

Serious Incident Investigation and Learning Procedure

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SERIOUS CLINICAL INCIDENT

Incident occurs - make safe where possible

H & S Manager informs medical director or associate medical director

Medical Director informs the Chief Executive of serious incident

Service Manager to complete the 3 day report

Medical Director or AMD will meet with relevant clinical directors, team managers and clinicians directly involved once confirmed as serious incident & that duty of candour has been actioned

Patient Safety Officer will add the incident to STEIS within 48 hours

Patient Safety Officer to send the 3 day report to the commissioners

If after the 3 day report the incident is graded as non-serious, Patient Safety Officer will request de-escalation on STEIS and inform appropriate staff

Confirmed SIs will then have a full investigation with key staff

Recommendations & action plans will be drawn up within 45 working days and added to action log and the Clinical Governance & Quality Manager will ensure recommendations are implemented on time

Executive sign off (on front page) by Medical Director or CEO

Patient Safety Officer will add agreed recommendations and lessons learnt to STEIS by 60 working days

Clinical Governance & Quality Manager will email final report via nhs.net to commissioners by 60 working days

Medical Director to arrange sharing of lessons learnt

NON SERIOUS CLINICAL AND NON-CLINICAL INCIDENT

Incident occurs – make safe where possible

H&S Manager informs Medical Director or AMD and Clinical Director to request confirmation of incident status

Once confirmed non-SI an action plan is produced and managed locally by relevant clinical staff

SERIOUS NON CLINICAL INCIDENT: E.G: IG OR DATA INCIDENT

Health & Safety Manager informs T&T Director or Associate Director Quality & Governance of incident

Service Manager to complete the 3 day report

Health & Safety Manager will add the incident to STEIS within 48 hours and Director of T&T will inform ICO

Director of T&T confirms status & that duty of candour has been actioned and inform the Health & Safety Manager

Health & Safety Manager to inform Associate Director of Quality and Governance and H & S Manager of the 3 day report to be sent to the commissioners

If after the 3 day report the incident is graded as non-serious, Health & Safety Manager will request de-escalation on STEIS and inform Associate Director of Quality and Governance

Director of T&T or Associate Director Quality & Governance will meet with whoever reported the incident, the informatics and it managers and arrange an SI investigation

Recommendations & action plans will be drawn up within 45 working days

The Health & Safety Manager will add the action plan to the SI action log and the Director T&T will ensure actions are implemented on time

Executive sign off (on front page) by director of T&T or CEO & report to ICO

Health & Safety Manager will add agreed recommendations and lessons learnt to STEIS by 60 working days

Associate Director Of Quality & Governance will email final report via nhs.net to commissioners by 60 working days

Director of T&T to arrange sharing of lessons learnt

Serious Incident Investigation and Learning Procedure

1 Introduction

The 2017 revision of the Serious Incident Investigation and Learning Procedure seeks to respond to recent developments both within the organisation and externally to ensure that there are responsive processes in place to help the Trust's workforce manage, report and investigate serious incidents, so that lessons can be learnt and changes made which improve safety for all.

Serious incidents in healthcare are rare and as the Trust provides outpatient care and treatment only, it experiences a lower level of risk of incidents than in mental health trusts with in-patient facilities. However, a good organisation will recognise harm and the potential for harm and undertake swift, thoughtful and practical action in response.

The Trust uses a Structured Investigation methodology (incorporating Root Cause Analysis tools and techniques) to investigate serious incidents and this procedure sets out how the Trust will provide an effective response to serious incidents which may have put patients, staff, students and members of the public, or the Trust itself at risk. The reporting, investigating and learning from serious incidents is a key part of the Trust's Risk Management Strategy.

The Trust believes that staff, service users, their relatives and carers should, where appropriate, be given the opportunity to critically review incidents that have arisen and investigations that are undertaken after an incident within a culture of learning and openness in order for the Trust to learn and improve the way care is organised and delivered.

2 Purpose

The procedure is based on NHS England's Serious Incident Framework (March 2015) and aims to standardise the way serious incidents are managed to ensure:

- The effective management of the serious incident;
- A thorough and fair investigation of the circumstances which gave rise to the incident, is carried out;
- That the investigation is followed up by measures to avoid or minimize the risk of a repetition of any such incident in the future including sharing lessons learnt;
- That full and detailed records are kept of the incident and the investigation process;
- That associated monitoring arrangements are met.

Primary Purpose of an Investigation under this Procedure

The primary purpose of an investigation conducted under this procedure is to seek to understand the reasons why a serious incident occurred, and, in particular, to seek to identify weakness and processes operating within the system that contributed to the incident.

The investigation will be done without legal advice and is not intended to apportion blame or determine liability and it is not intended that an investigation under this procedure will constitute a completed investigation for legal purposes.

Should a claim arise following an incident the Trust may refer the matter to the NHS Litigation Authority (NHSLA) and appointed lawyers for legal investigation, which may involve the preparation of formal witness statements prepared with legal advice, and the commissioning of independent expert advice.

3 Scope

This procedure applies to all serious incidents requiring investigation whether identified via incident reporting, through a complaint or a claim for compensation. See definition section below.

‘Fair Blame Statement’

The Trust is committed to taking an integrated approach to learning from incidents of all types in order to improve and assure its services. The Trust recognises that such learning can only take place in a non-threatening environment and that fear of disciplinary action may deter staff from reporting an incident.

The Chief Executive has confirmed that no disciplinary action will result from reported incidents or mistakes subject to certain exceptions:

- incidents that warrant police investigation of individual members of staff
- incidents that reveal that actions of an individual are judged to be far removed from acceptable practice, and, thereby, having put patients at risk
- repeated failure by a member of staff to report incidents
- malicious use of the reporting system.

4 Key Definitions

Serious Incident requiring investigation (SIRI)

This term is used interchangeably with Serious Incident (SI) and Serious Untoward Incident (SUI). For the purposes of this document we refer to ‘SIs’ and ‘serious incidents’. There is no definitive list of events / incidents that constitute a serious incident. Every potential serious incident must be considered on a case-by-case basis using the description below.

A serious incident requiring investigation is defined as an incident that occurred in relation to NHS funded services with acts or omissions in care resulting in one of the following:

- unexpected or avoidable death of one or more people. This includes
 - suicide / self- inflicted death; and
 - homicide by a person in receipt of mental health within the recent past;¹
- unexpected or avoidable injury to one or more people that has resulted in serious harm²;

¹ defined as being in receipt of care within the last 6 months

- actual or alleged abuse, including abuse that results in, or was identified through a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation;
- a 'Never Event' –wholly preventable patient safety incidents that have the potential to cause serious patient harm or death, have occurred in the past and are easily recognised and clearly defined³ ;
- 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: data loss and/or information governance related issues, property damage, security breach/concern, inappropriate enforcement / care under the NHS (1983) and Mental Capacity Act (2005);systematic failure to provide an acceptable standard of safe care; incidents in population programmes like screening and immunisation where harm potentially may extend to a large population; or activation of Major Incident Plan;
- Major loss of confidence in the service/ prolonged adverse media coverage or public concern about the quality of healthcare or an organisation.

Can a 'near miss' be a serious incident?

Yes it can. The outcome of an incident does not always reflect the potential severity of harm that could be caused should the incident (or similar incident) occur again. Deciding whether or not a 'near miss' should be classified as a serious incident should be based on assessment of risk that considers:

- The likelihood of the incident occurring again if the current systems / process remain unchanged; and
- The potential for harm to staff, patients, and the organisation should the incident occur again.

This does not mean that every 'near miss' should be reported as a serious incident but, where there is a significant existing risk of system failure and serious harm, the serious incident process should be used to understand and mitigate that risk.

Major Incident

A Major Incident is any occurrence which presents a serious threat to the Trust, disruption to a service or causes (or is likely to cause) such numbers or types of casualties or losses as to require special arrangements to be implemented by the Trust. If an internal disaster is declared then the Major Incident Plan should be followed in respect of managing the immediate incident and this procedure should be followed in respect of investigation and learning lessons following the incident.

Examples of potential internal disasters include: major burglary, theft; sabotage; vandalism; major computer failure; major failure off fabric of building; fire, flood or gas leak; loss of utility; hostage situation; major violent incident, serious injury to a person on site; attempted suicide on site; switchboard failure.

² Serious harm includes: severe harm – resulting in permanent harm; chronic pain (lasting more than 12 weeks or after time healing expected); or psychological harm, impairment of sensory, motor or intellectual function or impairment to normal working or personal life not likely to be temporary (i.e. has lasted, or likely to last for continuous period of at least 28 days).

³ Revised Never Events Policy and Framework, NHS England, April 2015

5 Organisational Roles and Responsibilities

5.1 The Board of Directors

The Board of Directors is accountable for ensuring the Trust has robust mechanisms in place to ensure there is effective governance to promote and facilitate learning from incidents and reduce risk of harm.

The Medical Director, as chair of the Clinical Quality Safety and Governance Committee will provide the Board with an anonymised summary of serious incident investigations, the lessons learnt and the resulting action plan in Part 1 of the Board. Incidents requiring investigation but not yet completed will be raised in Part 2 of the Board.

5.2 Clinical Quality Safety Governance (CQSG) Committee

The CQSGC has delegated responsibility to lead on clinical and corporate governance, clinical quality and safety and to provide assurance to the Board of Directors that clinical quality, safety and governance are being managed to high standards. It is chaired by the Medical Director. Reports are received from a number of leads of work streams managing the collection of evidence to provide assurance.

The lead for the Patient Safety Clinical Risk work stream provides assurance to CQSGC that the Trust has followed its processes for serious incident investigation, whilst being open with patients and relatives and supporting staff directly involved, and that action plans have been implemented and lessons learnt for completed investigations. Completed SI investigation reports will be received by the committee.

5.3 Patient Safety Clinical Risk (PSCR) Work stream

The PSCR work stream is chaired by the Associate Medical Director who is responsible for monitoring the Trust's management of patient safety and clinical risk across all clinical areas of the Trust. Serious incident investigations will be reviewed along with the implementation of action plans and sharing lessons to be learnt.

5.4 AFS and CYAF Clinical Governance and Quality Meetings

These clinical directorate meetings provide support, challenge and oversight of the management of the incident process from notification to completion of actions plans for the relevant directorate services. The meetings are responsible for having visibility of action plans, monitoring the implementation of actions and sharing lessons learnt within the directorate.

6 Individual Roles and Responsibilities

6.1 Chief Executive

The Chief Executive is to be informed of all serious incidents by the Medical Director, who is responsible, on receipt of a preliminary investigation of an incident, to determine

whether it is a serious incident for external reporting to the Clinical Commissioning Group (CCG) via the Strategic Executive Information System (STEIS). Alternatively the incident may be assessed as not meeting the national SI definition, but nevertheless there would be learning from a detailed investigation.

The responsibility for assessing a serious clinical incident remains with the Medical Director. The responsibility for assessing a serious non clinical incident will be delegated to the Transformation and Technology Director, involving Information Governance or non-clinical accidents or injuries.

6.2 Medical Director

The executive responsible for patient safety and clinical risk. Responsible for assessing, overseeing and signing off the investigation of serious clinical incidents. Where the incident involves a death, the Medical Director, or relevant clinician is responsible for reporting this to HM Coroner. Where the incident relates to safeguarding the Medical Director or Named Professional for Safeguarding will inform the relevant social services department.

6.3 Transformation and Technology Director

The executive responsible for non-clinical risk. Responsible for assessing, overseeing and signing off the investigation of serious non clinical incidents. To provide expert advice and support for the investigation of IG incidents, and will usually act as incident coordinator for all serious IG incidents. To ensure that ICO serious incidents are submitted within required timescales. Responsible for supporting the Communications team in establishing telecommunications links should a helpline be required following an incident.

6.4 Associate Medical Director

The individual with delegated responsibility for patient safety and clinical risk, accountable to the Medical Director. Responsible for chairing the Patient Safety Clinical Risk Work stream and ensuring that incidents which meet the criteria for serious incidents are appropriately investigated, that strategies to improve areas are identified in the reports and lessons learnt and shared. To provide quarterly reports to the Clinical Quality Safety Governance Committee on serious incident management.

6.5 Associate Director Quality and Governance

The Associate Director Quality and Governance will:

- Notify the commissioners of the serious incident verbally and by email once the decision has been made by the Medical Director
- provide expert advice and support for the investigation of serious non clinical incidents
- usually act as incident coordinator for the investigation of serious non clinical incidents including:
 - Ensuring all relevant documents of the investigation process and evidence are retained. This includes records of any media briefings or information shared with individuals (staff, service users/carers, and other professionals) a record of information provided should be included in the incident file
 - Informing relevant key stakeholders and keeping a record of stakeholder links

- Liaising with the Communications Director for the creation and delivery of a media handling plan – keeping the Chief Executive and Medical Director informed.

6.6 Health and Safety Manager

The Health and Safety Manager will:

- be responsible for ensuring preliminary facts for serious incidents are promptly gathered, providing support as required.
- be responsible for reporting serious incident notification, including preliminary facts, to the Chief Executive and Medical Director and that the Associate Medical Director, relevant service Director, Associate Director Quality and Governance.
- notify the commissioners in respect of a serious incident by telephone and email once a decision has been made by the Review Panel, in the absence of the Associate Director of Quality and Governance.
- In the absence of the Associate Director of Quality & Governance act as incident coordinator for serious non clinical incident investigations including:
- ensuring patient safety incidents are reported at least weekly to the National Reporting and Learning System (NRLS).

6.7 Clinical Governance and Quality Manager

The clinical governance and quality manager will:

- ensure that all action plans are on the SI action log in a timely manner
- liaise with identified staff to ensure that serious incident processes and timescales are followed including compliance with duty of candour and serious incidents investigation
- ensure all STEIS reporting deadlines are adhered to
- ensure the patient safety and clinical risk workstream meetings manage the SI log and support staff as appropriate to complete actions

6.8 Patient Safety Officer

The Patient Safety Officer will:

- act as support to any investigation team established by the Medical Director under this procedure
- be responsible for uploading serious incident information onto STEIS once agreed by the Medical Director
- ensure the SI action log is tabled at the Patient Safety and Clinical Risk work stream meetings
- coordinate attendance of relevant staff at any meetings and record the outcome of such meetings and follow through relevant actions as directed by the Medical Director.

6.8 Director of Communications

The director is responsible for managing enquiries from the media and general public. The director will ensure that the Trust has arrangements in place for dealing with incidents, and will commission a specific media plan. If the incident prompts multiple enquiries and a helpline is required the director will oversee the setting up of a helpline which may involve engaging external communications expertise if required.

6.9 Clinicians

Where the serious incident involves a patient the lead clinician for the care of the patient will be immediately informed. The clinician is responsible for passing on information relating to the incident to the patient (where relevant), his/her family and GP/referrer. The most senior clinician involved in the patient's care is responsible for ensuring that **Duty of Candour** requirements are met. See section 8 for details.

6.10 Service Leads/Managers

Service Leads / Managers are responsible for:

- ensuring that relevant individuals have been notified in person or by phone where a serious incident has been identified and an incident form has been subsequently completed
- ensuring that staff and patients receive adequate support (section 8). Advice should be sought from the Director of HR and/or head of discipline or Medical Director in the event that a member of staff is not fit to work after an adverse event or during an investigation
- undertaking an initial fact finding investigation
- ensuring that if confirmed as a serious incident that staff are aware an investigation will be conducted and understand what that process entails
- ensuring that the Clinical Director and Associate Clinical Director are informed about any serious incident and involved, where appropriate, in the development of action plans emerging from investigations.

6.11 Clinical Directors

Clinical Directors are responsible for ensuring that the tasks of the service lead/managers are completed and that action plans with implications for the Directorate as a whole are implemented and lessons learnt. The Clinical Directors together with the Medical Director will ensure that action plans of relevance to the whole Trust are implemented including an annual review meeting for staff of lessons learnt from serious incidents.

6.12 All staff and students

All staff and students are responsible for identifying and reporting incidents that occur in the course of their work. All incidents are reported to the Health and Safety Manager using the incident form on the intranet and website. If a serious incident has occurred the Medical Director, relevant Clinical Director and Health and Safety Manager or Associate Director Quality and Governance must be informed as soon as the situation has been made safe.

7 Procedures

Step 1: Immediate Response & Reporting

- The first priority is for staff to ensure the needs of the individual(s) are attended to and the environment made safe. See section 8 for information on support available for staff, patients and relatives.
- All potential serious incidents must be reported without delay in person or by phone to the Medical Director, relevant Clinical Director, Lead Clinician (if patient

affected) and Health and Safety Manager / Associate Director Quality and Governance.

- As soon as an incident is identified it should be reported to the Health and Safety Manager via the Trust incident form, which can be found here on the [Trust intranet form](#).
- Where there is a doubt as to whether an incident is serious, advice should be sought from the Medical Director or Associate Medical Director for clinical incidents and the Transformation and Technology Director or Associate Director Quality and Governance or Health and Safety Manager for non-clinical incidents.
- The H&S Manager or Associate Director Quality and Governance will inform the Chief Executive and Medical Director of the non-clinical serious incident or possible serious incident.
- The Communications Team must be informed immediately of any media interest or where media interest can be foreseen.
- If there is a suggestion that a criminal offence has been committed the Health and Safety Manager or the Estates Manager will contact the police and alert the Local security Management Specialist (LSMS) and the Estates Manager - the scene and evidence must be secured.
- In the event of abuse or neglect being suspected the relevant child or adult safeguarding policy will be implemented.
- Under Duty of Candour, early consideration should be given as to how best to provide information and support to patients, relatives, carers and staff involved. See section 8 for details.
- Once the situation is made safe the incident and immediate responses should be reported using the Trust incident form. This must be within 24 hours of the incident.
- Stakeholder notification: The external reporting of serious incidents should be undertaken by designated staff. This includes where staff of another organisation are involved in a serious incident. If unclear whether an external report should be made staff should contact the Health and Safety Manager or Associate Director Quality and Governance in the first instance. See **Appendix B** for details.

7.1 After incident fact finding

As soon as possible after an incident the Service Lead and Health and Safety Manager or Associate Director Quality and Governance should complete a fact finding exercise to determine if a full investigation is warranted. Information must be recorded (see template Appendix D) and will be used to inform the investigation process. It must be submitted to the Chief Executive and Medical Director with a copy to the Associate Director Quality and Governance.

The data gathering for this fact finding review should include the following:

- A safe environment has been established and the needs of the individual(s) affected have been attended to
- Staff involved have been identified and are aware of the support services available to them
- A factual timeline of events is established
- Relevant records held by the Trust, clinical and non-clinical have been identified and secured
- Details of equipment / other hardware involved identified and secured
- Initial witness statements
- Photographs of the scene (if relevant)

7.2 Out of Hours Arrangements

In the event of a serious incident out of clinic hours the evening receptionist and/or the on call key holder should contact the Director on Call for advice. The Director on Call should liaise with the Medical Director and Chief Executive.

7.3 Multiple Enquiries

A Serious Incident could lead to the need to respond to multiple enquiries from the public, e.g. 'hotline arrangements'. Director of Communications authorised to trigger these arrangements they are also to be set up on the website and social media outlets.

At the Tavistock Centre Seminar Room 4 has 2 analogue telephone extension sockets which could be utilised to set up a hot line arrangement. The Transformation and Technology Director has responsibility for telecommunications and would be responsible for establishing the telephone arrangements.

The Director of Communications should liaise with appropriate departments to find appropriate staff to answer the telephones. All calls must be documented carefully and contemporaneously – a relevant data recording pro-forma should be developed at the outset of any hot line arrangements. This should list simple question prompts and agreed responses (if relevant) to ensure comprehensive data gathering and appropriate, consistent information is provided to callers.

Step 2: Serious Clinical Incident Review (within 24 hours)

7.4 SI Review

- On identification of a potential serious clinical incident the Medical Director, or Associate Medical Director will meet with the relevant Clinical Directors, team managers and clinicians as appropriate. The purpose of the meetings will be to review what is known about the incident including the harm and decide whether the incident meets the serious incident criteria. Where possible the incident form should be available.
- For non-clinical incidents the Transformation and Technology Director will convene all equivalent meetings.
- The Medical Director (or Associate Medical Director in absence of MD) or the Transformation and Technology Director will:
 1. make one of the following decisions
 - i. Confirm it is a serious incident and request a 3-day report (see Appendix D for template)
 - ii. Require further information in the form of a 3-day report to help determine whether the incident meets SI criteria
 - iii. Confirm it is not a serious incident but is a significant event from which there could be learning from an investigation. Request a comprehensive internal investigation that is managed by the Directorate team and follows the SI processes, including timeframes for reporting back
 - iv. Confirm the incident is not serious and that the investigation will follow local incident management processes.
 2. For serious incidents: Confirm the lead investigator and serious incident coordinator and timescales for reporting.

- STEIS timescales require submission of a final, executive signed report by 60 working days from the date the Trust identified the incident.
- Independent (external) investigations will be identified and arranged by the commissioner or NHS England e.g. major systems failure with multiple stakeholders. Homicides following recent contact with mental health services require an independent investigation. These will be commissioned by the commissioner.

NOTE: serious incidents or those which may be confirmed following a 3 day report **MUST** be reported to STEIS before receiving the 3-day report as there is a 48 hour reporting requirement. If on reviewing the 3-day report the incident is assessed as not serious the Patient Safety Officer will submit a de-escalation request to STEIS and the Associate Director Quality and Governance will inform the CCG by email.

7.5 Serious incident investigation team

The Medical Director will appoint two senior staff with one taking the lead investigator role supported by a coordinator; the *prima facie* facts of the case (e.g. incidents involving professional matters) may require the inclusion of appropriate independent professional involvement. The investigation team is entitled to call on documentary and witness evidence from any relevant source to assist in the investigation.

7.6 Informing Stakeholders

See **Appendix B** for list of list of persons/authorities who need to be informed after a serious incident. The list is not exhaustive. The rights of confidentiality of individuals who may be involved in incidents either as victims or as witnesses should be maintained. Information shared should only be what is essential and anonymised.

The Investigation Lead will, with the coordinator decide the manner of the communication with individuals, and whether it should be done on an individual or group basis.

Step 3: Initial Incident Review –3-day report

The written report, usually the incident form with any additional information, must be submitted to the Chief Executive, Medical Director or Transformation & Technology Director, Associate Director Quality and Safety, the Patient Safety Officer and relevant clinical director within three working days of the incident happening. The 3-day report template Appendix D should be used.

The 3-day report fulfils the following key functions:

- Helps to determine whether a full investigation is warranted
- Provides additional information in relation to the incident and identifies the major concerns
- Confirms that immediate actions have been undertaken
- Ensures the patient/family have been informed of the investigation process and that they have the opportunity to contribute their questions
- Provides a concise report when no further action is needed
- Assurance that a safe environment has been established and the needs of the individual(s) affected have been attended to
- Staff involved have been identified and are aware of the support services available to them
- A factual timeline of events is established

- summary of the incident
- Relevant records held by the Trust e.g. patient, maintenance etc. have been identified and secured
- Details of equipment / other hardware involved
- Initial witness statements
- Photographs of the scene (if relevant)

The report will be reviewed by the Medical Director for clinical SIs or the Director of Transformation and Technology for non-clinical SIs.

7.7 Requesting a de-escalation

If following review of the 3-day report it is agreed that an incident does not in fact meet the serious incident criteria, a request for de-escalation should be submitted to commissioners for review. This will be the responsibility of the incident coordinator or patient safety officer.

The request should include relevant background information and provide a clear justification for why de-escalation is being sought. De-escalation will normally only be granted where it is clear that the incident does not meet the serious incident threshold.

Step 4: Comprehensive investigation

The Trust has a set of guidelines on how to carry out a 'Root Cause Analysis' which will be made available to staff delegated with the responsibility in undertaking an investigation. The Trust has a Comprehensive Investigation Template.

The investigation should be informal but fair, ensuring that all those who may be expected to make representations have an opportunity to do so and that the confidence of all interested parties in the process and fairness of the investigations is secured.

Before the investigation commences, the Lead Investigator will arrange for the following:

- circulate information about the procedures of the investigation to all involved;
- unless there are clear exceptional reasons, inform the patient/client and their family/next of kin⁴ of the investigation, and ask if they wish to provide relevant information to the enquiry;
- seek reports from staff who have been involved in the incident;
- seek reports from any other relevant persons, Trust subject matter experts, and/or arrange to interview including independent experts;
- consult with relevant professional organisations and defence societies; taking advice from HR if required;
- ensure that all reports received are legible, signed and dated.

Consider the needs of any family member/next of kin in the light of the event that prompted the enquiry, and consider making arrangements to offer access to clinical support independent of the case and the investigation.

⁴ Note many adult patients do not provide the Trust with details of their next of kin or the name of someone they wish to be informed in the event of a serious incident. If the trust becomes aware of interested parties e.g. via HM Coroner following a death of a patient then this person(s) should be contacted and invited to contribute to the investigation

The nature of the enquiry will be investigatory and not adversarial, with the investigation team taking the initiative by requesting statements or calling witnesses to meet with them. The team shall decide whether to call as witnesses to the enquiry any person who has submitted a statement and, where witnesses do appear, the approach shall be informal.

Staff have the right to be accompanied to an interview by a friend or colleague. Although the investigation is not part of the disciplinary procedure for staff or an inquiry into legal liability or guilt, witnesses may be accompanied by their trades' union representative or other person not connected with the incident if they so wish.

7.8 Independent External Investigations

The circumstances in which a Serious Case Review (SCR) should take place, following serious harm to a child, are determined by the Local Safeguarding Children's Board and conducted by an independent investigator. Organisations involved are usually required to complete an Individual Management Review (IMR) of their own involvement. In other circumstances where an incident is exceptionally serious or where very senior members of staff are involved or where the incident is likely to have serious reputational consequences for the Trust or implications for other organisations, the Chief Executive in consultation with the Medical Director may order an independent investigation. Such investigations can also be commissioned by the Lead Commissioner on an ad hoc basis and will be managed externally. Independent investigations requested by commissioners must be agreed with an Executive Director and any associated activity facilitated and managed within the relevant service. Independent investigations should be completed within 6 months.

7.9 Joint Investigations

- Where more than one NHS body is involved in a serious incident, the organisation which identified the incident may make the initial notification via STEIS having first made contact, wherever possible, with the organisation where the incident originated. The only exception to this may be when dealing with an allegation of abuse, in which case local safeguarding arrangements should be followed.
- A lead organisation must be identified and clear responsibilities agreed between all organisations involved. This is often covered within a RASCI (Responsible, Accountable, Supporting, Consulting, Informed) matrix to support the robust and effective oversight management of serious incidents.
- Anything uncovered by local investigation that may be pertinent e.g. timelines, care/service delivery problems and causal factors, should be communicated to the agreed lead to ensure full analysis of the incident.
- Where the incident involves a general practitioner, residential or care home or independent provider, the governance department of the relevant commissioning sector should be informed.
- Any external communication must be agreed through the Medical Director or Associate Medical Director.
- Where a serious incident crosses the boundary of two or more commissioning sectors, the relevant organisations will liaise directly to ensure each other is notified, a lead organisation identified and investigation timescales locally agreed.

Step 5: Action Plan

The relevant Clinical Director or associate Director and those responsible for implementation, usually the team manager, are required to draw up an action plan

based on the Investigation team recommendations within the STEIS reporting timescale of 60 working days. The relevant clinical director will be responsible for ensuring that the action plan is implemented.

Step 6: Completion of Investigation Report

During a prolonged investigation, there must be regular reports on progress to the Chief Executive, Medical Director and other key stakeholders including clear explanations for any delays.

The final investigation report should follow the Trust template and be written in such a way as to be accessible and understandable to all readers. It should be anonymised using job titles only and thoroughly proof read. An anonymisation key identifying individuals referred to in the report and action plan must be kept with the investigation records.

The report produced should include:

- Statement of panel membership and terms of reference;
- Description of the method of enquiry;
- Detailed description of the sequence of events leading to the incident (i.e. chronology and timeline)
- The author’s conclusion on the sequence of events, the root causes for the events and the lessons to be learnt from them;
- Recommendations for action.

Staff who have contributed their accounts to the report will be sent the report following submission to the Medical Director. The Clinical Director is responsible for ensuring investigation reports have undergone appropriate scrutiny and constructive challenge and include the agreed action plan.

If there are any disagreements concerning the content of the report the relevant individual should contact the Medical Director, Associate Medical Director or Transformation and Technology Director to arrange a meeting to discuss the content. Any agreed amendments should be made in advance of submitting the final report to the Medical Director.

Step 7: Executive Director Sign-off

Evidence of Executive level sign-off is required for all serious incident investigation reports. The final report should be submitted to the Medical Director or Director of Finance for review and Executive Sign off on the front of the report prior to external submission by Day 60.

Step 8: Reporting Arrangements

The report must be presented to the Chief Executive for endorsement and action as necessary. The report will be received by the Clinical Quality Safety and Governance Committee (CQSGC) via a report from the Patient Safety and Clinical Risk (PSCR) work stream chair.

The Medical Director, as chair of the Clinical Quality Safety and Governance Committee will provide the Board with an anonymised summary of serious incident investigations, the lessons learnt and the resulting action plan in Part 1 of the Board. Incidents requiring investigation but not yet completed will be raised in Part 2 of the Board.

Once signed off by the Medical Director, if the incident has been reported on STEIS a copy of the report must be provided to the CCG and NELCSU using the secure email address: gands.camdenccg@nhs.net and nelcsu.incidents@nhs.net.

The report will also be considered by the relevant work stream reporting to the Clinical Quality Safety and Governance Committee and by the Safeguarding Committee (if the incident relates to safeguarding).

Step 9: Dissemination of Learning from Serious Incident Reviews

Lessons learnt from serious incident investigations will be shared widely within the Trust using a number of methods including, but not limited to:

- Individual sharing of lessons within team meetings;
- Presentation and discussion of issues by the Associate Medical Director at Directorate Clinical Governance and Quality Meetings ;
- Induction and INSET;
- 'Quality News' and electronic Communication Briefings (cross Trust and directorate);
- Development of section within the new Intranet for easy access to serious incident learning and actions taken within the Trust;
- Annual learning event for Trust staff;
- Monitoring and auditing of action plan implementation;
- Implementation of National Guidance on Learning from Deaths (NQB March 2017).

Step10: Monitoring Action Plans

Where action is programmed over a period of time, the Chief Executive and Board of Directors may require further reports on progress in implementation. If the outcome of the investigation has implications for the Trust as a whole, consideration will have to be given as to how it is to be so alerted, taking into account the need to preserve confidentiality. Appropriate joint action by other agencies may be necessary.

The PSCR work stream reporting to CQSGC will monitor progress against the action plan on a quarterly basis until complete.

8 Supporting staff and patients (including Duty of Candour)

8.1 Support for Staff and Students

8.1.1 Providing direct support

The Trust recognises that a serious incident will be a potentially stressful and difficult situation; it is committed to providing appropriate support. It is the responsibility of the staff member's manager or students 'clinical lead, in conjunction with the incident

coordinator to address the support needs of staff/students. There are two phases of support:

Immediate support which may take the form of:

- Guidance and information about what to do practically
- If possible, extra staff should be drafted in to allow staff involved time to “breathe” and talk
- Checking out when staff are next on duty, and arranging changes to shifts
- Identifying whom it may be appropriate to follow up with a telephone call at home.

Post incident (on-going) support which may involve:

- De-brief
- Clinical Supervision
- Informal support from colleagues
- Support by professional colleague (e.g. Clinical Practitioner)
- Students advice and consultation service
- Referral or self-referral to Occupational Health
- Referral and or self-referral to the Staff Consultation Service (details in Stress Management Procedure).

It can be difficult for staff to acknowledge the need for support both to themselves and to others. Staff should be informed about support available and the manager should talk to them about support needs on more than one occasion.

8.1.2 Staff Member or Student called as a witness

In the event that a member of staff is called to appear as a witness in an investigation they will receive one to one support and advice from the Associate Medical Director in the first instance. In addition, staff will be encouraged to seek advice and support from their trades’ union or professional association should they wish to do so. They may bring a colleague to any interview conducted under the investigation process.

8.2 Duty of Candour

- The new statutory duty of candour was introduced for NHS bodies in England (trusts, foundation trusts and special health authorities) from 27 November 2014⁵ requiring all health and social care providers to be open with people when things go wrong. The regulations impose a specific and detailed duty of candour on all providers where harm to a service user from their treatment is moderate, severe, or prolonged psychological harm or results in death.
- The Trust is committed to acting openly and transparently with service users, whether the harm is as a result of a patient’s care or treatment or not. Therefore, on receipt of every reported incident the Health and Safety manager will assess whether the incident is a notifiable patient safety incident and meets the level of harm under the Duty of Candour legislation.
- In most situations, initial contact with a patient or family should be made by the most senior clinician involved in the patient’s care – standard principles of

⁵ The obligations associated with the statutory duty of candour are contained in regulation 20 of The Health and Social Care Act 2008 (Regulated Activities) Regulations 2014.

confidentiality still apply i.e. where the patient has expressed a wish that the details of their care are not disclosed to family / carers.

- In accordance with the principles of Duty of Candour, patients, and/or their families / carers must:
 1. As soon as is reasonably practicable after a notifiable patient safety incident occurs, be told about the incident, ideally in person, within 10 working days of the incident being reported. This discussion must be fully documented and kept in the patient's notes. Ideally, this will be followed up with a letter to the patient / family;
 2. Be given a full explanation of what is known at the time, including what further enquiries will be carried out;
 3. Where harm has occurred as a result of the Trust's actions or failure to act, the family/carer must receive an apology, as a sincere expression of sorrow or regret for the harm that has occurred and keep a written record of the notification to the patient. Reasonable support should also be offered to the patient and/or their families / carers;
 4. Be provided with feedback on the outcome of the investigations within 10 working days of the final report receiving executive approval.
- The initial correspondence should consider the following areas:
 - Expression of condolence and regret;
 - Describe the process of investigation (and where relevant that other agencies may also be carrying out investigations);
 - Describe the current position in the investigation process;
 - Describe factors that will influence the timescale of the investigation;
 - Send the Terms of Reference to the family for agreement and ask them how they would like to be involved in the investigation e.g. if they wish to provide a timeline of events;
 - Describe how the information about the event will be assimilated and disseminated;
 - Provide contact information for the person who will link with the family from the Trust;
 - provide support for patient / patient's representative.

8.2.1 Support for Patient/Patient's Representative

Support to patients and relatives must be timely, and comes in the form of specific support and information giving. It is essential that the lead clinician contacts the patient/family as soon as is appropriate, even if they have already been contacted by the police (as may be the case in a patient death).

The Lead Clinician will consider what support needs to be offered to patients/relatives, and responsibility agreed. This may involve one or more of the following:

- Visit from appropriate clinical support
- Visit from relevant senior member of Trust staff to relative to explain what to expect from the Trust's investigation process

Patients/relatives/carers who are involved in a serious incident will be offered a named contact that is a senior member of staff. This will be organised by the Coordinator. This

nominated individual will take into account specific cultural and religious support requirements.

9 Training Requirements

The responsibility for training in serious incident reporting lies with the Associate Director Quality and Governance. An overview of reporting and managing a serious incident is covered as part of induction and mandatory INSET training.

Staff asked to investigate a serious incident will receive one to one training from the Associate Director Quality and Governance on investigation techniques and how to undertake a root cause analysis. This training will be made available to other senior staff on request. Where necessary additional external serious incident investigation training will be arranged.

10 Process for monitoring compliance with this procedure

Issue	Frequency	Person responsible for the report	Person responsible for monitoring	Overseeing Work stream
Timeliness of serious incident management	Quarterly	Patient Safety Officer	Associate Medical Director	PSCR / CQSGC
Duty of candour	Quarterly	Patient Safety Officer	Associate Medical Director	PSCR/ CQSGC
Monitoring serious clinical incident actions progress	Quarterly	Patient Safety Officer	Associate Medical Director	PSCR/CQSGC
Liaison with stakeholders, reports meet CCG requirements, action plan that addresses recommendations	Quarterly	Associate Director Quality and Governance	Associate Medical Director	PSCR/CQSGC
Monitoring serious non clinical incident actions progress	Quarterly	Health and Safety Manager	Associate Director Quality and Governance	CGR/CQSGC

11 References and Resources

Description	Link
An Organisation with a Memory: Report of an Expert Group on Learning from Adverse Events in the NHS. London: Department of Health (2000)	http://webarchive.nationalarchives.gov.uk/20130107105354/http://dh.gov.uk/en/publicationsandstatistics/publications/publicationspolicyandguidance/dh_4065083
Being Open: communicating patient safety incidents with patients, their families and carers, National Patient Safety Agency (November 2009)	http://www.nrls.npsa.nhs.uk/resources/?EntryId45=83726
Building a Memory: Preventing Harm, Reducing Risks and Protecting Patient Safety, London: National Patient Safety Agency (2005)	http://www.nrls.npsa.nhs.uk/resources/?entryid45=59797
Checklist for Reporting, Managing and Investigating	https://www.igt.hscic.gov.uk/resources/HSCIC%20SRI%20Reporting%20and%20Checklist%20Guidanc

Information Governance Serious Incidents Requiring Investigation. Health and Social Care Information Centre HSCIC (2015)	e.pdf
CQC Regulation 20: Duty of candour (2014)	http://www.cqc.org.uk/sites/default/files/20150327_duty_of_candour_guidance_final.pdf
Degree of harm FAQs, NRLS, 2015	
<i>Health and Safety (Consultation with Employees) Regulations 1996</i> . (Statutory Instrument 1996 No. 1513). London: The Stationery Office. Available at: www.opsi.gov.uk	
Investigating clinical incidents in the NHS, House of Commons, Public Administration Select Committee (March 2015)	https://www.publications.parliament.uk/pa/cm201415/cmselect/cmpubadm/886/886.pdf
Joint statement on the professional duty of candour (June 2015)	http://www.gmc-uk.org/Joint_statement_on_the_professional_duty_of_candour_FINAL.pdf_58140142.pdf
Learning, Candour and Accountability, Care Quality Commission (December 2016)	https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf
National Guidance on Learning from Deaths, National Quality Board (March 2017)	https://www.england.nhs.uk/wp-content/uploads/2017/03/nqb-national-guidance-learning-from-deaths.pdf
National Framework for the Reporting and Learning from Serious Incidents Reporting Investigation (2010) NPSA	http://www.nrls.npsa.nhs.uk/report-a-patient-safety-incident/serious-incident-reporting-and-learning-framework-sirl/
Never Events Policy and Framework, Revised, NHS England (March 2015)	https://www.england.nhs.uk/wp-content/uploads/2015/04/never-evnts-pol-framwrk-apr.pdf
Openness and honesty when things go wrong the professional duty of candour NMC and GMC (June 2015)	https://www.nmc.org.uk/globalassets/sitedocuments/nmc-publications/openness-and-honesty-professional-duty-of-candour.pdf
Serious Incident Framework, NHS England (March 2015)	https://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incident-framwrk-upd.pdf
<i>Six Steps to Root Cause Analysis</i> (third edition) Maria Dineen (2011) ISBN:978-0-9544328-2-9	https://www.consequenceuk.com/six-steps-to-rca/

12 Associated documents⁶

Being Open and Candid with patients involved in an incident procedure
 Health and Safety Policy
 Incident Reporting Procedure
 Infection Control Procedure (in relation to needle stick incidents)
 Information Governance Policy
 Major Incident Plan
 Media Handling Procedure
 Risk Management Policy and Strategy
 Root Cause Analysis Guidelines
 Staff Training and Development Policy and Procedure
 Sickness Absence Procedure

⁶ For the current version of Trust procedures, please refer to the intranet.

Appendix A: Equality Impact Assessment

Completed by	Dr Rob Senior
Position	Medical Director
Date	29th of June

The following questions determine whether analysis is needed	Yes	No
Is the policy likely to affect people with particular protected characteristics differently?		X
Is it a major policy, significantly affecting how Trust services are delivered?		X
Will the policy have a significant effect on how partner organisations operate in terms of equality?		X
Does the policy relate to functions that have been identified through engagement as being important to people with particular protected characteristics?		X
Does the policy relate to an area with known inequalities?		X
Does the policy relate to any equality objectives that have been set by the Trust?		X
Other?		X

Appendix B Stakeholder Information

Lead Clinician (patient incidents)

The lead clinician for the care of any patient involved in a serious incident must be informed immediately. The clinician is responsible for ensuring information is passed to the patient (where relevant), his/her family (as appropriate) and his/her GP.

Clinical Commissioning Group (CCG)

The CCG must be informed of any serious incident reported to STEIS. The CCG monitors compliance against target timescales for submission, evaluates the quality of investigation reports and implementation of action plans.

NHS England – Strategic Executive Incident System (STEIS)/ National Reporting and Learning System (NRLS)

All Serious incidents must be reported to STEIS and those meeting the definition of a patient safety incident should also be reported to the NRLS.

Information Commissioners Office (ICO)

Information Governance incidents meeting the Level 2 IG Severity of Incident criteria must also be reported to the ICO. This is assessed by the IM&T and Estates Director.

Patient and or Patient's Representative

In line with the Trust's Duty of Candour Procedure, the Trust will seek to be as open as possible with the patient or representative at all stages of the investigation following a serious incident. The Trust will share findings and action plan for lessons learnt at the completion of the investigation.

Patient's GP

The lead clinician responsible for the care of the patient involved in a serious incident must inform the patient's GP by telephone, followed up by a written report. However, if the patient has previously instructed the Trust not to contact their GP, then advice should be taken from the service director and/or Caldecott Guardian and the outcome of that discussion recorded in the patient notes.

HM Coroner

In incidents involving death, the death should be reported to HM Coroner by the relevant clinician or Medical Director. The Coroner may open an inquest in which case Trust staff will be expected to cooperate by supplying statements as required.

Social Services

If the incident relates to safeguarding the relevant social service department must be informed. The Medical Director or the Named Professional for Safeguarding will decide whether social services should be notified.

Incidents involving staff from other organisations

If staff of another organisation are involved in a serious incident, the relevant senior manager of that organisation must be informed as soon as possible, and it is the responsibility of the Associate Director Quality and Governance to inform the relevant manager in the partner agency of the outcome of the initial investigation and any decision made in respect of detailed investigation. The manager should ensure that there is clarity between agencies as to roles and responsibilities in respect of staff

involved in incidents and ensure that the Medical Director is kept informed. HR Director should also be involved.

Professional Bodies

If a member of staff's professional body is a regulated body, then the case should be referred if the respective professional code of conduct may have been breached.

Deanery

Following publication of the London Deanery's 'Framework for Managing Trainees' (2010) NHS organisations are required to inform the Deanery when a trainee has been directly or indirectly involved in a serious incident. This should be undertaken by the Trust Director of Medical Education with responsibility for trainees who will be notified of the incident by either the Medical Director, Associate Medical Director or Associate Director Quality and Governance.

Appendix C: Target Deadlines for SI Investigation Process

Action	Responsibility	Timescale (working days)
Serious incident occurs – report to Service Director, Medical Director, H&S Manager and Associate Director Quality and Governance etc. in person / by telephone or email	All staff	Immediately incident known
CEO and Medical Director informed of possible serious incident. Communications team to be informed if possible issue	H&S Manager or AD Quality and Governance	Immediately
Initial review to establish facts of what happened, secure patient records / equipment and determine whether there is harm	Team Manager and H&S Manager / AD Quality and Governance	ASAP
Complete notification on incident form	All staff	Within 24 hours
Review Panel to consider whether incident is serious or potentially serious (awaiting 3 days report). To be reported on STEIS within 48 hours	Health and Safety Manager (non-clinical) or Patient Safety Officer (Clinical)	Within 2 days
Inform relevant stakeholders (GP, CCG, NPSA and other Trusts if Trust led). Consideration in contacting the Patient or patients family that an investigation is taking place and they understand the process (Duty of Candour). Invite involvement	Clinical Governance & Quality Manager	Within 2 days of declaring the SI
Complete three day report	Team Manager supported by H&S Manager / AD Quality and Governance	Within 3 days
Review Panel to be convened to consider three day report and determine whether still an SI and approve plan / de-escalate as required including agreeing Terms of Reference.	Health & Safety Manager (non-clinical) or Patient Safety Officer (clinical) to facilitate meeting and MD or AD Quality & Governance approve or de-escalate.	4 days
If de-escalation then request to commissioners to be made via STEIS	Health & Safety Manager (non-clinical) or Patient Safety Officer (clinical)	4 days
Where appropriate scope of investigation to be agreed with the family (ToR)	Clinician contact or Clinical Governance & Quality Manager	14 days
Three day report saved with Serious incident file	AD Quality and Governance	4 days
Draft report submitted to those who contributed accounts to the report for review and agree actions. Any disagreements concerning content of the report to be raised with the Associate Director Quality and Governance to arrange a meeting to discuss. Should the Medical Director be involved in this discussion?	Clinical Governance & Quality Manager and staff reviewing report	40 days
Complete additional amendments	SI Lead Investigator	45 days
Completed investigation report including recommendations sent to the Medical Director for review and Executive Sign off	SI Investigator	50 days

Report signed off by Medical Director and confirmed to Clinical Governance & Quality Manager and Patient Safety Officer (clinical) or Health & Safety Manager (non-clinical)	Medical Director	58 days
Copy of the final report provided to CEO and sent to commissioners (with Medical Director Signature added to front) NELCSU.Incidents@nhs.net and gands.camdenccg@nhs.net STEIS updated with recommendations and lessons learnt. Internal incident system updated	Patient Safety Officer (clinical) AD of Quality & Governance (non-clinical)	60 days
Communicate the outcome of the investigation to the patient, relatives, witnesses, clinicians of the patient and relevant managers.	Chair of Investigation Team and Clinical Governance & Quality Manager	65 days
Finalise action plan completed	Service Director	70 days
Report forwarded to Patient Safety Clinical Risk (PSCR) Work stream Chair for review Report forwarded to Corporate Governance & Risk (CGR) Work stream Chair for review	Patient Safety Officer (PSCR) Health & Safety Manager (CGR)	
Report received at Clinical Quality Safety and Governance Committee as part of the PSCR/CGR reports	Associate Medical Director/ Medical Director/Associate Director of Quality and Governance	
Anonymised summary of the serious incident and action plan in CQSGC report to Board – Part 1	Medical Director	
Verbal report of SIs before investigation completed in Part 2 of the Board	Medical Director	
Action plan to be reviewed quarterly via the PSCR and CGR work streams as appropriate and an update provided to the CQSGC	Associate Medical Director/ Associate Director of Quality and Governance	

Appendix D: 3-day Report Template

PRELIMINARY (3-day) REVIEW TOOL FOR SERIOUS INCIDENTS

This review should be completed by a senior manager and returned to the Associate Director Quality and Governance. Should there be learning or further follow up, this document may be shared more widely within the Trust. Guidance on completing the preliminary review is contained at the end of the document.

Date of Incident			
Date incident notified			
Carenotes number			
Internal incident no.			
Gender			
DoB			
Length of Time known to Trust			
Category of Incident			
Borough of residence			
Description of incident (summary)			
Multiagency Contact Summary			
Tavistock Contact Summary			
Team		Referral Date	
		Discharge Date	
		Date Last Seen	
Team		Referral Date	
		Discharge Date	
		Date Last Seen	
Team		Referral Date	
		Discharge Date	
		Date Last Seen	
Risk Assessment Date			
Diagnosis			
Media interest: (Y/N)			
If yes, have communications team been notified?(Y/N)			

People involved

Reviewer's Details			
Directorate/Team completing review		Date of review	
Name of person completing review		Role of person completing review	

Service User's Details			
Service user's initials		NHS Number	
Date of birth		Date of death (if applicable)	
MHA status <i>(at the time of incident)</i>		Length of time in treatment with T&P	
Diagnosis		Last CPA date (if applicable)	
Name of consultant		Name of key worker/ care co-ordinator	
Name of carer/relatives		Contact details of carer/relatives	

Background information

Incident details			
Incident Date		Internal incident No.	
Names and roles of any witnesses		Date statements taken	
Staff involved?		Profession	
Were the police involved?		Police reference	

Please give a brief summary of clinical history

Timeline of Service User Contact

Care and Treatment Review (please refer only to pre-incident reviews; any post-incident reviews can be referred to in the Immediate action/learning section below)

Question	Yes / No	Evidence
Is the care plan clear		
Is there evidence that the care plan was being followed?		
Is there an up-to-date risk assessment?		
Is there evidence that identified risks were being managed?		
Were physical healthcare concerns being followed up?		
Was there appropriate liaison with other organisations?		
If the service user also had mental health problems, were these being treated appropriately? (SMS)		
Have the carer/relatives raised any concerns about the service user's care and treatment?		
Have carer/relatives been contacted about the incident?		

Is there any other information about the service user's care that causes concern or that you would like to highlight?

--

Contact with service user, families and carers post-incident

Clinical teams are required to make contact with the service user involved in the incident and to offer to meet with them to speak about what has happened. Where the service user lacks capacity to make decisions about their care, or has died, this contact should be with the person's next of kin. Service users and family members should be given a named contact within the clinical team for any queries.

Name (and relationship) of person contact made with	
Dates, method of contact	
Summary of matters discussed	
Service user / family member contact details	
Designated contact person in clinical team	

Duty of Candour

In addition to the expectation that service users and families will be contacted in all incidents, the Trust has an obligation to meet certain requirements under Duty of Candour.

Was this incident an unexpected or unintended incident that appears to have resulted in: <ul style="list-style-type: none"> - Death of the service user; - Impairment of sensory, motor or intellectual functions likely to last for a continuous period of more than 28 days; - Changes to the structure of the service user's body; - Prolonged pain; - Prolonged psychological harm; OR - Shortened life expectancy 	
Did the consequences of the incident require professional treatment to prevent: <ul style="list-style-type: none"> - The death of the service user; OR - Any injury, which left untreated, would lead to any of the outcomes above. 	
<i>If the answer to either question above is YES, then this incident meets criteria for Duty of Candour and the following section must be completed.</i>	

Have the team:	Y/N	Date
Met with the service user / family / NOK in person		
Spoken with the service user / family / NOK if meeting has not been possible		
Offered an apology		
Provided information about the facts of the incident known at this stage		
Advised the family / Next of kin that there will be an investigation to understand what has happened and to learn lessons for the future		
Followed this up in writing to the service user / family / Next of kin (Please submit a copy with this preliminary review)		
If any steps have not occurred above, please state the reasons, and actions taken to address this here. All steps above are mandatory.		

Outcome of preliminary review

Immediate actions / learning already implemented

	Action / learning
1	
2	
3	

Further recommendations and issues identified from this preliminary review

	Recommendation / issue identified for the team or Trust
1	
2	
3	

3-day Preliminary Review Guidance

Why have I been asked to complete a preliminary review?

- An incident reported by your team has been identified as a potentially serious incident, or an incident from which learning may be gained, under the trust-wide Serious Incidents Procedure.
- The preliminary review allows the Trust to ascertain the facts known about the incident, ensure that all processes have been followed, and to determine whether any further follow up (e.g. a serious incident investigation is required).

What happens next?

Once you have completed the preliminary review, the next steps are:

- The contents of the review will be reviewed by the Associate Director Quality and Governance.
- In accordance with the National Serious Incidents Framework and the trust-wide Serious Incidents Procedure, the Associate Director Quality and Governance will make a recommendation for any follow up required. The options are:

No further action	No further follow up is required
Short management report	A serious incident investigation is not required, but you will be asked to write a brief cover note summary, which will be shared within the Trust, alongside this preliminary review
Level 1 investigation	A serious incident investigation will be undertaken, by a lead investigator from the Trust
Level 2 investigation (external)	A serious incident investigation will be undertaken by a panel, chaired by somebody external from the Trust

- This recommendation is reviewed by the Medical Director or Associate Medical Director (Patient Safety), who will decide the level of follow up.

Is there anything else I need to do?

Consider whether you have:

- Acted on immediate findings, including intervening to ensure safety;
- Ensured compliance with Duty of Candour;
- Ensure any staff members affected by the incident are supported
- Arranged a debriefing for staff members involved;
- Ensured patients involved or who witnessed the incident, have had an opportunity to discuss it with staff members;
- Collected any outstanding statements and submitted these to the Clinical Governance Team;
- Updated care plans and risk assessments in light of the incident.

If you have any queries, please contact the Associate Director Quality and Governance

Appendix E: Guidance for Incident Form Completion

For detailed guidance please refer to the following documents available on the Intranet and the T&P Website: Incident Reporting Procedure; and Serious Incident Procedure; <http://intranet/PolicyDocs/http://tavistockandportman.uk/about-us/policies-and-procedures>

- This form should be used with reference to the Trust's Incident Reporting Procedure for incidents of ALL types that occur at the Trust. [TRUST INCIDENT FORM](#):
- It should be completed as soon after the incident as possible, and should record FACTS only and not opinions
- If it is necessary to protect the confidentiality of a patient involved in an incident the case can be reported anonymously, however the reporter should always be able to identify the patient should further investigation be required.

Scoring risk⁷

The severity of adverse events and remaining risks are scored using the matrices below. The score is the = sum of consequence score x likelihood score.

Further detailed information on scoring is contained in the Incident Reporting Policy and Procedure which also has a list of definitions to guide you in your scoring of consequence and likelihood. Action to be taken following an incident is determined by its risk score see below:

Trust Risk Matrix

Likelihood	Almost certain to occur	5	5	10	15	20	25
	Likely to occur	4	4	8	12	16	20
	Could occur	3	3	6	9	12	15
	Unlikely to occur	2	2	4	6	8	10
	Very unlikely to occur	1	1	2	3	4	5
Risk Matrix			1	2	3	4	5
			Negligible	Minor	Moderate	Major	Catastrophic Fatal
			Consequence				

Action to be taken as determined by grading of incident

Green (Low risk) score 1-5	generally require no further investigation
Yellow (moderate risk) score 6-8	may require local (Directorate) action to mitigate risk and learn from incident
Amber (high risk) score 9-12	Incidents that are scored 9-15 should undergo a preliminary investigation then relevant Director will determine whether a full root cause analysis is to be carried out.
RED (Catastrophic/extreme) score 15-25	Incidents that are scored 16-25 should be investigated under the Trust's Serious Incident Procedure; the process is overseen by the Chief Executive.

⁷ For more information on grading incidents refer to the Incident Reporting Procedure available on the Intranet and the Website