Avon and Wiltshire Mental Health Partnership NHS Trust

Document Information

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5.2	22 June 2018	Extended to end June 2019 We are confident the policy includes the required information, we are currently developing a number of different ways of working and when these have been fully developed we will review and amend the policy and guidance as required	Associate Director of Governance	Approved
5.2	Dec 2018	Amendment made to ensure that when a safeguarding referral is made, an incident form must also be completed.	Associate Director of Nursing	Approved

5.3	July 2019	Extended until 31 October 2019	Head of Patient Safety	Approved
5.4	November 2019	Extended until end January 2020	Medical Director	Approved

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1. Introduction

Avon and Wiltshire Partnership Mental Health NHS Trust (AWP) are committed to ensuring the safety of service users, staff, visitors and contractors alike.

The reporting, management and investigation of adverse incidents are fundamental elements of risk management. Sharing the learning about adverse incidents (including near misses) enables the organisation to implement changes to practice, processes and systems so that the risk of harm is reduced. In addition to the human costs, if incidents are not properly managed, they may result in a loss of public confidence in the organisation and a loss of assets.

Reporting of incidents is more likely to take place in an organisation where there is a well-developed safety culture and strong leadership. The Trust Board have made their support for safety transparent by their actions, and will not strive to achieve other objectives at the expense of safety.

2. Background

Effective risk management has always required the reporting and learning from adverse incidents but the focus on adverse incidents in healthcare arguably has its origins in the publication of the report 'Organisation with a Memory' (DH, 2000). This reviewed the international evidence on safety within and outside healthcare settings and concluded that failures in healthcare could be avoided if organisations were able to properly learn the lessons of experience. They highlighted two key issues:

- The potential for error in healthcare systems is a significant and serious challenge that needs concerted effort to manage.

- The best way of improving reporting and reducing error rates is to focus on and target systems failures rather than taking action against individual staff.

The National Patient Safety Agency (NPSA) subsequently outlined the expectations on healthcare organisations in respect of patient safety in their publication "Seven Steps to Patient Safety" (NPSA, 2004) and in 2010 the Department of Health issued a new national reporting framework for the management of serious untoward incidents. More recently, the Francis Report (2013) has led to the introduction of a 'duty of candour' within the NHS. This policy embraces all of these requirements. Additionally there are many other external agencies, not least the Health and Safety Executive, which require organisations to have robust incident management processes in place and, in certain circumstances, to be notified of specific incidents.

This policy is an underpinning document to the Trust's Risk Management Strategy and other key related documentation is:

- Risk Assessment Policy
- Complaints, Compliments, Concerns and Comments Policy
- Claims Policy
- Being Open Policy
- Employee Disclosure Policy (whistle-blowing)

3. Policy Statement

The Trust is striving to have a positive reporting culture throughout the organisation and will manage and investigate incidents when they occur in accordance with national best practice. The Trust is a learning organisation and will endeavour to learn from incidents when they occur and make changes to practice to improve safety.

4. Purpose

The purpose of this policy is to:

- State the strategic direction and principles adopted by the Trust in relation to the communication, reporting, management and investigation of adverse incidents and near misses; the sharing of learning from these incidents and the implementation of the recommendations that arise.
- Define incidents and near misses and understand their severity in terms of impact and then communicate clearly the corresponding level of investigation required
- Provide clear procedures to staff on how to communicate report, manage, investigate and learn from adverse incidents and near misses.
- Provide clear guidance to staff on how to support service users, families, colleagues and others when an adverse incident occurs
- Support a fair blame approach to the management of incidents so that the Trust is consistent and proportionate in its response.
- Ensure timely reporting of incidents to other agencies as appropriate (for example, the Clinical Commissioning Groups (CCGs); the Local Area Teams (LATs); NHS England; the Health and Safety Executive (HSE); the National Reporting and Learning Service (NRLS); NHS Protect and the Care Quality Commission (CQC), etc.
- Support a consistent and timely approach to facilitate external scrutiny of the most serious adverse incidents (for example, by Her Majesty's Coroner and NHS England commissioned inquiries)

5. Objectives and Outcomes

The objectives are to:

- Optimise reporting of all safeguarding referrals, adverse incidents and near misses in a timely fashion
- Ensure that adverse incidents (particularly serious incidents) are managed appropriately and that staff, service users and others are supported throughout and subsequently
- Ensure that the AWP 'Being Open Policy is applied to the management of adverse incidents

- Ensure that investigations are undertaken at a level commensurate with the seriousness of the incident and in a timely fashion

- Ensure that reporting to external organisations is undertaken in a timely fashion and, where multiple investigations are being undertaken simultaneously, these processes are co-ordinated

- Ensure that, through thorough investigation, lessons learned are shared and recommendations are identified

- Ensure that information on adverse incidents is collated and analysed, so that themes and trends are identified to inform learning

6. Scope

This policy applies to all staff (including all temporary staff, volunteers and contractors as well as those in paid substantive posts) and relates to all incidents involving service users, staff and others.

7. Definitions

7.1. Adverse (or untoward) Incident

The Trust has adopted the definition of an adverse incident originally identified by the NPSA:

"Any event or circumstance leading to unintentional harm or suffering" (NPSA, 2007).

The Trust web-reporting system enables staff to select from a list of the most common types of adverse incidents and, although this is not exhaustive, it acts as a list of events that should be reported as an adverse incident.

An adverse incident is sometimes referred to as an untoward incident.

There are a number of specific types of adverse incidents which are defined as follows

7.1.1. Serious adverse Incident

This is defined as any event or circumstance arising that led to serious unintended or unexpected harm, loss or damage

Essentially serious adverse incidents are those which cause the most harm either to individuals (staff, service users, visitors, contractors, others) or to the organisation. The Trust has developed a 'serious untoward incident classification' (appendix B8) and this defines those incidents which are considered to be serious.

The organisation would expect serious adverse incidents to be graded 'red' on the risk ranking matrix on the incident form.

7.1.2. Major Incident

This is a serious adverse incident which is also likely to produce significant legal, media or other interest which, if not properly managed, may result in loss of the Trust's reputation or assets. Such an incident is likely to require co-ordination with other agencies to resolve. A strike, loss of water or power, are examples of incidents that are likely to be classed as major incidents.

In the case of a major incident, staff should refer to the Major Incident Plan as the definitive document.

7.1.3. Patient Safety Incident (Clinical Incident)

The NPSA provided a specific definition for a patient safety incident which the Trust has adopted. This is defined specifically as "any unintended or unexpected incident which could have or did lead to harm for one or more patients receiving healthcare. It is a specific type of adverse event." (NPSA, 2007)

7.1.4. Staff Incident

The Trust defines this as "any unintended or unexpected incident which could have or did lead to harm for one or more staff members during the course of their duties"

7.1.5. Non-person incident

This is any adverse incident that does not involve known individuals, e.g., burglary of Trust premises, IT systems failure.

7.1.6. Near Miss

This is an unplanned or unexpected event, clinical or non clinical, which has the potential to result in injury, damage, etc., but which does not realise its full potential for harm. There are two types of near miss:

Prevented incidents – which are those incidents where something goes wrong, but it does not cause any harm because an individual or system acts to prevent this:

e.g. a service user is given a prescription for the wrong dose of a medication, but the error is noticed and corrected by the pharmacist.

No harm incidents – which are those incidents where something goes wrong, but by chance it does not cause any harm:

e.g. a pharmacist supplies a service user with the wrong medication, but the service user suffers no ill-effects from this.

7.1.7.Hazard

This is defined as a situation that poses a level of threat to life, health, property, or the environment

7.1.8. Likelihood

This is defined as the chance of something happening or the degree of probability.

7.1.9. Impact

This is an assessment of the consequences of the incident or the potential consequences of a near miss.

7.1.10. Harm

This is defined as something that causes physical or psychological/emotional damage or injury or death to a person. Harm may also be caused to property or equipment either through damage sustained or loss.

7.1.11 Safeguarding Referral

A safeguarding referral includes all alerts or concerns where a member of staff has notified the local Authority of a protection concern relating to a child or adult at risk. Domestic Abuse, MAPPA, PREVENT and Modern Slavery, Human Trafficking referrals are also considered to be a safeguarding referral.

7.2. Risk Rating

"The probability that a specific adverse event will occur in a specific time period or as a result of a specific situation. Risk is the combination of likelihood and consequence of a hazard being realised. A clinical risk or healthcare risk is the chance of an adverse outcome resulting from clinical investigation, treatment or patient care." (NPSA, 2007)

The Trust uses four colour grades:

7.2.1. ***Red Incident -*** All serious adverse incidents are red incidents**.**

7.2.2. Orange Incident - These are usually moderate in severity

7.2.3. Yellow Incident - These are usually minor in severity

7.2.4. ***Green Incident -*** These are usually incidents that cause no harm.

7.3. Risk Reduction

This is defined as the measure taken to minimise or reduce the impact of an identified hazard or event.

7.4. Causal Factors

This is defined as acts or omissions that contributed to an adverse event occurring

7.5. Investigation

An investigation is defined as a formal examination or enquiry into something.

7.6. Root Cause Analysis (RCA)

This is a process of investigation in which details of the whole pathway leading to the incident are recounted in order to highlight the problem areas and to devise controls or solutions to them. Any issues that may involve individual fault are removed from this exercise at the beginning and dealt with on a one to one basis alongside this process

7.7. STEIS

STEIS (Strategic Electronic Information System) is the system by which the Trust notifies the Clinical Commissioning Groups; Local Area Teams and NHS England of serious untoward incidents.

7.8. National Reporting and Learning System (NRLS)

The NRLS is the system to which the Trust sends all details of its patient safety incidents via an electronic link. The Trust receives reports on data from this system and is able to benchmark its incidents with similar Trusts.

7.9. Security Incident Reporting System (SIRS)

SIRS is the system through which the Trust sends all details of security incidents to NHS Protect. This includes physical assaults against staff, non-physical assaults against staff, and burglary, theft and criminal damage to NHS (and staff or service user's) property.

7.10.Fair Blame

This is a term that is often used in conjunction with incident reporting and reflects the NRLS drive to help the NHS move away from asking “Who was to blame?” to “Why did the individual act in this way?”

It is clear from international research and local experience that the majority of incidents are caused by organisational systems failure, rather than the failure of an individual.

It is impossible to completely remove the possibility that the fault may lie with an individual but this policy makes it clear that an event will be properly analysed before the organisation concludes what caused it to occur. At times it may be prudent to re-assign staff to other duties or exclude them until the investigation is concluded.

There may be occasions when it is necessary to attach blame to a member of staff where there has been an act of maliciousness, criminal or gross/repeated professional misconduct.

8. Responsibilities

Trust expectations of individual members of staff are included in the procedures attached as appendices. These describe the roles of staff (at all levels of the organisation) with regard to reporting, managing and investigating adverse incidents; cooperating with external investigations and sharing learning and implementing recommendations.

Corporate responsibilities are as follows:

8.1. Trust Board

The Trust Board has ultimate responsibility for risk management. It is responsible for engendering through their leadership the development of a strong safety and fair blame culture.

8.2. Chief Executive

The Chief Executive is ultimately responsible for ensuring that the necessary resources and systems are in place to provide for the effective management of and learning from adverse incidents.

8.3. Executive Management Team

The Executive Management Team is responsible for ensuring that appropriate systems are in place to respond in a timely manner to adverse incidents, to ensure that the appropriate level of investigation takes place and to ensure that controls are implemented as quickly as possible. The lead director for incident management is the Director of Nursing and Quality.

8.4. Head of Patient Safety Systems

The Head of Patient Safety Systems is responsible for maintaining a central electronic record of all incidents; providing reports which highlight trends; offering support and advice regarding the processes of reporting, managing and investigating incidents; linking with external investigations; and co-operating with the processes for sharing learning and implementing recommendations.

8.5. Clinical Directors

Clinical Directors are responsible for:

- Ensuring that the corporate systems for managing and investigating incidents are cascaded and implemented within their areas and that all staff are aware of their roles and responsibilities
- Overseeing the implementation of this policy in relation to incidents
- Providing a senior clinical contribution to the investigation and management of clinical incidents
- Approving investigation reports
- Ensuring lessons are learned from incidents and changes to practice are made.

8.6. All Managers

All managers are responsible for ensuring that all staff and relevant contractors are familiar with this policy. They are responsible for ensuring that staff are appropriately supported following an adverse incident and through any complaint or judicial process that may follow on thereafter.

8.7. All Staff

Every member of staff is responsible for reporting an adverse incident or near miss when it occurs and adhering to the requirements of this policy.

Where staff have raised a Safeguarding Referral (including adults, children, domestic violence, MAPPA and PREVENT) , an incident form must also be completed.

8.8. Quality and Standards Committee

This Board reporting committee is responsible for receiving reports on incident activity and learning to provide assurance to the Trust Board.

8.9. Critical Incident Overview Group

The Critical Incident Overview Group is responsible for developing strategies and plans to encourage the reporting of adverse incidents and the development of a positive safety culture and for monitoring the implementation of this policy. It reports to the Executive Management Team, though has the authority to report directly to Board,

when circumstances dictate. This Group is responsible for directing the management and learning from the Trust's most serious incidents.

8.10. Local and Specialist Governance Groups

Each Delivery Unit has an integrated governance group. These groups have responsibility for reviewing incident data and incident reports alongside other patient experience data and disseminating learning throughout their service. They are responsible for monitoring the implementation of action plans arising from serious untoward incident investigations.

9. Communication

Communication with those affected by an incident should occur as soon as possible. Reference should be made to the Being Open Policyto describe how this should be approached.

Staff should communicate that an incident has occurred by completing an adverse incident form as described in the reporting section. In the event of the incident being graded as red, there are further communication processes that apply, as follows:

A1: **Communication Flowchart -** This flowchart shows the communication triggers in the event of a serious incident and shows the timescales by which details of a red incident are communicated to appropriate members of the executive management team and communications. This document is relevant to all managers. This document forms Appendix A1.

A3: **Structure for Communicating Information -**This is a guidance sheet which describes what information should be known and communicated by required timescales. This document forms Appendix A3

A4 **On-call Record Book** – this is the book used by Directors to record the communication between the on-call Director; the Operations Director and external partners and stakeholders. This book is relevant to all Directors and is independent of this policy.

A5: **Communications (Media)** – processes exist within the Trust's Communication department to alert the Communications Teams for all relevant external stakeholders to serious incidents and to handle media enquiries. These procedures are independent of this policy.

A6: **NHS England Serious Incident Framework March 2013** - this document describes external reporting requirements of NHS England and the mechanisms by which details of serious incidents are sent electronically to them. This document is relevant to the Nursing and Quality Directorate and can be accessed here.

10. Incident Reporting

The Trust takes a comprehensive approach to incident reporting and reference should be made to the following documents:

B1: **Adverse Incident Reporting Procedure -**This procedure describes how incidents should be reported in the Trust and can be found as Appendix B1.

B2: **External Agency Reporting -** This is a table describing the external agencies that need to be notified of certain incident types, the required timescales and the responsible individuals for leading that reporting. This table can be found as Appendix B2 in this policy.

B3: **Incident Risk Matrix - This** is a matrix showing how incidents should be assessed for impact and likelihood of recurrence. This matrix can be found as Appendix B3 in this policy.

B6: **Riddor Report Form** **-** This is an electronic form that needs to be completed in addition to the incident report form for any incident that managers suspect may meet the criteria for reporting to the Health and Safety Executive (HSE). These forms are sent to the Head of Health and Safety who will decide whether the incident is Riddor reportable and take responsibility for external reporting to the HSE.

B7: **Guidance regarding Riddor Incidents** **-** This is guidance that describes the classification of incidents reportable to the Health and Safety Executive.

B8: **Serious Untoward Incident Classification -** This document identifies the incidents that are considered serious and should be graded as 'red'. This can be found as Appendix B8.

B9: **Classification of Incidents Where Someone Dies -** This document identifies the circumstances in which a person may die and specifies the reporting and investigation requirements for each of these. This can be found as Appendix B9.

B10 Safeguarding - full guidance is located on Ourspace

11. Incident Management Procedures

The Trust endeavors to ensure a timely, appropriate response and effective management of incidents and reference should be made to the following documents:

C1: **Incident Management Procedure -** This procedure describes how incidents should be managed and the differing responsibilities of individuals and can be found as Appendix C1

C2: **Guidance on Supporting Staff following an Unexpected Death; Serious Incident; Complaint or a Claim by a service user -** This is guidance for managers on supporting staff that is relevant not only to incident management but also unexpected deaths, complaints and claims. This guidance can be found as Appendix C2:

C3: **Procedure for staff on supporting service users and families following a serious untoward incident -** This procedure for managers and staff describes how to best support service users and families following a serious untoward incident. This procedure can be found as Appendix C3.

C4: **Guidance for staff on assisting the Coroner -** This is guidance for managers and staff on how to prepare reports for the Coroner and to prepare them for giving evidence in an Inquest setting. This guidance can be found as Appendix C4

C6: **Memorandum of Understanding with the Police**

The overarching document which outlines the working relationships between police and healthcare organization can be accessed here. This provides a broad framework that will be supported by locally agreed working arrangements.

C8: **Guidance on Appearing as a Witness in Court**

This provides information to support staff when they are required to give evidence as a witness in court and is available as Appendix C8 .

C9: **Guidance on Working with Families Following a Homicide -** This is guidance for managers on how to support and work with the families of both perpetrators and victims of homicides and is available as Appendix C9

C10: **Advice on how to construct a witness statement -** This provides guidance for staff involved in a red-graded/serious incident on how to write the witness statement that they will need to do. It is available as Appendix C10

C11: **Procedure for Dealing with Independent Inquiries**

This procedure describes how the Trust will work with independent inquiries. It is available as appendix C11.

C12: **Procedure for Dealing with Domestic Homicide Reviews (DHRs)**

This procedure describes how the Trust will work with DHR inquiries. It is available as appendix C12.

C13: **Procedure for Dealing with Serious Case Reviews (SCRs)**

This procedure describes how the Trust will work with SCR inquiries. It is available as appendix C13.

12. Incident Investigation Procedures

The Trust has thorough arrangements for incident investigation and reference should be made to the following documentation:

D1: **Incident Investigation Procedure -** his procedure describes a consistent and timely approach to the investigation of adverse incidents and near misses, where the degree of scrutiny is based on the severity of the incident and can be found as Appendix D1

D4: **Guidance for managers conducting Staff Interviews -**This guidance provides advice for managers when conducting staff interviews and is available as Appendix D4

D8: **Template for a Management Report for a Medication Incident including guidance for completion -**This is the template for Medication Error Management Reports and is available as Appendix D8.

D12: **Guidance on Conducting a Root Cause Analysis Investigation** - This document provides guidance on conducting a Root Cause Analysis and is available as Appendix D12.

D13: **Template for a Root Cause Analysis Investigation** - This is the template for Root Cause Analysis reports and is available as Appendix D13:

D.16: Template for a 72 hour Red Management Report including guidance on completion - This is the template for 72 hours management reports and is available as Appendix D16

D.17: Template for an Optional Management Report including guidance on completion. - This is the template for optional management reports and is available as Appendix D17

D18 **Template for a combined management report and Concise Root Cause Analysis (RCA) Report: Falls -** This is the template for the combined management report and RCA template for serious falls and is available as Appendix D18.

D19: **The Supervising Reviewer's Checklist -**This provides guidance for supervising reviewers (senior staff who support RCA chairs by reviewing the RCA report before it is finalized) and is available as Appendix D19

D20: **The joint protocol for the management of investigations regarding serious incidents concerning patients nursed at the University Hospitals Bristol NHS Foundation Trust and care coordinated by Avon and Wiltshire Partnership NHS Trust. -** This is the protocol that guides joint investigations with UBHT and is available as Appendix D20

D21: **The joint protocol for the management of investigations regarding serious incidents concerning patients nursed at the Royal United Hospital Bath NHS Trust and care coordinated by Avon and Wiltshire Partnership NHS Trust. -** This is the protocol that guides joint investigations with the RUH and is available as Appendix D21

D22: **Template for multi-incident Root Cause Analysis investigations for falls. -** This is the template for multi incident RCA investigation reports for serious falls and is available - Withdrawn from use

D23: **Joint Protocol for the management of investigations regarding serious untoward incidents concerning service users who are under the care of both Bristol City Council Health and Social Care Service and Avon and Wiltshire Partnership NHS Trust** - This is the protocol that guides joint investigations with Bristol Social Services and is available as Appendix D23

D24: **Joint Protocol for the management of investigations regarding serious untoward incidents concerning service users who are under the care of both Great Western Hospitals NHS Foundation Trust and Avon and Wiltshire Partnership NHS Trust** - This is the protocol that guides joint investigations with the Great Western Hospital and is available as Appendix D24

13. Learning and Responding Procedures

The Trust endeavors to learn from adverse incidents and make changes to practice where indicated. Reference should be made to the following documents:

E1: **Procedure for Learning and Responding to adverse incidents** - This procedure describes how the organization will learn from incidents and communicate this learning and is available as Appendix E1

14. Raising Concerns – Whistle Blowing

14.1. The Trust supports a culture of fair blame because it is the most effective way of encouraging reporting so that lessons may be learned and controls put in place. Research has shown that with many incidents the system rather than the individual is to blame.

14.2. Exceptional cases will arise where there is clear evidence of wilful or gross neglect or where there is repeated evidence of poor performance despite interventional support. In these cases appropriate managerial action will be undertaken.

14.3. All employees must be familiar with the trust policy for raising concerns that is available on the intranet. Whistle Blowing Policy

15. Training

The Trust's overarching policy for training is the Learning and Development Policy and this should be read in conjunction with this policy. These matrices describe the

minimum statutory, mandatory and required training for all staff groups in respect of incident management including investigations and can be found here.

Learning and Development Policy also describes the Trust's arrangements for training, in particular how there are processes in place to ensure staff receive the training they require and how non-attendance is followed up. These arrangements are further supported by management supervision and appraisal processes.

The Trust lead for incident management has agreed the training standard with the Learning and Development Team and training standards have been informed by statutory requirements, professional standards and national best practice.

The Trust lead for incident management participates in a programme of continuous professional development to ensure they remain up to date and keep abreast of developments in this field.

16. Monitoring and Audit

This policy will be reviewed after three years or earlier if indicated. Compliance with the policy will be monitored through a variety of different mechanisms as follows:-

The Trust reports on the efficacy of its incident reporting and management arrangements through bi-annual reports to the Quality and Standards Committee.

The Trust benchmarks its reporting performance with other mental health trusts through consideration of the patient safety reports issued by the National Reporting and Learning Service. Details of this analysis are included within the reports to Board.

The Trust reports on the timeliness of its reporting and investigating via performance monitoring with its commissioners.

The Trust has quality control processes so that all red incident investigation reports are reviewed by an independent manager.

Periodically the Trust's incident management arrangements are audited by external agencies, e.g. NHS Protect.

The effectiveness of incident- related training is evaluated routinely.

An annual report is provided to the Board on the Trust's incident management arrangements.

Additionally committees and groups will review and consider incident data, themes and trends that relate to their terms of reference.

17. Legislation and Evidence Base

The Trust has a duty of care to its service users and the processes of reporting, managing and investigating adverse incidents supports the organisation in meeting this duty.

This policy is also part of the AWP response to The Health and Safety at Work Act 1974, which requires employers to assess the risks to the health and safety of employees and others arising from the work of the organisation (Great Britain, 1974).

The reporting of adverse incidents is one of the ways in which risks to the Trust's employees and others are identified.

18. Standards

This policy is governed by the outcome measures publicised by the Care Quality Commission, and is also informed by their reporting requirements.

The policy takes account of the risk management standards issued by the NHSLA's Clinical Negligence Scheme for Trusts and well as the standards required by the National Reporting and Learning Service and the Department of Health.

The policy is cognisant of statutory obligations such as those laid out by the Health and Safety Executive and NHS Protect.

19. References

- Department of Health (2000) An organisation with a memory.
- [Department of Health (2001) Safety First: Five-year report of the National Confidential Inquiry into Suicide and Homicide by People with Mental Illness [online]
- Department of Health (2006) Standards for Better Health
- Great Britain (1974) Health and Safety at Work etc Act [online]. London: HMSO.
- Great Britain (2000) Race Relations (Amendment) Act [online]. London: HMSO
- Great Britain (2006) Disability Discrimination Act [online]. London: HMSO.
- NHS Litigation Authority (updated) Policy templates: Policy for the management of incidents (online). Available at NHSLA Publications, General Templates, Standard two
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- The Mid Staffordshire NHS Foundation Trust : Public Inquiry – Chaired by Robert Francis QC (2013) [online].