more details see policy CORP17.

2.2 Patients and their families

The relevant team manager (or service manager as appropriate) must ensure immediate and ongoing support is offered to patients and their families following an incident with harm or

death. The communication needs of a patient and or family should be considered when meeting or sharing information.

Wherever possible patients and their families (and/or victims of incidents in the event of a criminal incident) should be contacted to tell them about an incident where there was harm or a death including providing an apology, any immediate action and/ or review being undertaken. In the event of serious incidents or a death this must occur before it becomes public knowledge. If this is an incident or serious near miss the patient should continue to receive treatment as appropriate and to a high quality.

All incidents should be acknowledged and reported as they are identified. Incidents raised by patients and their families must be taken seriously and any concerns treated with confidentiality, compassion and understanding. Staff should be open and honest with patients and their families to explain and apologise for when things go wrong and to listen to any concerns from the patient/ family.

If the incident or death is investigated through the serious incident process to identify any learning then the patient and/ or family will be given information by the investigator/ author to explain the process, what they can expect and to provide a single point of contact. The patient and/or family will also be given an information leaflet by the investigator (**Information on investigations into serious incidents Re: COR 152.17**)

Figure 1 describes when and how patients and their families need to be involved in the reporting and review of patient incidents and deaths. These requirements are described in more detail in the policy on being open and duty of candour CORP24.

3. What to do when an incident happens or a patient dies

Figure 1 takes you through the steps to take when it is detected an incident with harm, a serious near miss or death happens. It also describes how the processes for reporting and reviewing an incident or death link to the serious incident investigation process as required.

Prior to following the below steps ensure the immediate safety and offer support to the patient, their family, other patients and staff (Appendix 3). Consider if a safeguarding alert needs to be raised (Appendix 6) and/ or if the Police need to be involved (Appendix 8). If this relates to serious self-harm or suspected suicide consider the risk of contagion and liaise with the Trust's suicide prevention lead as required.

The engagement of patients and families in learning and identifying any changes to reduce the risk of reoccurrence is crucial.

Figure 1: What to do when an incident happens or a patient dies

PATIENT or STAFF INCIDENT (including near misses)

Staff member to report on the Ulysses incident system **asap**

Patient Incidents only- Clinical Team/ Service Manager to speak to patient & family as appropriate where there has been harm to apologise, explain what happened & listen to any concerns (within **10 days** of detection of incident)

Manager to asses incident considering impact (physical, property or psychological) & likelihood of recurrence. Assessment to be completed within **7 days.**

Based on level of harm or damage

No further review

High risk incident/ potential SI Initial review report requested(IRR)

Significant care concerns

Local team review requested

SERIOUS INCIDENT (SI)* ***(potential or identified)***

Staff member to report incident on the Ulysses incident system & email brief details **asap** to SeriousIncidents.Reporting@oxfordhealth.nhs.uk

Clinical Team/ Service Manager to speak to patient & family to apologise, explain what happened & listen to any concerns (within **10 days** of detection of incident)

SI team to inform commissioner within **2 days** of detection of serious incident

Manager to review incident within **7 days-** assess level of harm/damage

Initial review report (IR) completed approved by Directorate & within **5 days** sent to SeriousIncidents.Reporting@oxfordhealth.nhs.uk

If SI criteria met*

IR discussed at Trust-wide senior weekly clinical review meeting: decision made about level of investigation & immediate actions required

No further review

IR shared with commissioner. Investigation started.

If appropriate – SI team to link with external review processes e.g. mental health homicide reviews, domestic homicide review, child serious care reviews

Investigators to contact patient/ family to meet to explain the investigation process & timescales & to ask for their concerns/ view on care.

Patient/ family to be offered chance to comment on the draft report.

Clinical team/ directorate to be able to comment on the draft report & develop action plan.

Investigator pulls together comments

Internal panel reviews draft report

Investigator finalises report within **60 working days** of commissioner being informed of SI. SI team to share final report with commissioner, patient/ family (within **10 days**) & clinical team.

Commissioner confirms investigation can be closed

Actions monitored centrally. Themes reported to Directorate level & Trust-wide quality groups.

DEATH ***(patients in current care or patients who have been discharged from services but seen recently)***

Every death is screened by 2 senior clinicians & outcome documented in patient notes as **asap****

Clinical Team/ Service Manager to speak to patient & family to apologise explain what happened & listen to any concerns (within **10 days** of knowing about death)

See Appendix 1 for scope of which deaths are reported onto the Ulysses incident system

Out of scope - no further action required

In scope

Staff member to report death on the Ulysses incident system

Initial review report (IRR) or equivalent report for child deaths (form B) to be completed within **5 days** of reporting on Ulysses

IR reviewed through Directorate level mortality review process

Themes & learning from deaths reported through Directorate level & Trust-wide level mortality review groups

Safeguarding/ SI team to lead on external multi-agency processes as required. For example;

Death of a person with a learning disability to follow- LeDeR notification & Oxfordshire CCG Vulnerable Adult Mortality Review

Death of a child to follow-CDOP

Notes;

* Definition of a serious incident = consequences of the event are so significant to patients/ their family or the potential for learning is so great that a heightened level of response is required. This will include incidents that meet the national 'never event' criteria. See Appendix 7 for more detail.

** To note a coroner will independently review all deaths where the cause of death is unknown, violent or unnatural, or sudden & unexplained. For more details go to https://www.gov.uk/after-a-death/when-a-death-is-reported-to-a-coroner

4 Appendices

The following appendices are provided at the end to support the implementation of the policy;

- Appendix 1 Details which deaths need to be reported onto the incident management system for further review.
- Appendix 2 Guidance on grading an incident or death and what triggers which kind of review
- Appendix 3 Taking immediate actions
- Appendix 4 Describes which patient safety incidents that are automatically reported externally to the national reporting and learning system (NRLS)
- Appendix 5 Describes the serious work related incidents to staff that are automatically reported externally to the Health and Safety Executive (HSE)
- Appendix 6 Children and Adult Safeguarding
- Appendix 7 Definition of a serious incident
- Appendix 8 Involving and sharing information with the Police
- Appendix 9 National Requirements

5 Responsibilities

All staff (including agency, bank, students and contractors) are responsible and accountable for:

- Ensuring the immediate safety of patients, their families, other patients, colleagues and the environment following an incident or death.
- Once a member of staff becomes aware of an incident or death (in scope see Appendix 1) this must be reported on the electronic incident management system as soon as possible, for service incidents this must be within 24 hours. If the serious incident criteria is met (definition in Appendix 7) some brief details about the incident or death also need to be emailed to the patient.safety@oxfordhealth.nhs.uk
- Taking appropriate immediate actions following an incident or death to prevent or reduce the
  chance of reoccurrence and escalating concerns where needed.
- Being part of a learning culture and supporting/ making improvements as identified through a review of incident trends or the outcome of reviews and investigations.

Team Managers, Modern Matrons, Service Managers or equivalent in addition to the above are responsible and accountable for:

- Ensuring the policy and expected timescales are followed by the staff they manage.
- Speaking to patients and their families following a patient incident with harm or a death, this should be completed within 10 days of detection of the incident.
- Considering and organising support for patients, their families and staff as required.
- Ensuring they are set up to automatically receive the incidents and deaths (in scope) as reported for their teams on the incident management system.
- Completing the 'manager's form' and grading of incidents and deaths reported on the incident system within 7 days, including identifying any immediate actions.
- Ensuring initial review reports are completed when required and within timescale
- Carrying out serious incident investigations as identified.

- Supporting the sharing and learning from incidents and deaths, including developing and taking
actions as required.
- Undertaking training as required.

Heads of Service, Heads of Nursing, Service Directors, and Clinical Directors in addition to the above are responsible and accountable for:

- Promoting the importance of engaging with patients and their families following an incident or deaths.
- Identifying authors to carry out serious incident investigations, including considering dedicated time to complete.
- Promoting the importance of reporting and learning from incidents and deaths.
- Developing and maintaining a governance framework across the Trust to include reviewing the themes, learning and trends from incidents and deaths.
- Ensuring actions identified are fully implemented.

The Quality and Risk team is responsible and accountable for:

- Supporting and enabling the implementation of all aspects of the policy.
- Managing the incident reporting system including making system changes, carrying out data quality checks and providing training/ support to staff in us
- Ensuring the reporting of incidents and deaths to external agencies as required (Appendix 4 and 5) as well as linking with external investigation/ review processes.
- Developing and providing reports on incidents and deaths across the Trust to enable teams to identify learning, give an oversight of the process and provide assurance.
- Disseminating learning across the Trust and supporting governance arrangements. Including liaising with the suicide prevention lead, clinical practice educators etc.
- Managing and supporting the completion of the serious incident investigation process.
- Carrying out serious incident investigations as identified.
- Supporting and training staff in relation to reporting, managing and investigating incidents and deaths.
- Monitoring and capturing the evidence for the completion of actions identified from serious incident investigations.

Director of Nursing and Clinical Standards is responsible and accountable for:

- Developing and maintaining a learning culture to continually improve the safety of care provided.
- The overall processes and systems to report and learn from incidents and deaths to comply with this policy and national requirements.

The Accountable Officer for Controlled Drugs and Counter-fraud – is responsible and accountable for:

- Sharing information within Local Intelligence Networks (LIN) in relation to controlled drug incidents and/or fraudulent behaviour of relevant people in relation to patient safety

CQC Registered Managers/ Nominated Individuals are responsible and accountable for ensuring notifications are made to the CQC in line with the regulations. As of September 2017, the required notifications are as follows:

Regulation		Information reported to	Delegated Responsibility
16	Notification of a death of a person who uses services	NRLS automatically	Quality & Risk Team
17	Notification of death of a person who is detained or liable to be detained under the Mental Health Act 1983	Directly to CQC	Mental Health Act Team
17	Services that are designated as low, medium or high security are required to notify CQC of any unauthorised absence of a person detained or liable to be detained under the Mental Health Act 1983, and of the return of persons from unauthorised absences.	Directly to CQC	Mental Health Act Team
18	Notification when a child or young person under 18 years if placed on a psychiatric ward intended for adults (where placement lasts longer than 48 hours)	Directly to CQC	Mental Health Act Team
18	Deprivations of Liberty	Directly to CQC	Mental Health Act Team
18	Where a detained patient has received treatment under Section 57, Sections 58 or 62A a report on the treatment and the patient's condition must be completed	Directly to CQC	Mental Health Act Team
18	All other incidents (for example serious injuries, serious events that stop services running, allegations of abuse)		Quality & Risk Team

6 Training

All staff will receive an overview of incident reporting as part of the corporate induction programme, with more detailed training on the incident reporting system as part of their local induction and on request.

Root cause analysis (RCA) training is provided to staff who will undertake a serious incident investigation. Staff are required to complete a refresher at least 3 yearly.

7 Monitoring and Evaluation

The Trust-wide senior weekly clinical review group reviews all possible and actual serious incidents (including high risk incidents and deaths where concerns have been identified) and determine from the initial review report the level of further investigation required & ensure immediate actions have been taken. This group reports into the weekly Executive Team meeting.

Each clinical directorate has a monthly quality governance meeting which reviews the themes, learning and actions taken from incidents and deaths including serious incidents.

In addition, each directorate has a mortality review process which reports into the Trust-wide mortality review group.

On a quarterly basis a report on incidents, deaths and patient safety work is presented to the Trust- wide safety quality sub-committee, the quality committee and Trust board meeting.

The following measures and reporting will oversee the implementation of the policy.

Monitoring and Evaluation

Criteria	Measurement	Lead	Frequency	Reported to	Monitored by
System in place to ensure that all incidents and deaths in scope are reported/ managed	Number and type of incidents and deaths reported over time Mean and Median time between incident or death detected and reported (as soon as possible, 24 hours for serious incidents) Mean and Median time between incident reported and being graded by manager (7 days) Mean and Median time between incident or death reported and initial review report received as required (5 days)	Team and Service Managers	Quarterly reported by Quality and Risk Team	Safety Quality sub-committee	Quality committee
System to manage serious incident investigation process	Number, theme and learning from serious incidents over time Mean and Median time between serious incident detected and reported to commissioner (2 days) Number and % of final Investigation reports sent to commissioner within 60 days (or within agreed extension) Number of different staff who have led/ supported a serious incident investigation in financial year Number of basic RCA training sessions held in last 12 months Number and % of serious incidents downgraded Number and % of serious incident investigations patients/ their families there is evidence they have been offered an opportunity to be involved, and the number who were involved. Number and % of final reports shared with patient/ family within 10 days, if they wished to receive a copy. Number of actions overdue	Quality and Risk Team	Quarterly	Safety Quality sub-committee	Quality committee

Appendix 1. Deaths need to be reported onto the incident management system for further review

Initial Screening

An initial screening of the care provided to the patient should be carried out for all patients who have died whilst in the care of Oxford Health NHSFT or have had a face-to-face clinical interaction with services within the last six months.[1] The only variations to this will be for;

- GP OOH service – each death will be screened whereby the service was the last professional to see the person face to face prior to their death or if any concerns were raised by their family about the care provided.
- Community hospitals – the care of all patients who die within 90 days of being discharged will be screened or where a concern has been raised about the care.

The screening will be a review of care (using the clinical record) by at least two clinicians; one of which should be a senior member of the team (e.g. team leader/ward manager). This review should determine any immediate care concerns and also categorise the death using the tool below. It does not need to be in-depth but a thorough enough overview to identify potential care concerns (including those not specifically contributable to the death). The outcome of this review e.g. the category of the death and reasoning for this decision, must be documented in the progress notes and titled as 'initial screening of death' so that it can be easily found within the patients care record.

The initial screening should consider where information is available:

- Past medical/mental health history and ensure all aspects of physical and psychological care are considered within care provided.
- Events prior to the patient's death (chronology/changes in presentation/actions taken/appropriate assessments)
- For patients who die in our care, the screening should also ensure that the family of the patient has been contacted and condolences offered.

The below categorisation tool is to support the screening and decision-making process. A regular audit will be carried out to review the screening e.g. the category of the death and reasoning for this decision.

Deaths to be reported onto the Ulysses Incident Reporting System:

- **Majority of unexpected** deaths of service users/patients (children, adults of working age and older people) currently under the care of Oxford Health NHSFT or who have received a clinical interaction within the last six months (at a minimum categories UN2 and UU see below). Those services which provide a 'single contact' such as street triage services/GP OOH will only need to enter such deaths if the care provided was the last care prior to death or if concerns were identified in the initial screening.
- **Expected** deaths **where any care concerns or areas for learning** were identified through the initial screening by the clinical team.
- **All deaths** of patients with a **learning disability**.
- **All deaths of patients who are detained.**
- All inpatient mental health deaths.

All deaths reported onto the Ulysses incident reporting system should have an **initial review report** completed and sent to the Head of Service and Head of Nursing within 5 days of knowing about the death. For child deaths where a CDOP 'form B' has been completed this will act as an equivalent initial review report.

Categorising and Decision-making tool (part of initial screening)

Definition of an Expected Death:

Where a patient's demise is anticipated in the near future and his/her Doctor (GP or consultant) has seen the patient within the last 14 days before the death (for the condition that they died from).

Definition of an Unexpected Death:

All other deaths that do not fit the criteria for expected.

Type	Example Description and action to take
Expected Natural (EN1)	A group of deaths that were expected to occur in an expected time frame. e.g. people with terminal illness or perhaps in palliative care services. **Action:** These deaths should be screened to ensure there were no concerns with care delivery however they are unlikely to need a further review. If any concerns are identified a Ulysses incident form and initial review report should be completed. Initial review report to be sent to the Head of Service and Head of Nursing within 5 days. Documentation of the initial screening by the clinical team must be completed in the patients care record within the progress notes headed 'initial screening of death' including as relevant confirmation of communication with family and condolences given (in line with the duty of candour).
Expected Natural (EN2)	A group of deaths that were expected but were not expected to happen in that timeframe. e.g. someone with cancer, liver cirrhosis, heart failure, or respiratory disease but who dies earlier than anticipated. **Action:** These deaths should be reviewed by the clinical team as part of an initial screening and in some cases e.g. if lessons can be learned for future patients or care concerns are identified, will benefit from further review through reporting the death on Ulysses and completing an initial review report. Initial review report to be sent to the Head of Service and Head of Nursing within 5 days. Documentation of the initial screening by the clinical team must be completed in the patients care record within the progress notes headed 'initial screening of death' including as relevant confirmation of communication with family and condolences given.
Expected Unnatural (EU)	A group of deaths that are expected but not from the cause expected or timescale e.g. some people who misuse drugs, are dependent on alcohol or with an eating disorder. These may be individuals who are resistant to treatment. **Action:** These deaths should be reviewed by the clinical team as part of an initial screening and in some cases, e.g. if lessons can be learned for future patients or care concerns are identified, will benefit from further review through reporting the death on Ulysses and completing an initial review report. Initial review report to be sent to the Head of Service and Head of Nursing within 5 days. Documentation of the initial screening by the clinical team must be completed in the patients care record within the progress notes headed 'initial screening of death' including as relevant confirmation of communication with family and condolences given

Type	Example Description and action to take
Unexpected Natural (UN1)	Unexpected deaths which are from a natural physical health cause e.g. a sudden cardiac condition or sudden stroke. **Action:** These deaths should be reviewed by the clinical team as part of an initial screening and in some cases, e.g. if there are concerns identified regarding recognition of illness, management of symptoms etc... will need further review through reporting the death on Ulysses and completing an initial review report. Initial review report to be sent to the Head of Service and Head of Nursing within 5 days. Documentation of the initial screening by the clinical team must be completed in the patients care record within the progress notes headed 'initial screening of death' including as relevant confirmation of communication with family and condolences given. The death should be reported onto the Ulysses incident recording system. Consideration should also be given as to whether it is necessary to follow the Serious Incident process.
Unexpected Natural (UN2)	Unexpected deaths which are from a natural cause but which didn't need to be e.g. side effects of medication, some alcohol dependency and where there may have been care concerns (non-recognition of deteriorating patient), death following seizure. **Action:** These deaths should be reviewed in the initial screening and reported on Ulysses, and an initial review report should be completed and sent to the Head of Service and Head of Nursing within 5 days. Documentation of the initial screening by the clinical team must be completed in the patients care record within the progress notes headed 'initial screening of death' including as relevant confirmation of communication with family and condolences given. Consideration should also be given as to whether it is necessary to follow the Serious Incident process.
Unexpected Unnatural (UU)	Unexpected deaths which are from unnatural cause e.g. suicide, homicide, poisoning, abuse or neglect. **Action:** These deaths should be reviewed in the initial screening and reported on Ulysses, and an initial review report should be completed and sent to the Head of Service and Head of Nursing within 5 days. Documentation of the initial screening by the clinical team must be completed in the patients care record within the progress notes headed 'initial screening of death' including as relevant confirmation of communication with family and condolences given. Consideration should also be given as to whether it is necessary to follow the Serious Incident process. Following a suicide or serious near miss each team is encouraged to carry out a multi-disciplinary team clinical review as well.

Appendix 2. Guidance on grading an incident or death

Risk Matrix

Incidents and deaths in scope are graded using the National Patient Safety Agency (NPSA) risk matrix to assess the severity/ impact of the incident and the likelihood of it happening again, each on a 1 to 5 scale. Impact is based on physical harm, psychological harm or damage to Trust property. Examples of psychological harm could be post-traumatic stress disorder, other stress that requires clinical treatment, clinical depression or anxiety. The incident matrix is only an aid to decision making, and whilst it is a robust system it is not meant to replace clinical or management judgment in regard to the significance of individual events/incidents.

The grading gives each incident a score (severity x likelihood of reoccurrence) and an associated category of very low (green), low (yellow), moderate/high (orange) or extreme (red, otherwise known as a serious incident). A "never event" as per national guidance must be categorised as a red incidents. This grading and then score will determine how the incident will subsequently be managed and investigated.

All pressure ulcer damage must be reported as an incident. Grade 3 or 4 pressure damage must be assessed for avoidability using the agreed tool. Avoidable pressure ulcers at grade 3 or 4 must be reported and investigated through the serious incident process.

Clearly the incident may not fall neatly into one category. If there is any doubt then the incident grade should be increased. In the event of a near miss the severity of impact should be based on if the incident had occurred to ensure that all learning is captured.

The quality and risk team review the grading of all incidents and deaths in scope and any queries around risk rating will be followed up with the team manager.

Below is the risk matrix table to be used.

	Likelihood				
Severity	**1**	**2**	**3**	**4**	**5**
	Rare	**Unlikely**	**Possible**	**Likely**	**Almost Certain**
5 Catastrophic	5	10	15	20	25
4 Major	4	8	12	16	20
3 Moderate	3	6	9	12	15
2 Minor	2	4	6	8	10
1 Negligible	1	2	3	4	5

The following two tables give some examples and definitions to help identify the severity (impact) and likelihood of an incident or death.

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

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
Impact on the safety of patients, staff or public (physical/psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients
Quality/complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report	Totally unacceptable level or quality of treatment/service Gross failure of patient safety if findings not acted on Inquest/ombudsman inquiry Gross failure to meet national standards
Human resources/ organisational development/staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	Local media coverage – long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the House) Total loss of public confidence
Service/business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss/interruption of >8 hours Minor impact on environment	Loss/interruption of >1 day Moderate impact on environment	Loss/interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

<u>How the grading decides the level of review and investigation</u>

The grading and decision tree is also described in the diagram on 'What to do when an incident happens or a patient dies'. The majority of orange categorised incidents and all red incidents will be reviewed in detail

Local team review

For the incidents graded within the blue boxes below the team will be asked to complete a **local team review** focused around a team discussion to capture learning and identify any actions.

Table 3 Risk scoring = consequence × likelihood (C × L)

	Likelihood				
Consequence	1	2	3	4	5
	Rare		Possible	Likely	Almost certain
5 Catastrophic	5	10	15	20	25
4 Major	4	8			20
3 Moderate	3		9	12	15
2 Minor	2				10
1 Negligible	1	2	3	4	5

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

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

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

Initial review report

For the incidents graded within the blue boxes below the team will be asked to complete an **initial review report within 5 days.** The purpose of this review is to establish the key facts, identify any actions required, and enable a decision to be made about whether it should be further investigated through the serious incident process. All incidents where an under 18 is admitted to an adult mental health ward will require an initial review report.

In relation to deaths the below should be reported onto the incident management system and an initial review report completed. Except for child deaths where a CDOP 'form B' has been completed this will act as an equivalent initial review report. The Directorate level mortality review processes will discuss the initial review report.

- Majority of unexpected deaths of service users/patients (children, adults of working age and older people) currently under the care of Oxford Health NHSFT or who have received a clinical interaction within the last six months (mortality review guidance provides more detail). Those services which provide a 'single contact' such as street triage services/GP OOH will only need to enter such deaths if the care provided was the last care prior to death or if concerns were identified in the initial screening
- Expected deaths where any care concerns or areas for learning were identified through the initial screening by the clinical team.
- All deaths of patients with a learning disability.
- All inpatient mental health death
- All deaths of patients who are detained.

Table 3 Risk scoring = consequence × likelihood (C × L)

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

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

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

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

Appendix 3. Taking immediate actions

The majority of incidents which occur will involve little or no harm to patients and/or relatives/carers and/or staff. However, whenever an incident occurs it is critical that the immediate safety of any patient, member of staff or member of the public, and the environment of care, is reviewed and secured without delay.

When an incident has occurred it is the duty of the 'person in charge' to ensure that the immediate needs of the patient(s), families and staff member(s) have been attended to and that all immediate actions required to re-establish a safe environment of care have been taken. This may include removing hazards, ensuring patients and staff are safe, co-ordinating the actions of staff, and ensuring all practice is consistent with guidelines.

When an incident occurs involving the 'person in charge' this individual must notify their immediate line manager. Advice can be sought from the service manager.

Where the incident constitutes a major incident, the Business Continuity Policy CORP 23 should be followed.

In addition to the immediate management of staff and patient safety, and initiation of relevant protocols, if the incident involves a death or serious harm the scene of the incident should be isolated and secured to prevent the removal or contamination of evidence, unless an individual's safety is at imminent risk. The area should only be returned to use upon the direction of a police officer. See Appendix 8 for more guidance on Involvement and sharing information with the Police.

If the incident was caused by or involved a medical device, it is important that the device is immediately withdrawn from use until any investigation is concluded. In the case of a death the device should be left in situ until released by the police, and then the procedure for decontamination of medical devices should be followed see Medical Devices Policy, CP08.

In the event of a death the verification procedure in CP23 needs to be followed.

Incidents where there are safeguarding children/child protection and/or safeguarding vulnerable adults concerns the local procedures agreed by the Safeguarding Children or Safeguarding Adults boards (see CP14 Child Protection & Safeguarding Children Policy and CP25 Safeguarding Vulnerable Adults) should be followed.

Appendix 4. Reporting to the external national reporting and learning system (NRLS)

The Quality and Risk Team are responsible for the reporting of patient safety incidents (as defined nationally) to the NRLS. A patient safety incident is an unintended or unexpected incident which could have, or did, lead to harm for one or more patients receiving NHS-funded healthcare.

It is good practice for incidents to be uploaded to the NRLS on at least a monthly basis, and serious incidents resulting in death within 2 days.

Criteria	
Injuries that lead to death or are likely to lead to permanent damage, or damage that lasts or is likely to last more than 28 days to	• a person's sight, hearing, touch, smell or taste • any major organ of the body (including the brain and skin) • bones • muscles, tendons, joints or vessels • intellectual functions, such as intelligence, speech, thinking, remembering, making judgments or solving problems • any injury or other event that causes a person pain lasting or likely to last for more than 28 days
Injuries or events leading to psychological harm, including	• post-traumatic stress disorder • other stress that requires clinical treatment or support • psychosis • clinical depression • clinical anxiety
Any injury that requires treatment by a healthcare professional in order to prevent	• death • permanent injury • any of the outcomes,

Appendix 5. Serious work-related incidents to staff that are reported to the Health and Safety Executive

Reportable work-related incidents are categorised as a RIDDORs if the staff member has been injured and therefore off sick from work or unable to perform their normal work duties for more than seven consecutive days (not including the day of the accident but including any weekends or other rest days).

Reportable work-related incidents must be reported as soon as practicable, and a report sent to Health and Safety Executive (HSE) within fifteen days. All work-related deaths must be reported immediately.

RIDDOR incidents include:

Death

• all deaths of staff must be reported if they arise from a work- related accident, including an act of physical violence to a worker
• any death which occurs to an employee within a year of being involved in a reportable injury (from the date of the incident) must be reported without delay whether or not the injury has previously been reported

Major injuries

• a fracture, other than to fingers, thumbs and toes
• amputation of an arm, hand, finger, thumb, leg, foot or toe
• permanent loss of sight or reduction of sight
• crush injuries leading to internal organ damage
• serious burns (covering more than 10% of the body, or damaging the eyes, respiratory system or other vital organs)
• scalping (separation of skin from the head) which require hospital treatment
• unconsciousness caused by head injury or asphyxia
• any other injury arising from working in an enclosed space, which leads to hypothermia, heat induced illness or requires resuscitation or admittance to hospital for more than 24 hours

Reportable occupational diseases

Diagnoses of certain occupational diseases, where these are likely to have been caused or made worse by work must be reported. These diseases include carpal tunnel syndrome, severe cramp of the hand or forearm and tendonitis of the hand or forearm.

Reportable dangerous occurrences

Dangerous occurrences are certain, specified 'near-miss' events (incidents with the potential to cause harm.) Not all such events require reporting.
The list includes, but not limited to sharps injuries from a needle or other sharp instrument known to be contaminated with a blood-borne virus (BBV), e.g. hepatitis B or C or HIV.

Exemptions

Deaths and injuries arising from certain categories are not categorised as reportable, for example the movement of a vehicle on a road (unless the person was loading or unloading the vehicle or working alongside the road, e.g. constructing or maintaining the road or adjacent buildings).

Appendix 6. Children and Adult Safeguarding

Refer to the Trust policies on Child Protection & Safeguarding Children (CP14) and Safeguarding Vulnerable Adults (CP25).

Safeguarding children

Where an incident or death involves a child, either one receiving Trust services or one who is affected by an adult or other person receiving services, the Trust will co-operate fully with any related multi-agency investigation process such as partnership review or serious case review as commissioned by the relevant local safeguarding children board.

Where a partnership review or serious case review is commissioned by the local safeguarding children board (LSCB), the Trust will undertake the internal management review (IMR) in line with the terms of reference provided by the board.

If there are clinical care concerns there will be a joint investigation led by a member of the safeguarding team and in partnership with the relevant service lead to complete the review.

The report and action plan will be signed off by the Director of Nursing and Clinical Standards or deputy before submission to the local safeguarding children board. These will usually be considered as a serious incident.

Child deaths

LSCB child death overview panels (CDOP) have a statutory responsibility to review all available information on all child deaths up to the age of 18 years (excluding those babies who are stillborn and planned terminations of pregnancy carried out within the law (117) in the LSCB area(s). The Trust will support this statutory LSCB role.

There are two interrelated processes for reviewing child deaths (either of which can trigger a serious case review):

- Rapid response by a group of key professionals who come together for the purpose of enquiring into and evaluating each unexpected death of a child
- A child death overview panel reviews all child deaths up to the age of 18 years

Allegations

Incidents which indicate an allegation relating to staff should be reported to the Trust's safeguarding lead and in turn the local authority designated officer (LADO).

Safeguarding vulnerable adults

Where a serious allegation is made under the safeguarding adults (vulnerable adults) arrangements about a Trust service or a specific member staff, it must be reported as a potential serious incident and this procedure followed. Where an internal management review or serious case review is commissioned by the local safeguarding adult board, the Trust will collaborate on the investigation process and make available any internal investigation report as required. These will usually be considered as a serious incident and will follow this procedure.

Where Trust staff report a concern about a service external to the Trust but where Trust patients may be involved, the serious incident procedure should be followed at least initially until there is sufficient information to make a judgement about the level of severity of the incident.

Domestic homicide reviews are led by the local community safety partnership and the Trust has a duty to cooperate with these reviews if the victim/s and or perpetrator have been or were current patients.

Multi-agency public protection arrangements (MAPPA) serious case reviews

The safeguarding board must commission a MAPPA serious care review if both of the following conditions apply:

- the MAPPA offender (in any category) was being managed at level 2 or 3 when the offence was committed or at any time in the 28 days before the offence was committed
- the offence is murder, attempted murder, manslaughter, rape, or attempted rape.

There may be other conditions when a MAPPA serious case review is commissioned by the safeguarding board.

When a MAPPA serious case review is commissioned the Trust will undertake the IMR in line with the terms of reference provided by MAPPA. The report and action plan should be signed off by the Director of Nursing and Clinical Standards before submission to MAPPA. These will usually be considered as a serious incident.

Appendix 7. Definition of a serious incident including a death

A serious incident is defined nationally in the NHS England Serious Incident Framework; here is a link to the framework NHS England » Serious Incident framework

Once an incident has been identified as a serious incident a root cause analysis investigation will be commissioned to be completed within 60 days unless an extension is agreed with the commissioner. There are three levels of serious incident investigation; the level should be proportionate to the incident.

1. Concise investigations -suited to less complex incidents which can be investigated usually by one individual at a local level

2. Comprehensive investigations - suited to complex issues which should be investigated by two or more people ideally from different professional backgrounds

3. Independent investigations - suited to incidents where the integrity of the internal investigation is likely to be challenged or where it will be difficult for an organisation to conduct an objective investigation

Serious incidents are defined where there are identified acts and/or omissions in care that result in incidents meeting one of the criteria below:

Unexpected death of one or more people. This includes

- suicide/self-inflicted death
- homicide by a person in receipt of mental health care within the recent past 12 months

Unexpected or avoidable injury to one or more people that has resulted in serious harm or avoidable injury that requires further treatment by a healthcare professional in order to prevent: —

- the death of the service user; or
- serious harm.

Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self- neglect, domestic abuse, human trafficking and modern-day slavery where:

- healthcare did not take appropriate action/intervention to safeguard against such abuse occurring; or where abuse occurred during the provision of NHS-funded care.

This includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS funded care caused/contributed towards the incident.

A Never Event - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death. See Never Events Policy and Framework for the national definition, NHS England » Never events

An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:

- Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues;
- Property damage;
- Security breach/concern;
- Incidents in population-wide healthcare activities like screening and immunisation programmes where the potential for harm may extend to a large population;
- Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS);
- Systematic failure to provide an acceptable standard of care (requiring a ward to close)
- Activation of Major Incident Plan (by provider, commissioner or relevant agency)

Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation.

It may be appropriate for a 'near miss' to be a classed as a serious incident because while the impact/actual harm may not be severe or catastrophic, the **potential for harm** was significant. In deciding the manager should consider: the likelihood of the incident occurring again if current systems/process remain unchanged; and the potential for harm to staff, patients, and the organisation should the incident occur again.

Appendix 8. Involving and sharing information with the Police

The Trust works actively with the Police and other agencies such as the National Probation Service and the Crown Prosecution Service (CPS) to protect the public, patients and staff though a variety of multidisciplinary and interagency groups. These include MAPPA (Multi Agency Public Protection Arrangements) MARAC (Multi Agency Risk Assessment Conference) and the MDOP (Mentally Disordered Offenders Panel).

This procedure should be read in conjunction with the Police documents "Tackling Violence and Antisocial Behaviour in the NHS Joint Working Agreement between the Association of Chief Police Officers, the Crown Prosecution Service and NHS Protect" and the "Interagency Joint Working Protocol for the Management of Mental Health Thames Valley Area".

The Trust recognises the need to work in partnership with the police and criminal justice system in order to protect patients and service users, staff and the public.

The Trust will support patients and service users in their care to report crime.

The Trust supports the NHS Zero Tolerance policy with regard to violence and aggression towards staff and encourages the reporting of all physical assaults on staff to the police.

It is expected that in instances where violent and aggressive behaviour occurs on an inpatient ward then staff will have, or be able to call upon, sufficient resources within the hospital to manage this behaviour. Exceptions to this might include:

1. Where the perpetrator has, or is thought to have, a weapon.
2. Where there are a number of perpetrators.

It is then appropriate for staff to call for the police to assist them in regaining control of the situation. Once control is regained, Trust staff will resume management of the area. It must be realised that if police are asked to help regain control of a high risk situation, then they will use the techniques and tools in which they are trained. Staff must assess each situation as to whether it is safe for them to manage or whether the help of the police is required. Police should not be routinely called to assist; an individual assessment must be made.

Throughout any incident the responsibility for a patient's health remains with the Trust and is the priority.

<u>Procedure for involving the police</u>

Recording details of the incident

The police control room grade all calls on their seriousness to prioritise their response. Staff must say whether the situation requires immediate action or they are happy for the local beat officers or police community support officers to be informed and attend in due course. Senior staff must be informed at the earliest opportunity that the police have been contacted and an incident form completed.

A police officer may then attend the incident to start to investigate. At that stage a crime number will be issued. A note of these numbers should be kept and recorded with details of the incident in the patient's notes and in related incident reports. You should also note down the name and shoulder number of the police officer attending.

Preserving evidence
It is important if a serious crime is suspected or in the event of an unexpected death that potential evidence is not tampered with. In the case of an unexpected death, once death has been confirmed, the patient and the room where they were found should be left untouched and all patient property and effects secured. Similarly any weapons or other means by which someone may have been harmed should also be preserved e.g. ligatures. Once in attendance the police with give further advice.

Police may request the following information when reporting assaults:

- Suspect's name, DOB, address and contact details. Also any relevant history in relation to violence.
- Victim's name, DOB, address and contact details. Police will need to take a statement
- Witness' names, DOBs, addresses and contact details. Police will need to take a statement.
- Has the scene (where the incident took place) been preserved by stopping other members of staff or patients from entering the area?
- Police will need the full circumstances of what happened.
- Do not wash or allow suspect or victim to do so if possible.
- Do not move items if possible.
- Do not clean up the scene, but do try to stop others accessing it.
- Secure any CCTV footage.
- Make notes about what has happened and who said what.
- Police will need to get access to medical information (a doctor's statement) for any injuries that have been examined.
- Provide police with details of any injuries; if possible take a picture of the injury or marks as marks can fade really quickly.

Confidentiality and information sharing
Whilst issues of confidentiality need to be considered in all situations involving patients where a crime has been committed, information can be shared with the Police in line with Caldicott principles. The Trust Integrated Information Governance Policy (CORP19) will provide guidance but if further help is needed advice can be sought from either the Trust Caldicott Guardian who can be contacted via the Trust offices or the Head of Information Governance via the switchboard.

Further to the above, there will be times when police investigations/activities may cause additional stress to a patient (e.g. statement taking, charging, court appearances, bail arrangements etc.) Where it is felt these additional stressors may have a serious effect on a patient's mental state (for example, exacerbating self-harm or suicidal ideation), consideration should be given to proactively discussing the concerns with the police. The relevant clinician should seek advice/guidance for the Trust Caldicott Guardian and/or Head of Information Governance to ensure appropriate levels of information sharing. An inter-agency safety plan may then need to be developed to ensure sufficient support is in place at times when the police/criminal justice system will have heightened contact. This would be particularly relevant where a patient might otherwise have contact with the police without the care-team being aware.

Appendix 9. National Requirements

The following national requirements underpin the policy;

- NHS England Serious Incident Framework
- The NHS England Never Events Framework
- CQC regulations, safety domain
- NHS England duty of candour requirements
- CQC duty of candour requirements
- National Quality Board – National Guidance on Learning from Deaths

Full Equality Impact Assessment Form

This form is an Equality Impact Assessment Form. It is used to review services and policies to ensure fair and consistent services for staff, service users and carers. It is a legal duty to prevent discrimination.

The form consists of two parts. Part 1 is screening to see if the Procedural Document or service requires a full assessment. It is through this screening process that you can find out whether the Procedural Document or service requires a Part 2.

Part 1

Equality Impact Assessment	
Service Area All	**Date:** September 2017
Title of Procedural Document , strategy or service Policy for reporting and learning from incidents and deaths, including serious incidents (SI) RMHS1	

Short description of policy, strategy or service:
This policy sets out the processes and expectations for the reporting, review and learning from all incidents and deaths including those which require an investigation under the serious incident framework.

What is the likely positive or negative impact on people in the following groups?
Older or younger people The support for patients, families and staff following an incident or death if covered explicitly in the policy. This includes tailoring the support and considering people's different needs. No particular group is disadvantaged by the policy. Involving patients and families in investigations is a key part of the approach for serious incident investigations.
People with disabilities As above.
People from different ethnic/cultural backgrounds (including those who do not speak English as a first language) As above.
Men, women or transgender people As above.
People with different religious beliefs or no religious beliefs As above.
Gay, lesbian, bisexual or heterosexual people As above.
People from a different socio-economic background As above.

Evidence
What is the evidence for your answers above? N/A
What does available research say? N/A
What further research would be needed to fill the gaps in understanding the potential difficulties or known effects of the Procedural Document? N/A
Have you thought about consulting/researching this gap? What would you need? N/A
Does the Procedural Document need a Full Equality Impact Assessment? No