Southern Health
NHS Foundation Trust

SH NCP 60

Procedure for Reporting and the Management of "Serious Incidents"

Version: 5

Summary:	Provides managers with the process and procedures into the management and investigation of a Serious Incident, including guidance, templates and information.	
Keywords (minimum of 5): *(To assist policy search engine)*	Managing Incidents, SI, Root Cause Analysis, RCA, IMA, Panels, Templates	
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Version Control

Change Record

Date	Author	Version	Page	Reason for Change
2014	K Wilkinson	1		New procedure following amendments and revision of the Policy and Procedure for Managing Incidents Inclusion of the Investigation, Analysis and Improvement Policy into the Procedure for the Management of Serious Incidents Requiring Investigation.
1.12.15				Review date extended to December 2015
12.08.2015	Jane Druce	2		Updated to new National SIRI reporting Framework March 2015 version, NHS England)
1.12.2015	K Wilkinson & J Druce	2		Updated to reflect National SI Reporting Framework, and revised SI Process within SHFT
10.2.2016	K Wilkinson	2		Updated to reflect additional Mortality Reporting Procedures
07.04.2016	H Ludford	2	10, 16, 18 - 22	Minor amendment to include minor amendments panel and ToR's
15.09.2016	S Pearson	2	Appx1	Change to flowchart to provide further info re Duty of Candour and engagement with families.
25.01.2017	K Wilkinson	3		Amendments to reflect Organisational Changes Updated Appendices
31.01.2017	H Ludford	3		Updated following comments from the Family First group. Minor amendments. Full review to be carried out April 2017
11/4/17		3		Review date extended from April to May 17 - awaiting the new national framework document before review can be completed
26/06/17	S Pearson	4		Additional clarification to specified sections of policy – review date extended to December 2017
10.7.17		4	11	Correct typo, move paragraph from section 8.1 to 9.4
22/12/17				Review date extended from Dec 17 to April 2018
8/2/18		4	33	Addition of appendix 13: Guiding Principles: Sharing Reports Approved at Families First Involvement Group 12.12.17
22/5/18	S Pearson	5		Policy review
18/1/19		5		Review date extended from April to July 19 - waiting for new SI framework to be published by NHSI before review can be completed
20/6/19				Review date extended to Sept 19

Reviewers/contributors

Name	Position	Version Reviewed & Date
Quality and Governance Team		Version 1 - July 2014
Professional Leads		
Information Governance Team		
Safeguarding Team		
Clinical Leads/Clinical Directors		
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Contents

Procedure for Reporting and Managing Serious Incidents

1.0 Introduction

1.1 Serious Incidents in healthcare are adverse events, where the consequences to patients, families and carers, staff or organisations are so significant or the potential for learning is so great, that a heightened level of response is justified. This procedure describes the circumstances in which such a response may be required and the process and procedures for achieving it.

2.0 Purpose of the Procedure

2.1 This procedure is applicable to all staff, whether they are employed by the Trust, another organisation or are contractors delivering services on behalf of the Trust.

Its purpose is to ensure that Serious Incidents (SI) are identified correctly, investigated thoroughly and, most importantly, learned from to reduce the likelihood of similar incidents happening again. This SI investigation procedure is based on national best practice, and uses the NHS England 2015 Serious Incident Framework as its basis. An end-to-end process flow map is included at Appendix One.

2.2 In summary, this highlights the importance of working in an open, honest and transparent way where patients, victims and their families are put at the centre of the process, and focuses attention on the identification and implementation of improvements that will reduce the likelihood of recurrence, rather than simply the completion of a series of tasks.
Those staff designated as investigating officers must have completed an investigator training programme approved by the Trust before undertaking a root cause analysis investigation to support the highest quality investigations, in addition to following the processes detailed in this document.

Immediate Action to undertake when a Serious Incident Occurs

Immediate actions will include:

- Ensuring the immediate safety of all involved in the incident, including the safety of patient(s), staff members and the public
- Informing the service manager or on call manager of the incident
- Following relevant Trust policies relating to infection control, falls, medicines management and safeguarding
- Reporting the incident on Ulysses

3.0 Definition of a Serious Incident

3.1 Serious incidents are events in health care where the potential for learning, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.

Where it is not clear whether or not an incident fulfils the definition of a serious incident, providers and commissioners must engage in open and honest discussions to agree the appropriate and proportionate response.

If an incident is deemed to be a serious incident initially but further investigation reveals that the definition of a serious incident is not fulfilled - the incident can be downgraded.

The NHS England: Serious Incident Framework 2015 and the 2016 update document entitled Frequently Asked Questions provide guidance notes of what could be considered a Serious Incident however the decision should be made on a case by case basis through a panel approach.

3.2 Serious incidents are often triggered by events leading to adverse outcomes for patients, staff and/or the organisation involved. They may be identified through various routes including, but not limited to, the following:

- Incidents identified during the provision of healthcare by a provider;
- Concerns or allegations expressed about a provider by a patient or third party;
- Initiation of other investigations for example:
    - Serious Case Reviews (SCRs)
    - Safeguarding Adult Reviews (SARs)
    - Safeguarding Adults Enquiries (Section 42 Care Act)
    - Domestic Homicide Reviews
    - Death in Custody Investigations, led by the Prison Probation Ombudsman
    - Information shared at Quality Surveillance Group meetings
    - Complaints
    - Whistle-blowing
    - Prevention of Future Death
    - Reports issued by the Coroner.

If an incident is identified where the Trust is not involved in the delivery of care in which the incident occurred, then the Trust must take action to ensure that the relevant provider(s) and commissioner(s) are informed. In these cases contact the Quality Governance Serious Incident and Incident Team,Tatchbury Mount, Calmore, SO40 2RZ Tel: 023 80 874149.

3.3 There is no definitive list of serious incidents and lists should not be created locally. Every incident must be considered on a case-by-case basis using the description below. The broad circumstances included in the National Revised Serious Incident Framework (March 2015[1]) in which a serious incident must be declared are:

- Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in ***unexpected or avoidable death***[2]. This includes
    - suicide/self-inflicted death
    - homicide by a person in receipt of mental health care within the recent past (normally within 6 months of discharge from care)
    - death of an individual who was subject to detention under the Mental Health Act 1983

- ***Unexpected or avoidable injury*** that that has resulted in serious harm, or requires further treatment by a healthcare professional in order to prevent death or serious harm

- ***Actual or alleged abuse;*** sexual, physical or psychological abuse, neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-

[1] https://www.england.nhs.uk/patientsafety/serious-incident/

[2] Caused or contributed to by weaknesses in care/service delivery (including lapses/acts and/or omission) as opposed to a death which occurs as a direct result of the natural course of the patient's illness or underlying condition where this was managed in accordance with best practice.

neglect, domestic abuse, human trafficking and modern day slavery where healthcare did not take appropriate action to safeguard against such abuse occurring[3] or where abuse occurred during the provision of NHS-funded care.

- A ***Never Event*** – regardless of whether it resulted in actual serious harm or death. See http://www.england.nhs.uk/patientsafety/serious-incidents/

- An incident that prevents, or threatens to prevent, an ***organisation's ability*** to deliver an acceptable quality of healthcare services, including the following:

  - Failures in the security, integrity, accuracy or availability of information, data loss and/or information governance related issues, see following SHFT Policy for Information Governance Guidancehttp://www.southernhealth.nhs.uk/workday/policies/ig/
  - Property damage
  - Security breach/concern (this will include absence without authorised leave for patients who present a significant risk to themselves or the public)
  - Screening and immunisation programme incidents where the potential for harm may extend to a large population
  - Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act Deprivation of Liberty Safeguards (MCA DOLS);
  - Systematic failure to provide an acceptable standard of safe care. This may include ward/ unit closure or suspension of service
  - Activation of Major Incident Plan[4]

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

3.4 It may be appropriate for a 'near miss' to be a classed as a serious incident. 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 potential serious harm, the serious incident process should be used to understand and mitigate that risk. Where an incident is considered to have a potentially significant impact albeit that a near miss occurred this should be discussed at a 48 hour incident assessment panel.

3.5 Where the Trust has identified an incident that has occured which involves mutliple providers, or other agencies, the division should contact the Quality Governance Serious Incident and Incident Team, Tatchbury Mount, Calmore SO40 2RZ Tel: 023 80 874149. The team will alert other providers, commissioners, and partner organisations as required in order to initiate discussions in regard to the identification of the lead organisation, scoping and reporting arrangements, organisational SI report sign off and commissioner sign off arrangements. See Appendix Eight identifies other sectors and providers to which this may apply.

4.0 Steps of the Serious Incident Investigation Procedure

4.1 The procedure is described in five steps:

- Incident reporting & Immediate Managers' Assessment (IMA) Form
- 48 Hour Incident Assessment Panel

[3] Includes failure to gather information on which to base care plan/treatment, assess mental capacity, seek consent to treatment, or failure to share information in the best interest of the client to prevent further abuse, and/or to follow policy on safer recruitment.

[4] Visit: http://www.england.nhs.uk/ourwork/eprr/

- Incident Investigation, Root Cause Analysis Report & Improvement Action Plan
- Divisional SI Assurance Panel
- Corporate SI Assurance Panel

Commissioner sign-off follows these, and is managed externally to SHFT.

4.2 Those SI incidients, where the final actual impact grading is major or catastrophic, will require the divisions to attend a Corporate Evidence of Improvement Panel which occurs three to six months after the Corporate SI Assurance Panel. The panel will receive evidence of actions and improvements identified in the action plan of the incident to assure the Trust that learning and improvements have taken place as a result of the incident that occured.

4.3 Key responsibilities of senior staff within the SI Process are detailed in Appendix Two

4.4 Terms of Reference for the above panel meetings are available at Appendix Three, Four, Five and Six.

4.5 **Involvement of Patients, Service Users, Families and Loved Ones** is clearly applicable throughout the investigation process and this is referenced in the supporting policy document. This level of involvement is more that the legalistic requirement to fullfil Care Quality Commission: Regulation 20 Duty of Candour. This engagement should be personable, honest and open. The Trust is genuinely trying to seek the views of Patients, Service Users, Family and Loved Ones as to the level of care provided, their involvement in care planning and to gain an understanding of any concerns. Any concerns and questions should be addressed during the investigation process and responses included in the final report.

Communicating with a distressed patient or bereaved family can be difficult for investigating officers and the Trust's Family Liaison Officer should be included as required. The involvement of the Family Liaison Officer (FLO), who sits within the Quality Governance team, is of paramount importance when the clinical records have not identified or listed an accurate Next of Kin contact details for those who have died. The FLO will actively search for a Next of Kin through other agencies:

- Coroners Officers
- General Practitioners
- The Police
- Other involved services.

The points of contact with **Patients, Service Users, Families and Loved Ones** are advised within this procedure however communication plans should be individually organised and no standard applies. People will all have different needs and the FLO will be able to assist in signposting people to other third sector services who can provide counselling and more individualised support if it is required.

It should be noted that **Patients, Service Users, Families and Loved Ones** need to engage with investigations at the correct time for them and should be allowed to do so. With regard to the SI 60 working day timeframe, the investigation can still be undertaken but can be re-opened if new engagement occurs past the closure point. Most people are unaware of the 60 day timescales and may choose to engage when this has been explained. Contact details of the IO and the FLO should be provided to everyone who chooses not to engage.

An important aspect of the process is the sharing of the final report. Where possible the final report should be shared in person to allow questioning, discussion about points and to ensure clarity of understanding. This should be organised through a planned appointment at a location where the repicient feels comfortable. The FLO will be able to accompany investigating officers to final report meetings.

The FLO sits to the side of the investigation process as predominantly a support service however she will be seeking the views of those involved in the investigation process after the event for Trust-wide learning and improvement.

5.0 Step One: Incident Reporting & Immediate Managers' Assessment (IMA) Form

5.1 Report and submit all incidents onto the Ulysses Risk Management System, by the end of the shift, or within 24 hours if immediate submission is not practicable. A summary user guide is available at http://www.southernhealth.nhs.uk/workday/incident/
Or using a downtime form, from the link below if the system is unavailable
http://www.southernhealth.nhs.uk/workday/incident/help-and-guidance/

The service manager (or deputy) should make an assessment of whether the threshold for an IMA is met, this would normally be all incidents identified as moderate and above and those where learning or impact from a near miss is significant.

5.2 The Ulysses IMA, which is the Managers Form within the Ulysses Risk Management System, should be completed for all serious incidents (see section 3.3), all incidents that the duty of candour is applicable, any incidents that are rated red, or identified as a near miss red event, or if this is requested within the service or by the Quality Governance Team. See Procedure for Reporting and Managing Incidents SH NCP 17.

5.3 The most senior person on duty should complete the IMA within 24 hours of the incident occurring (working days are considered to be Monday to Friday), a copy of the draft IMA if it is not embedded into the Ulysses System must be sent to the Incident and Investigation Team generic e-mail address:hp-tr.incidentreports@nhs.net to enable external reporting onto StEIS within 48 hours of the incident occuring. The IMA form will be reviewed at the 48 Hour Incident Assessment Panel to agree whether further investigation is required. The outcome of the panel should be documented on the Managers' Form along with the names of those involved in the panel decision, and the incident form stage 'closed' by the manager so that notification of progress is documented.

The IMA should detail immediate safety concerns, actions taken to manage those risks and any immediate learning or actions to improve clinical care.

Where Information Governance SIs are identified, please refer to up to date guidance on the Trust website ***http://www.southernhealth.nhs.uk/workday/policies/ig/***

6.0 Step Two: 48-Hour Incident Assessment Panel

6.1 The completed IMA should be taken to the 48 Hour Incident Assessment Panel.

6.2 It is the responsibility of the division to arrange these panels and to include a member of the Corporate Governance Incident and Investigation Team in this discussion, if possible. Details and terms of reference are included at Appendix Three.

6.3 The panel will take into account not only the outcome for the patient, but other factors such as events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response. Serious incidents can extend beyond incidents which affect patients directly and include incidents which may indirectly impact patient safety or an organisation's ability to deliver ongoing healthcare, in making a decision about the level of investigation required.

6.4 There are three possible outcomes from the 48 Hour Incident Assessment Panel:

- No further investigation required – the panel will review the learning and make recommendations for sharing that learning with the patient (if appropriate), family/carers and staff.
- Threshold for SI not met, but investigation felt to be required for additional learning – the panel will commission an investigation inclusive of Root Cause Analaysis (process detailed for RCA to be followed) – a Red Incident.
- Threshold for SI met – (see Section 7.0)

6.5 When a SI is identified, NHS England Local Area Teams and Relevant Commissioning Group require a 72 hour report. This is included in the managers form template (e-RCA) on Ulysses. This should be signed off by the 48 Hour Incident Assessment Panel for sharing with those agencies. It is the responsibility of the Corporate Quality Governance Serious Incident and Incident Team to ensure sign-off by the Incident Assessment Panel and to forward the 72 hour report to the relevant Commissioners or Local Area Team.

6.6 The 48 Hour Incident Assessment Panel will take into account specific issues that may apply to the particular incident, such as it being a Never Event[5] and for investigations requiring input from multiple agencies.

7.0 Step Three: Incident Investigation, Root Cause Analysis (RCA) & Improvement Action Plan

7.1 If the threshold for a SI or a Red (internal RCA) incident is met, the 48 Hour Incident Assessment Panel is responsible for identifying a Commissioning Manager (CM). The responsible Clinical Service Director and the Area Manager of Head of Nursing will normally be the CM but may delegate this function to other senior staff.

7.2 The CM is responsible for the following;

- Identifying the Investigating Officer (IO) and ensuring that all conflicts of interests are disclosed and recorded
- Identifying a specialist clinical advisor[6] to help the IO, if appropriate
- Devising Terms of Reference (ToR) for the investigation (The CM must take into account any concerns raised by the patient and family/carers, as appropriate to the circumstances, in devising these terms of reference). It may be appropriate for the CM to formally meet with the patient/family/carers, before devising terms of reference)
- Sharing the ToR with the patient, family and carers (as appropriate)
- Agreeing with the patient, family and carers (as appropriate) how often they wish to be kept informed of the progress of the investigation while it is being undertaken
- Agreeing what form of contact the service will have with the patient, family and carers (as appropriate) during the course of the investigation, including any forms of support
- Consideration of a referral to theTrust's Family Liaison Officer
- Sharing the ToR with the staff who will be involved in the investigation
- Meeting with the IO on a regular basis to ensure that the investigation is being undertaken in a correct and timely manner
- When the final report is received and approved by the Trust Corporate SI Assurance Panel, sharing this report with the patient, family/carers (as appropriate) and with the staff team involved in the investigation, along with recommendations, actions and updates on those actions.

[5] For a List of Never Events follow this link www.nhs.uk/patient-safety/serious-incidents

[6] Specialist Clinical Advisor can include Expert Medical Opinion, Falls Specialist, Infection Control Team, Tissue Viability Nurses

- Attendance at the Trust Corporate SI Assurance Panel to present the findings of the report, actions and learning from the incident.

The CM and the IO will not be the same person, to allow a level of independence and assurance. The CM will be supported by the Lead Investigating Officer for the Division and some of these responsibilities, such as support to the IO, can be delegated by agreement.

7.3 IOs may only be appointed where they have completed the Trust approved training as determined by the Corporate Quality Governance Serious Incident and Incident team or can evidence prior training. Full training guidance is not included in this procedure as it is referenced in the policy; however a summary of the NPSA (former National Patient Safety Agency) standard for RCA investigation reports are included at Appendix Nine to support quality assurance.

The IO is responsible for the following:

- Carrying out a full investigation inclusive of recognised RCA techniques: report to be embedded in the Ulysses system.
- Highlighting care or service delivery problems identified in the course of the investigation and recording these
- Establishing causative factors
- Making recommendations for practice
- Submitting the final report to the CM.

7.4 The IO will undertake an investigation and complete the analysis using RCA tools. This will consider whether any individual, team or organisational processes delivering care or services could be improved to reduce the likelihood of similar incidents occurring again and to focus efforts for improvement and learning.

7.5 The final report and its recommendations should be discussed at a Divisional SI Assurance Panel within 45 working days of the incident being reported. The terms of reference for the panel are detailed in Appendix Four.

7.6 The responsibility for devising actions from the recommendations lies with the CM. This may be delegated in practice to representatives of the service area, such as the area service manager, head of nursing and the Clinical Services Director. It is essential that the service where the incident occurred are involved in the process of developing the action plan which is recorded on Ulysses Risk Management System. A standard action should be included in the report for the CM to share the report with the team where the incident took place. The improvement action plan may be devised within the Divisional SI Assurance Panel or another meeting with input from the IO, if appropriate.

7.7 The actions should be SMART:

- **S**pecific, well defined, clear to anyone
- **M**easurable, meaningful and attainable
- **A**chievable, attainable and how the achievement will be evidenced
- **R**ealistic, results orientated and reasonable
- **T**ime-based, tangible, trackable

The completion date for the action plan must be within 6 months of the date of the incident occurring.

7.8 The leads for the service area (such as the service manager, head of nursing or the CSD) have responsibility for ensuring that the action plan is monitored, updated and closed in a timely fashion, within local governance fora. Outcomes should be shared with area managers and divisional directors for assurance that there is a robust system in place to share learning.

7.9 Once approved by Corporate SI Assurance Panel, the CM has responsibility for ensuring that the report, recommendations, actions and updates on actions are shared with the patient, family/carers (as appropriate) and the staff team involved in the investigation.

7.10 It is important that the report in its entirety is treated as the intellectual property of the IO and no changes should be made to it without the knowledge and agreement of the IO. Changes may be made to the report at any stage with the knowledge and approval of the IO.

8.0 Step Four: Divisional Serious Incident Assurance Panel

8.1 Every Division in the Trust must establish a Divisional SI Assurance Panel, the purpose of which is to quality- assure and sign off the investigation report to submit to the Corporate SI Assurance Panel. It is the responsibility of the division to ensure these are in place and timely, ie held within 45 days of the investigation being commissioned. Terms of reference for the Divisional SI Assurance Panel are detailed in Appendix Four.

Outcomes from the Divisional SI Assurance Panel are either approved for submission to Corporate SI Assurance Panel for final assurance, or returned for further investigation or clarification by the division.

9.0 Step Five: Corporate Serious Incident Assurance Panel

9.1 Once the investigation report has been agreed by the Divisional SI Assurance Panel, it will be submitted to the Corporate SI Assurance Panel by the CM within 45 working days of the incident being reported.

9.2 The Corporate Quality Governance Serious Incident and Incident Team will maintain a list of the Corporate SI Assurance Panel dates and it is the responsibility of the division to book themselves onto a panel for their SI investigation. See Appendix Five – Terms of Reference for Corporate SI Assurance Panel.

The quality of the report will reviewed against the Corporate SI Assurance checklist and feedback form. This will include checks relating to duty of candour compliance, RIDDOR reporting, safeguarding reporting, involvement of medical trainees, final impact grading and overall quality of the report and use of the Central Alert System (CAS) for any immediate learning identified to be shared across the Trust. In addition to these checks, the report will be reviewed against the Commissioners Closure Panel Checklist. Templates for both these checklists are in appendices ten and eleven.

9.3 If the report is considered completed, it can be closed at this stage and it is the responsibility of the Corporate Quality Governance Serious Incident and Incident Team to upload the final approved report onto the StEIS System for Commissioner review and close. It is also the responsibility of the Corporate Quality Governance Serious Incident and Incident Team to update the final grading of the incident following panel decision.

If changes are required to the report, these should be made on the Ulysses system by the IO, or the Divisional Lead Investigating Officer with the knowledge and agreement of the IO and the report rebooked onto the next agreed corporate panel review date or alternatively to the Corporate Minor Amendments Panel

9.4 When approved by Corporate SI Assurance Panel, the report will be shared with commissioners within 60 working days of the incident being reported as an SI onto StEIS.

10.0 Step Six: Corporate Minor Amendments Panel (if required)

10.1 The Chair of the Corporate SI Assurance Panel will stipulate which reports can be seen at minor amendments panel as opposed to returning to full panel. The panel should be used for the approval of minor changes before the report is submitted to the commissioners on StEIS System for Commissioner review and closure. The quality of the report will be reviewed against the Corporate SI Assurance Panel Checklist and Feedback Form and the Commissioners Closure Panel Checklist. Templates for both these checklists are in appendices ten and eleven.

10.2 On occasion where the panel decides that only very minor amendments are needed to the SI report then the revised report is approved via virtual review (via email) and does not go to a formally convened minor amendments panel. Where this occurs email trails of any amendments, or the sign off for the report will be uploaded to Ulysses by the Corporate Quality Governance Serious Incident and Incident Team.

11.0 Corporate Evidence of Improvement Panel (if required)

Where an incident has been approved for external sharing and the final impact grading has been designated as either major or catastrophic. The Division will be required to attend a Corporate Evidence of Improvement Panel. The purpose of the panel is to actively seek assurance of improvement changes and ensure that the action plan actions have been completed and closed. An attendance date will occur three to six months post the Corporate SI Assurance Panel.

The panel will provide a feedback form to the Divisional Director. This will detail if the panel were assured that the evidence provided on actions and learning form the SI have been ebbeded and shared in the division. Alternatively if further assurance is required and attendance at a future panel to provide this assurance is required. See Appendix Twelve for the Evidence of Improvement Panel Feedback Form.

12.0 Shared Learning

Each Division should establish a system to ensure that learning and notable practice is disseminated across the divisional areas. This can be achieved either through the governance routes or additionally through newsletters, staff forums and/or training sessions. Further guidance can be found in the Trust Organisational Learning Strategy and the Learning from Incident page on the Trust Intranet, which can be accessed by following this link - http://www.southernhealth.nhs.uk/knowledge/governance/learning-and-sharing/

13.0 Inquests

Due to the serious nature of SI's, RCA Reports, IMA's and Incident Forms may be required for submission as evidence at a Coroner's Inquest. It is essential that following Divisional SI Review Panels and Corporate Assurance SI Review Panels that the final agreed investigation, which include any addendum reports are sent to the corporate Governance Investigation and Incident team.

The Divisional Director / Associate Director/Clinical Director or nominated deputy as designated should routinely identify any recommendations made by the Coroner and translate these into actions to embed into clinical practice. The Divisional Director should liaise with the Head of Legal Services and the Corporate Quality Governance Investigation and Incident team, to ensure the actions are included as an addendum to the report and forwarded to the Corporate Governance Investigation and Incident team.

Further information regarding Inquests can be accessed in the Inquest Management Protocol SH NCP 9.

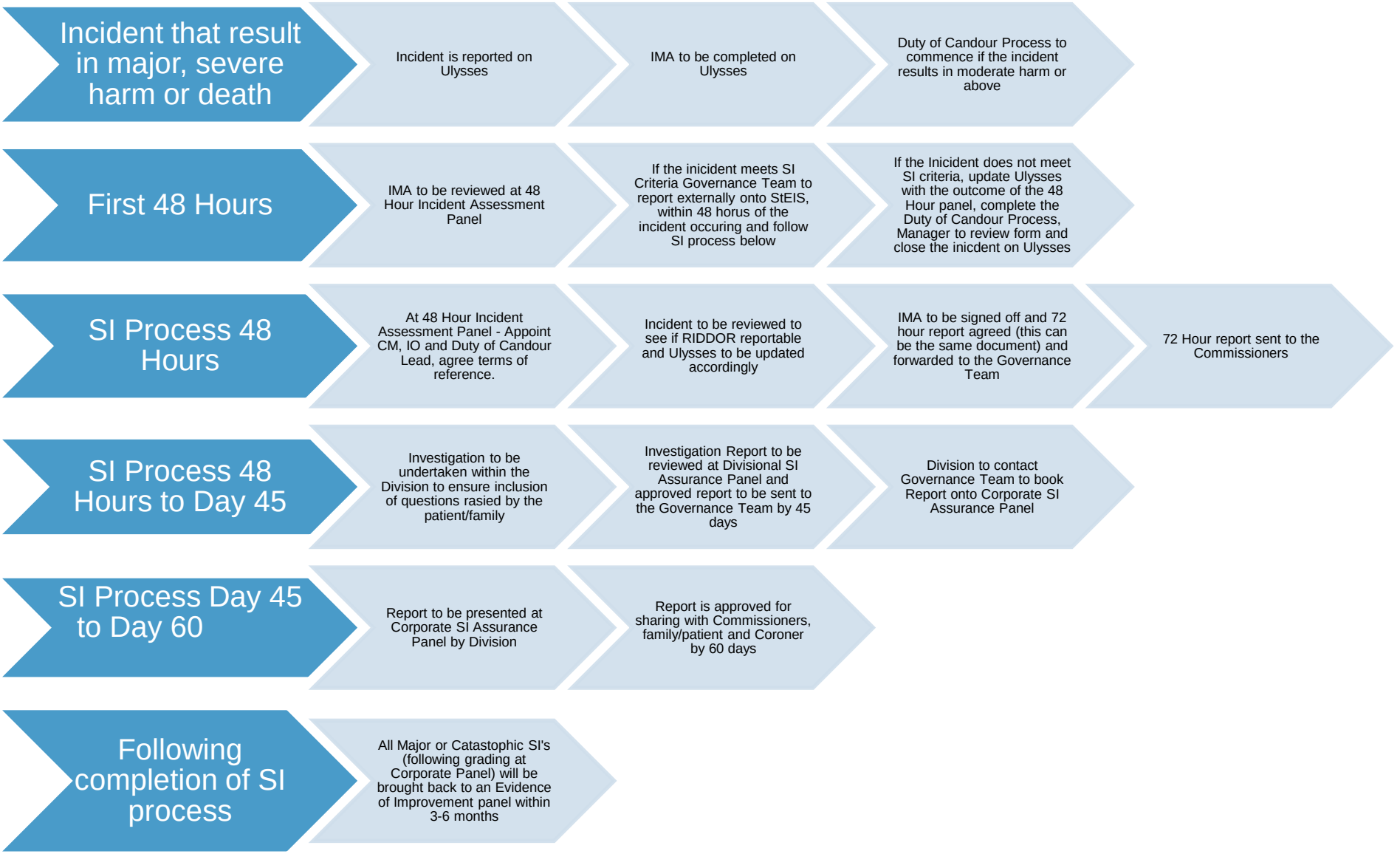
14.0 Associated Documents

To be read in conjunction with this policy:

- Duty of Candour Policy SH NCP 12
- Being Open Procedure (incorporating Duty of Candour) SH NCP 13
- Procedure for Reporting and Investigating Deaths SH NCP 75
- Policy for Managing Incidents and Serious Incidents SH NCP 16
- Procedure for Reporting and Managing Incidents SH NCP 17
- Inquest Management Protocol SH NCP 9
- Safeguarding Adults Policy SH CP 15.2
- Safeguarding Children's Policy SH CP 56
- Serious Case Review Procedure SH CP 98
- Infection Prevention and Control Policy SH CP10
- Ward/department Closure: Due to a suspected or confirmed outbreak of infection SH CP 99
- Pressure Ulcer Prevention and Treatment Policy SH CP 121
- Health and Safety Policy SH HS 04

Appendix One - End to End Process Map for all incidents resulting in major, severe harm or death

Please note that all incidents other than those resulting in major, severe harm or death should be managed in line with SH NCP 17 Procedure for Reporting & Managing Incidents



Please use this flowchart in conjunction with the Duty of Candour Policy/Procedure whilst remembering that Patient, Service User, Family and Loved One engagement is much more than the legalistic requirement.

Appendix Two
Summary of Key Responsibilities within the SI Process

Responsibilities and Accountabilities of the Divisional Director
• Responsible and accountable for overseeing the process for SI investigations: • Ensure effective communication and support for patients, service users, relatives and carers affected. • Ensure divisional senior managers undertake SI Commissioning Manager (CM) role. • Ensure staff undertaking investigations have been RCA trained and are given adequate time and administrative support. • Ensure 48 Hour Incident Assessment Panels are in place. • Ensure Divisional SI Assurance Panels quality assure RCA investigations within **45 working days**. • Update the central Communications Team, if there may be media interest. Patients, service users and their relatives and carers should be fully informed beforehand. • Ensure robust divisional quality and learning frameworks are in place • Ensure the Duty of Candour / involvement of patients, service users, families and loved ones is undertaken for all incidents of moderate actual impact and above
Responsibilities and Accountabilities of the Commissioning Manager (CM)
• Appoint and oversee the most appropriate member of staff to undertake the Duty of Candour Process, ensuring that agreement is sought with the family / patient / carer on how often and by what means they wish to be kept informed of the progress of the investigation whilst it is being undertaken. Consideration should also be given to what type of support they may require. • Devising terms of reference for the RCA investigation and enter these onto the e-RCA system (The commissioning manager must take into account any concerns raised by the patient and family/carers, as appropriate to the circumstances, in devising these terms of reference. It may be appropriate for the commissioning manager to formally meet with the patient/family/carers, as appropriate, before devising terms of reference) • Identify and document the investigating officer on e-RCA to allow them to edit and develop the report, and ensuing that all conflicts of interests that the IO may have in investigating the incident are disclosed and recorded • Identifying a specialist clinical advisor to help the IO, if appropriate • Ensure that the Investigating Officer has administration support and protected time to undertake the investigation. • Sharing the ToR with the patient, family and carers (as appropriate) • Arrange to meet with the IO on a regular basis. • Ensures that the Investigation report is completed and booked onto the Divisional SI Assurance Panel within 30 days of the reporting of the incident. • Quality-assure the RCA report prior to submission to the Divisional SI Assurance Panel. • Book the Corporate SI Assurance Panel date following Divisional SI Assurance Panel approval • Agreeing with the patient, family and carers (as appropriate) how often they wish to be kept informed of the progress of the investigation while it is being undertaken • Sharing the ToR with the staff who will be involved in the investigation • When the final report is received and approved by the Corporate SI Assurance Panel, sharing this report with the patient, family/carers (as appropriate) and

with the staff team involved in the investigation, along with recommendations, actions and updates on those actions.

- Ensure that staff from the service where the incident occurred develop the action plan to address root causes and lessons learnt prior to the report being presented to the Divisional SI Assurance Panel.

Responsibilities and Accountabilities of the Investigating Officer (IO)

- Allocate time to undertake the investigation, usually at least 5 days. The IO's line manager is responsible for supporting this.
- To have completed the Trust approved RCA investigation training and have read the Duty of Candour Policy SH NCP 12, and Procedure SH NCP 13.
- To follow the agreed terms of reference, and meet with the CM on a regular basis to update on the progress of the report.
- To report any additional serious concerns that come to light during the course of the investigation to the CM.
- To prepare the RCA report using the Ulysses e-reporting RCA template.
- To attend the Divisional SI Assurance Panel to present the findings.

Responsibilities of the Corporate Governance Investigation and Incident team

- Log reported SIs within two working days via the StEIS National reporting system.
- Update StEIS, including the 72-hour report, and the RCA report following Corporate Assurance Panel approval, within 60 days.
- Ensure the SIs are communicated to executives and senior managers.
- Negotiate additional timescale changes with commissioners if required.
- Support SI final closure process with Clinical Commissioning Groups on behalf of the Trust following Corporate Assurance Panel approval.
- Support thematic analysis of RCAs reported, findings and learning.
- Book, support and administer the Corporate Assurance Panel
- Provide a weekly SI report to Care Quality Commission and other external agencies as required.
- Provide RCA and incident management training and support.

Responsibilities of Specialist Advisors

External experts should be sought from within the NHS in the first instance and would only be employed from outside of the NHS in exceptional circumstances. In all cases, this will be by agreement, and identified in the terms of reference for the investigation**.**

Infection Control Related SIs: For example MRSA Bacteremia and Clostridium Difficile related death, where this appears on part one of the death certificate; or outbreaks of diarrhoea and vomiting which have involved a ward closure will be supported by the Trust Infection Prevention and Control Team.

Information Governance Related SI's: The SI will be managed in accordance with the Information Governance Team Guidance. They will report the SI onto the IG SI Toolkit and inform the Corporate Governance Investigation and Incident team for StEIS reporting. On completion of the investigation a copy of the report will be forwarded to the Corporate Governance Investigation and Incident Team for closure on StEIS.

Falls Related SI's: Where an SI is related to a fall a member of the falls team should be included as part of the investigation team.

Safeguarding Adults and Children: Where abuse of an adult or child has been suspected, then advice should be sought from the Safeguarding Teams.

Appendix Three: Terms of Reference for 48 Hour Incident Assessment Panel
(within 48 hours of incident reported)

1.0 Constitution

1.1 The Senior Management Committee (SMC) resolve to establish 48 Hour Incident Assessment Panel Meetings, which function as part of the Incident Process

1.2 The 48 Hour Incident Assessment Panel Meetings are authorised by the Quality and Safety Committee (QSC) via the Patient Safety Group to take action in respect of any activity within their terms of Reference. They are authorised to seek any information they require from any employee and all employees are directed to co-operate with any request made by the panel Chair.

1.3 The definition of 48 hours is within 2 working days (Monday to Friday) of the incident or death occuring or the Trust being made aware that it had occurred and report on the Safeguard Ulysses Risk Management System.

2.0 Purpose, Duties and Responsibilities

2.1 The purpose of the 48 Hour Incident Assessment Panel Meeting, is to review information pertaining to the occurrence of a death or incident. The panel is responsible for reviewing IMA's linked to patient deaths and those incidents with significant patient harm graded as major or catastrophic.

2.2 The 48 Hour Incident Assessment Panel's duties include the following:

- Determine if the information contained within the IMA form is adequate
- Determine whether the recommendations made by the IMA author are appropriate with regards to:

  Immediate actions required to prevent harm to the patient or others
  Requirement to contact the Police
  Referrals to Safeguarding
  Level of investigation required including whether the incident is SI reportable
  Steps taken in relation to duty of candour / patient, service user, family and loved one involvement
  Support for the staff involved in the incident
  Requirement to notify commissioners of any concerns identified with 3rd party organisations
  Assess if the Incident is RIDDOR[7] reportable
  (All of the above will be considered against the Corporate Assurance/CCG quality checklists).

- Determine the Investigation Commissioning Manager (usually the panel Chair) and Investigating Officer. Whilst the Commissioning Manager does not need to be the panel Chair, the panel Chair is responsible for ensuring the terms of reference are provided to the Investigating Officer within 5 working days of the panel convening.

- Make an accurate record of the panel membership and its conclusions on the Ulysses System.

[7] RIDDOR - Reporting of Injuries, Disease and Dangerous Occurrences, further information can be obtained from the Health and Safety Team or the following Health and Safety Executive Website http://www.hse.gov.uk/riddor/

- Communicate the outcome with regards to SI reporting to the Governance Incident and Investigation Team to ensure that the external reporting to StEIS is completed. This must occur on the same day as the 48 Hour Incident Assessment Panel as national external reporting must be undertaken within 48 hours (2 working days) of the incident occuring.
- Develop a plan for internal executive communication if required
- Develop a plan for external media communications if required

2.3 Special Circumstances for Consideration at 48 Hour Incident Assessment Panel

- Never Events: Where an incident is identified as a Never Event[8] the 48 Hour Incident Assessment Panel should include the Medical Director / Director of Nursing or their nominated deputies.
- Death of a patient detained under the Mental Health Act 1983; Any death of a patient detained under the Mental Health Act 1983 must additionally be reported to the CQC without delay and must also be investigated using the ERCA process.

3.0 Membership

3.1 The Divisional Clinical Director, Clinical Service Director or Associate Director of Nursing should chair the panel which can take place either face to face or via Lync Conference call facilities. If none of these members of staff are available, the panel can be chaired by a nominated senior clinician.

3.2 Those invited and expected to attend would be:

- The manager of the service in which the incident occurred
- The individual completing the IMA (if different from above)

3.3 Further invited members to be considered dependant on the incident type;

- Senior Service Managers
- Clinicians involved
- Safeguarding representative
- A Member of the Corporate Incident and Investigation Team
- Business Manager
- Human Resources expert
- Subject matter experts dependant on the incident

3.4 Quoracy would be the Chair and 70% of the invited attendees

4.0 Accountability

4.1 The Divisional Clinical Directors are accountable for ensuring that 48 Hour Incident Assessment Panels are held to review IMAs involving a patient/ service user death or those incidents with significant patient harm graded as major or catastrophic.

[8] As identified within the NHS England Serious Incident Framework - Never Events List which can be found on the following link www.england.nhs.uk/ourwork/patientsafety/never-events/

Appendix Four: Terms of Reference for Divisional SI Assurance Panel
(Within 45 working days of the incident occurring)

1.0 Constitution

1.1 The Senior Management Committee (SMC) resolve to establish Divisional SI Assurance Panel Meetings, which function as part of the Incident Process

1.2 The Divisional SI Review Panel are authorised by the Quality and Safety Committee (QSC) via the Patient Safety Group to take action in respect of any activity within their terms of Reference. They are authorised to seek any information they require from any employee and all employees are directed to co-operate with any request made by the panel Chair.

1.3 The definition of 45 days is - within 45 working days (Monday to Friday) of the incident or death occuring or the Trust being made aware that it had occured.

2.0 Purpose, Duties and Responsibilities

2.1 The purpose of the Divisional SI Assurance Panel Meeting, is to review and sign off the Investigation Report pertaining to the occurrence of a death or incident for approval to forward to the Corporate SI Assurance Panel.

2.2 The Divisional SI Assurance Panel duties include;

- Determine if the investigation report meets the requirements; for quality, effectiveness, analysis and the terms of reference using the Trust's ERCA tool reference for the report
- Determines if effective engagement and information has been provided by specialist advisors, other agencies engaged in the patient's care pathway
- Determines that investigation has met all the requirements of the duty of candour / involvement of patients, service users, families and loved ones and agrees a communication plan for sharing the final report
- Drafts and agrees the action plan for the investigation, ensuring nominated staff are aware of their actions to undertaken and by when
- Ensures that the Trusts obligations to the safeguarding process have considered and undertaken as appropriate to the incident
- Ensures the report documents the mechanisms for sharing the learning from the report for the team involved, divisional area, divisional and trust wide and by whom

2.3 To make amendments to investigation report, as discussed within the panel.

2.4 The panel should make an accurate record of the panel membership and its conclusions on the Ulysses System.

2.5 Communicate the outcome of the panel to the Corporate Quality Governance Team and confirm a booking onto the Corporate SI Assurance Panel.

3.0 Membership

3.1 The Clinical Services Director or Associate Director of Nursing should chair the Divisional SI Assurance panel which can take place either face to face or via Lync conference call facilities. If none of thee members of staff are available, the panel can be chaired by a nominated senior deputy/senior clinician.

3.2 Those invited and expected to attend as minimum would be;

- The Area Manager of the Service
- Head of Nursing of the Location
- The Commissioning Manager if not the manager of the service
- The Investigating Officer
- Relevant specialist staff

Quoracy would be the Chair and 60% of the invited attendees

4.0 Accountability

4.1 Divisional Directors / Clinical Directors are accountable for ensuring Divisional SI Assurance Panels are held involving a SI reportable incident.

Appendix Five: Terms of Reference for Corporate SI Assurance Panel
(Between 45 and 60 working days of the incident occurring)

1.0 Constitution

1.1 The Senior Management Committee (SMC) resolve to establish Corporate Assurance SI Panel Meetings, which function as part of the Incident Process

1.2 The Corporate SI Assurance Panel are authorised by the Quality and Safety Committee (QSC) via the Patient Safety Group to take action in respect of any activity within their terms of Reference. They are authorised to seek any information they require from any employee and all employees are directed to co-operate with any request made by the panel Chair.

1.3 The definition of between 45 and 60 days is - within 45 and 60 working days (Monday to Friday) of the incident occuring or the Trust being made aware that it had occured.

2.0 Purpose, Duties and Responsibilities

2.1 The purpose of the Corporate SI Assurance Panel Meeting, is to review and approve the Investigation Report pertaining to the occurrence of a death or incident for approval for sharing, with patient/family/carers, commissioners and coroners.

2.2 The Corporate SI Assurance Panel duties include;

- Divisions will be expected to present to the panel meeting, a summary from their investigation of; their findings, trends or themes, learning from the incident and how this will be shared, support given to the patient/ relatives / carers /staff and an action plan to support the investigations findings.
- Ensure that Duty of Candour / involvement of patients, service users, families and loved ones has been completed to the expected standard and arrangements are made to share the report appropriately
- Provide feedback to the Division on the standard of the report for learning.
- Determine the final actual impact grading for the incident.
- Ensures the report documents the mechanisms for sharing the learning from the report for the team involved, divisional area, divisional and trust wide and by whom
- Review if the incident is RIDDOR reportable
- Review if the incident has been reported to Safeguarding
- Determines whether a Medical Trainee has been involved in the incident for sharing with the Deanary
- All of the above actions will be evidenced by way of completion of the Corporate Assurance panel checklist

2.3 To make amendments to investigation report, as discussed within the panel.

2.4 The panel should make an accurate record of the panel membership and its conclusions on the Ulysses System.

2.5 The Corporate Assurance panel will also check the report against the CCG Quality checklist in order to ensure compliance to this.

2.6 Communicate the outcome of the panel to the Corporate Incident and Investigation Team and book the report onto the Corporate SI Assurance Panel within 45 working days of the incident occurring.

3.0 Membership

3.1 The Corporate SI Assurance Panel will be chaired by a member of the Executive team, or an Associate Director with delegated authority, for example to the Deputy Medical Director or Associate Director of Quality Governance. The Panel can take place either face to face or via Lync conference call facilities.

3.2 Those invited would be;

- The Commissioning Manager
- Relevant specialist staff
- Associate Director of Quality and Governance
- Head of Legal Services, Risk & Patient Safety
- Incident and Investigation Manager
- Divisional Lead Investigating Officer
- SI Support Officer - to administer the meeting

Quoracy would be the Chair and 60% of the invited attendees

3.3 Heads of Quality from the Clinical Commissioning Groups may also attend, with regard to specific SI's or for assurance purposes.

4.0 Accountability

4.1 The Executive Director with responsibility for SI Management is accountable for ensuring that all SI Investigation reports are reviewed in the Corporate SI Assurance Panel.

Appendix Six: Terms of Reference for Corporate Minor Amendments Panel
(Between 45 and 60 working days of the incident occurring)

1.0 Constitution

1.1 The Senior Management Committee (SMC) resolve to establish Corporate Assurance SI Panel Meetings, which function as part of the Incident Process.

1.2 The Corporate SI Assurance Panel are authorised by the Quality and Safety Committee (QSC) via the Patient Safety Group to take action in respect of any activity within their terms of Reference. They are authorised to seek any information they require from any employee and all employees are directed to co-operate with any request made by the panel Chair.

1.3 The definition of between 45 and 60 days is - within 45 and 60 working days (Monday to Friday) of the incident occuring or the Trust being made aware that it had occured.

2.0 Purpose, Duties and Responsibilities

2.1 The purpose of the Corporate Minor Amendments Panel Meeting, is to review and approve the minor amendments made to the Investigation Report pertaining to the occurrence of a death or incident for approval for sharing, with patient/family/carers, commissioners and coroners.

2.2 The Corporate Minor Amendments Panel duties include;

- Divisions will be expected to present to the panel meeting, the minor amendments which they have made to the report following review by the Corporate SI Assurance Panel.
- Ensure that Duty of Candour has been completed to the expected standard and arrangements are made to share the report appropriately
- Review the final actual impact grading for the incident which may been completed at Corporate SI Assurance Panel and adjust accordingly if necessary.
- Ensures the report documents the mechanisms for sharing the learning from the report for the team involved, divisional area, divisional and trust wide and by whom
- Review if the incident is RIDDOR reportable if not ascertained by the previous panel.

2.3 To make amendments to investigation report, as discussed within the panel.

2.4 The panel should make an accurate record of the panel membership and its conclusions on the Ulysses System.

2.5 Communicate the outcome of the panel to the Corporate Incident and Investigation Team and book the report onto the Corporate SI Assurance Panel within 45 working days of the incident occurring.

3.0 Membership

3.1 The Corporate SI Assurance Panel will be chaired by the Associate Director of Quality Governance or the Head of Legal and Insurance Services. The Panel can take place either face to face or via Lync conference call facilities.

3.2 Those invited would be;

- Investigating Officer
- Lead Investigating Officer – Divisional
- SI Support Officer

Quoracy would be the Chair and two others

3.3 Heads of Quality from the Clinical Commissioning Groups may also attend, with regard to specific SI's or for assurance purposes.

4.0 Accountability

4.1 The Assoicate Director of Quality Governance acts on the delegation of the Chair of the Corporate SI Assurance Panel with accoutability for ensuring that minor amendments have been completed in accordance of the documented evidence of the panel.

Appendix Seven: Terms of Reference for Corporate Evidence of Improvement Panel
(Within 3 Months of the SI report's approval at the Corporate SI Assurance Panel)

1. Constitution

1.1. The Senior Management Committee (SMC) resolves to establish a divisional-based forum known as the Evidence of Improvement Panel.

1.2. The Evidence of Improvement Panel is authorised by the Quality & Safety Committee (QSC) to take action in respect of any activity within its Terms of Reference. It is authorised to seek any information it requires from any employee and all employees are directed to co-operate with any request made by the meeting Chair.

2. Purpose

2.1. The purpose of the Evidence of Improvement Panel is to oversee and assure the Quality & Safety Committee (QSC) and the Patient Safety Group that all serious incidents which receive a final impact grade of major or catastrophic are monitored to ensure closure of the resulting improvement action plan.

2.2. The Evidence of Improvement Panel will check that the final part of the Duty of Candour (Regulation 20) requirement has been fulfilled and evidence exists that the final report has been shared with family members.

2.3. The Evidence of Improvement Panel members will actively seek assurance of improvement changes and ensure that the action plan actions have been completed and closed.

2.4. The Evidence of Improvement Panel members will actively seek assurance that learning has taken place as a result of the incident.

3. Membership

3.1. The Associate Medical Director for Patient Safety will Chair and in their absence, the nominated deputy will preside over the meeting, either the Associate Director of Quality Governance or the Associate Medical Director – Patient safety.

3.2. A quorum will be 50% of core members in addition to the Chair.

3.3. Members will attend at least 75% of meetings annually, meetings will occur monthly.

3.4. <u>Core Members</u>

- Medical Director or Chief Nurse
- Associate Director of Quality Governance
- Associate Medical Director – Patient Safety
- Lead Investigating Officer for the Relevant Division

An agreed consistent secretary will provide secretarial support to the meeting.

Functions to be undertaken;

- agenda construction
- meeting booking
- circulation of papers
- minute taking

3.5. <u>Co-opted Members</u>

Any other member of staff from across the Trust or externally, may be invited to attend the meeting on a periodic or ad-hoc basis usually related to the incident which has occurred. These may include;

- Associate Directors of Nursing
- Divisional Senior management
- Divisional Clinical Directors
- Heads of Profession
- Locality Managers
- Action Owners

3.6. Attendance will be requested and a date will be allocated 12 weeks following the Serious Incident Corporate Panel where the incident was impact graded as a major or catastrophic. The request for attendance will be sent to the Divisional Director.

3.7. The Clinical Quality Managers of the CCGs will be asked to attend relevant panels where appropriate.

4. Duties & Responsibilities

4.1. To review the improvement evidence supplied by the Division applying scrutiny, check and challenge.

4.2. To review the improvement action plan and be assured that actions have been closed and understand why there is a delay if the actions have not been closed.

4.3. To review and challenge the change evidence:

- Updated policies
- Updated standard operating procedures (SOPS)
- New policies
- New standard operating procedures (SOPS)
- New staffing models
- Service functionality changes

4.4. To be assured by the presenting team that the Duty of Candour (Regulation 20) requirements have been completely fulfilled and this is evidenced.

4.5. To receive assurance through evidence that any concerns raised by the Coroner at inquest have been satisfied.

4.6. To challenge the level of learning and check the evidence:

- Team learning
- Locality learning
- Divisional learning
- Organisational learning

4.7. Gain assurance that no similar incidents of this type have occurred within the Division.

4.8. Provide an update report to the QSC on a quarterly basis.

5. Accountability

5.1. The Chair will provide verbal reporting to the Senior Management Committee (SMC) and the Board.

5.2. The Chair will provide a quarterly report to the Quality and Safety Committee (QSC) and Patient Safety Group.

6. Review

6.1. The Terms of Reference of the meeting shall be reviewed within 6 months of the date approved.

6.2. This will include a review of its effectiveness to ensure it has performed in accordance with these terms of reference, specifically that:

- The Evidence of Improvement Panel meeting has occurred and been quorate
- The Evidence of Improvement Panel meeting has reported to Trust Board via Quality and Safety Committee (QSC)
- Has provided service quality improvement and is able to evidence this?

Appendix Eight
Interface with other Sectors & Organisations

Where more than one agency is involved, this may require a multi-provider approach. In such cases, collaborative working between partner agencies is essential, and ideally, only one investigation should be undertaken. It is for Trusts to decide the lead agency, through discussions with those agencies identified. However, Commissioners can faciliate discussions for co-ordinating complex multi-provider SI's.

Case type	Lead investigator
Pressure Ulcers	SHFT is the primary care provider when: • SHFT Staff are seeing the patient weekly or more frequently who may have a package of care also being delivered by another provider • The patient is on the SHFT virtual ward • Patient is not having any personal care provided by a care agency • Patient is in the care of other agencies e.g. residential home but we have not completed appropriate assessment or care
Other NHS Providers	The Governance Incident and Investigation Team, hold a key contact list for local NHS Providers, who will faciliate multi-provider SI's for their organisation.
HR investigations: 'Just-Culture'	The need for disciplinary action against staff may become apparent during the course of a SI, in which case, a separate process will be used, as described in SH HR 29 Disciplinary Procedure. Disciplinary action is only considered where one or more of the following applies: • Use of the NPSA Incident Decision Tree indicates that it may be appropriate to implement disciplinary action. • There is a police investigation that proceeds to a prosecution. • There are repeated occurrences involving the same individual • In the view of the trust and /or any professional body the action causing the event was far removed from acceptable practice, constituting gross misconduct. Where this occurs, the Investigating Officer should report this to the Commissioning Manager to address separately to the SI investigation
Involvement of Criminal Justice System Agencies	Wherever possible, serious incident investigations should continue alongside criminal proceedings but this should be considered in discussion with the Police (i.e. following a formal request by police, coroner or judge) the Trust SI investigation may be put on hold and this should be discussed with those involved. In such cases, it is vital that the reasons for the delay are communicated to the patient, family/carers (as appropriate) in writing.
Deaths in Custody- where health provision is delivered by the NHS	Prison and Probation Ombudsman (PPO) or the Independent Office for Police Conduct (IOPC) are responsible for carrying out the relevant investigations. The Trust must fully support these investigations where required to do so, see http://www.ppo.gov.uk/updated-guidance-for-clinical-reviews/

Serious Case Reviews and Safeguarding Adult Reviews	The Local Authority via the Local Safeguarding Children Board or Local Safeguarding Adult Board (LSCB, LSAB as applicable), has a statutory duty to investigate certain types of safeguarding incidents/ concerns. The Trust must contribute towards safeguarding reviews and enquiries as required to do so.
Homicide by patients in receipt of mental health care	Where patients in receipt of mental health services commit a homicide, NHS England will consider and advise on the investigation pathway and, if appropriate, will commission an independent investigation.
Serious Incidents in National Screening Programmes	Serious Incidents in NHS National Screening Programmes must be managed in line with the guidance: *Managing Safety Incidents in National Screening Programmes*

Appendix Nine

NPSA Guidance on the Principles of Root Cause Analysis and Report Writing


NRLS-0769B-RCA-investigat~t-writing-200


NRLS-0769D-RCA-tools-inve~iew-guide-2

Appendix Ten Corporate SI Assurance Panel Checklist and Feedback Form

To be completed and returned to the investigating officer and commissioning manager within 24 hours of the panel taking place

Incident Number STEIS Number	Incident Date	Panel Chair	Panel Type
			Corporate Panel
Investigating Officer	Commissioning Manager	Division	Panel Date

Serious Incident Report Grading (*reviews the quality of the report submitted)*

Excellent ☐	Meets all requirements. Excellent quality report. No changes required.
Very Good ☐	Meets all requirements. Very good quality report. Minor typo and format changes.
Good ☐	Meets the majority of the requirements. Requires review of 3 minor factors raised by the panel. Minor typo and format changes.
Average ☐	Meets the some of the requirement but requires some review of contributory factors and root cause. Includes spelling and grammatical errors. Requires re-formatting. Appears rushed with incomplete analysis of the information. Panel has more questions requiring answers
Below Average ☐	Fails to meet the minimum requirement. Fails to summarise the events of the incident and 'tell the story'. Does not address the Terms of Reference or important factors such root causes and duty of candour. Requires a re-write of 70% or more of the document.

Impact Grading

The duty of candour has been met?	Yes ☐	No ☐
Does the Incident require RIDDOR reporting?	Yes ☐	No ☐
Has the Incident been reported to Safeguarding?	Yes ☐	No ☐
Immediate Action / CAS Alert	Yes ☐	No ☐
Require sharing with the Board	Yes ☐	No ☐
Impact grade applied at this panel?	Yes ☐	No ☐
Was there a medical trainee involved in the incident (If yes copy to DME)	Yes ☐	No ☐

*Catastrophic	*Major	Moderate	Low	No Impact
☐	☐	☐	☐	☐

***Date for Improvement Panel for Catastrophic or Major Incidents

Panel Outcome

Panel Approval Upload to STEIS	Return to Minor Amendments Panel	Return to Corporate Panel	Date for Commissioner Panel
☐	☐return date =	☐return date =	☐

Feedback Text

Appendix Eleven Commissioners Closure Panel Checklist

Commissioner Closure Check List.pd

Appendix Twelve Evidence of Improvement Panel Feedback Form

Evidence of Improvement Panel Feedback Form

To be completed and returned to the Divisional Director within 24 hours of the panel taking place

Incident Number/ STEIS Number	Incident Type and Incident Date	Panel Chair for Evidence of Improvement Panel	Panel Type
		Chris Gordon	Evidence of Improvement
Presenter	**Head of Division/ Division**	**Date Submitted to Commissioners**	**Panel Date**

Documentation

Embed document here	Presentation and Appendices:

Evidence of completion of Action Plan?	Yes ☐	No ☐
Associated change evidence?	Yes ☐	No ☐

Panel Outcome

Feedback and Evidence uploaded onto Ulysses	To return to Evidence of Improvement Panel
☐	☐return date =

Feedback Text

Panel comments and additional actions identified:

Evidence of Actions:

Further Actions:

Appendix 13

Guiding Principles: Sharing a Draft Report with **patients, service users, family and carers who are involved in the Investigation.**

There is presently no mandatory or statutory requirement for serious incident investigation reports to be shared in draft with patients, service users, family and carers who are involved in the Investigation. However it is considered best practice. It is hoped that clearer guidance will be provided from NHS England and the National Quality Board in early 2018.

Southern Health NHS Foundation Trust follows these guiding principles:

Whilst conducting an investigation it is vital that a positive relationship is built with **patients, service users, family and carers** and they are supported to become involved in the investigation. This includes establishing a communication agreement and this work can be supported by the **Family Liaison Officer**.

Towards the end of the investigation, the investigator should share a copy of the draft report with **patients, service users, family and carers**, the organisation, and any person included in the report. This gives everyone mentioned in the report a chance to comment on the draft findings. It is advisable that the investigator arrange to meet with the family and others to go through the details of the report in person.

The rare exception to this is if the Investigating Officer is told by Police not to share information. More usually, the Trust's investigation would be delayed until the Police investigation was completed.

The draft report should not be shared until all of the avenues of investigation have been completed as missing lines of enquiry will cause distress and incorrectly suggest that the investigation has been completed.

The report will contain all the information that has been gathered and **patients, service users, family and carers** who are involved in the investigation should be supported to **challenge the factual accuracy** of the report and **highlight any avenues which have not been explored**. They should also be allowed **to make comment on the findings and recommendations**, which the investigator and commissioning manager should take into consideration when finalising the report.

Patients, service users, family and carers who are involved in the Investigation should be respectfully reminded that the draft report is confidential and should not be shared until finalised. This is because it may include a factual inaccuracy which has not been corrected or question that has not been answered and may cause distress if it became public.

Once finalised a final report should be shared with **patients, service users, family and carers**, and other organisations who are involved in the Investigation. This should occur within ten days of the final sign off and be documented on Ulysses.

References:
https://www.hsib.org.uk
https://www.ombudsman.org.uk/about-us/corporate-information/freedom-information-and-data-protection/our-publication-scheme/our-privacy-policy