

Policy control document

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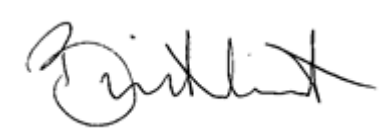
Policy title	Policy for reporting and learning from incidents and deaths
Policy code	RMHS1
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Approval history	
Name of committee	Date
Integrated Governance Committee	25 th January 2012
Safety Quality Sub-Committee	July 2015
Quality Committee	17 th July 2015
<i>Safety Quality Sub-Committee</i>	September 2017
<i>Quality and Clinical Governance Group</i>	March 2021
<i>Quality and Clinical Governance Group (sign off of the Trust's PSIRF Approach and Response Plan)</i>	November 2023

Date of next review	31 st January 2027
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Chair of approving committee

Britta Klinck



Signature

Title

Chief Nurse

Date

December 2024

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 When a revision is issued previous versions will be withdrawn.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

Change control

Number of pages (excluding appendices and equality analysis): 16

Summary of revisions:

Includes changes relating to the national Learn From Patient Safety Events service (LFPSE) introduced from October 2023 and the Trusts implementation of the Patient Safety Incident Response Framework from 4th December 2023.

As well as the introduction of the Medical Examiner function from September 2024.

The introduction of the changes have been developed incrementally and signed off within the Trust quality governance framework and embedded into practice ahead of updating this policy.

Policy for Reporting and Learning from Incidents and Deaths

Policy code RMHS01

Version 6

Date of approval December 2024

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1. Purpose

This policy sets out the processes and expectations for the reporting, review and learning from all incidents and deaths. We take a similar approach and use the same local incident management system (Ulysses) for incidents as we do for reporting deaths and this policy covers both.

All incidents relating to patients, visitors, staff, students, contractors delivering a service/working on Trust premises should be reported as close to the time of the incident as possible. Team/ward managers will automatically receive the incident by email 'notification' at the time reported and are expected to review and add any further details on Ulysses within 14 working days.

2. Scope

This policy applies to all staff in the organisation whether they are employed permanently, temporarily through agency or bank arrangements or are students on placement. Incidents involving visitors on Trust premises or contractors delivering services on our behalf should be reported by a staff member on Ulysses unless there is an alternative contract agreement about how incidents will be managed.

3. Introduction and Key Messages

As part of the national Patient Safety Strategy around developing a safer culture, safer systems, and safer patient care was the development of the Patient Safety Incident Response Framework (PSIRF) published in 2023¹. This is a significant change in how the NHS thinks and behave in relation to responding, learning and making changes from incidents to improve patient care. The Trust implemented and started working under the PSIRF from 4th December 2023. The term and processes in relation to serious incidents no longer exist. This Policy is aligned with PSIRF and also the national guidance on Learning from Deaths by the National Quality Board published in March 2017 ([NHS England » Learning from deaths in the NHS](#)).

PSIRF changes the incidents we focus on and the type of review we undertake, with greater flexibility and attention to learning from what has happened, why and the actions we can take. However it does not change the need to report all patient incidents or incidents resulting in staff injuries on Ulysses.

We recognise the significant impact incidents/deaths have on patients and their families and carers, and also staff. Our approach is to be open, compassionate, to listen and individualise our contacts to recognise the different needs of those we involve and engage to learn from incidents/deaths. We are mindful not to cause further distress or harm when identifying learning from an incident/death. Our focus is on using the findings to inform and support quality improvement activity and any other actions taken. PSIRF does not change our obligation or commitment to patients and families to comply with the Duty of Candour requirements and to answer any questions they may have following an incident, see separate Policy on the Duty of Candour (CORP24).

Oxford Health NHS Foundation Trust (OHFT) attaches a great deal of importance to the culture across the organisation and ensuring that it is one that puts patient care first, is open, just, compassionate and continually looking at ways to learn and apply improvements to enhance patient care. Staff and patients are encouraged to raise any concerns about the quality of care, patient safety and poor behaviours and we have developed a range of ways people can do this. By learning from incidents, deaths and near misses we can make care as safe as possible. Reporting

¹ The Patient Safety Incident Response Framework replaced the Serious Incident Framework.

an incident is not about identifying blame, we use incident information to identify learning to act on as well as any emerging themes. This is supported by Patient Safety Incident Response Framework (PSIRF) which states that the review of patient safety incidents “are insulated from remits that seek to determine avoidability/ preventability/ predictability; legal liability; blame; professional conduct/competence/ fitness to practise; criminality; or cause of death.” (NHS England, PSIRF 2022) If there are concerns about a staff members practice within an incident this will be followed up by their line manager and any appropriate HR process followed.

As part of implementing PSIRF we developed a document called PSIRF Approach and a detailed Patient Safety Incident Response Plan (PSIRP) for the organisation, both are published here [Patient Safety Incident Response Framework \(PSIRF\) - Oxford Health NHS Foundation Trust](#). A key part of the changes are how we respond and learn from incidents with the introduction of incident learning huddles to better engage those involved and affected to identify learning and changes, more details below. All incidents that meet the PSIRP are overseen by the central Patient Safety Team and led by those with specialist training. Every PSIRP case receives a review/investigation with the outcome scrutinised and signed off by senior clinicians and an Executive Director in a panel.

To identify learning for change from both incidents/ deaths we will always aim to collaborate with other organisations to carry out reviews and identify actions where a patient has received care from several health and care providers. The healthcare providers within the Buckinghamshire, Oxfordshire and Berkshire West Integrated Care System have developed a procedure for working together to share concerns and review incidents/deaths. To find out more please contact the team at patient.safety@oxfordhealth.nhs.uk.

4. Local Incident Management System

The Trust uses Ulysses as our local incident management system to report and manage incidents, significant near misses and deaths. All staff logged onto a Trust owned device can report an incident on Ulysses via the intranet (<https://ulysses.oxfordhealth.nhs.uk/>). All staff are responsible for reporting incidents, significant near misses or deaths (see section below to clarify what deaths should be reported) as soon as possible from knowing about the event. Incident reports are based on what is known at the time of reporting, information can be changed/amended as more is found out. Incidents/deaths are reviewed by multiple people each day including team/ward managers, subject experts (for example infection prevention and control team, safeguarding leads, information governance leads, medicine safety officers, medical device safety officer), and the quality/patient safety team. There is guidance on how to report an incident/death and for managers how to manage an incident/death on Ulysses available here [Guidance for reporting and managing incidents on Ulysses](#). Incidents reported more than 20 years ago will be deleted, based on incident date.

Ulysses is linked automatically to the national Learn From Patient Safety Events service (LFPSE) to share all patient incidents in ‘real-time’ with NHS England and the Care Quality Commission to support national learning. A sub-set of patients incidents under the PSIRF are also reported on the national STEIS system at the moment, due to be replaced by additional functionality within the LFPSE.

OHFT has an active Ulysses user group which regularly meets to develop the incident reporting system so that it supports staff to report and learn from incidents/deaths. If you need help accessing or using Ulysses contact the Quality and Risk Team on 01865 902351.

Information and analysis on incident data and deaths is available to all staff on the Trust's On-line Business Intelligence platform called TOBI. Staff need to request access to TOBI through the IT service desk by requesting to be a, Microsoft Power BI Add User. TOBI is then accessed on-line here <https://app.powerbi.com/home?experience=power-bi>.

5. Associated documents

This policy should be read with the following OHFT documents;

- OHFT Patient Safety Incident Response Approach and Patient Safety Incident Response Plan (PSIRP), [Patient Safety Incident Response Framework \(PSIRF\) - Oxford Health NHS Foundation Trust](#)
- Central alerting system Policy (to manage and action learning from national patient safety alerts) (RMHS23)
- Duty of candour Policy (CORP24)
- Safeguarding children and adults Policy (CP14 and CP25)
- Concerns, complaints and compliments Policy (CORP25)
- Management of clinical sharps injuries and exposure to blood (RMHS21)
- Health and safety Policy (for details about reporting RIDDOR) (RMHS00)
- Medical devices Policy (CP08)
- End of life Policy (CP23)
- Legal proceedings Policy (CORP17) and Coroners Preventing Future Death Notices protocol.
- Emergency preparedness, resilience and response and business continuity Policy (CORP23)

Key national documents;

- Patient Safety Incident Response Framework, [NHS England » Patient Safety Incident Response Framework](#)
- Learning from Deaths by the National Quality Board published in March 2017 ([NHS England » Learning from deaths in the NHS](#))
- Guidance on harm grading for patient incidents [NHS England » guidance on recording patient safety events and levels of harm](#)
- Health and Safety Executive guide on Reporting of staff injuries, diseases and dangerous occurrences regulation (RIDDOR) [HSE RIDDOR guide](#)

6. Patient, public and visitor 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 considered first, and support is offered. For child deaths the immediate response is managed through the multi-agency rapid response process. This will be led by the staff member in charge/team or ward manager or senior clinician. They should also consider if a safeguarding alert needs to be raised with the Local Authority and/ or if the Police need to be involved (if involving the Police see Appendix 1).

All patient related incidents and significant near misses should be reported by the staff member who has the detail on the Trust's local incident management system, Ulysses. We use Ulysses to review individual incidents and decide on any further actions or reviews/investigations needed as well as to identify any themes over time. The majority of incidents involve little or no harm/ injury to patients or staff however we can often learn the most from these incidents.

Where an incident constitutes a major or critical incident, whereby an incident means the organisation is not able to deliver a critical service to patients or we need to instigate a psychosocial

response for survivors/members of the public members, please follow the guidance in the Emergency Response Policy (CORP23).

If the incident was caused by or involved a medical device, it is important that the device is immediately withdrawn from use until any review/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).

As explained above, the Trust implemented and started working under the Patient Safety Incident Response Framework (PSIRF) from 4th December 2023. As part of implementing PSIRF we developed a document called OHFT Patient Safety Incident Response Approach for the whole organisation and a detailed Patient Safety Incident Response Plan (PSIRP), both are published here [Patient Safety Incident Response Framework \(PSIRF\) - Oxford Health NHS Foundation Trust](#). The documents provide more details about how we respond/review and learn from patient incidents.

We use a range of approaches to review/investigate an incident such as an incident learning huddle, case record review (also known as an initial incident report) and full in-depth investigations. There are descriptions about the different approaches and tools we use on the intranet here [OHFT different learning responses](#) or contact the patient safety team to find out more on patient.safety@oxfordhealth.nhs.uk.

6.1 Level of harm

For every patient incident the reporter is asked to categorise the level of harm to the patient.

National guidance from NHS England was developed in August 2023 to refine the descriptions for the categorisation of different levels of harm from patient safety incidents, and include the reporting of psychological harm. This development was linked to the introduction and roll out of the new national Learn from Patient Safety Events service (LFPSE). The aim is to improve the consistency of reporting incidents. Ulysses automatically links to the national system LFPSE.

The full national guidance is available here, [NHS England » Policy guidance on recording patient safety events and levels of harm](#) and summarised below. From 2023 Ulysses was amended to incorporate the changes. For every incident there are two key mandatory questions to ask the reporter (member of staff) to what extent was the patient physically harmed in the incident? and to what extent was the patient psychologically harmed in the incident? There are help notes on Ulysses which include the national descriptions. We also internally ask the overall impact of the incident. See table 1 for harm definitions agreed by NHS England and the Care Quality Commission.

We have a legal duty of candour which requires a verbal contact with patients/families within 10 working days of knowing about an incident and then following this up in writing for all incidents with moderate and above physical or psychological harm.

Table 1. Level of Harm

Impact	National Definitions	
	Physical harm	Psychological harm (an assessment based on information you have at point of recording)
No harm/near miss	No physical harm	No psychological harm. Being involved in any patient safety incident is not pleasant, but please select no harm if you are not aware of any specific psychological harm that meets the description of low psychological harm or worse. Pain should be recorded under physical harm rather than psychological harm.
Low harm	<p>Low physical harm is when all of the following apply;</p> <ul style="list-style-type: none"> • Minimal harm occurred – patient required extra observation or minor treatment • Did not or is unlikely to need further healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit • Did not or is unlikely to need further treatment beyond dressing changes or short courses of oral medication • Did not or is unlikely to affect the patient’s independence • Did not or is unlikely to affect the success of treatment for existing health conditions 	<p>Low psychological harm is when at least one of the following apply;</p> <ul style="list-style-type: none"> • Distress that did not or is unlikely to need extra treatment beyond a single GP, community healthcare professional, emergency department or clinic visit • Distress that did not or is unlikely to affect the patient’s normal activities for more than a few days • Distress that did not or is unlikely to result in a new mental health diagnosis or a significant deterioration in an existing mental health condition
Moderate harm (duty of candour applies)	<p>Moderate harm is when at least one of the following apply;</p> <ul style="list-style-type: none"> • Has needed or is likely to need healthcare beyond a single GP, community healthcare professional, emergency department or clinic visit, and beyond dressing changes or short courses of medication, but less than 2 weeks additional inpatient care and/or less than 6 months of further treatment and did not need immediate life-saving intervention • Has limited or is likely to limit the patient’s independent, but for less than 6 months 	<p>Moderate psychological harm is when at least one of the following apply:</p> <ul style="list-style-type: none"> • Distress that did or is likely to need a course of treatment that extends for less than 6 months • Distress that did or is likely to affect the patient’s normal activities for more than a few days but is unlikely to affect the patient’s ability to live independently for more than 6 months • Distress that did or is likely to result in a new mental health diagnosis, or a significant deterioration in an existing mental health condition, but where recovery is expected within 6 months.

Impact	National Definitions	
	Physical harm	Psychological harm (an assessment based on information you have at point of recording)
	<ul style="list-style-type: none"> Has affected or is likely to affect the success of treatment, but without meeting the criteria for reduced life expectancy or accelerated disability described under severe harm 	
Severe harm (duty of candour applies)	<p>Severe harm is when at least one of the following apply;</p> <ul style="list-style-type: none"> Permanent harm/permanent alteration of the physiology Needed immediate life-saving clinical intervention Is likely to have reduced the patient's life expectancy Needed or is likely to need additional inpatient care or more than 2 weeks and/or more than 6 months of further treatment Has or is likely to have, exacerbated or hastened permanent or long term (greater than 6 months) disability, or their existing health conditions Has limited or is likely to limit the patient's independence for 6 months or more 	<p>Severe/prolonged psychological harm is when at least one of the following apply;</p> <ul style="list-style-type: none"> Distress that did or is likely to need a course of treatment that continues for more than 6 months. Distress that did or is likely to affect the patient's normal activities or ability to live independently for more than 6 months Distress that did or is likely to result in a new mental health diagnosis or a significant deterioration in an existing mental health condition and recovery is not expected within 6 months.
Fatal, if the incident contributed to the patient's death (duty of candour applies)	<p>You should select this option if, at the time of reporting, the patient has died and the incident that you are recording may have contributed to the death. You will have the option later to estimate to what extent the patient safety incident contributed to the death.</p> <p>Note. The Trust uses the incident management system to manage our learning from deaths processes some incidents related to a death are reported as having a fatal outcome even if the incident did not contribute to the death. We also have a cause group called deaths to capture deaths for certain vulnerable patients, unexpected deaths when the person is open to a team and any death where we have concerns about the care provided. Every incident is reviewed to ensure the correct notification and review is completed to identify any learning.</p>	N/A

7. Patient deaths not related to an incident

The Trust takes our role and responsibilities very seriously around learning from deaths, the overall responsibility sits with the Chief Medical Officer, who chairs the Mortality Review Group and Suicide Prevention Steering Group which receive quarterly reports. The Trust has separate guidance for the mortality review process saved alongside this policy on the intranet. The guidance sets out the initial screening process for all known deaths for patients under our care, to include understanding if there are any concerns about the care provided or any concerns from the family, the categorisation of the death (commonly called the Mazars) and the decision-making steps to support what is reported onto Ulysses and next steps. The deaths reported onto Ulysses are reviewed within the established weekly patient safety forums alongside incidents with significant learning/moderate or above harm to identify where a further review is needed based on the potential to identify more learning.

The following deaths are flagged in Ulysses and will have a mortality review usually in the form of an incident learning huddle or case record review (also called an initial review report). This outcome is then reviewed to understand if a full investigation may be needed;

- All unexpected deaths
- All deaths where bereaved families and carers, or staff, have raised a significant concern about the quality of care provision
- Deaths which the Medical Examiner has highlighted a concern for further review
- Requests from other organisations to review the care provided to people who are its current or past patients if there are concerns about care
- People with a learning disability or diagnosis of autism
- Patients detained under the Mental Health Act at their time of death
- Children and young people aged under 18
- We suspect the person took their own life by suicide
- People under our care who die when on a palliative or end of life pathway

We actively participate in the external multi-agency reviews of deaths for people related to;

- Medical examiner reviews the cause of death (we need to notify the medical examiner office when one of our employed doctors proposes a cause of death/completes a medical certificate for a patient and the death is not referred to the Coroner)
- Domestic abuse related deaths commissioned by community safety partnerships
- Safeguarding Adult Reviews/Child Safeguarding Practice Reviews (further details in the policies CP14 and CP25)
- Coroner reviews and inquests via the Trust's legal team
- Learning from lives and deaths of someone with a learning disability (aged 4 and above) or an autistic person (aged 18 and over) (LeDeR) (notification of deaths go to [Report the death of someone with a learning disability or an autistic person](#))
- Child deaths (through the Child Death Overview Panel process), more information is in the Safeguarding Children's Policy CP14
- People who were homeless or with no fixed abode at time of death (Oxfordshire only) (notification of deaths to go to [Homeless Mortality Reviews \(HMRs\) - Oxfordshire Safeguarding Adults Board](#))
- All deaths of a patient detained under the Mental Health Act are reported to the Care Quality Commission.
- Mental health homicide reviews (speak to the patient.safety@oxfordhealth.nhs.uk who manage the notifications and process to NHS England and commissioners).

We are also part of two national real time surveillance systems in relation to suspected suicides to support quick identification of deaths and multi-agency learning.

Our review and oversight of deaths runs in parallel to the response plan for patient safety incidents and is aligned with the national guidance on Learning from Deaths. As part of our mortality surveillance work we report information on deaths every quarter to the Trust's Quality Committee and the regional Learning from Deaths Network. A report on all deaths that come under our Patient Safety Incident Response Plan including our learning goes to the public Board of Directors meeting.

8. Incidents involving a staff member, students or contractors

As with patient related incidents, incidents which lead to harm to staff or students/contractors whilst delivering a service or on a Trust premises should be reported on the Trust's local incident management system, Ulysses. We use Ulysses to review individual incidents and decide on any further actions or reviews/investigations needed as well as to identify any themes or trends. Staff incidents are not submitted to the LFPSE.

The majority of staff related incidents reported fall under violence by patients towards staff. The Trust's Health Security and Safety Committee and Reducing Violence Group oversees staff incidents and quality improvement activity.

Incidents which indicate an allegation about a staff member should be reported to the Trust's safeguarding lead and then possibly the local authority designated officer (LADO). For advice either contact the safeguarding childrens consultation line 07770648673 or the safeguarding adult consultation line 07785458201.

Incidents by staff towards staff should not be reported on Ulysses and should be raised through the appropriate HR process.

RIDDOR is a legal requirement under Health and Safety law whereby an employer needs to record work-related accidents, incidents and ill-health which have caused harm to staff, visitors, students and contractors and then report this to the regulator, the Health and Safety Executive (HSE). RIDDOR stands for the Reporting of Incidents, Diseases and Dangerous Occurrences Regulations. Reporting to the HSE should happen within 10-15 days of the incident depending on the type of injury. The HSE will then assess the risk and they may carry out an investigation so that they can provide advice about how to avoid a similar accident happening again. When a work-related injury is reported on Ulysses the incident is reviewed at the time and shared with the Health and Safety Team. Incidents with moderate harm and above are reported and reviewed through the quality governance framework weekly. The team/ward manager is contacted for possible/actual RIDDOR incidents close to the time of reporting the incident. The Health and Safety Team oversee and advise on RIDDOR reporting. The Quality and Risk Team lead on the reporting to the HSE via a separate web portal. The Trust's Health, Security and Safety Committee monitor trends and learning from staff injuries. See the Health and Safety Policy and the [HSE RIDDOR guide](#) for more details. If you are unsure about whether to report an accident, or need advice please contact the Health and Safety Team on HealthandSafety@oxfordhealth.nhs.uk.

9. Support for Staff

The relevant team manager (or service manager as appropriate) must ensure immediate and ongoing support is offered to staff directly following an incident with harm/death of a patient. This can then be supported by supervision and reflective practice. There is a range of support available to staff following an incident/death and during or after any review/investigation, with a list of some of the services available on the intranet here [staff support](#).

Team managers can arrange for a psychological debrief to take place following an incident, this can be as a group or individually. This is often referred to as Post Incident Psychological Support (PIPS) and is arranged by an email request being sent to postincident.support@oxfordhealth.nhs.uk. The aim is that support is offered to staff (and patients/families) before we start reviewing/investigating an incident. There is also pastoral care offered by the chaplaincy team.

The Trust has introduced a trauma risk management (TRiM) approach, whereby trained practitioners provide 1:1 peer support, monitor trauma exposed individuals and where appropriate assist them to access professional support. To access TRiM support email trim@oxfordhealth.nhs.uk. Psychology support for staff can also be accessed through the Occupational Health service.

There is a resource for professionals affected by the suicide of a patient including how to look after yourself, what managers should consider when conveying the information about a death and the formal processes to expect following a death. The Royal College of Psychiatrists resource is available here, [if-a-patient-dies-by-suicide---for-mental-health-professionals.pdf](#)

10. Support for Patients and Families

The relevant team/ward 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 Trust will always attempt to involve and engage patients/families in a review where serious harm occurs, or there is the potential for significant learning. We will offer patients/families;

- ❖ A single point of contact (usually starting with the clinical team who knows/knew the patient)
- ❖ Support and signposting to services as required
- ❖ The opportunity to tell us what concerns and questions they have, which we will make every attempt to respond to and explain where we cannot answer a question
- ❖ Regular communication on the progress and timescales with completing a learning review/investigation (as relevant)
- ❖ To share the outcome of our learning review/investigation (if completed), this could be through a meeting, over the telephone and/ or in writing

If a patient or family member raises concerns or a complaint following an incident/death we will look into this, offer support and respond to any questions. However in line with the Patient Safety Incident Response Framework (PSIRF) and being proportionate with resources we may not always carry out a specific learning response/review if we already understand the underlying factors/issues to address and actions are being taken forward. If a patient/family member is dissatisfied with how we have reviewed an incident, we will listen, review the

decision and explain our rationale, and if they remain unhappy we will seek advice from the Chief Nurse and/or Chief Medical Officer.

OHFT established a Family Liaison Service independent to clinical teams to support families mostly bereaved by the suicide of a loved one who was under our care or recently discharged. The service provides general bereavement support, signposting to external agencies, information and practice advice, as well as support to help raise concerns and questions with the Trust. Referrals can be made by emailing family.liaison@oxfordhealth.nhs.uk. Amparo Listening Ear is also commissioned to provide support to people across the Thames Valley area who are bereaved by suicide, this is a free and confidential service, more can be found out at www.amparo.org.uk.

The legal duty of candour applies to 'notifiable' patient safety incidents that are unexpected/unintended, occurred during the provision of care and the incident has directly resulted in moderate harm, severe harm or death (regardless of any omissions or concerns about the care provided). We will always aim to be open and honest with patients/families when an incident occurs, supporting any immediate actions and identifying any learning going forward. The duty of candour should be carried out by a member of the clinical team, with the initial verbal contact to be completed within 10 working days of the incident. This is the first opportunity to offer a patient/family support. See the Duty of Candour Policy (CORP24) for more details and help with undertaking this role.

11. Management of Actions

If a Coroner issues a Regulation 28 Prevent Future Deaths (PFD) report to the organisation the development of an action plan is led by the legal team with the agreed actions added to Ulysses for central monitoring, in the same way as for incident learning huddles and PSIRP reviews. For more details see the Coroners PFD Notices protocol.

The actions from PSIRP cases, incident learning huddles and PFD reports are added onto Ulysses for central monitoring, this is completed by the Quality and Risk Team within 7 working days of the action plan being signed off. Action leads are sent automatic reminders about actions by the system. The progress with actions is reported weekly with monitoring by the central Patient Safety Team and oversight by the Trust's Regulatory Action Monitoring Group. The evidence of closure of actions is held on Ulysses and audited on a monthly basis.

12. Summary of how we report, respond and learn from incidents

Reporting an incident/death on Ulysses creates an opportunity to understand and learn from what happened, offer support and look at how we can improve patient care and staff safety.

Every incident/death reported on Ulysses is automatically sent by an email 'notification' to the relevant team/ward manager, relevant subject experts, senior clinicians and managers on the day reported. Every incident is also reviewed by a member of the Quality and Risk Team. Where there is moderate harm or above, or significant potential for learning, the incidents are also sent to the patient safety team and reviewed in a series of weekly patient and staff safety forums at a clinical directorate level and Trust-wide level to follow up support and actions required.

A weekly Trust-wide forum (called the Clinical Standards Weekly Review Meeting) focuses on patient and staff safety, bringing together a range of data and softer intelligence including incidents, incident learning huddle outcomes, Patient Safety Incident Response Plan (PSIRP) cases and outcomes, use of restrictive practice, complaints, Coroner inquest findings, staff

injuries and HR casework - to identify themes and immediate actions. This forum reports weekly into the Executive Team. We review the themes and learning from completed PSIRP reviews and incident learning huddles on a monthly basis through the Trust's Quality and Clinical Governance Group chaired by the Chief Nurse or Chief Medical Officer as well as continuing to look for trends across all incidents and deaths on a quarterly basis to help identify emerging themes.

We use incident learning huddles to understand more about incidents/deaths, to ensure support is in place for those affected, to identify immediate learning and to clarify if incidents require further review as detailed in the PSIRP or if there is a new emerging issue/risk.

The key findings and areas for improvement for each PSIRP review are shared with those affected by the incident/death to check factual accuracy, scrutinised by senior clinicians from the relevant clinical directorate, and then finally signed off by a Trust panel involving the Executive Directors, Chief Nurse and Chief Medical Officer or deputies as agreed. Any areas of good practice and areas identified for improvement are widely shared across the Trust using different approaches to spread the learning as far as possible. We also share themes with regional forums such as the Buckinghamshire, Oxfordshire and Berkshire West (BOB) patient safety and improvement forum and also the learning from deaths network.

Monthly summaries of significant learning from incidents/deaths are shared and posted on the intranet here [learning from incident summaries](#). There are also regular patient safety webinars open to all staff on improvement themes, these are recorded and available to watch back - [patient safety webinars](#), and learning is fed into mandatory training.

The Trust uses the circulation of risk notes to highlight learning from a significant risk, safety issue or a collection of incidents around a similar theme. These may be patient or non-patient related. A risk note highlights the learning, any related policy or procedural documentation and gives advice to staff about changing practice. These notes are communicated Trust-wide with the expectation that they are discussed in team meetings for relevant services. All risk notes are saved on the intranet here [Patient Safety - Risk notes - All Documents](#).

We also take action from learning external to the Trust through learning shared at regional and national forums and through patient safety alerts distributed via the national central alerting system, see Policy RMHS23 for more details about the management of national patient safety alerts.

Below is a diagram summarising how the reporting, review (learning response) and learning processes work in the management of patient incidents and deaths.



13. Roles and Responsibilities

This section describes the specific responsibilities of key individuals under this policy.

- **Chief Executive** has overall responsibility for implementing this policy.
- The **Non-Executive Director** that chairs the Trust's Quality Committee takes an independent oversight on implementing the Patient Safety Incident Response Framework (PSIRF) and the Learning from Deaths agendas, ensuring processes and reporting lines are robust and transparent, and championing quality improvement that leads to actions to improve patient safety.
- **Chief Medical Officer and Chief Nurse** are the Executive Directors that lead on the quality of care provided including patient safety, learning from deaths and quality improvements. They lead on embedding our culture as a compassionate, open and learning organisation. The detail of overseeing the implementation of the policy is delegated from the Chief Executive.
- **Heads of Service, Associate Directors of Nursing and Clinical Directors** ensure their Directorate processes are aligned with the Policy, support teams to carry out the expectations and requirements of the policy. Supported by the Directorate quality governance teams.
- **Head of Patient Safety** supported by the central **Patient Safety Team** is responsible for the processes and support in place to enable the policy to be implemented, including managing the local incident management system, Ulysses, and overseeing compliance with the national requirements of the PSIRF and Learning from Deaths agenda.
- **All staff** are responsible for ensuring the immediate safety of patients, their families, other patients, colleagues and the environment following an incident or death. Staff need to report on Ulysses all patient incidents, staff incidents involving harm/injury and deaths as described in the mortality review guidance. Reporting should happen timely to enable support and actions to be taken. Clinical staff are also responsible for screening patient deaths as per the mortality review guidance.

14. Training

All staff receive information about the local incident reporting system and requirements at corporate induction, with more detailed training at their local induction supported by the Quality and Risk Team and guidance documents. There are lots of resources available on the intranet to support staff.

The patient safety team provide recorded and live training sessions on a range of subject areas to support this policy, including training for managers/deputies and for staff who understand reviews/investigations.

For help with reporting an incident/death on Ulysses contact the Quality and Risk Team on 01865 902351 and for support managing/responding to an incident contact the Patient Safety Team on patient.safety@oxfordhealth.nhs.uk.

15. Monitoring of the Policy

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

Criteria	Measurement	Lead	Frequency	Reported to
Incident surveillance and learning	<p>i) Quarterly analysis of patient and staff related incidents reported including themes/patterns over time, changes to the incident system Ulysses, timeliness between incident/death and date reported on Ulysses and timeliness between incident reported and reviewed by manager.</p> <p>ii) Quarterly analysis of national patient safety alerts</p>	Head of Patient Safety	Quarterly	<p>i) Incident analysis report to the Quality and Clinical Governance Group</p> <p>ii) National patient safety alerts report to the Quality and Clinical Governance Group</p>
Compliance with PSIRF (including deaths under the PSIRP)	Oversight and reporting of processes and impact from implementing PSIRF standards. Specific measures to be set each year. Reporting on the actions and learning identified.	Head of Patient Safety	Monthly	PSI report to the Quality and Clinical Governance Group
Learning from Deaths	Analysis of deaths and learning.	Head of Patient Safety	Quarterly	Report to the Mortality Review Group and then the Quality Committee

Appendix 1. 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 through 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 in their care to report crime.

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

Procedure for involving the police

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. 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 will 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.

Equality Analysis (EqA) Screening Form

Protected Characteristic	Positive Impact	Neutral Impact	Negative Impact	Comments/Evidence
Age		√		
Disability		√		
Sex/Gender		√		
Race/Ethnicity		√		
All Faiths & None		√		
Sexual Orientation		√		
Transgender		√		
Pregnancy & Maternity		√		
Marriage & Civil Partnership		√		

Completed by:-

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Date: 2nd December 2024