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NHS
Gloucestershire Health and Care
NHS Foundation Trust

CLINICAL GOVERNANCE POLICY
Incident Reporting and Management

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Policy Number	CGP001
Version:	V3.1
Purpose:	This policy is a Trust-wide document and applies to all Gloucestershire Health and Care NHS Foundation Trust (GHC) staff. This policy has been updated to reflect the Trust's move from the Serious incident framework (SIF) to the Patient Safety Incident Response Framework (PSIRF) and other elements of the National Patient Safety Strategy (NHSE 2019).
Consultation:	There has been consultation within the patient safety team, legal services, and information governance and subject matter experts across the trust
Approved by:	Quality Assurance Group, Board and Clinical Policy Group
Date approved:	Clinical Policy Group 16/12/2023
Author:	[redacted] Head of Patient Safety and Learning
Date issued:	26/02/2024
Review date:	01/02/2027
Audience:	All Trust employees
Dissemination:	Intranet, Patient Safety Bulletin, Patient Safety and Learning Noticeboards and through service governance processes
Impact Assessments:	This Policy has been subjected to an Equality Impact Assessment. This concluded that this policy will not create any adverse effect or discrimination on any individual or particular group and will not negatively impact upon the quality of services provided by the Trust.

Version History

Version	Date Issued	Reason for Change
V1.1	01/10/2019	A merged policy for the new organisation
V1.2	March 2020	No New QEIA
V2	24/07/2020	Introduce a review of all moderate and above incidents by the Patient safety team before final closure / Extend the 72-hour initial investigation, up to 5 days / Include a Senior Clinical

		Lead (SCL) for all declared SIRIs / A revised process for monitoring compliance and embedding learning
V2.1	05/10/2020	Addition of Action Card 3: Reviewing No/Low Harm Incidents, consequential renaming of Action Card 4.
V2.2	13/07/2023	Extension to review date of 3 months
V3	26/02/2024	Updated to reflect the Trust's move from the Serious incident framework (SIF) to the Patient Safety Incident Response Framework (PSIRF) and other elements of the National Patient Safety Strategy (NHSE 2019)
V3.1	25/11/2024	IUC Service SOP added to Policy and scope section amended

SUMMARY

This policy states the purpose, responsibilities and process for the reporting and management of patient safety incidents.

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ABBREVIATIONS

Abbreviation	*Full Description*
AAR	After Action Review
CQC	Care Quality Commission
DoC	Duty of Candour
GHC	Gloucestershire Health and Care NHS Foundation Trust
HSE	Health and Safety Executive
PSII	Patient Safety Incident investigation
PSIRF	Patient Safety Incident Response Framework

PSIRP	Patient Safety Incident Response Plan
RIDDOR	Reporting of Injuries, Diseases and Dangerous Occurrences Regulations

1. INTRODUCTION

Gloucestershire Health and Care NHS Foundation Trust (GHC) is committed to ensuring high quality healthcare in a safe environment. By providing a system for incident reporting and management, incidents can be reported and investigated. Incident trends can be analysed to understand where development and learning can improve patient experience and quality of care. Lessons can also be learned from incidents and shared across the organisation to prevent recurrence.

2. PURPOSE

Effective incident reporting, investigation and the institution of appropriate control measures will reduce the likelihood of incidents recurring. This will help contribute to improved patient safety and service provision and support activities that make the trust a safer place to work and visit for staff, patients, and the public.

The Trust's Incident Reporting system must be used to report an incident which has resulted in or could have resulted in harm to a patient, visitor, or member of staff or if, as a result of the incident, there has been harm to the Trust, either financially or by way of reputation. The system is also used for the reporting of near misses and deaths and will provide functionality to report good practice.

The objective of incident investigation is to understand what happened, why it happened and to identify any actions that need to be taken to prevent a similar incident in the future. The depth and scope of the investigation is described in the Trust's patient safety incident response plan (PSIRP).

Professional staff should also ensure they comply with their own professional guidelines (e.g. General Medical Council, General Dental Council and Nursing and Midwifery Council) regarding the reporting and investigation of incidents. Members of Trust staff must ensure that incident reports are made promptly and accurately.

The Trust is committed to a culture which promotes openness, honesty and that focuses on improving practice, rather than focusing on individual deficiencies and blame. The Trust accepts that fear of disciplinary action may deter staff from reporting incidents and has therefore chosen to adopt an open approach, and that all reports are viewed as an opportunity to learn and improve. Disciplinary proceedings will only result in exceptional circumstances, for example where there has been a breach of the law, gross negligence, or professional misconduct.

3. SCOPE

This policy applies to all colleagues working in or for the Trust, including new starters, locums, temporary staff, students, agency, bank, and other colleagues contracted to work in the organisation. There are no limitations on its circulation within the Trust and the wider NHS community, and it can be made available to patients, their families, and the public on request. There is a separate SOP detailing the process for reporting incidents in the Integrated Urgent Care Service: Incident Reporting and Management for the Integrated Urgent Care Service SOP.

4. DUTIES

Chief Executive and Executive Director of Nursing, Therapies and Quality
The overall responsibility for effective risk management in the Trust, including incident reporting and management lies with the Chief Executive. At an operational level, the Executive Director of Nursing is the Director designated with responsibility for governance and risk management. Overall, patient safety is delegated to the Medical Director. The Executive Director of Nursing will liaise with the Executive Medical Director for medical issues relating to clinical risk management, patient safety and staff concerns regarding service delivery.

The Executive Director of Nursing key responsibilities in respect of incident reporting and management are:

- Notifying the Board of Director of incidents reported as Never Events.
- Notifying the Board of Director of incidents considered as meeting the criterion of a PSII.
- Presenting reports to open and closed board which provide details of new cases, issues of concern, outcome and learning and assurance.

Executive Directors
Responsible for ensuring that risk, including incident reporting and management, is managed appropriately in their area of responsibility. Key responsibilities include through a shared schedule of attendees ensure executive presence at panel meetings to coordinate the management of incidents meeting the requirements of the organisation's PSIRP.

Board of Directors
The Board of Directors has delegated authority for incident reporting and management to the Quality Committee. The Board of Directors will be directly appraised of:

- New PSIIs, claims, complaints graded as 'red' and dated inquest hearings.
- Never Events.
- Performance against agreed Key Performance Indicators as part of the agreed performance monitoring arrangements.
- Receive an aggregated learning report which incorporates learning from incidents and wider integrated governance functions (complaints, claims, inquests, learning from deaths, clinical audit compliments, and other pathways).

Quality Assurance Group (QAG)
The QAG is responsible (as per its terms of reference) for identifying deteriorating trends and/or areas where the Trust is a potential outlier or underperformer, gaining assurance on effective and/or improving systems, seeking to understand the rationale for any improvement or deterioration in performance, identify and prioritise scope for improvement opportunities, ensure the best utilisation of resources (staffing/financial/information/training) and cooperative working to support patient safety and quality.

Its key responsibilities in relation to incident reporting and management include:

- Approve and monitor relevant key performance indicators.
- Approving this policy.

Medical Director
The key responsibilities in relation to incident reporting and investigation include:

- Providing a point of escalation for any aspects of incident reporting that relate to medical staff.

The Head of Patient Safety
The Head of Patient Safety is responsible for ensuring procedures for managing clinical incidents are consistent with national and local guidance and the practices enshrined within the National Patient Safety Strategy.

Specialist Advisory Committees
Several specialist advisory committees are identified in the Trust with responsibility for incident management. Their key responsibilities in relation to incident reporting and investigation include:

- Review incident trends according to the defined function to ensure organisational learning takes place.
- Escalating any outstanding issues or concerns to the committee they report to.

Patient Safety and Learning Team
The Patient Safety and Learning Team are responsible for communicating and co-ordinating the process of risk management throughout the Trust. Their key responsibilities in relation to incident reporting and investigation include:

- Managing the Trust's system for reporting incidents and near misses and encouraging prompt reporting of all incidents.
- Liaising with statutory and other official bodies, for example the Health and Safety Executive, Care Quality Commission, NHS England, the Information Commissioner, NHS Resolution, and the Integrated Care Board (ICB).
- Supporting the review of incident trends and providing information and analysis on incident trends to assist responsible committees and individuals.
- Supporting the review of incidents reported as moderate, major, or catastrophic harm to ensure statutory requirements for Duty of Candour are complied with.
- Reporting of all patient related incidents through the Learning from Patient Safety Events (LFPSE) via an online portal.
- Providing investigator training to relevant staff.
- Promoting lessons learned and initiatives which can be used to reduce incident causes.
- Identify issues arising from incident investigations for inclusion in the Trust clinical audit programme.

Service Responsibilities
Each service's key responsibilities in relation to incident reporting and investigation include:

- Reviewing incident data and trends.
- Addressing any significant concerns or issues.
- Communicating any lessons learnt locally.
- Ensuring all relevant lessons learned are shared both Trust wide and in the wider health community.
- Escalating any significant concerns outside the control of the division to the relevant Trust forum.
- Ensuring the timely completion of incident investigations by all staff within the division.

Senior Leadership Team in Services
Responsible for ensuring that risk, including incident reporting and management, is managed appropriately in their area of responsibility. Key responsibilities include:

- Addressing significant concerns/issues from incident investigation escalated by Lead Clinicians, Service Directors, Service Managers and Matrons or by local departmental /

specialty meetings.
- Ensuring that actions from incident investigations are implemented within given timescales.
- Escalating any significant concerns outside the control of the senior leadership team to the relevant Trust forum.
- Ensure appropriate action is taken to deliver Divisional KPI relating to incident reporting and management.

Investigation Leads
Individuals identified as a Lead investigator for an incident are responsible for:
- Leading an investigation into the specific incident.
- Producing a report using the Trust templates.
- Ensuring National and local practice is reflected within the investigation.

Managers
All managers are responsible for:
- Ensuring that all incidents that occur in their area of responsibility are reported in a timely manner and in accordance with Trust Policies and Procedures.
- Receiving all Datix reports occurring in their area(s) of responsibility and ensuring that immediate action has been taken to manage the incident.
- Identifying causes of incidents and putting in place measures to minimise the likelihood of recurrence by establishing any lessons to be learnt and implementing these locally.
- To review investigation of incidents reported for their area(s) of responsibility.
- Informing their head of department, service manager, locality manager of any lessons to be shared both Trust wide and in the wider health community.
- Escalating any significant concerns to their head of department, service manager, locality manager, matron, clinical lead, or other appropriate individual.
- Ensuring that staff are adequately supported following an incident and as required during an investigation. Support can either be provided via their manager, their GP, or the Wellbeing Line.
- Consulting with the human resources department regarding any precautionary measure, capability or disciplinary action proposed regarding a member of their staff following an incident.

Senior Member of Staff on Duty
The Senior member of staff on duty when a serious incident occurs in a hospital setting the member of staff must immediately:
- Inform their immediate manager or Service Director (or equivalent)/Clinical Director. If out-of-hours contact the Senior Manager on-call via switchboard who will manage the incident until the next working day.
- In the case of a person detained under the Mental Health Act it is the responsibility of the patient's responsible clinician to notify the coroner of all cases of death as a direct result of an incident. If the Consultant is unavailable, another Consultant in the same specialty should be advised of the incident and asked to support.
- Preserve the scene to prevent unauthorised entry or tampering with evidence, this may include taking photographs (consider whether consent is required) and recording the position of equipment and people involved in the incident.
- Isolate/retain all evidence i.e. medical records, equipment, drugs, and other documentation.

Professional Bodies and Trade Unions

The above bodies accept the responsibility of working with the Trust on issues with the shared intention of investigating and learning from incidents. Trade Unions can play a vital role in representing employees in individual matters and supporting them through difficult and stressful situations.

Members of Staff Present in the Community
The members of staff present when a serious incident or unexpected death occurs in a community setting. The member of staff must immediately:

- Inform the Senior Manager on duty. If out-of-hours support is required, contact the Community Manager on-call who will manage the incident until the next working day.
- Seek to inform the GP if the incident has involved a patient death or serious injury. The GP will contact the police to notify of any unexpected death in the community.
- Clinician must contact the patient's next-of-kin. Where there is difficulty in locating the next-of-kin, the police may be asked to assist.
- It is the responsibility of the GP to ensure the coroner is notified of all cases unexpected death in the community.

All Staff
Staff responsibilities include:

- Reporting incidents and near misses promptly. Staff working in the Trust on a locum or agency basis, or as a contractor or volunteer must also report incidents. Where a member of the public has been involved in an incident, staff must complete an incident form on their behalf.
- If a witness to or directly involved in an incident, addressing the immediate health needs of the person(s) involved in an incident, ensuring that the situation is made safe, informing their manager, and completing a Trust incident on Datix.
- Undertaking immediate action to manage the incident and identifying actions needed to minimise the chances of recurrence.
- Engaging in the investigation of incidents and providing information when required.

On-Call Managers
On-call managers are responsible for co-ordinating and managing incidents requiring immediate actions during out-of-hours and at weekends in accordance with the on-call action cards.

General Roles, Responsibilities and Accountability

Gloucestershire Health and Care NHS Foundation Trust (GHC) aims to take all reasonable steps to ensure the safety and independence of its patients and service users to make their own decisions about their care and treatment.

In addition **GHC** will ensure that:

- All employees have access to up-to-date evidence-based policy documents.
- Appropriate training and updates are provided.
- Access to appropriate equipment that complies with safety and maintenance requirements is provided.

Managers and Heads of Service will ensure that:

- All staff are aware of and have access to policy documents.
- All staff access training and development as appropriate to individual employee needs.
- All staff participate in the appraisal process, including the review of competencies.

Health and Safety Manager
Will be notified of any serious incident that primarily affects staff or any non-clinical serious incident and has responsibility for:

- Review all health and safety related incidents and report themes and trends to the Health and Safety Committee.
- Provide specialist advice and guidance to managers on RIDDOR investigation and ensure the quality and completion of RIDDOR reports.
- Report relevant incidents to the Health and Safety Executive.
- Take a strategic lead on violence and aggression incidents.

Safeguarding Team

- Review all safeguarding related incidents and report themes and trends to the Director of Nursing, Therapies and Quality.
- Provide specialist advice and guidance to managers.
- Report relevant incidents to external agencies as appropriate.
- Take a strategic lead the investigations of section 42 enquiries.
- Support in the completion of S42 Summary Reports resulting from a serious incident that is investigated through the safeguarding process.

Local Security Management Specialist

- Receive and review all security incidents.
- Provide specialist advice in relation to security and management of violence towards staff.

Local Counter Fraud Specialist

- Receive and review all incidents where fraud may be suspected.
- Provide specialist advice in relation to fraud related issues.

Head of Information Governance and Records and Data Protection Officer

- Review all incidents involving data protection / information security breaches.
- Provide specialist advice.
- Report relevant incidents to the Information Commissioners Office (ICO).

Accountable Officer for Controlled Drugs
All Controlled Drug related incidents are reported to the Accountable Officer for Controlled Drugs who will investigate incidents and report to NHS England in a quarterly Occurrence Report.

Medication Safety Officer (MSO)
The MSO is a role recommended within the NHS England » Patient safety alert to improve reporting and learning of medication and medical devices incidents.

MSO responsibilities include:

- Being an active member of the national medication safety officer network.
- Acting as the organisational link with the MHRA and NHSE to receive essential communications and escalate concerns related to the safe use of medications.
- Implementing local actions to improve medication safety which align with national safety initiatives, including national patient safety alerts.
- Supporting the management of medication incidents in the organisation.

Medical Device Safety Officer (MDSO)
One of the MDSO key roles is to promote the safe use of medical devices across their organisation and provide expert advice. The MDSO will report medical device incidents to the Medical Devices Committee.

Communications Team
Will be notified of any incident that is likely to be of interest to the media or external stakeholders (e.g. CCG, CQC, NHS England or Members of Parliament). Advice should be sought from the communications team before any contact with the media or external stakeholders, both on a proactive and reactive basis.

Out of hours the on-call manager will notify and liaise with communications.

Employees (including bank, agency and locum staff) must ensure that they:

- Practice within their level of competency and within the scope of their professional bodies where appropriate.
- Read and adhere to GHC policy.
- Identify any areas for skill update or training required.
- Participate in the appraisal process.
- Ensure that all care and consent comply with the Mental Capacity Act (2005) – see section on MCA Compliance below.

5. MENTAL CAPACITY ACT COMPLIANCE

Where parts of this document relate to decisions about providing any form of care treatment or accommodation, staff using the document must do the following: -

- Establish if the person able to consent to the care, treatment or accommodation that is proposed? (Consider the 5 principles of the Mental Capacity Act 2005 as outlined in section 1 of the Act. In particular principles 1,2 and 3) Mental Capacity Act 2005 (legislation.gov.uk).
- Where there are concerns that the person may not have mental capacity to make a specific decision, complete and record a formal mental capacity assessment.
- Where it has been evidenced that a person lacks the mental capacity to make a specific decision, complete and record a formal best interest decision making process using the best interest checklist as outlined in section 4 of the Mental Capacity Act 2005 Mental Capacity Act 2005 (legislation.gov.uk).
- Establish if there is an attorney under a relevant and registered Lasting Power of Attorney or a deputy appointed by the Court of Protection to make specific decisions on behalf of the person (N.B. they will be the decision maker where a relevant best interest decision is required. The validity of an LPA or a court order can be checked with the Office of the Public Guardian) Office of the Public Guardian - GOV.UK (www.gov.uk).
- If a person lacks mental capacity, it is important to establish if there is a valid and applicable Advance Decision before medical treatment is given. The Advance Decision is legally binding if it complies with the MCA, is valid and applies to the specific situation. If these principles are met it takes precedence over decisions made in the persons best interests by other people. To be legally binding the person must have been over 18 when it was signed and had capacity to make, understand and communicate the decision. It must specifically state which medical treatments, and in which circumstances the person refuses and only these must be

considered. If a patient is detained under the Mental Health Act 1983 treatment can be given for a psychiatric disorder.

- Where the decision relates to a child or young person under the age of 16, the MCA does not apply. In these cases, the competence of the child or young person must be considered under Gillick competence. If the child or young person is deemed not to have the competence to make the decision then those who hold Parental Responsibility will make the decision, assuming it falls within the Zone of Parental control. Where the decision relates to treatment which is life sustaining or which will prevent significant long-term damage to a child or young under 18 their refusal to consent can be overridden even if they have capacity or competence to consent.

6. POLICY DETAIL

External Reporting and Informing Key Stakeholders
Depending on the type of incident, the incident may require reporting to an external agency or key stakeholder, for example, the Care Quality Commission, the Health and Safety Executive, NHS Digital, or the Information Commissioner.

Incident Reporting and Management Training
All staff new to the Trust will receive training in how to report incidents from the Datix team. All new managers will be required to undertake handler training form the Datix team.

Specialist training for staff undertaking specialist incident investigations will be provided as part of the Trust's training programmes.

Investigations involving the Police and/or HSE
Where an incident requires investigation by the police and/or HSE and information is required to be shared, the Trust will follow the guidance contained in the Trust Data Protection policy.

Legal Proceedings
Reporting of an incident does not constitute an admission of liability by any person. However, incident report forms may be made available to all parties in the event of legal proceedings, and it is therefore essential that they are completed accurately and factually. Never express opinions.

The Trust is vicariously liable for the acts and omissions of its employees whilst at work. Where it is considered that staff have acted in good faith, the Trust will take full responsibility in the event of any legal action arising from an incident.

Incidents to be Reported
An incident is anything which gives rise to, or has the potential to produce, expected or unwanted outcomes involving the health, safety or welfare of patients, employees, visitors, or other persons in contact with the Trust's services.

Examples of the types of incidents that should be reported are detailed in a factsheet available on the Trust intranet, this list is not exhaustive, and staff should use this process for reporting anything, which causes them concern regarding the health, safety or wellbeing of themselves or others involved with, or affected by, the Trusts activities.

RIDDOR Reporting
Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 1995 (RIDDOR) require that certain work-related injuries, diseases, and occurrences affecting staff to be reported to the

HSE. The Unit / Team / Department Manager is responsible for reporting these occurrences in Datix.

Further guidance as to what is reportable and how it can be reported is given on the Health and Safety section of the Trust Intranet.

Incidents Involving Defective or Mislabelled Drugs or Adverse Reactions And Medical Devices
All incidents relating to medical devices must be reported to the Medicines and Healthcare products Regulatory Agency (MHRA). The Head of Patient Safety and Learning will manage the external reporting although any staff member can use the Yellow Card process.

Immediate Response to an Incident
The initial response to any incident must be to make the situation safe thus preventing further harm to people using the Trust services, visitors, staff and / or others.

Immediate medical assistance must be requested where necessary. If appropriate the emergency services (Fire, Police, and Ambulance) must be contacted.

It is important to protect and support other service users, staff and visitors who may be present or in the vicinity of the incident. This support must be on-going.

All information must be added to clinical records as soon as possible following an incident. The review should be an impartial factual review of incident to cover care and treatment provided in summary. If the incident involves a person who is no longer in the care of the Trust, all information will need to be added to the person's clinical records, this will be completed by the manager of the team the person was last open to.

Preservation of Evidence
For incidents which involve medical devices, do not disassemble, clean, decontaminate or alter control settings. Clearly identify defective items, isolate the equipment.

In the case of a possible or actual criminal incident no action must be taken to clean up an area until the Police have attended. Any evidence must be preserved until the Police have completed their investigation. However, if the safety of service users or staff is at risk, reasonable precautions must be taken to remove the danger.

The clinical records and any related records must be secured at the earliest opportunity. If the records are required for on-going care, they must be copied first to preserve the record. This is the responsibility of the Senior Manager present at the incident.

Duty of Candour
For all patient safety incidents healthcare professionals have a duty of candour which is a professional responsibility to be open and honest when things go wrong. Professional DoC focuses not only on the duty to be open and honest with patients but also on the need to be open and honest within organisations in reporting adverse incidents or near misses that may have led to harm. Professional DoC is regulated by each profession's regulatory body.

For all moderate, major, or catastrophic patient safety incidents, CQC Regulation 20 DoC must be considered, and a reasoned decision made and recorded in Datix as to whether the incident

meets criteria. The Patient Safety Team and DoC Lead will support DoC reasoning as part of the incident review process.

See the Duty of Candour section on the intranet for all guidance and resources.

Clear recording of action taken at each stage of the process and details of any contact with patients, families, or carers, must be maintained on the relevant incident on Datix.

Incident Grading and Escalation
Not all incidents need to be investigated to the same extent or depth. Categorising incidents according to the actual impact and the potential future risk to people using services, visitors, staff, others, and the organisation establishes the level of local investigation and causal analysis that should be conducted.

Ward/Departmental Managers and supervisors are responsible for reviewing and grading the incident within 48 hours of the incident occurring, using the risk grading matrix which is included on the incident report form on the incident reporting system, Datix.

Every other working day an Incident Tracker Meeting is convened to triage incidents to identify those that meet the criteria for AAR, Patient Safety Huddle, PSII or other learning response. During this meeting, the requirement for the Duty of Candour is confirmed. If further information is needed to support decision making this will be identified during this meeting, requested, and then relisted for review at the earliest opportunity; to ensure compliance with reporting timescales.

Where appropriate the Head of Patient Safety and Learning will:

- Inform the Chief Executive and Medical Director (if appropriate) at an early stage.
- Agree with local senior staff on duty, the nature and extent of the required communication with patients, relatives and staff and identify responsibilities of individual staff accordingly.
- Ensure that people using Trust services or next of kin and staff are informed before the media.
- Brief the Head of Communications, who will prepare a ‘press brief’ for approval.

Investigation Appropriate to the Actual / Potential Level of Harm

Major / Catastrophic Incidents
All incidents reported relating to the death of a service user will be subject to the Trusts ‘Learning from Deaths and Mortality Reviews’ policy and procedure. This policy describes how the Trust ensures that it responds to and learns from the deaths of people who use our services. The policy describes how we will review these deaths, how we will decide which deaths will be reviewed, how these reviews will be reported and how we will support and include families and carers in this process.

The Patient Safety Team will determine if a Patient Safety Huddle is required or whether the incident should go directly to a learning response.

Moderate Incidents
If following triage at the Incident Tracker Meeting the incident meets the requirements for reporting as defined in the PSIRF plan a review appropriate to the level of harm will be commenced.

Minor and No Harm Incidents
Local learning is captured for these incident types within the Datix Managers Review.

Ensuring Local and Organisational Learning
The Trust has developed a Learning Assurance Framework. Please access this on the Trust intranet.

Support for Staff
Following an incident, the immediate needs of staff in relation to support and supervision should be considered, this should consider both internal Trust staff and external staff who have been affected by the incident. Immediate supportive debriefing will be provided by a manager / senior health professional as part of the management of the incident; time should be given to allow people to talk through both the events that have occurred and the effect it has had upon them.

Formal debriefing will be arranged following an incident which has the potential to cause any on-going distress; any staff affected by the incident should be given the opportunity to attend; however, participation in this process is a matter of individual choice.

The Wellbeing Line provides specialist support for staff and teams involved in serious, traumatic, and distressing incidents.

Additionally, there is support available from professional forums and the Royal Colleges.

7. DEFINITIONS

Incident: any event or circumstance arising that could have, or did, lead to unintended or unexpected harm, loss or damage to a person, property, or the organisation.

An incident can cover a wide range of situations, but a reportable incident is an event that contains one or more of the following components:

- Harm to an individual
- Monetary loss to an individual or the Trust
- Damage to the property of an individual or the Trust
- Disruption to services provided by the Trust
- Damage to the reputation of the Trust.

Harm: Injury (physical or psychological), disease, suffering, disability, or death.

Near miss: Any event or circumstance that did not result in harm, loss, or damage, but had the potential to do so.

Serious incident: This is an incident which has resulted in significant harm or disruption to services or has the potential to do so if action is not taken to address the underlying risk.

Patient safety incident response framework (PSIRF): national initiative designed to further improve safety through learning from patient safety incidents. The PSIRF outlines how providers should respond to patient safety incidents, and how and when an investigation should be conducted. It includes the requirement for the publication of a local **Patient Safety Incident Response Plan (PSIRP)**.

Patient Safety Incident investigation (PSII): An in-depth investigation resulting in the production of a written report using a national template.

Never Event: all Never Events are defined as serious incidents although **not all Never Events necessarily result in serious harm or death**. Never Events are a particular type of serious incident that meet **all** the following criteria:

- 'They are **wholly preventable**, where guidance or safety recommendations that provide strong systemic protective barriers **are available at a national level and should** have been implemented by all healthcare providers'.

The current Never Events List can be found at: NHS England » Never events

8. PROCESS FOR MONITORING COMPLIANCE

Are the systems or processes in this document monitored in line with national, regional, trust or local requirements?	YES

Monitoring Requirements and Methodology	Frequency	Further Actions
Biannual audits will be conducted by the Patient Safety Team to confirm that the process and principles adopted are being completed	Bi-annual	Report to Medical Director
Key performance indicators are listed in the Learning Assurance framework which will form part of reporting	Annual	Report to QAG

9. INCIDENT AND NEAR MISS REPORTING AND REGULATION 20 DUTY OF CANDOUR REQUIREMENTS

To support monitoring and learning from harm, staff should utilise the Trust's Incident Reporting System, DATIX. For further guidance, staff and managers should reference the Incident Reporting Policy. For moderate and severe harm, or deaths, related to patient safety incidents, Regulation 20 Duty of Candour must be considered and guidance for staff can be found in the Duty of Candour Policy and Intranet resources. Professional Duty of Candour and the overarching principle of 'being open' should apply to all incidents.

Appendix 1: Incident Severity Matrix

		Consequence				
		1 Negligible	2 Minor	3 Moderate	4 Major	5 Catastrophic
Likelihood	1 Rare	1	2	3	4	5
	2 Unlikely	2	4	6	8	10
	3 Possible	3	6	9	12	15
	4 Likely	4	8	12	16	20
	5 Almost certain	5	10	15	20	25

Consequence

From the table below, 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.

	Consequence score (severity levels) and examples of descriptors				
	1	2	3	4	5
Domains/subject type	Negligible	Minor	Moderate	Major	Catastrophic
Impact on the safety of patients, colleagues or public (physical/psycho logical harm)	Minimal injury requiring no/ minimal intervention or treatment. No time off work	Minor injury or illness, requiring minor intervention Requiring time off work for >3 days Increase in length of hospital stay by 1-3 days	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	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	Incident leading to Death Multiple permanent injuries or irreversible health effects An event which impacts on a large number of patients

			number		
	Minimal injury requiring no/minimal intervention or treatment No time off work	Minor injury or illness requiring minor intervention Requiring time off work for <3 days Increase in length of hospital stay by 1–3 days	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 event An event which impacts on a small number of patients	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	Incident leading to Death Multiple permanent injuries or irreversible health effects An event which impacts on many patients
	Incorrect medication dispensed but not taken Incident resulting in a bruise / graze Delay in routine transport for patient	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 1/2 pressure ulcer Laceration, sprain, anxiety requiring occupational health counselling (no time off work required)	Wrong drug or dosage administered with potential adverse effects Physical attack causing moderate injury Self-harm requiring medical attention Grade 3 pressure ulcer Healthcare-acquired infection (HCAI) Incorrect or inadequate information /communication on transfer of care	Wrong drug or dosage administered with adverse effects Physical attack resulting in serious injury Grade 4 pressure ulcer Long-term HCAI Retained instruments/ material after surgery requiring further intervention Haemolytic transfusion reaction Slip/fall	Unexpected death Suicide of a patient known to the service in the past 12 months Homicide committed by a mental health patient Large-scale cervical screening errors Removal of wrong body part leading To death or permanent incapacity Incident leading to

			Vehicle carrying patient involved in a road traffic accident Slip/fall resulting in injury such as a sprain	resulting in injury such as dislocation/fracture/ blow to the head Loss of a limb Post-traumatic stress disorder Failure to follow up and administer vaccine to baby born to a mother with hepatitis B	paralysis Incident leading to long-term mental health problem Rape/serious sexual assault
Quality/ complaints/audit	Peripheral element of treatment or service suboptimal Informal complaint/ inquiry	Overall treatment or service suboptimal Formal complaint (stage 1) Local resolution Single failure to meet internal standards Minor implications for patient safety if unresolved Reduced performance rating if unresolved	Treatment or service has significantly reduced effectiveness Formal complaint (stage 2) complaint Local resolution (with potential to go to independent review) Repeated failure to meet internal standards Major patient safety implications if 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	Totally unacceptable level or quality of treatment/ service Gross failure of patient safety if findings not acted on Inquest/ ombudsman inquiry Gross failure to meet national standards
Human resources / Organisational development / staff competence	Short-term low level that temporarily reduces service quality (< 1 day)	Low staffing level that reduces the service quality Low colleagues' morale	Late delivery of key objective/ service due to lack of colleagues Unsafe staffing level or competence (>1 day)	Uncertain delivery of key objective / service due to lack of colleagues Unsafe staffing level or competence (>5	Non-delivery of key objective/ service due to lack of colleagues Ongoing unsafe staffing levels or competence

			Very low colleague morale Poor colleague attendance for mandatory/key training	days) Loss of key colleagues No colleagues attending Mandatory / key training	Loss of several key colleagues. No colleagues attending mandatory training / key training on An ongoing basis
Statutory duty/ inspections	No or minimal impact or breech of guidance/ statutory duty	Breech of statutory legislation Reduced performance rating if unresolved	Single breech 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
Adverse publicity/ reputation	Rumours Potential for public concern	Local media coverage – short-term reduction in public confidence Elements of public expectation not being met	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 House) Total loss of public Confidence
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	Incident leading >25 per cent over project budget Schedule slippage Key objectives

				Key objectives not met	being met
Finance including claims	Small loss Risk of claim remote	Loss of 0.1–0.25 per cent of budget Claim less than £10,000	Loss of 0.25–0.5 per cent of budget Claim(s) between £10,000 and £100,000	Uncertain delivery of key objective/ Loss of 0.5–1.0 per cent of budget Claim(s) between £100,000 and £1 million Purchasers failing to pay on time	Non-delivery of key objective/ Loss of >1 per cent of budget Failure to meet specification/ slippage Loss of contract / payment by results Claim(s) >£1 million
Service/ business interruption Environmental impact	Loss/interruption of >1 hour Minimal or no impact on the environment	Loss of service/ interruption of >8 hours Minor impact on environment	Loss of service/ interruption of >1 day Moderate impact on environment	Loss of service/ interruption of >1 week Major impact on environment	Permanent loss of service or facility Catastrophic impact on environment

Likelihood:

	1	2	3	4	5
Descriptor	Rare	Unlikely	Possible	Likely	Almost Certain
Frequency	Not expected to occur for years	Expected to occur at least annually	Expected to occur at least monthly	Expected to occur at least weekly	Expected to occur at least daily

Probability	<1%	1 – 5%	6 – 20%	21 – 50%	>50%
	This will probably never happen or occur	Do not expect it to Happen/recur but it Is possible it may do so	Might happen or Recur occasionally	Will probably Happen/recur but It is not a persisting issue	Will undoubtedly happen/recur possibly frequently

Appendix 2: Gloucestershire Health and Care NHS FT Family Liaison Service

Gloucestershire Health and Care NHS FT Family Liaison Service

Description and working protocol – information for staff

GHC has established a Family Liaison Service to provide compassionate support, signposting, practical advice and advocacy to families and carers who have been bereaved by the suicide of a loved one who was under our care or recently discharged, and families/carers who are involved with Serious Incident Reviews following incidents that resulted in harm to a service user.

The aim of this protocol is to inform teams about the Family Liaison Service and provide guidance to the Family Liaison Practitioners.

What does the Family Liaison Service offer?

- General bereavement support to adults (listening, empathy, validation, psychoeducation)
- Signposting to local and national support agencies for people bereaved by suicide
- Information and practical advice about the processes families and carers are likely to encounter (e.g., serious incident reviews, inquests) and help with navigating systems and jargon.
- Support throughout the Trust serious incident review process to help families raise concerns and questions and have these explicitly included in reports.

What does the Family Liaison Service ***NOT* offer?**

- Mental health care; but if a family member or carer requires mental health care, advice, and support on how to seek such will be provided.
- Bereavement support to individuals under the age of eighteen; this should be provided by suitably trained staff within child bereavement services and families can be signposted to these services by the Family Liaison Service.

Those who deliver the Family Liaison Service will be independent of Serious Incident Reviews, however they will function as a conduit between the family and the Serious Incident Review Team and an advocate for the family to ensure their views are heard and accurately reflected.

Who is eligible for the Family Liaison Service?

In the first instance, any adult family member, friend, or carer who was actively involved with the patient/service user concerned and who the clinical team has contact with.

However, the ‘family’ should not be seen homogenous unit. Geography, family breakups and

splits all play their part here. A child dies, but the parents are divorced, which one do you contact? A sibling dies and those remaining are at loggerheads with different views on what happened to the bereaved. A partner may not get on with, or be estranged from, the biological family. The Family Liaison Service and the referring clinician or team should consider carefully who the 'family' is. This information may not be fully understood until contact with the known family member or carer is established.

Who is NOT eligible for the Family Liaison Service?

This service is not offered to family members or carers under the age of 18 years; young people under 18 years will be signposted to appropriate specialist services.

Who provides the Family Liaison Service?

The Family liaison service is made up of a small number of skilled mental health clinicians who have training and experience of collaborating with individuals and families bereaved by suicide. These clinicians are termed **Family Liaison Practitioners (FLPs)**.

The service is currently coordinated by the Head of Patient Safety and Learning.

Family Liaison Practitioners (FLPs) will not:

- Be a member of the clinical team who provided care for the patient concerned.
- Have had past contact with the patient concerned or their family/carer.
- Pass opinion on the care the patient received.
- Be Serious Incident Investigation lead or co-authors.

How are families/carers referred to the Family Liaison Service?

Clinical leads or managers who have contact with family members or carers following the suspected suicide of a service user or after a serious incident resulting in harm should ask the family if they would like to receive contact from the Family Liaison Service for support, signposting, and practical advice.

Referral to the Family Liaison Service should be considered in all incident review meetings.

The Serious Incident Review coordinators and authors should consider whether families or carers might benefit from referral to the Family Liaison Service if they are not already engaged by this point. Even though families/carers might decline support from the service when initially offered by the clinical team, they may accept later.

Referrals should be emailed to family.liaison@ghc.nhs.uk and include reason for referral, contact details and confirmation that the family member/carer has agreed to referral. The Family Liaison Service coordinator will contact the referrer for further information as appropriate.

When and how will the family/carer be contacted?

Contact by phone, email or letter will be established within one week of referral and visits/calls will be arranged thereafter according to need.

It is understood that families/carers may not be ready for contact at this time and a letter or email will be sent with contact details of the FLP to reinforce ongoing availability.

How long does input from the Family Liaison Service last for?

There is not a limit regarding duration of contact with the service; this will be negotiated between the family/carer and the FLP. As the processes associated with suicides and serious incidents can last for several months or longer, it is important that the Family Liaison Service is available for as long as required.

If a family member or carer develops needs that cannot be met by the Family Liaison Service e.g. mental health needs, they will be supported in seeking appropriate support or input.

How is the Family Liaison Service evaluated?

This is a relatively new service and will initially be evaluated by seeking feedback from recipients during and at the end of input.

As we become more established, we intend to develop more robust feedback and evaluation mechanisms and peer review.

If a recipient is dissatisfied with the Family Liaison Service, they will be invited to discuss this with the coordinator and signposted to PCET.

Family Liaison Service Procedure

- Referral is received via family.liaison@ghc.nhs.uk or contact with the coordinator.
- Coordinator will allocate referral to a FLP.
- FLP will establish contact within one week of referral.
- Contact thereafter will be in accordance with expressed wishes and need. If a family/carer is requiring high levels of contact for a prolonged period, discussion will take place with a coordinator as to the most appropriate action.
- FLPs will endeavour to establish additional family members who may require support.
- Coordinators will maintain regular contact with FLPS who are engaged with families or carers.
- FLP team reflective practice and business meetings are held six weekly.
- FLPs are responsible for seeking ad-hoc supervision and supervision as required.
- FLPs will inform another FLP when they are visiting families at home and when they leave, in line with lone worker expectations.

A spreadsheet will be maintained by the coordinator to monitor Family Liaison Service provision and FLP activity. The Serious Incident Investigation will have access to this spreadsheet so that they are aware which families are receiving FLP input.