Policy:

Incident Management Policy and Procedure (Including Serious Incidents)

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This is version 4 of this policy, which replaces the previous version (ratified March 2013). This revision contains substantial changes from the previous version.

This policy will be available to all staff via the Sheffield Health & Social Care NHS Foundation Trust Intranet and on the Trust's website. The previous version will be removed from the Intranet and Trust website and archived. Word and pdf copies of the current and the previous version of this policy are available via the Director of Corporate Governance.

Any printed copies of the previous version 3 should be destroyed and if a hard copy is required, it should be replaced with this version.

Contents

Sheffield Health and Social Care NHS Foundation Trust

1. Introduction

The process for the management of Serious Incidents was reviewed by NHS England in 2015, in line with this the Trust commissioned a comprehensive external review of its internal incident management processes and implemented the recommendations from this review. As well as this NHS England reviewed the Never Events framework and launched the Statutory Duty of Candour process.
Following the external review the Trust has developed 6 Critical Success Factors (CSF) for incident management which are:

- Deliver an easy to use, clear, and objective process that encompasses all incident types
- Deliver measurable improvements in staff & patient safety
- Deliver a process that staff and all other stakeholders believe in
- Deliver a collective shared purpose and shared ownership across all levels of the Trust
- Deliver reliability (and therefore consistency) in approach regardless of Directorate or investigator
- Be able to show that each team, service, Directorate, and the Trust as a whole learns, improves, and sustains the improvements as a consequence of learning from all incidents and near misses it experiences (i.e. lapses in care and practice standards occur less and systems are better designed)

Successful incident management is underpinned by the development of a proactive culture whereby effective incident reporting, investigation and learning from incidents take place that reduce the likelihood of incidents reoccurring. This reporting culture contributes to improved service user safety and service provision and makes the Trust a safer place to work and visit for staff, service users and the public.

The open reporting of incidents (including near misses and 'errors') is positively encouraged by the Trust as an opportunity to learn and to improve safety, systems and services. In order to reinforce the fact that the prime concern of the Trust with regard to the reporting of risks or incidents is to ensure that learning takes place, the Board of Directors encourages the use of the NHS England Incident Decision Tree (2008), which aims to promote fair and consistent staff treatment within and between healthcare organisations. The Incident Decision Tree helps to move away from attributing blame and instead looks to find the cause when things go wrong. Identifying contributory systems failures is crucial to successful incident management.

Clearly, in cases where one or more of the following apply;

- the incident has resulted in a police investigation
- there is a breach of criminal law or professional conduct
- there are repeated unsafe occurrences involving the same individual
- in the view of the Trust and/or any professional body the action(s) causing the incident were far removed from acceptable practice
- there is evidence of an attempt to conceal the fact that the incident occurred or to tamper with any material evidence relating to the incident

The Trust will apply the concept of 'fair blame' (individual responsibility for individual actions, with accepted principles of service and corporate governance). Staff will also be supported through the Whistleblowing Policy and Procedure (Freedom to speak up) and the Statutory Duty of Candour/Being Open Policy.

2. Scope

This policy applies to all staff working in all areas of the Trust. All incidents that occur on Trust premises or involve Trust employees must be reported using this policy.

3. Definitions

Term Used	Description
Abuse	Abuse is a violation of an individual's human rights by any other person or persons.
Accident	An unplanned event, act or omission, which causes injury to people, damage or loss to property or contributes to both. (these may be classified as Serious Incidents depending on the severity of the damage caused)
Care Quality Commission (CQC)	The CQC is the independent regulator of all health and social care services in England.
Consequence	A result or effect of some previous occurrence
Contemporaneous Records	Current and up to date data recorded within the record
Employees	Employees under SHSC control whether they are directly employed or not i.e. apprentices, seconded employees etc. NB: Direct employees of Sheffield Health & Social Care NHS Foundation Trust that are directly managed by Sheffield City Council will work to that organisation's policies and procedures unless a specific agreement is reached to the contrary.
Grade	A position or degree in a scale, as of quality, rank, size or progression
Harm	Physical or mental injury, moral evil or wrongdoing, to injury physically, morally or mentally
Hazard	The potential of anything to cause harm, for example chemicals, electricity or manual handling of heavy loads
Incident	An unplanned event, act or omission, which causes injury to people, damage or loss to property or contributes to both. (these may be classified as Serious Incidents depending on the severity of the damage caused)
Ill Health	(excluding service users) including any industrial injury/disease not covered by RIDDOR
Information Governance Incident	Any incident involving the actual or potential loss of data, including personally identifiable information
Investigation	The act or process of investigating, careful search or examination in order to discover the truth
Likelihood	The condition of being likely or probable
Medication incident	Any incident involving medication, e.g. prescribing, dispensing, administration or storage.
Missing Patient	Level of vulnerability/concern for safety determines classification of incident. See Missing Patients Policy on Risk Website & the Trust intranet site
Near miss	An unplanned event, act or omission, which does not cause injury or damage but has the realistic potential to do so.
Never event	Serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers i.e. in-patient suicide using non-collapsible rails, 'Never events' are defined by the NPSA from the evidence base and reviewed periodically (NPSA 2010) (refer to Appendix F for a list of the current 'never' events' that apply to the Trust

NHS Funded Care	The treatment of patients in: NHS establishments or services; in independent establishments including private healthcare; or the patient's home or workplace. Either all or part of the patient's care in these settings is funded by the NHS.
NRLS	National Reporting and Learning System - managed by the NPSA, the system
Patient Safety Incident	Any unplanned or unexpected incident which could have or did lead to the harm of one or more service users receiving NHS funded care (NPSA 2004)
Permanent Harm	Directly related to the incident and not related to the natural cause of the patient's illness or underlying condition, permanent lessening of bodily functions, sensory, motor, physiologic or intellectual, including removal of the wrong limb or organ, or brain damage.
Responsible Person	Employees nominated and authorised to assess and report on incidents. They will, scrutinise and countersign incident reporting forms and investigation forms. Responsible persons will have responsibility and control of premises and/or work activities. They will usually be team managers or staff in charge of services, and health and social care professionals or clinicians
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995.
Risk	The chance that something will happen that will have an impact on achievement of the organization's aims and objectives. It is measured in terms of likelihood (probability of the risk occurring) and consequence (impact or magnitude of the effect of the risk occurring).
Risk Rating	A position or degree in a scale, as of quality, rank, size or progression
Risk Reduction	Reducing the likelihood on occurrence by Transfer (some of the financial risk to risk pooling schemes), Treatment (take action to change how the activity is carried out) or Termination (ceased the activity giving rise to the risk).
Safeguard System	This is the system/database used to electronically record all incidents (further information from Risk Management Department or via website). Data from it feeds the Trust's governance systems confidentially through In-Form.
Security Incident	• Physical assault of NHS Staff • Non-Physical assault of NHS staff (including verbal abuse, attempted assaults and harassment) • Theft or criminal damage (including burglary, arson and vandalism to NHS property or equipment (including equipment issued to staff) theft or criminal damage to staff or personal property arising from these types of security incident
Serious Incident	Those incidents assessed as Major or above using the Trust Risk Grading Matrix (Risk score 15 – 25).
Ulysses	The organisation that provides the Safeguard Risk Management System

4. Purpose

To ensure that all incidents are appropriately managed and investigated based on their severity, and that there is relevant learning and improvement in care as a result of incidents. Qualitative and quantitative data analysis will be used to highlight any trends which may be

occurring and uncover any further need for intervention. It is therefore essential that all incidents, irrespective of whether they have caused actual harm, or were a near miss, must be reported to the Trust in a timely manner. This will help to build up an accurate picture of events across the Trust.

5. Duties

The Board

The Board is responsible for:

- ensuring robust incident reporting, investigation and management systems are in place and that these are monitored and reviewed and compliant with external regulation
- that serious incidents are reviewed, and recommendations/actions implemented
- that data from incident reports is analysed to identify themes and trends and appropriate action is taken

Quality Assurance Committee

The Quality Assurance Committee is responsible for overseeing that robust incident management processes are in place. The Committee is also responsible for receiving assurance from the Service User Safety Group that actions following serious incidents are effectively monitored and implemented.

Service User Safety Group

The Service User Safety Group is responsible for ensuring that the Incident Management Policy is effectively implemented across the Trust; that all directorates have robust governance systems in place to ensure all incidents are reported and learning occurs at team and directorate level and ensure that that the actions following serious incidents are monitored and lessons learned are shared across the organisation.

Executive Directors

Executive Directors are responsible for:

- Agreeing Terms of Reference for Executive Level Serious Incident investigations;
- Agreeing lead investigators for Executive Level Serious Incident investigations;
- Ensuring Executive Level Serious Incident investigation reports are heard by a panel, whose membership includes the Executive Director of Operations and the Executive Director of Nursing and Integrated Governance;
- Final approval of Executive Level Serious Incident investigation reports and action plans;
- Performance management of incident management procedures;
- Appraising Board members of Executive Level Serious Incidents.

The Medical Director

The Medical Director has overall accountability for patient safety and risk management. The Medical Director also has responsibility for approving all executive level serious incident reports and action plans, prior to them being signed off by the Executive Directors Group.

Executive Director of Nursing, Professions and Care Standards

The Executive Director of Nursing, Professions and Care Standards is accountable for care standards (including compliance with the Care Quality Commission), implementation of the

Mental Health Act and has lead responsibility for the professions; medical, nursing, and allied health care as well as responsibility for infection prevention and control, safeguarding children and vulnerable adults.

Director of Human Resources

The Director of Human Resources is responsible for:

- Ensuring that support for staff following incidents is available via the Workplace Wellbeing service;
- Ensuring Occupational Health guidance, advice and service is available for staff following incidents;
- Ensuring that an HR representative forms part of Executive Level Serious Incident investigation teams;
- Ensuring that media communications, in relation to incidents, are managed effectively through the Communications Manager.

Clinical, Service and Corporate Directors

Clinical, Service and Corporate Directors are responsible for ensuring that their staff comply with the requirements set out in this policy. This will be achieved through:

- ensuring that all incidents/accidents are reported, investigated and managed in accordance with this policy
- ensuring that all staff, including temporary staff, are aware of this policy and their duties with regard to incidents/accidents
- ensuring all incidents/accident reports and recommendations relating to their Directorate are reviewed at the appropriate team or Directorate level to support learning, the reduction of risk and the prevention of recurrence
- ensuring all risks identified following the investigation of an incident/accident relating to their Directorate are recorded on the appropriate electronic risk register (team, directorate or corporate) and reviewed and updated as required
- ensuring that accidents/incidents/recommendations or actions relating to other Directorates or services in the Trust are communicated effectively within their services, ensuring any identified risks are recorded on the appropriate electronic risk register (team, directorate or corporate) and reviewed and updated as required
- reviewing the data derived from incident reports to identify any themes or trends for their sphere of responsibility, and taking appropriate action as needed
- sharing full reports including lessons learned, recommendations and actions through their Directorate and team governance framework
- ensuring staff, service users and carers or others involved in incidents are kept informed and receive support as appropriate in line with the requirements of the Statutory Duty of Candour
- ensuring all staff in their Directorate receive training at induction and subsequently as required by this policy

Specialist Advisors

Specialist Advisors are staff with particular areas of knowledge and specialist expertise who are available to support staff in implementing this policy. They include the Clinical Risk Manager, the Health & Safety Risk Advisor, Head of Clinical Governance, the Senior Nurse for Infection Prevention and Control, the Senior Nurse for Patient Safety, Local Security Management Service Advisor and Fire Officer and the Safeguarding Adults and Children Lead Nurse(this is not an exhaustive list).

Managers

Under Section 7 of the Health and Safety at Work Act 1974, managers for an area are responsible for ensuring incidents are appropriately managed, for example investigated, acted upon and lessons are learnt.

Managers are responsible for the completion of the 48 hour report (due with the Clinical Commissioning Group (CCG) in 72 hours) and the initial Review of Care (RoC).

Managers are also responsible for supporting staff following a traumatic incident and ensuring that service users and carers or others involved in incidents are kept informed and receive support as appropriate in line with the requirements of the Statutory Duty of Candour.

Investigation Officers

Investigation Officers are responsible for carrying out thorough investigations into the incidents they are nominated to investigate, in accordance with the terms of reference set, using approved investigation techniques.

All Staff

All staff have a duty of care to provide safe services and do no harm, to be responsible for keeping themselves and others safe and are expected to report incidents as part of their general duties under Section 7 of the Health and Safety at Work Act 1974.

All staff members are expected to notice accidents, incidents and near misses and report and manage them in accordance with this Policy.

Individual Directorate Patient Safety Champions will:

- Review, analyse and look for trends across their defined area/service/directorate
- Ensure that the analysis of incidents and local risk registers are escalated and reviewed within their internal and trust wide Governance structures to support learning
- Raise awareness and understanding of NHS England's Serious Incident management document (2015)
- Share information and lessons learned following incidents
- Support staff and clients following an incident where appropriate to do so
- Liaise with the trust Risk Management Department regarding the progress of incident management and seeking advice where appropriate

The Clinical Governance Department will:

- Provide support, advice and the infrastructure to enable the effective reporting, investigation and management of incidents
- Review all incident notifications received, ensure the grading is appropriate and follow-up as necessary and offer advice and support if needed. (Level 1 incidents are the responsibility of the local team to investigate, manage and disseminate learning to colleagues)
- Respond pro-actively to more serious incidents (level 2 and 3) requesting further information and pursuing compliance with external reporting requirements and timescales
- Report externally to the Health & Safety Executive (RIDDOR), the Clinical Commissioning Group (CCG) and other external agencies as required. This will include updating as information becomes available.
- Report to NHS England via the Strategic Executive Information System (StEIS) within 48 hours of a reportable incident. Updating of StEIS as information becomes available, including reports from internal investigations.
- Review investigation reports for serious incidents against standards set by the commissioners and request further information/investigation if needed
- Prepare overviews of serious incident reports for the Executive Directors and Board

- Make sure any feedback from Executive Directors, Board or Commissioners is communicated to the investigating officers and the relevant directorates, for cascading to relevant staff
- Keep all accident/incident information for a period of three years; for use by the Trust's solicitors/insurers should a claim arise relating to negligence or breach of statutory duty.
- Maintain the Safeguard database for incidents and action plans.
- Provide a monthly briefing of Serious Incidents to Executive Director Group.
- Provide quarterly data and analysis of themes, trends, lessons learnt and monitoring of actions taken to the Directorates/Services, Trust Service User Safety Group and Trust Board.
- Provide Training on Root Cause Analysis/Incident Investigation, and advice and support for Investigating Officers
- Act as Investigating Officers for higher level investigations such as level 3 inquiries in partnership with service Investigating Officers

6. Process

Response, Communication and Notification

6.1 Immediate Response by the Trust

In all instances, the first priority for the Trust is to ensure the needs of individuals affected by the incident are attended to, including any urgent clinical care which may reduce the harmful impact.

A safe environment should be re-established, all equipment or medication retained and isolated, and all relevant non-electronic documentation copied and secured to preserve evidence to facilitate the investigation and learning. If there is a suggestion that a criminal offence has been committed, the immediate vicinity where the incident occurred should be preserved, as far as practicably possible and the police must be contacted.

Early consideration to the provision of information and support to service users, relatives and carers and staff involved in the incident must be given, in accordance with the Trust's Statutory Duty of Candour/Being Open Policy (see sections 6.4 and 6.5 for further details).

If the incident is a potential adult or child safeguarding concern, a safeguarding alert must also be raised.

6.2 Internal Reporting Requirements

- All incidents, (irrelevant of their severity) including near misses must be reported using the Trust's Safeguard Web electronic incident reporting system. All electronically reported incidents are configured to notify the Clinical Governance department and the appropriate Directorate level manager
- If the electronic system is not available, the incident must be reported using the paper Incident Report Form and sent to the Clinical Governance department for uploading onto the Safeguard incident reporting system
- Incidents must be reported before the end of the working shift in which the incident occurred.
- Incidents are factual accounts of events, and must include details of immediate actions taken including support offered to individuals involved.
- Incidents are sent to the designated reviewer. Designated reviewers are appointed by the Team manager and recorded on the Safeguard system.

- The designated reviewer must review the incident details and complete the initial submission of the incident using Safeguard Web within 3 days of notification.

6.2.1 Moderate, Major, Catastrophic Incidents

Incidents with an actual impact of 'moderate or above, must be reported and escalated to Directorate leads by the ward/area manager within 24 hours of the incident occurring, or to the on-call duty manager if out of hours. The Statutory Duty of Candour must be considered for all incidents with an actual impact of moderate or above.

6.2.2 Serious Incidents

Under the new 'NHS England Serious Incident Framework' serious incidents are no longer defined by grade, but every incident considered on a case-by-case basis using the examples in Appendix B.

By default, when the statutory Duty of Candour is considered to apply to the incident, it must also be considered as a serious incident.

Serious incidents must be reported to the Strategic Executive Information System (StEIS) within 48 hours of the incident occurring or 48 hours of the Trust becoming aware of the incident. This reporting will be done by the Clinical Governance Department.

Where a serious incident occurs out of normal working hours, the senior manager on-call must be notified immediately. The Clinical Governance Department must be informed as soon as possible the next working day.

Examples of serious incidents are included in Appendix B.

6.2.3 Near miss incidents

Near misses are not always the same as negligible or minor incidents and should never be treated as such, a near miss is an unplanned event that did not result in injury, illness, or damage – but had the potential to do so. Only a fortunate break in the chain of events prevented an injury, fatality or damage; in other words, a miss that was nonetheless very near.

Near misses should be dealt with in relation to the potential harm that would have occurred had the actual incident not been avoided. For example if a near miss had the potential for moderate, major or catastrophic harm the incident should be investigated in the same way as an actual incident at a moderate, major or catastrophic level. Near misses which would have resulted in negligible or minor harm should be dealt with in the same way as actual negligible or minor incidents with the local team or services learning from these via the same process as actual low level incidents.

Remember that consideration should always be given to the potential severity of the near miss had it actually impacted upon a patient, staff member or visitor and the appropriate level of investigation pursued.

6.2.4 Never Events

Never events are serious, largely preventable service user safety incidents that should not occur if the available preventative measures have been implemented ie in-patient suicide using non-collapsible rails. 'Never events' are defined by NHS England from the evidence base and reviewed periodically (NHS England 2015). See Appendix G for a list of the current 'Never Events' that apply to the Trust.

The Risk Management Department will immediately report a Never event to the Head of Clinical Governance, who will inform the Board and other stakeholders.

6.3 External Reporting Requirements

Dependant upon the type of incident and/or severity of the incident being reported will dictate whether additional action/reporting to external agencies is required and this will be determined on a case by case basis.

The table below gives details of such requirements.

Type of Incident	Example(s)	Reporting Criteria	Who Reports
Criminal	Service user/carer/visitor/staff deliberately causing harm/damage	Must be reported immediately to the police, via telephone and to risk via the electronic reporting system (or paper reporting)	Person in charge receiving notification from staff member
Drug/Medication	Adverse reaction to drug Controlled Drug incident	All incidents must be reported to Chief Pharmacist via the electronic reporting system (or paper reporting)	Person in charge receiving notification from staff member
Medical Device	Failure of equipment/ device eg hoist, syringe driver Human error	All incidents to be reported via online reporting or paper reporting to the lead for medical devices	Person in charge receiving notification from staff member
Patient Safety	Harm or potential harm caused in course of Trust duties	All patient safety incidents to be reported to the NRLS via direct upload to database	Risk Management Department
RIDDOR	Injuries sustained to staff in the course of their work eg Moving and handling injury Fracture Occupational dermatitis	All major injuries and any absences from work following the incident for a period of 7 days or more must be reported to the HSE via online reporting	Risk Management Department
Security	Verbal/physical or potential abuse of staff Loss/damage to staff/NHS property	All incidents meeting the SIRS criteria must be uploaded to the SIRS system via Safeguard	Local Security Management Specialist in conjunction with Risk Management Department
Serious Incident Refer to Appendix B for further details	Death or serious harm (or potential serious harm) of person in receipt of care	Reportable to the CCG and NHS England via online StEIS system. Extreme incidents are reportable directly to the CQC, Monitor and other stakeholders, via telephone or email.	Risk Management Department

6.3.1 Reporting of Incidents to the Care Quality Commission

Certain serious incidents must be reported directly to the CQC. Incidents falling into this category will be identified and reported via the Risk Management Department. Staff with queries relating to this should contact the Head of Clinical Governance in the first instance.

6.3.2 Reporting of Serious Incidents to NHS Improvement

Certain serious incidents, such as those that may result in adverse media coverage, or independent investigation, must be reported to NHS Improvement. These incidents will be identified and reported via the Risk Management Department. Staff with queries relating to this should contact the Head of Clinical Governance in the first instance.

6.4 Communication following an Incident the Statutory Duty of Candour/Being Open

The Trust's 'Statutory Duty of Candour/Being Open' policy makes it incumbent on the Trust to disclose information. In respect of this policy where a patient is harmed as a result of a mistake or error made whilst in the Trust's care, SHSC believes that the individual's family or those who care for them, should receive a face to face apology, be kept fully informed as to what has happened, have their questions answered and know what is being done in response to the incident.

This policy endorses the Trust's commitment to our service users to:

- Apologise face to face for the harm and/or mistake;
- explain, openly and honestly, what has happened once all the facts are known;
- describe what will be done in response to the event to ensure the risk of recurrence is minimised;
- offer support and counseling services that might be able to help;
- provide the name of a person to speak to; and
- give updates on the results of any investigation

The Statutory Duty of Candour/Being Open Policy can be accessed from the Trust's intranet site.

6.5 Supporting Staff and service users following an Incident/Traumatic Event

The line manager/person in charge of the shift must ensure all staff and service users involved in a traumatic/ stressful incident are offered support following an incident.

In the first instance a debrief session should be held as soon after the event as possible to allow staff the opportunity to reflect on the situation and explore how it has made them feel. This would usually be organised and facilitated by the ward/team manager. The exact nature of the support mechanisms used will be dependent on the type and severity of the incident and the needs of the individual(s) involved and will always follow the principles of 'being open' as detailed in the Statutory Duty of Candour/Being Open Policy.

The manager/person in charge should consider actions to protect the individual(s) wellbeing at this time. As appropriate, staff will be offered reasonable access to:

- Immediate medical treatment if required
- Advice/counselling from Workplace Wellbeing
- Occupational Health Services
- Advice from Human Resources
- Legal advice (at the discretion of the Trust)
- Time away from work (nature of leave to be agreed on a case by case basis)
- Time out to consult with their Union and/or professional body

Subsequently managers should ensure staff can access ongoing peer support within and/or external to the team, as well as support from themselves.

All incidents involving the use of Restrictive Interventions must be subject to a post incident review facilitated by a senior clinician. The review must include the views of the service user where possible and all staff involved in the incident

Further debrief sessions may be required for particular incidents/staff.

On the completion of the investigation, all individuals involved will be provided with the investigation findings, lessons learned and recommendations for further action. The ward/team manager may wish to consult with the Risk management team for advice and support.

Support for Staff called as witnesses:
In the event that a member of staff is called as a witness in relation to an incident then the line manager must contact the Risk Management Department who will provide support and guidance to all witnesses with reference to preparing for and attending court.
Line managers are also responsible for supporting their staff through the incident processes, including any resulting inquests. They must also escalate any concerns in this regard to the appropriate service and clinical Directorate, who may consider additional/alternative staff support is necessary.

In some instances, the Trust may require legal representation at court (eg Coroners Court). Where this is deemed necessary and appropriate, following discussion with the relevant directors, Complaints and Litigation Lead, Head of Clinical Governance and the Medical Director, the Complaints and Litigation Lead will organise and instruct a solicitor to work with the Trust for the case. The Risk Management Department will facilitate the support for all witnesses in preparing for and attending court in conjunction with the legal representative(s).

If a staff member is experiencing continuing difficulties with the event then professional advice must be sought from the Occupational Health Service and Human Resources Department in the first instance. Staff may refer themselves to the Trust's Workplace Wellbeing service, if they require additional/alternative support to that provided by the line manager. Line managers may also suggest that this would be of benefit to some individuals. The Occupational Health Service is able to take self referrals as well as referrals from line managers.

6.6 Additional Support

Medical staff are encouraged to become a member of one of the Defence Organisations ie the Medical Protection Society (MPS) or the Medical Defence Union (MDU) who will provide additional advice/support in such situations.

Other organisations that would possibly provide additional support/advice include Unison, The Royal College of Nursing, Royal Pharmaceutical Society of Great Britain, The British Association of Social Workers, The British Association of Occupational Therapists, The College of Occupational Therapy and The Health Professions Council.

If in doubt on any matter, please contact the Risk Management Team for further advice and support.

6.7 Incidents Involving the Health & Safety Executive (HSE) and the Police

Whilst all service user records must be preserved securely and safely for evidence, unless there is a real reason to believe the records will be tampered with, the police do not have the

right to cease/remove service user records. Where the police do request records for evidential purposes, a formal written request using form CID 49 (contact Complaints and Litigation) must be completed by the requesting officer. This must be sent directly to the Complaints and Litigation team at Trust Headquarters upon receipt. The relevant records can then be copied and the copies released to the police.

6.8 Media Involvement/Media Enquiries

The Trust's Communications Manager will handle all enquiries from the media; prepare statements for release to the media on behalf of the Trust, etc. Staff receiving any media enquiries must direct these immediately to the Communications Manager, or if out of office hours, the senior manager on call.

The Director of Clinical Governance will notify the Communications Manager of all serious incidents likely to cause media interest. Where adverse media coverage is either received or perceived, contact with NHS Sheffield and NHS England's communications leads will be established in order to agree a media handling strategy. Where necessary, NHS England will brief the Department of Health Media Centre.

6.9 Grading the Incident

All reported incidents and near misses are graded according to their **actual effect** and the **likelihood of occurrence in the future**. By grading incidents, the level of investigation required can be established.

Incidents are graded using a risk rating matrix (see Appendix E).

6.9.1 Impact Rating

Any incidents where the actual impact is graded as a 4 (major) or 5 (catastrophic) must be immediately reported to the person in charge/line manager, who will contact the relevant Service and Clinical Director and the Risk Management Department.
The table below shows the incident severity ratings.

Incident Severity Rating Table		
Grading	**Impact**	**Examples of Incident Categories** (see Appendix G for further details)
1	**Negligible**	Minimal injury requiring no/minimal intervention, small financial loss, service interruption/loss >1 hour, expected death
2	**Minor**	Minor injury/illness requiring minor intervention, claim >£10,000,service interruption/loss >8 hours,
3	**Moderate**	Moderate injury requiring professional intervention, claim <£10,000 but >£100,000, service interruption/loss >1 day
4	**Major**	Major injury leading to long-term incapacity/disability, claims <£100,000 but >£1m, service interruption/loss >1 week
5	**Catastrophic**	Incident leading to death, permanent injury, claims >£1m, permanent loss of service

The grading of the incident determines the level of investigation required and the reporting arrangements necessary. Irrespective of the severity of the incident, all incidents, including near misses, must be reported via Safeguard Web, or using a paper Incident Report Form.

The immediate assessment of incident grade should be undertaken quickly and it is not necessary for the assessor to be in possession of all the facts at the time of grading. There is

always scope for regrading the incident as facts and issues emerge. Incidents will be also be graded by the dedicated reviewer of incidents for the service/area the incident occurred in.

Likelihood Rating

As well as the actual impact of the incident, incidents are graded on the **likelihood of the incident occurring in the future**.

Appendix E gives more detail on assessing the likelihood of occurrence in the future. The table below shows the likelihood descriptors.

Likelihood			
Score/Descriptor	**Likelihood**	**Frequency**	**Probability**
1 Rare	This will probably never happen recur	Not expected to recur for years	<0.1 %
2 Unlikely	Do not expect it to happen recur but it is possible it may do so	Expected to occur at least annually	0.1-1.0 %
3 Possible	Might happen or recur occasionally	Expected to occur at least monthly	1-10 %
4 Likely	Will probably happen/ recur but it is not a persisting issue	Expected to occur at least weekly	10-50 %
5 Almost Certain	Will undoubtedly happen/recur, possibly frequently	Expected to occur at least daily	> 50 %

6.9.2 Overall Risk Rating

Once the severity and the likelihood have been assessed, the overall risk rating of the incident can be established. This is done by calculating the **severity x likelihood** using the risk matrix below.

Risk Score					
	LIKELIHOOD				
SEVERITY SCORE	**1 Rare**	**2 Unlikely**	**3 Possible**	**4 Likely**	**5 Almost Certain**
1 Negligible	**1**	**2**	**3**	**4**	**5**
2 Minor	**2**	**4**	**6**	**8**	**10**
3 Moderate	**3**	**6**	**9**	**12**	**15**
4 Major	**4**	**8**	**12**	**16**	**20**
5 Catastrophic	**5**	**10**	**15**	**20**	**25**

Incidents rated as ‘amber’ or ‘red’ should again be escalated immediately to the person in charge/line manager, who will contact the relevant service and clinical director and the Risk Management Department.

Further advice or assistance on the grading of incidents can be obtained from the Risk Management Department.

6.10 Investigation Levels

All incidents, irrespective of the severity, warrant follow up and exploration in order to understand what happened and why it happened to prevent recurrence.

The level of investigation undertaken should be appropriate and proportionate to the incident and is summarised in the table below.

Colour	Classification	Risk Rating	Type of Investigation	Monitoring Arrangements
Green	Very Low	1 – 4	*Local Level Investigation* Overview of circumstances surrounding incident Outcome of investigation reviewed at team/ward level and action plan developed where necessary	Team Governance Overview Local Risk Register
Yellow	Low	5 – 8	*Local Level Investigation* More in-depth investigation may be required to consider causal factors, chronology of events and discussion with key staff involved in order to meet possible Duty of Candour requirements Action plan developed and implemented	Team Governance Overview Local Risk Register
Orange	Moderate	9 – 12	*Comprehensive Investigation* May be deemed as Serious Incident and/or Duty of Candour – Directorate Level Root cause analysis investigation	Directorate Governance Overview/Service User Safety Group Overview Directorate/Corporate Risk Register
Red	High	15 – 25	*Comprehensive Investigation* May be deemed as Serious Incident Serious Incident and/or Duty of Candour – Directorate Level or Executive Panel Level Root cause analysis investigation	Service User Safety Group Overview/Executive Directors Group/Board Overview Corporate Risk Register

6.10.1 Low Level Incidents

Incidents with an actual impact of 'negligible' or 'minor' or with a risk rating of 'Very Low' or 'Low' (using the risk matrix), should be investigated within the department/service within 5 days of the incident occurring and an electronic incident investigation record (Manager's Form A), or paper incident investigation record completed. This should provide details of the underlying causes and all actions to be taken to prevent recurrence.

Any information given to service users, carers/family, staff and/or members of the public must be recorded. Where paper incident reporting is still in place, all completed investigations should be shared with the Clinical Governance Department within a maximum of 15 working days of the incident

Staff feedback, dissemination of lessons learned and following up of any action plans is the responsibility of the team/ward manager using their local team governance and risk register processes. Monitoring of incidents/trends will be undertaken through Directorate reviews of team governance reports, incident dashboards and local risk registers. A post incident debriefing, counselling and support will be arranged by the team/ward manager as appropriate for service users, carers, visitors and staff.

6.10.2 Serious Incidents

All potential serious incidents (i.e. those with an actual impact of 'moderate or above', or with a risk rating of 'Moderate' or 'High') related to the care and treatment of service users will begin with a 48 hour report (see Appendix F) and a comprehensive Review of Care (RoC) (Appendix G), to be completed within 10 working days by the local service manager and given final approval by the Directorate Senior Management Team. Where a RoC indicates that no further comprehensive investigation is required and this is supported by the Senior Management Team the risk team will request that the incident is considered for delog from StEIS.

Following the completion of the RoC all incidents requiring further investigation at this level will be triaged by the Risk Team and assigned a 'case manager' from within the Clinical Governance Department who will support the investigation and investigators through the incident management processes.

Serious incidents (see Appendix B for examples) are generally those incidents deemed to be externally reportable to NHS England via the StEIS system. Confirmed serious incidents require a full and thorough root cause analysis investigation to be carried out by nominated investigators who are trained in root cause analysis techniques.

For incidents that that require a comprehensive root cause analysis investigation, an approved report, chronology and action plan must be submitted within 12 weeks of the incident being reported to the StEIS system. In exceptional circumstances, an extension request may be submitted to NHS Sheffield outlining the rationale why the report cannot be submitted within the given timescales. All extension requests must be authorised by the Clinical Risk Manager before submission. In most cases, a draft report must be submitted within the initial 12 week deadline.

6.10.2.1 Directorate Level Investigation

For Directorate level serious incidents requiring further investigation, the relevant Service and Clinical Directors will set the terms of reference for the investigation and nominate investigators.

A report must be produced, using the standard template provided by the Clinical Governance department and an action plan generated to address any recommendations made within the report. The report and action plan must be approved through Directorate governance structures, e.g. Senior Management Team meetings. Once approved at Directorate level, the report and action plan will receive final approval from the Medical Director or deputy.

The Directors of the service where the incident occurred are responsible for ensuring the required actions are implemented and the learning and findings of the incident are fed back to relevant staff. See action plan monitoring (section 6.13) and lessons learned (section 6.14) for further details.

6.10.2.2 Executive Level Investigation

Executive level serious incidents will usually be serious incidents that warrant an independent investigation (level 3), commissioned by NHS England. Incidents deemed to be at this level will be reported to relevant external stakeholders by the Head of Clinical Governance, e.g. Care Quality Commission, NHS Improvement or Sheffield City Council.

The completed 48hr report is cascaded to Board members and other individuals with specialist interest.

These incidents will be investigated by an investigation team, comprising of two investigators, a case manager and when required an HR representative. The lead investigators are nominated by the Deputy Chief Executive and the Medical Director and should normally be from outside of the Directorate where the incident has occurred. The terms of reference for this level incident are set by the Executive Directors.

The Director of Human Resources will nominate the HR representative who will form part of the investigation team when this is required.

These incidents are performance managed by NHS Sheffield and they may request periodic updates on progress throughout the 12 week investigation period.

Unlike Directorate level serious incidents, once the investigation report has been completed and recommendations made, a panel meeting must be held to discuss the findings of the report. The two lead Executive Directors, Service and Clinical Directors from the relevant Directorate(s), Head of Clinical Governance and the investigating officer(s) should attend. Where this is not possible, nominated deputies may be appointed to attend. The panel will discuss the report findings in detail and agree the recommendations. Following the panel meeting, the relevant Directors will develop the action plan to address the recommendations.

The completed investigation report, chronology and action plan will be presented to the Executive Directors Group for approval, prior to submission to NHS Sheffield.

A summary of the incident, together with the action plan, will be presented to the Board of Directors within the confidential section of the next available Board meeting.

The report and action plan will also be sent external stakeholders initially informed of the incident, unless arrangements are made contrary to this by the Head of Clinical Governance.

The relevant Directors are responsible for implementing the action plan and providing feedback on the findings, lessons learned and support to the staff involved. See action plan monitoring (section 6.13) and lessons learned (section 6.14) for further details.

6.11 Investigating the Incident

Incidents should be investigated using root cause analysis techniques, by individuals who are trained to do so. The nominated incident case manager will support individuals in using the various tools available via the risk team.

6.12 Involving Service Users, Carers, Families in Serious Incident Investigations

In accordance with the Trust's Duty of Candour policy, investigators will determine, in liaison with the case manager, on a case by case basis whether it is appropriate to involve service users or their carers/families in the investigation process. In all cases, service users, carers/families will be informed that the Trust is undertaking an investigation into the incident.

Where it is deemed appropriate, as is usual for the majority of cases, service users, carers/families will be offered the opportunity to be involved. This will involve the relevant Director or the risk department sending a letter to the family, etc providing the lead investigator(s) contact details. The investigators will then arrange to talk to or meet with the family, etc. Where families, etc, do not wish to be involved in the actual investigation, once the report and action plan are completed, they will be contacted again to advise them of the report completion and to ascertain how they would like to receive feedback on the findings. A copy of the finalised report will be shared, or discussed, with them, where this is requested.

6.13 Recommendations, Action Planning and Monitoring

Recommendations made following serious incident investigations must be relevant, appropriate and follow the SMART format at all times. Recommendations that are vague, irrelevant or unfocused are not acceptable. Similarly all actions drawn from recommendations must follow the SMART format and must be precise focused and above all achievable (appendix H).
The implementation of action plans resulting from incidents is the responsibility of the Directorate within which the incident occurred. Sometimes another Directorate may have to do something to enable the other Directorate to resolve the issue, e.g. an incident occurs on an acute ward that requires an IT solution to solve the problem. Whilst the action on the action plan will be directed at the 'IT Manager', is remains the responsibility of the inpatient Director to ensure it is actioned.

6.13.1 Low Level Incidents

Action plans resulting from this level of incident must be monitored at local/team level. Issues arising from incidents should be recorded in local risk registers, where necessary. Teams may wish to record details of actions taken following incidents within their team governance reports, particularly where improvements to quality/safety have been made. Where risks have been recorded in risk registers, implemented actions should be recorded, which should mitigate/remove the risk.

6.13.2 Directorate Level

Action plans resulting from Directorate level serious incidents (including those meeting the threshold for Duty of Candour) must be monitored through Directorate governance processes, e.g. Senior Management Team meetings. Issues arising from incidents should be recorded in either directorate or corporate risk registers, where necessary. Directorates may wish to record details of actions taken following incidents within their team governance reports, particularly where improvements to quality/safety have been made. Where risks have been recorded in risk registers, implemented actions should be recorded, which should mitigate/remove the risk.

The Service User Safety (SUS) Group also oversees actions arising from serious incidents, looking at one Directorate's outstanding actions at each monthly meeting. Directorate representatives are called to provide progress updates/evidence of implementation.

On full implementation of the actions, the relevant Service and Clinical Directors and Executive Director of Operational Delivery must sign the action plan to confirm its closure. A signed copy will be held in the serious incident file held by the Risk Management Department.

6.13.3 Executive Level

Action plans resulting from Executive level serious incidents must also be monitored through Directorate governance processes, e.g. Senior Management Team meetings. Issues arising

from incidents should be recorded in the corporate risk register, where necessary. Actions taken following this level of incident may be recorded within the Trust's Annual Report, particularly where significant improvements to quality/safety have been made. Where risks have been recorded in risk registers, implemented actions should be recorded, which should mitigate/remove the risk.

As with Directorate level serious incidents, actions will be monitored monthly, by Directorate and by the SUS Group.

Due to the seriousness of this level of incident, progress on action plans will also be monitored by the Medical Director and the Head of Clinical Governance, in conjunction with the relevant Service and Clinical directors. Regular meetings will take place, until full implementation, to discuss progress and agree where additional resources may be required to ensure implementation.

On full implementation of the actions, the relevant Service and Clinical Directors, Medical Director and Head of Clinical Governance must sign the action plan to confirm its closure. A signed copy will be held in the serious incident file held by the Risk Management Department.

The Board will also be kept informed of action plan implementation progress for these incidents.

6.14 Sharing the Learning

The sharing of the lessons learned post investigation is a critical part of incident management. Learning from service user safety incidents is a collaborative, decentralised and reflective process that draws on experience, knowledge and evidence from a variety of sources. The learning process is a process of change evidenced by demonstrable, measurable and sustainable change in knowledge, skills, behaviour and attitude. Learning can be demonstrated at organisational level by changes and improvements in process, policy, systems and procedures relating to service user safety. Individual learning can be demonstrated by changes and improvements in behaviour, beliefs, attitudes and knowledge of staff at the front line.
All Directorates to compile a twice yearly learning from experience report where they set out the key recommendations arising from incidents and complaints, what has been implemented as a consequence and the measurable improvements in quality and safety achieved as a consequence.

6.14.1 What Constitutes Learning

Learning following an incident should be linked to safety related policy, practice and process issues raised by the incident. Examples of learning are given below:

- solutions to address incident root causes which may be relevant to other teams, services and provider organisations;
- identification of the components of good practice which reduced the potential impact of the incident, and how they were developed and supported;
- systems and processes that allowed early detection or intervention which reduced the potential impact of the incident;
- lessons from conducting the investigation which may improve the management of investigations in future;
- documentation of identification of the risks, the extent to which the risks have been reduced, identified and how this is measured and monitored

6.14.2 Disseminating Learning from a Serious Incident

Learning from serious incidents is disseminated through various means in the Trust. The Service User Safety Group, which has representatives from across the Trust, discusses all actions arising from serious incidents at each meeting (taking one Directorate at a time). This enables the Directorate representatives to take the actions and learning from all serious incidents back into their Directorates to share with their teams and learn from others' experiences.

Monthly reports on ongoing serious incidents are produced by the Risk Management Department and disseminated across the Trust. This enables Directorates, where the incidents did not occur, to understand the type of incidents that have occurred elsewhere, so they can take proactive, preventative action, where necessary, to avoid recurrence in their areas of responsibility.

Learning from Executive Level serious incidents is shared with the Board, through the reporting of the executive summary and action plan.

Quarterly reports are produced by the Risk Management Department which provide an analysis of all incidents reported across the Trust. Serious incidents are recorded within these reports in greater detail and all root causes and lessons learned from them are included. These reports are presented to the Quality Assurance Committee, a Board sub-committee, as well as being published on the Trust's intranet site for all staff to access. A quarterly 'lessons learned bulletin' is sent to all staff and published on the Trust's intranet and a quarterly learning forum will be held where cross Directorate attendance will be encouraged.

Teams/wards also discuss incidents, complaints and claims at their regular team governance meetings, in order to feedback findings, heighten understanding and share the learning.

6.14.3 Wider Sharing of Lessons

Investigations may identify issues of national significance or where the dissemination of national learning is appropriate. Service user safety incidents are reported through the NRLS. When updates to the incidents are recorded on the Safeguard system, updates are sent to the NRLS. When an incident is closed, the root causes and lessons learned are inputted onto Safeguard, which then shares the findings with the NRLS and the Care Quality Commission where appropriate.

As the report and action plan is shared with relevant external stakeholders, this enables learning to be shared across organisational boundaries.
Where NHS England perceives that lessons learned in one Trust may be relevant to others, this will be communicated through them and assurances sought from individual Trust Boards that necessary measures are either already in place or are being taken to prevent recurrence in their Trust.

6.14.4 Learning from Serious Case Reviews (SCR)

The Executive Director of Nursing is the Trust's representative on Sheffield's Safeguarding Adults Board (SAB) and Sheffield's Safeguarding Children's Board (SCB). They are responsible for ensuring that communication between both the SAB and SCB and the Trust Board is maintained. Learning lessons is the prime rationale of SCRs, and SABs and SCBs are responsible for commissioning each SCR; sharing the learning across all organisations; and monitoring at agreed review periods whether the lessons have been taken on board. The SAB is responsible for ensuring that they receive regular progress reports on a commissioned SCR and to take action if the delay appears unreasonable.

NHS organisations in partnership with the SAB should have local policies for implementing the findings from SCR, a process to report to their own boards, and action plans to implement and monitor changes in practice.

7. Dissemination, storage and archiving (Control)

A copy of the policy will be placed on the SHSC intranet within 5 working days of finalisation and the previous version removed by Corporate Governance team. A communication will be sent out via the Communications Digest to all SHSC employees informing them of the revised policy. Managers are responsible for ensuring the hard copies of the previous versions are removed from any policy/procedure manually or files stored locally. Clinical and Service directors are responsible for ensuring that all their staff are aware of and know how to access all policies.

The Corporate Governance team will maintain an archive of previous versions of this policy, and make sure that the latest version is the one that is posted on the Trust intranet.

Where paper policy files or archives are maintained within teams or services it is the responsibility of the team manager to ensure that paper policy files are kept up to date and comprehensive, and that staff are made aware of new or revised policies. Older versions should be destroyed to avoid confusion. It is the responsibility of the team manager to make sure the latest version of a policy is available to all staff in the team.

8. Training and other resource implications

Directorates were requested to, and put forward, a number of individuals to receive 'top investigator level training' resulting from our external review of serious incident processes. This training took place in October 2016. Any individual who will carry out a serious incident investigation should have received root cause analysis training within the preceding three years.

Training on undertaking Reviews of Care (RoCs) has been given to team managers, where required and requested through directorates. Further training on this can be provided through the Risk Team.

9. Audit, monitoring and review

Sheffield Health and Social Care NHS Foundation Trust

Minimum Requirement	Process for Monitoring	Responsible Individual/ group/ committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
A) How the Trust monitors compliance with the policies duties	Appraisal	Line manager	Annual	Line Manager	Line Manager/ Appraisee	Line Manager/ Appraisee
B) How the Trust monitors compliance with reporting	Review/ Audit/ Reporting	Risk Management Department	Monthly	Clinical and Services Directors	Clinical and Services Directors	Clinical and Services Directors
C) How the organisation monitors reporting to external agencies	Review of NRLS reports/SIRS data/StEIS system/ Monitor returns	Risk Management Department	Quarterly/ 6 monthly	Quality Assurance Committee	Risk Management Department	Quality Assurance Committee
D) How the Trust monitors staff raising concerns	Supervision/ Review	Line manager/ HR & Workforce Group	Monthly/Annual	Education Training Development Steering Group	HR & Workforce Group	HR & Workforce Group – for action Board – for assurance

Policy documents should be reviewed every three years or earlier where legislation dictates or practices change. The policy review date is August 2019.

10. Implementation plan

Action / Task	Responsible Person	Deadline	Progress update
New policy to be uploaded onto the Intranet and Trust website. Archive old policy	Director of Corporate Governance	Within 5 working days of finalisation	
A communication will be issued to all staff via the Communication Digest immediately following publication.	Director of Corporate Governance	Within 5 working days of issue	
A communication will be sent to Education, Training and Development to review training provision.	Director of Corporate Governance	Within 5 working days of issue	

11. Links to other policies, standards and legislation (associated documents)

NHS England's Serious Incident Framework
Whistleblowing policy
Risk Management Strategy
Media Relations Policy
Missing Patient Policy
Major Incident (Emergency) Plan
Zero Tolerance Policy
Control of Infection – Outbreak Policy
Disciplinary Policy
Security Policy
Duty of Candour/Being Open Policy
Safeguarding Adults Policy
South Yorkshire Safeguarding Adults procedures
Safeguarding Children Policy
CQC Fundamental Standards

12. Contact details

Title	***Name***	***Phone***	***Email***
Clinical Risk Manager	Vin Lewin	16379	Vin.Lewin@shsc.nhs.uk
Head of Clinical Governance	Tania Baxter	63279	Tania.Baxter@shsc.nhs.uk

13. References

- NHS England's Serious Incident Framework (2015)
- Controlled Drugs (Supervision of management and use) Regulations 2013
- Organisation with a Memory - Department of Health (2000)
- Building a Safer NHS for Patients - Department of Health (2001)
- Doing Less Harm - Department of Health (2001)
- National Patient Safety Agency (2001)
- Steps to Patient Safety in Mental Health -National Patient Safety Agency (2008)
- A Professional Approach to Managing Security in the NHS - Counter Fraud and Security Management Service (2004)
- Root Cause Analysis Investigation Tools (National Patient Safety Agency September 2011)

Appendix A – Version Control and Amendment Log

Sheffield Health and Social Care NHS Foundation Trust

Version No.	Type of Change	Date	Description of change(s)
V4	Revision/ ratification / issue	November 2016	This revision contains substantial changes from the previous version.

Appendix B – Dissemination Record

Version	Date on website (intranet and internet)	Date of "all SHSC staff" email	Any other promotion/ dissemination (include dates)
4.0	Dec 2016	Dec 2016 via Communications Digest	

Appendix C – Stage One Equality Impact Assessment Form

Equality Impact Assessment Process for the Policy on Policies

Sheffield Health and Social Care NHS Foundation Trust

Policies Developed Under

Stage 1 – Complete draft policy

Stage 2 – **Relevance** - Is the policy potentially relevant to equality i.e. will this policy potentially impact on staff, patients or the public? If **NO** – No further action required – please sign and date the following statement. If **YES –** proceed to stage 3

This policy does not impact on staff, patients or the public (insert name and date)

Stage 3 – **Policy Screening** - Public authorities are legally required to have 'due regard' to eliminating discrimination , advancing equal opportunity and fostering good relations , in relation to people who share certain 'protected characteristics' and those that do not. The following table should be used to consider this and inform changes to the policy (indicate yes/no/ don't know and note reasons). Please see the SHSC Guidance on equality impact assessment for examples and detailed advice. This is available by logging-on to the Intranet first and then following this link https://nww.xct.nhs.uk/widget.php?wdg=wdg_general_info&page=464

	Does any aspect of this policy actually or potentially discriminate against this group?	**Can equality of opportunity for this group be improved through this policy or changes to this policy?**	**Can this policy be amended so that it works to enhance relations between people in this group and people not in this group?**
AGE	**No**		
DISABILITY	**No**		
GENDER REASSIGNMENT	**No**		
PREGNANCY AND MATERNITY	**No**		
RACE	**No**		
RELIGION OR BELIEF	**No**		
SEX	**No**		
SEXUAL ORIENTATION	**No**		

Stage 4 – **Policy Revision** - Make amendments to the policy or identify any remedial action required (action should be noted in the policy implementation plan section)

Please delete as appropriate: Policy Amended / Action Identified / no changes made.

Tania Baxter, Nov 16

Impact Assessment Completed by (insert name and date)

Appendix D - Human Rights Act Assessment Form and Flowchart

You need to be confident that no aspect of this policy breaches a person's Human Rights. You can assume that if a policy is directly based on a law or national policy it will not therefore breach Human Rights.

If the policy or any procedures in the policy, are based on a local decision which impact on individuals, then you will need to make sure their human rights are not breached. To do this, you will need to refer to the more detailed guidance that is available on the SHSC web site
http://www.justice.gov.uk/downloads/human-rights/act-studyguide.pdf
(relevant sections numbers are referenced in grey boxes on diagram) and work through the flow chart on the next page.

1. Is your policy based on and in line with the current law (including case law) or policy?

■ **Yes. No further action needed.**

☐ **No. Work through the flow diagram over the page and then answer questions 2 and 3 below.**

2. On completion of flow diagram – is further action needed?

☐ **No, no further action needed.**

☐ **Yes, go to question 3**

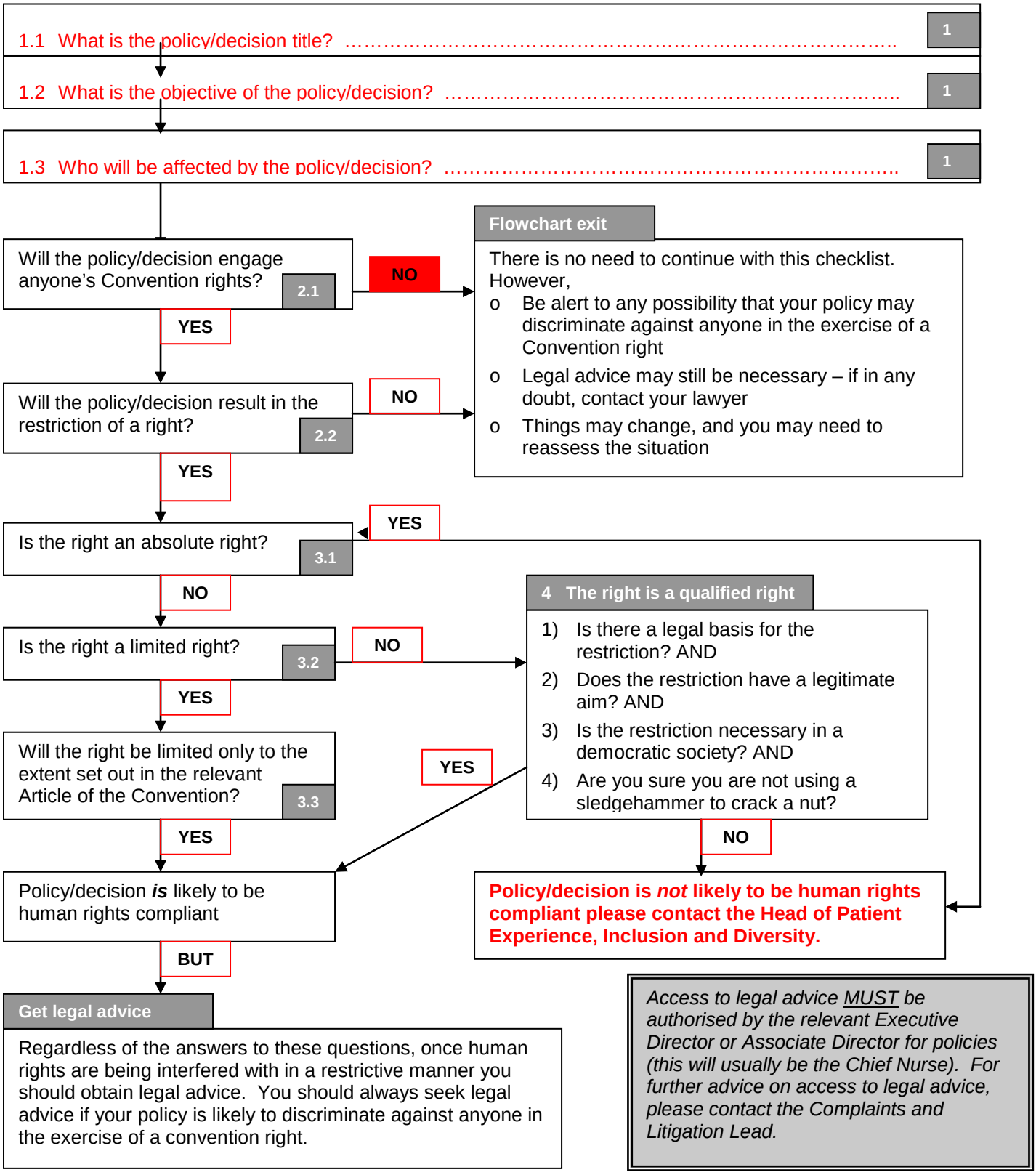
3. Complete the table below to provide details of the actions required

Action required	By what date	Responsible Person

Human Rights Assessment Flow Chart

Complete text answers in boxes 1.1 – 1.3 and highlight your path through the flowchart by filling the YES/NO boxes red (do this by clicking on the YES/NO text boxes and then from the Format menu on the toolbar, choose 'Format Text Box' and choose red from the Fill colour option).

Once the flowchart is completed, return to the previous page to complete the Human Rights Act Assessment Form.



Appendix E – Development, Consultation and Verification

The review of the former version 3 of this policy began in July 2016. This revision contains substantial changes from the previous version.

The risk matrix has been updated, in line with the Trust's Risk Management Strategy.

The policy has been revised in line with the commissioned comprehensive external review of the Trust's incident management processes.

NHS England launched their Serious Incident Framework in March 2015, and the CQC added the Duty of Candour as a Fundamental Standard.

The tools used within this policy were piloted as part of the consultation processes.

Consultation has taken place across all directorates, through the Service User Safety Group and the Nursing Leadership Group, prior to policy ratification.

Appendix F –Policies Checklist

Sheffield Health and Social Care NHS Foundation Trust

Please use this as a checklist for policy completion. The style and format of policies should follow the Policy Document Template which can be downloaded on the intranet.

1. Cover sheet ✓

All policies must have a cover sheet which includes:

- The Trust name and logo ✓
- The title of the policy (in large font size as detailed in the template) ✓
- Executive or Associate Director lead for the policy ✓
- The policy author and lead ✓
- The implementation lead (to receive feedback on the implementation) ✓
- Date of initial draft policy ✓
- Date of consultation ✓
- Date of verification ✓
- Date of ratification ✓
- Date of issue ✓
- Ratifying body ✓
- Date for review ✓
- Target audience ✓
- Document type ✓
- Document status ✓
- Keywords ✓
- Policy version and advice on availability and storage ✓

2. Contents page ✓

3. Flowchart N/A

4. Introduction ✓

5. Scope ✓

6. Definitions ✓

7. Purpose ✓

8. Duties ✓

9. Process ✓

10. Dissemination, storage and archiving (control) ✓

11. Training and other resource implications ✓

12. Audit, monitoring and review ✓

This section should describe how the implementation and impact of the policy will be monitored and audited and when it will be reviewed. It should include timescales and frequency of audits. It must include the monitoring template as shown in the policy template (example below).

Monitoring Compliance Template						
Minimum Require-ment	Process for Monitoring	Responsible Individual/ group/ committee	Frequency of Monitoring	Review of Results process (e.g. who does this?)	Responsible Individual/group/ committee for action plan development	Responsible Individual/group/ committee for action plan monitoring and implementation
A) Describe which aspect this is monitoring?	e.g. Review, audit	e.g. Education & Training Steering Group	e.g. Annual	e.g. Quality Assurance Committee	e.g. Education & Training Steering Group	e.g. Quality Assurance Committee

13. **Implementation plan** ✓
14. **Links to other policies (associated documents)** ✓
15. **Contact details** ✓
16. **References** ✓
17. **Version control and amendment log (Appendix A)** ✓
18. **Dissemination Record (Appendix B)** ✓
19. **Equality Impact Assessment Form (Appendix C)** ✓
20. **Human Rights Act Assessment Checklist (Appendix D)** ✓
21. **Policy development and consultation process (Appendix E)** ✓
22. **Policy Checklist (Appendix F)** ✓

Appendix G - Examples of Serious Incidents

NHS England's 2015 Serious Incident Framework states:

Serious Incidents in the NHS include:

- Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:
  - Unexpected or avoidable death 8 of one or more people. This includes
    - suicide/self-inflicted death; and
    - homicide by a person in receipt of mental health care within the recent past;
  - Unexpected or avoidable injury to one or more people that has resulted in serious harm;
  - Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent:—
    - the death of the service user; or
    - serious harm;
  - Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where:
    - healthcare did not take appropriate action/intervention to safeguard against such abuse occurring ; or
    - where abuse occurred during the provision of NHS-funded care.

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

- A Never Event - all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death.

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

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

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

This list is NOT exhaustive nor in any order of importance. Personal judgement will need to be exercised when deciding whether or not to report and manage an incident as a SI. Contact the Clinical Governance Department for advice.

Appendix H – List of Never Events

Never events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented by healthcare providers.

Incidents are considered to be never events if:

- The incident either resulted in severe harm or death or had the potential to cause severe harm or death.
- There is evidence that the never event has occurred in the past and is a known source of risk (for example through reports to the National Reporting and Learning System or other serious incident reporting system).
- There is existing national guidance or safety recommendations, which if followed, would have prevented the incident from occurring.
- Occurrence of the never event can be easily identified, defined and measured on an ongoing basis.

The term should not be used for incidents that do not meet these criteria. The types of incident that currently meet these criteria are listed below.

Mental Health Inclusions:

- Mis-selection of a strong potassium containing solution
- Wrong route administration of medication
- Overdose of Insulin due to abbreviations or incorrect device
- Failure to install functional collapsible shower or curtain rails
- Falls from poorly restricted windows
- Chest or neck entrapment in bedrails
- Patient being scalded by water used for washing/bathing

Inquest Process

Appendix I

Responsible Individual/Team	
Risk Dept	Notification of death of SHSC client received from HM Coroner
	Team/Service manager informed Clinical and Service Directors informed
Team Manager	Team/Service manager informs staff of death
Risk Dept	Client records examined to determine who care and treatment reports are required from
	Care and Treatment reports requested from individuals involved in care
Lead Individuals	Care and Treatment reports submitted (within 10 days of request)
Risk Dept	Care and Treatment reports reviewed/feedback to author(s) Approved reports issued to HM Coroner
Risk Dept	Inquest preparation meeting arranged for witnesses (once inquest listing date known)
Witnesses	Staff being called (witnesses) attend inquest preparation meeting
Risk Dept	Pre-Inquest Review (PIR) meeting with HM Coroner (where required)
	Inquest takes place

Appendix J– Risk Rating Matrices

Sheffield Health and Social Care NHS Foundation Trust

Choose the most appropriate domain for the identified risk from the left hand side of the table Then work along the columns in same row to assess the severity of the risk on the scale of 1 to 5 to determine the consequence score, which is the number given at the top of the column.

Table 1 – Measures of Consequences/Severity

Consequence Score (severity levels) and examples of descriptors					
	1	**2**	**3**	**4**	**5**
Domains	**Negligible**	**Minor**	**Moderate**	**Major**	**Catastrophic**
SAFETY Impact on the safety of patients, staff or public (physical/ psychological harm)	Minimal injury requiring no/minimal intervention or treatment. No time off work Incorrect medication dispensed but not taken Incident resulting in a bruise/graze Delay in routine transport for patient Expected death Missing patient (low risk)	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days Wrong drug or dosage administered, with no adverse effects Physical attack, such as pushing, shoving or pinching, causing minor injury Self-harm resulting in minor injuries Grade 1 pressure ulcer Laceration, sprain, anxiety requiring occupational health counseling (no time off work required) Missing patient (medium risk)	Moderate injury requiring professional intervention Requiring time off work for 4-14 days Increase in length of hospital stay by 4-15 days RIDDOR/agency reportable incident An event which impacts on a small number of patients Wrong drug or dosage administered with potential adverse effects Physical attack causing moderate injury Self-harm requiring medical attention Grade 2/3 pressure ulcer Healthcare Acquired Infection (HCAI) Incorrect or inadequate information/communication on transfer of care Vehicle carrying patient involved in a road traffic accident Slip/fall resulting in	Major injury leading to long-term incapacity/disability Requiring time off work for >14 days Increase in length of hospital stay by >15 days Mismanagement of patient care with long-term effects Wrong drug or dosage administered with adverse effects Physical attack resulting in serious injury Grade 4 pressure ulcer Long-term HCAI Slip/fall resulting in injury such as dislocation/fracture/blow to the head Post-traumatic stress disorder	Incident leading to death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients Unexpected death Suicide of a patient known to the service in the past 12 months Homicide (or suspected homicide) committed by a mental health patient Incident leading to paralysis Incident leading to long-term mental health problem Rape/serious sexual assault Loss of a limb

			injury such as a sprain Missing patient (high risk)		
QUALITY Quality/ Complaints/ Audit	Peripheral element of treatment or service sub-optimal Informal complaint/ inquiry	Overall treatment or service sub-optimal Formal complaint Local Resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance if unresolved	Treatment or service has significantly reduced effectiveness Serious complaint Repeated failure to meet internal standards Local resolution (with potential to go to independent review) Majority patient safety implications of findings are not acted on	Non-compliance with national standards with significant risk to patients if unresolved Multiple complaints/ independent review Low performance rating Critical report Major complaint/ claim	Incident leading to totally unacceptable level of quality of treatment/ service Gross failure of patient safety if findings no acted upon Inquest/ Ombudsman inquiry Gross failure to meet national standards
WORKFORCE Human resources/ organisational development/ staffing/ competence	Short-term low staffing level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality	Late delivery of key objective/ service due to lack of staff Unsafe staffing level or competence (>1 day) Low staff morale Poor staff attendance for mandatory/key training	Uncertain delivery of key objective/service due to lack of staff Unsafe staffing level or competence (>5 days) Loss of key staff Very low staff morale No staff attending mandatory/ key training	Non-delivery of key objective/service due to lack of staff Ongoing unsafe staffing levels or competence Loss of several key staff No staff attending mandatory training /key training on an ongoing basis
STATUTORY Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breach of statutory legislation Reduced performance rating if unresolved	Single breach in statutory duty Challenging external recommendations/ improvement notice	Enforcement action Multiple breeches in statutory duty Improvement notices Low performance rating Critical report	Multiple breeches in statutory duty Prosecution Complete systems change required Zero performance rating Severely critical report
REPUTATIONAL Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – Short-term reduction in public confidence Elements of public expectation not	Local media coverage – Long-term reduction in public confidence	National media coverage with <3 days service well below reasonable public expectation	National media coverage with >3 days service well below reasonable public expectation. MP concerned (questions in the

		being met			House) Total loss of public confidence
BUSINESS Business objectives/ projects	Insignificant cost increase/ schedule slippage	<5 per cent over project budget Schedule slippage	5–10 per cent over project budget Schedule slippage	Non-compliance with national 10–25 per cent over project budget Schedule slippage Key objectives not met	Incident leading >25 per cent over project budget Schedule slippage Key objectives not met
FINANCE Finance including claims	Small loss Risk of claim remote	Loss of 0.1-0.25% of budget Claim less than £10,000 Vandalism/ theft <£10k Cosmetic damage to premises	Loss of 0.25-0.5% of budget Claims between £10,000 and £100,000 Vandalism/ theft £10-50k	Uncertain delivery of key objective/ loss of 0.5-1.0% of budget Claim between £100,000 and £1 million Purchasers failing to pay on time Vandalism/ theft £50-£100k	Non-delivery of key objective of >1% of budget Failure to meet specification/ slippage Loss of contract/ payment by results Claims > £1 million Vandalism/ theft over £100k
ENVIRONMENTAL Service/business interruption Environmental impact	Loss/ interruption of >1 hour Minimal or no impact on the environment	Loss/ interruption >8 hours Minor impact on environment Cosmetic damage to premises	Loss/ interruption of > 1 day Moderate impact on environment Structural damage to premises	Loss/ interruption of > 1 week Major impact on environment Permanent irreparable damages to premises/ damage up to £100k	Permanent loss of service or facility Catastrophic impact on the environment Serious fire Permanent irreparable damage to premises/ damage over £100k

a) Scoring the likelihood

Use *Table 2 – Likelihood,* to score the likelihood of the assessed consequence/s. Use the descriptors as a guide to determine the likelihood score.
I.e. 1 = Rare; 2 = Unlikely; 3 = Possible; 4 = Likely; 5 = Almost Certain.

N.B. Remember you are scoring the likelihood of the consequence/s you have determined being realised.

Table 2 Likelihood

Score/Descriptor	Likelihood	Frequency	Probability
1 Rare	This will probably never happen recur	Not expected to recur for years	<0.1 %
2 Unlikely	Do not expect it to happen recur but it is possible it may do so	Expected to occur at least annually	0.1-1.0 %
3 Possible	Might happen or recur occasionally	Expected to occur at least monthly	1-10 %
4 Likely	Will probably happen/ recur but it is not a persisting issue	Expected to occur at least weekly	10-50 %
5 Almost Certain	Will undoubtedly happen/recur, possibly frequently	Expected to occur at least daily	> 50 %

b) Scoring/Rating the risk

Calculate the risk score by multiplying the consequence score by the likelihood to determine your risk rating score using *Table 3 – Risk Rating.*

It may be appropriate to assess more than one domain of consequence. This may result in generating different scores. Use your judgement to decide on the overall rating/score.

Table 3 – Risk Score

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

Table 4 Risk Rating below determines the overall Risk Rating given to the risk based on the scores from *Table 3 Risk Score.*

Table 4 Risk Rating

1-4	**Very Low**	**5-8**	**Low**	**9-12**	**Moderate**	**15-25**	**High**

c) Risk Management Plan (Actions)

Any risk management plan to control the residual risk must be devised and written down in an action plan format with SMART actions (Specific, Measurable, Achievable, Realistic, Timely), a named person and timescales should be allocated for each action.

It is essential that the plan to manage the risk is shared with everyone who needs to know about it, or is affected by it. With clinical risks, this will usually include service users and carers. A plan will not be effective if the people charged with implementing it do not know about it.

1. RECORDING, MONITORING AND REVIEW

All identified risks are recorded on the Trust's electronic risk management module – *Risk Web* which can be accessed by appropriate individuals.

It is important that there is a system in place to regularly monitor and review these risks, therefore the table below sets out the response and frequency of review expected based on the *Residual Risk Rating.*

RESIDUAL RISK:		RESPONSE REQUIRED	FREQUENCY OF REVIEW
SCORE	RATING		
1-4	Very Low	Remains on local risk register for monitoring.	Bi-annually
5-8	Low	Remains on local risk register with local level actions identified where possible to reduce the risk as low as is reasonably practicable.	Bi-annually
9-12	Moderate:	Actions must be identified and risk must be escalated to next level for consideration on to next level's risk register. Escalated via usual weekly reports.	Quarterly
15-25	High:	Actions must be identified and risk must be immediately escalated to next level. Escalated via direct notifications to appropriate individuals.	Monthly

Sheffield Health and Social Care NHS
NHS Foundation Trust

Serious Incident - Summary of Initial Information

Trust Incident Number:		**StEIS Ref:**	
Date/Time of Incident:		**Incident Location:**	
Incident Category:		**Actual Severity:**	
Details of Incident:			
Immediate actions taken:			
Detail of Contact/Involvement with Other Agencies:			

Further Service User Information:

Care Level		**MHA Status**	
Team/s Involved		**Current Diagnosis**	

Brief summary of involvement with SHSC services	
Details of last contact:	
Details of contact/planned contact with service user/family or carers:	
Initial review of records undertaken by:	
Does Duty of Candour Apply?	

INITIAL REVIEW OF CARE

PART 1: INCIDENT DETAILS			
Insight / Initials:		**Date of Incident:**	
SHSC Incident No:		**StEIS Reference:**	
Incident Category:			
Actual Impact/Outcome:			
Teams Involved:			
Directorates Involved:			
Brief Details of Incident			
Historical Summary/Overview of Care:			
Reviewers:			
Name ▪ ▪ ▪		Job title ▪ ▪ ▪	

PART 2: REVIEW OF CARE
Overall assessment of care provided
Please give details on your overall assessment of care – e.g. did the service user have a diagnosis and does this seem appropriate, was there an appropriate care plan and risk assessment in place and was it followed, is the care as you would expect it to be and in line with the service user's diagnosis and presentation?

Do you consider the overall care provided to be:	
Definitions Excellent: *A good standard of care consistently throughout, with notable practice* Good: *Care was mostly of a good standard, with some bits considered satisfactory* Satisfactory: *Care is considered satisfactory, mostly okay, but room for improvement* Requires improvement: *Care is considered to be mostly well below the standard the Trust expects to achieve*	
Further Comments:	

Compliance with policies/standards	
Relevant Policy/Standard	Compliance level Fully / Mostly / Partially / Minimal

Did any lack of policy compliance seriously affect the care provided?	Yes / No
Further comments:	

Team Reflection/Debrief Findings:

Further Actions Identified		
Action	**Responsible Person**	**Target Date**

PART 3: BEING OPEN	
Has initial contact been made with the service user/family by the relevant team involved in the service user's care?	Yes / No
Additional comments:	
Has the Trust written to the service user/family to include their views in the review?	Yes / No
Additional comments:	
Does the service user/family require additional information/ a response in addition to this review? If so this should be attached at Appendix 1.	Yes / No / NA
Does Duty of Candour apply to this incident?	No

PART 4: RECOMMENDATION REGARDING FURTHER INVESTIGATION	
In your opinion, is further investigation required?	Yes / No / Unsure
If yes: what level of investigation is required?	Further local level investigation / Fully objective systems analysis
What should the investigation focus on?	
If no: Please enter your rationale as to why not?	

Any additional comments regarding investigation:

Shared Learning Opportunities – are there local or wider learning opportunities arising from your review of this incident?
Please list:

PART 5: APPROVAL

Risk team – Is the team satisfied…	
▪ With the quality of the review?	Yes / No
▪ With the findings of the review?	Yes / No
▪ With the decision regarding further investigation?	Yes / No
▪ That there is evidence of local reflection and learning?	Yes / No
▪ That appropriate local improvements have been identified and there is a time limited action plan for implementing the learning?	Yes / No
▪ Regarding compliance with the DOC if applicable?	Yes / No / NA
Date discussed at Risk team meeting:	
Additional Risk team comments for consideration at directorate governance	

Directorate Governance – is the directorate satisfied…	
▪ With the quality of the review?	Yes / No
▪ With the findings of the review?	Yes / No
▪ With the decision regarding further investigation?	Yes / No
▪ That there is evidence of local reflection and learning?	Yes / No
▪ That appropriate local improvements have been identified and there is a time limited action plan for implementing the learning?	Yes / No
Meeting at which review was discussed:	
Date of meeting:	
Chair of meeting:	
Additional Directorate comments:	
Does this review highlight anything that needs to be added to the	Choose an

directorate's risk register?	item.

10 Steps to Setting SMART Recommendations/Action

Appendix M

Sheffield Health and Social Care NHS Foundation Trust

Making effective recommendations and actions to guide a team and organisation is very important for an investigator/leader to get right. Badly formulated recommendations and actions will steer an organisation in the wrong direction.

1. When developing your initial recommendations sort out the difference between your objectives and aims, goals and/or targets before you start. Aims and goals relate to your aspirations, objectives are your battle-plan. Set as many objectives as you need for success.

2. SMART stands for Specific, Measurable, Achievable, Realistic and Timely.

3. Don't try to use that order M-A/R-S-T is often the best way to approach developing recommendations and actions.

4. Measurable is the most important consideration. You will know that you've achieved your objective, because you have the evidence. Others will know too! Make sure you state how you will record and evidence your success.

5. Achievable is linked to measurable. Usually, there's no point in starting a job you know you can't finish, or one where you can't tell if or when you've finished it. How can I decide if it's achievable?

   - You know it is measurable.
   - Others have done it successfully (before you, or somewhere else.)
   - It's theoretically possible (i.e. clearly not 'not achievable')
   - You have the necessary resources, or at least a realistic chance of getting them.
   - You've assessed the limitations.

6. If it's achievable, it may not be realistic. If it isn't realistic, it's not achievable. You need to know:

   - Who's going to do it?
   - Do they have (or can they get) the skills to do the job?
   - Where's the money coming from?
   - Who is ultimately responsible?

   Realistic is about human resources, time, money, opportunity.

7. The main reason it's achievable, but not realistic is that it's not a high priority. Often something else needs to be done first, before you'll succeed. If so, set up two (or more) recommendations in priority order.

8. The devil is in the specific detail. You will know your recommendation is specific enough if:

   - Everyone who's involved knows that it includes them specifically.
   - Everyone involved can understand it.
   - Your objective is free from jargon.
   - You've defined all your terms.
   - You've used only appropriate language.

9. Timely means setting deadlines. You must include one; otherwise your recommendation/action isn't measurable. But your deadlines must be realistic, or the task isn't achievable. T must be M, and R, and S without these your recommendations can't be top-priority.

10. It is worth this effort! You'll know you've done your job well, and so will others.