London Ambulance Service

NHS Trust

# Serious Untoward Incidents Policy

**DOCUMENT PROFILE and CONTROL.**

**Purpose of the document**: To define the Trust's reporting process for Serious Untoward Incidents.

**Sponsor Department:** Patient Experiences

**Author/Reviewer:** Head of Patient Experiences. To be reviewed by May 2011.

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| TP/034 | Being Open Policy | |
| TP/004 | Complaints and Feedback Policy | |
| H&S011 | Incident Reporting Procedure | |
| TP/024 | Managing Patient Confidentiality when Dealing with the Media | |
| HR/07/07 | Management Policy Statement on Staff Responsibilities Regarding Communication | |
| TP/003 | Policy Statement on Duties to Patients | |
| TP/049 | Risk Register Procedure | |
| TP/005 | Risk Management Policy and Strategy | |
| H&S012 | Staff Safety Policy Statement | |
| H&S018 | Stress Management Policy | |
| HR/07/22 | Whistle Blowing Policy | |
| | *Serious Untoward Incident Guidance* (2009), NHS London, http://www.london.nhs.uk/publications/tools-and-resources/serious-untoward-incident-sui-reporting-guidance | |
| | *Reporting, Managing and Investigating Information Governance Serious Untoward Incidents* 2009, Department of Health http://www.connectingforhealth.nhs.uk/systemsandservices/infogov/security/risk/suichecklist.pdf | |
| | *National Framework for Reporting and Learning from Serious Incidents Requiring Investigation, NPSA* http://www.nrls.npsa.nhs.uk/report-a-patient-safety-incident/patient-safety-direct | |
| | *Information Resource to Support the Reporting of Serious Incidents, NPSA* - http://www.nrls.npsa.nhs.uk/report-a-patient-safety-incident/patient-safety-direct/serious-incident-reporting-and-learning-framework-sirl/ | |
| | *Local Authority Social Services & NHS Complaints (England) Regulations* (2009) - http://www.opsi.gov.uk/si/si2009/uksi_20090309_en_1 | |
| | *Being Open* guidance, NPSA - http://www.nrls.npsa.nhs.uk/resources/?entryid45=65077 | |

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| | *Building a Safer NHS for Patients (An Organisation with Memory*), (2001), Department of Health http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_4065083 | |
| | *Never Events* guidance, NPSA - http://www.nrls.npsa.nhs.uk/resources/collections/never-events/ | |
| | Root Cause Analysis – tools and templates, NPSA. http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/?locale=en&entryid45=59847 | |

Document Status: This is a controlled record as are the document(s) to which it relates. Whilst all or any part of it may be printed, the electronic version maintained in P&P-File remains the controlled master copy. Any printed copies are not controlled nor substantive.

## 1. Introduction

1.1 The London Ambulance Service NHS Trust (LAS) manages in excess of 1.4 million 999 calls and attends more than 1 million patients every year. The vast majority of patients receive very high standards of care. We recognise however that sometimes things do go wrong and it is therefore important that such incidents are reported and managed effectively and that we learn and improve as an organisation as a result of this. This document sets out the Trust's policy and practice guidelines regarding the identification, investigation and reporting of Serious Untoward Incidents (SUI).

1.2 The LAS is required to report all SUIs to NHS London and, where appropriate, to the National Patient Safety Agency (NPSA), the Health & Safety Executive (HSE) and the Care Quality Commission (CQC). A copy of the notification must also be sent to the co-ordinating commissioner.

1.3 The LAS observes the requirements as set out in the *SUI Reporting Policy* issued by NHS London (July 2009), and this guidance draws on the references cited in the NHS London document. The following should be therefore considered alongside the NHS London *SUI Reporting Policy* - http://www.london.nhs.uk/publications/tools-and-resources/serious-untoward-incident-sui-reporting-guidance

1.4 The LAS observes guidance as regards information governance incidents as set out by the Department of Health. This policy should therefore be considered alongside the *Checklist for Reporting, Managing and Investigating Information Governance Serious Untoward Incidents*
http://www.connectingforhealth.nhs.uk/systemsandservices/infogov/security/risk/suichecklist.pdf

1.5 The LAS similarly observes National Patient Safety Agency guidance on the national framework for serious incidents in the NHS, *'National Framework for Reporting and Learning from Serious Incidents Requiring Investigation'*
http://www.nrls.npsa.nhs.uk/report-a-patient-safety-incident/patient-safety-direct

1.6 The LAS believes that SUIs should be managed in accordance with the principles of the *Making Experiences Count* programme to achieve consistency of approach and this guidance is consequently compatible with the principles of *Local Authority Social Services & NHS Complaints (England) Regulations (2009)* -
http://www.opsi.gov.uk/si/si2009/uksi_20090309_en_1

## 2. Scope

The focus of SUI investigations policy is to deliver outcomes aimed at preventing recurrence and improving patient care. The LAS is committed to ensuring robust governance mechanisms are in place so that these benefits are realised.

This policy should be read and implemented in conjunction with a number of other Trust policies:

- Being Open Policy TP/034
- Complaints and Service User Feedback Procedure TP/004
- Disciplinary policy
- Investigating incidents, complaints and claims
- Incident Reporting Procedure H&S011 including RIDDOR
- Managing Patient Confidentiality when Dealing with the Media TP/024
- Management Policy Statement on Staff Responsibilities Regarding Communication (HR/07/07)
- Policy Statement on Duties to Patients - TP/003
- Risk Assessment & Risk Register Procedure TP/049
- Risk Management Policy and Strategy TP/005
- Staff Safety Policy Statement H&S012
- Stress Management Policy H&S018
- Whistle Blowing Policy – HR/07/22

## 3. Objectives

The purpose of this policy is to enable the LAS and its staff to:

- Understand what constitutes an SUI
- Respond quickly and appropriately to an SUI
- Take a consistent approach to the management of such incidents.
- Act in an open and transparent way.
- Involve and fully inform service users, stakeholders and staff, taking account of cultural belief systems
- Manage cases where poor practice is identified as a contributory factor in accordance with the Trust's workforce policies.
- Learn from all incidents and prevent recurrence as far as possible.
- Address the lessons to be learnt from such incidents from both operational and organisational perspectives, recognising that the majority of incidents occur because of failure in systems rather than individual practice.

- Share any learning across the health and social care economy

## 4. Responsibilities

4.1 The **Trust Board** will have overall responsibility for monitoring incident outcome

4.2 The **Chief Executive** is responsible for reporting an overview of any SUI investigations to the Trust Board.

4.3 The **Quality Committee** will be responsible for providing assurance to the Trust Board through reports.

4.4 The **SUI group** will be responsible for determining the severity of the incident and determine the appropriate response to the incident

4.5 The **Learning from Experience** group will oversee the implementation of the recommended actions and the changes to practice

4.6 **Head of Communications** will be responsible for media relations and liaison with other relevant agencies in this respect.

4.7 The **Head of Legal Services** is responsible for notifying the National Health Service Litigation Authority (NHSLA)

4.8 **Investigating Manager** will take the responsibility for overseeing the investigation and the final report.

4.9 **Head of Patient Experience** will be responsible for co-ordinating an overview of the incident process and liaising with external agencies.

4.10 **Assistant Director of Operations** has responsibility for informing the Health & Safety Executive of an incident that falls within the jurisdiction of that agency

4.11 **Local Managers** are responsible for documenting events prior to reporting the incident up to the relevant Assistant Director of Operations (ADO) / or line manager.

4.12 **Staff** are responsible for reporting any incident that may be a cause of concern.

## 5. Definitions

5.1 The principle definition of a SUI is something out of the ordinary or unexpected, with the potential to cause serious harm, and/or likely to attract public and media interest, that occurs on NHS premises or in the provision of an NHS or a commissioned service. This may be because it involves a large number of patients, there is a question of poor clinical or management judgement, a service has failed, a patient has died under unusual circumstances, or there is the perception that any of these has occurred.

5.2 SUIs are not exclusively clinical issues, for example information technology systems failure, ambulance vehicle fire, a road traffic accident incident involving a Trust vehicle may have consequences that make it an SUI.

5.3 Excluded from this definition are adverse outcomes reasonably associated with routine NHS activity. However, a 'near miss' and any identified emerging trends which constitute a significant risk are also included.

## 6. Who is responsible for identifying and reporting an incident that may be a Serious Untoward Incident?

6.1 Every member of staff has a responsibility to report any incident that may be a cause of concern. Staff should immediately bring to the attention of their line manager, or any manager if the line manager is not available, any incident that is the cause of serious concern or that appears to conform to any of the examples listed in NHS London guidance included at Appendix 1.

6.2 The most important element is that of timeliness – it is crucial that concerns are reported without delay. Staff should also use the LA52 incident reporting procedure which will be processed by the Safety & Risk department, who oversee and review all incident reports to check the grading is accurate and the incident escalated as a potential SUI accordingly.

6.3 As well as incidents identified by the Safety & Risk department, an SUI may be identified from a wide variety of sources throughout the Trust, including from any of the service-user and stakeholder feedback mechanisms managed by the Patient Experiences Department (PED), concerns raised at a Coroner's Inquest, or a legal claim against the Trust.

6.4 In instances where a local manager has been made aware of an incident, this should be reported to the relevant ADO or line/senior manager and by using the email facility PotentialSUINotification@lond-amb.nhs.uk. An LA52 should be completed, the risk graded, and the form sent to Safety & Risk.

6.5 In the case of the Emergency Operations Centre or Urgent Operations Centre, if an incident becomes apparent as it occurs, all relevant details of the incident must be recorded on the Call Receipt Form (AS1), using the electronic call logs. The incident must be reported through the Bronze, Silver and Gold structure on duty/on call structure and Gold will ensure that the incident is reported via the dedicated email facility cited. An LA52 should be completed, the risk graded, and the form sent to Safety & Risk.

6.6 In the case of Patient Transport Service, the local manager will document events and similarly ensure that the incident is reported using the email facility cited. An LA52 should be completed, the risk graded, and the form sent to Safety & Risk.

6.7 In the case of safeguarding children incidents, the Head of Patient Experiences will liaise with the London Safeguarding Children Board and other relevant agencies in accordance with NHS London requirements.

6.8 For incidents involving vulnerable adults, the Head of Patient Experiences will liaise with any relevant agencies.

6.9 In all other cases, the senior manager of the area concerned (e.g. Finance, IM&T) will document events and report via the email facility and using an LA52 which is then sent to Safety & Risk.

6.10 In all cases, notification via the email facility should be made within 24 hours or the next normal business day, with an LA52 completed, graded and sent to Safety & Risk within 5 working days.

## 7. Consideration of declaration of an incident as an SUI

7.1 The dedicated email facility will auto-forward to Senior Management Group (SMG) and a number of Senior Operational Managers, the Head of Legal Services, the Head of Safety & Risk and the Head of Communications, together with the Head of Patient Experiences and some key members of the Patient Experiences team. This

is initially to ensure that there is organisational awareness at a senior level to the potential for an SUI to be declared.

7.2 The Head of Patient Experiences has responsibility for compiling supporting documentation and preparing a brief summary of events. This should where known include details of the patient outcome (injury/death etc) and what immediate actions have been taken to manage the situation. This information will be placed on a designated intranet folder established for the purpose, which is a secure facility.

7.3 At least 3 of the following senior managers will constitute the Trust's SUI Group and come to a decision as to declaration of the incident as a SUI:

- Chief Executive Officer
- Deputy Chief Executive
- Director of Operations
- Medical Director
- Director of Corporate Services
- Head of Patient Experiences.

The Head of Communications will be kept informed and invited to join the SUI group as appropriate.

7.4 The SUI group will review the information available about the incident and determine the severity using the NPSA grading matrix (Appendix 2) to determine whether the incident should be investigated and reported as a potential or actual SUI.

**8. All incidents scored 15 and above (see Appendix 2) will trigger declaration of an SUI.**

8.1 This is supported by the NPSA grading tool at Appendix 3 which describes the action required for serious incidents and the responsibility for monitoring the action.

8.2 In the case of an information governance incident, the Trust's Caldicott Guardian and the Director of Information Management & Technology must be involved in the SUI Group, assisted as may be required by the Information Security Officer or Head of Records Management. The assessment matrix in relation to data loss incidents is set out at Appendix 7. Paragraph 1.4 provides a link to guidance.

8.3 In the case of a safeguarding incident, the Head of Patient Experiences will arrange for a senior practitioner, via liaison with the Safeguarding Lead at NHS London or any other appropriate agency, to be a member of the SUI Group. Paragraph 1.3 provides a link to the NHS London guidance.

8.4 The SUI Group may also decide to invite an external advisor, for example a senior manager from another ambulance, acute, primary care or mental health Trust or local authority, to assist and advise the SUI Group both in coming to decision as to whether to declare an SUI and/or with any ensuing investigation.

8.5 The SUI Group will also determine whether to invite a commissioning representative to join the group.

8.6 The Head of Patient Experiences will maintain a record of each considerative incident and the factors considered in determining whether or not an incident is determined as an SUI.

8.7 An SUI investigation should not be confused with an investigation conducted under the LAS Disciplinary Procedure. If, as a consequence of the SUI investigation, a disciplinary issue is identified, a separate investigation, conducted in accordance with the LAS Disciplinary Procedure, will ensue.

8.8 Where an SUI is not declared, the Head of Patient Experiences will be responsible for ensuring that a commensurate level of investigation is undertaken in line with the policy of the investigation of incidents, complaints and claims.

## 9. Reporting SUIs

9.1 The Trust Board will receive details of incidents being investigated under the SUI policy at the next formal meeting. In the event that an incident is so severe or is likely to attract media attention before that meeting, the Trust Board will be notified by email by a member of the SMG.

9.2 The Chief Executive will report an overview of any SUI investigations in Part I of the Trust Board meeting however the organisation reserves the right to discuss sensitive and confidential matters relating to the incident in Part II.

9.3 The Trust Board will receive updates on progress with investigations through to completion and recommendations for action.

9.4 The Quality Committee will oversee the SUI implementation plans and outcomes and will provide assurance to the Trust Board.

9.5 The Learning from Experience group will ensure action has been taken, lessons learnt and improvements made. This group will provide assurance to the Quality Committee.

## 10. External Agencies

10.1 The LAS is committed to cooperating fully with external agencies when they declare an SUI which directly or indirectly involves the LAS and will share information, providing that relevant statutory responsibilities (Data Protection, etc.) are met. The LAS will also involve and include other agencies as appropriate, e.g. if an LAS employee reports a criminal offence then the Police should be contacted immediately. The Head of Patient Experiences will liaise with the agencies involved to agree which will lead on the investigation.

## 11. Other Notification responsibilities

11.1 If an SUI occurs out of normal office hours (defined as Monday – Friday 9am -5pm) the senior manager on-call should notify the on-call Communications Manager who will inform the NHS London Communications Team. This contact should include brief details of the incident and contact details for the Head of Patient Experiences.

11.2 Within 24 hours of an SUI being declared, the Head of Patient Experiences is required to notify NHS London via UNIFY, to the Department of Health electronic Strategic Executive Information System (STEIS) in the format required by the system.

11.3 The Communications, Legal Services, Patient Experiences and Safety & Risk departments should all be informed when an SUI is declared to ensure consistency of approach to enquiries from interested parties and to avoid any duplication of investigation. This is the responsibility of the relevant heads of department or delegates.

11.4 Following declaration of an SUI all identified personnel will be informed within 24 hours of the incident occurring, where contactable, via a local management

representative who will ensure the appropriate debriefing and support for all staff involved.

11.5 The Head of Patient Experiences is responsible for notifying and keeping relevant managers informed of developments, including notification of declaration to the Chef Executive and SMG.

11.6 It is the responsibility of the relevant mangers as outlined below to similarly update any appropriate agency.

11.7 The Head of Safety & Risk is responsible for notification to the National Patient Safety Agency.

11.8 The relevant Assistant Director of Operations or equivalent senior manager with advice from the Head of Safety & Risk should inform the Health & Safety Executive of an incident that falls within the jurisdiction of that agency.

11.9 The Head of Legal Services is responsible for notifying the National Health Service Litigation Authority (NHSLA). NHS London must be informed of all critical dates i.e. Coroners' Inquest etc.

11.10 Where there may be a direct consequence for patient safety the Director of Corporate Services will notify the Care Quality Commission.

11.11 In the case of a data loss incident, the Head of Patient Experiences will liaise with the Information Security Officer to ensure notification to the Information Commissioner and any other relevant agencies in accordance with Department of Health and NHS London guidance. The Trust's Caldicott Guardian and the Director of Information Management & Technology will be similarly advised of any notifications of this nature.

11.12 In the case of a safeguarding incident, the Head of Patient Experiences will notify the local Safeguarding Board and any other involved or appropriate agencies.

11.13 Other reporting requirements are set out in the National Patient Safety Agency guidance, *Information Resource to Support the Reporting of Serious Incidents* - http://www.nrls.npsa.nhs.uk/report-a-patient-safety-incident/patient-safety-direct/serious-incident-reporting-and-learning-framework-sirl/

11.14 The Head of Patient Experiences will copy the SUI notification to the Head of Business Development who will forward this to the co-ordinating commissioner.

## 12. Media Relations

12.1 The Head of Communications will be responsible for media relations and liaison with other relevant agencies in this respect.

12.2 Following liaison between the Head of Patient Experiences, the Investigating lead (see below) and the Head of Communications, the patient(s) involved and/or relative(s) will be notified if any information relating to an SUI is to be released to the media, where practical to do so. This will usually be undertaken by an appointed representative. There may be occasions when this may not be practical for example where contact has not yet been made with the patient/family, or where the release of information is in response to the patient/family disclosing details to the media but where an approach to the LAS has not been made.

12.3 No member of staff will provide statements independently of this process and should refer to the *Policy Statement on staff responsibilities regarding communication* (HR/07/07). Other relevant Trust policies include the *Policy Statement on Duties to Patients* (TP/003) and *Managing Patient Confidentiality when Dealing with the Media* (TP/024).

## 13. Being Open

13.1 *"Research studies have shown that patients accept something has gone wrong when they are told about it promptly, fully and compassionately. This open approach minimises the trauma they feel."* ('Seven Steps to Patient Safety' NPSA 2003).

13.2 The LAS is committed to being open with patients who have been unintentionally harmed. 'Being Open' involves acknowledging, apologising and explaining when things go wrong as well as conducting a thorough investigation into the incident and offering reassurance that lessons learned will help prevent a similar incident recurring. The LAS *Being Open* policy has been developed in line with the NPSA guidance – see http://www.nrls.npsa.nhs.uk/resources/?entryid45=59792. This guidance should be utilised in conjunction with the LAS *Being Open* Policy.

13.3 More information about liaison responsibilities with patients, families, relatives, carers, authorised representatives and advocates are set out within section 15 of this document.

## 14. Administrative Management

14.1 Details of the progress of the investigation should be updated on STEIS by the Head of Patient Experiences within the first week of the incident and on a regular basis thereafter.

14.2 In the event that preliminary investigations indicate that the incident should no longer be classified as an SUI, the Head of Patient Experiences will update STEIS accordingly and liaise with NHS London to request de-escalation/re-grading.

14.3 A Datix case management file must be opened immediately on receipt of notification of the incident and should be maintained by the Safety & Risk department through to completion of the investigation and the final report.

## 15. Management of the Incident

15.1 In all instances, the first priority for the provider organisation 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 relevant documentation copied and secured to preserve evidence and facilitate investigation and learning. If there is a suggestion that a criminal offence has been committed, the police should be contacted. Early consideration must be given to the provision of information and support to patients, relatives and carers and staff involved in the incident, including information regarding support systems which are available to patients/ relatives/visitor/contractors.

15.2 Appendix 12 details the investigation process and should be followed in all SUI investigations in line with the policy on investigating incidents, complaints and claims.

15.3 The SUI group will appoint an Investigating manager drawn from a pool of appropriately qualified senior managers and has a responsibility to oversee the investigation and the final report.

15.4 The Head of Patient Experiences and the Investigating Manager will liaise with other involved agencies to agree arrangements where a joint investigation is at issue.

15.5 The Investigating manager will draw on expertise from around the Trust and any external agency to undertake the investigation and produce a report and recommendations.

15.6 The Investigating Manager will liaise with the Head of Patient Experiences and prepare progress briefings to keep all relevant senior managers and the SUI Group informed.

15.7 The SUI Group will monitor developments, maintain a strategic overview and assist the management of the investigation and dissemination of the outcome(s).

15.8 The Investigating manager will produce an interim and then final report for discussion by the SUI group who will confirm or amend the list of recommendations arising from the investigation.

15.9 The report will be produced in the format recommendaed by the NPSA and attached at Appendix 10.

15.10 The Head of Patient Experiences will monitor progress with the investigation and support will be made available to the Investigating Manager in discussion with SMG members as appropriate.

15.11 The Head of Communications will be party to the final discussions and recommendations and will advise the SUI group, SMG and the Trust Board on media handling.

15.12 The final report and recommendations will be sent to NHS London and the co-ordinating commissioner.

## 16. Special investigation team

16.1 Only the most serious incidents are likely to require a Chairperson from outside of the Board or the SMG. Incidents involving clinical matters will require the inclusion of appropriate senior clinical staff who are not closely associated with that aspect of the service under scrutiny.

16.2 Where legal matters are raised in the initial report, the Trust's legal advisors should be consulted.

16.3 Decisions also need to be taken at this stage on the level of support required for all involved in what is often a traumatic and stressful process. The need for Involvement of the Police and/or the Health and Safety Executive, in accordance with the draft Memorandum of Understanding, must be considered.

16.4 Terms of reference for the investigation must be produced in writing. Guidance for Special Investigation Teams is set out in Appendix 11. The investigating panel should be the minimum size necessary to do the job, but this will depend on the breadth and scope of the enquiry set out in the Terms of Reference, and the need to co-ordinate with other agencies.

16.5 In the case of safeguarding incidents, the Head of Patient Experiences will liaise with relevant agencies and in consultation with the SUI Group, consider the appointment of an external practitioner to act as Investigating Manager.

16.6 For Grade 1 incidents (SUIs) the investigation must be completed within 45 working days.

**17. Responsibilities of the Investigating Manager**

17.1 To be read in conjunction with the policy on investigating incidents, complaints and claims.

17.2 To provide draft terms of reference for the investigation for agreement with the SUI group or nominated individual.

17.3 To regularly report back on the progress of the investigation and ensure appropriate *Root Cause Analysis* methodology is utilised.

17.4 Where appropriate, to appoint a Trust representative to act as point of contact to enable a regular flow of information on behalf of the Trust to patient(s) and/or relatives and the SUI Group except in cases when this is decided by the SUI Group not to be necessary or appropriate; or, in joint agency cases, where it is agreed that another responsible body will undertake this role.

17.5 Every effort will be made to ensure that patient(s) and other involved or interested parties affected by the incident are informed at the earliest opportunity and in advance of any public announcement, taking into account the circumstances detailed at paragraph 9.

17.6 To agree a nominated representative from the local management team to provide regular feedback and support to any staff involved, as appropriate; and arrange counselling services, if required.

17.7 To liaise with the Medical Director to ensure clinical advice is provided, where appropriate.

17.8 To ensure that a comprehensive record of chronological record of the investigation is completed, describing the action taken as the investigation evolves.

17.9 To ensure contact with a patient/family is maintained. Notations should be included in this record describing each contact and all information that is provided to the patients, carers, relatives and families of those involved during and after the SUI investigation report is completed.

17.10 Produce the report of the investigation in accordance with the timescale set by NHS London, e.g. 45 working days. The report should identify the cause of the incident and contain any appropriate recommendations and an action plan including a time scale for their implementation.

17.10 To arrange a review reflecting on how the SUI was managed, in order to continuously improve the quality and effectiveness of this procedure, using the audit standards at Appendix 6.

17.11 To liaise with other involved agencies where appropriate, e.g., where a safeguarding incident occurs.

## 18. Reporting requirements and governance arrangements

18.1 The Head of Patient Experiences will be responsible for informing and updating NHS London who may report the incident to the Department of Health including the Chief Medical Officer if considered necessary. Full cooperation will be afforded the Chief Medical Officer in relation to any requests for details of the incident, the action taken and learning achieved.

18.2 The Head of Patient Experiences must ensure that the SUI process and reporting complies with NHS London requirements. All final reports will be completed using the National Patient Safety Agency template – see

http://www.nrls.npsa.nhs.uk/resources/collections/root-cause-analysis/?locale=en&entryid45=59847

An RCA executive summary shall be completed using the template at Appendix 9.

18.3 The final report and recommendations will be considered by the SUI Group.

18.4 All final reports should include time-limited recommendations for further action to be taken to prevent recurrence.

18.5 The final SUI reports must be produced within 45 days and in the recommended NPSA format (Appendix 10). Any extension that may be required will be negotiated by the Head of Patient Experiences with NHS London.

18.6 Reports will be made available internally using the secure intranet facility.

18.7 The final report agreed by SUI Group should be sent to NHS London via STEIS by the Head of Patient Experiences within the appropriate time frame.

18.8 The Head of Patient Experiences will ensure timely and effective dissemination of the final report internally and externally, including advising the SUI Group, Senior Management Group (SMG), the Quality Committee, and the Trust Board of the outcome of the investigation and the action taken and/ or proposed.

18.9 Agreements for sharing the final reports which have been led by other organisations should be established and explicit in the terms of reference.

18.10 The Investigating Manager will ensure a copy of the final report is made available to the patient/family.

18.11 Where possible, and with the authorisation of all parties involved (including the patient/authorised representative) anonymised versions of the final report will be published on the Trust's website, subject to familiar reporting restrictions, e.g. those imposed by the Courts where a criminal matter is subject to legal proceedings.

**19. Implementing agreed action measures**.

19.1 The Learning from Experience group will oversee the implementation of the recommended actions and the changes to practice resulting from this.

19.2 Feedback on implementation of any recommended actions will be provided to the patient/family by the Investigating Manager or an individual nominated by the SUI group.

19.3 In the event that, following an SUI, concurrent and related investigations are ongoing (e.g. disciplinary investigation), such investigations will not delay the report being made available to patient/family. The outcome of any related investigation will also be similarly made available, bearing in mind confidentiality considerations and legal restrictions.

19.4 The Head of Patient Experiences and Head of Safety & Risk where appropriate, will ensure that NHS London, any other relevant agencies and National Patient Safety Agency (NPSA) are notified of the outcome of the investigation and the actions taken or proposed.

19.5 HR, Legal Services or Corporate services will notify the relevant responsible agencies.

19.6 Monitoring to ensure implementation of any agreed action measures will be undertaken as part of the wider incident reporting system arrangements via the Clinical Quality, Safety & Effectiveness; Learning from Experience; and Risk Compliance & Assurance Committees as appropriate

19.7 The Quality Committee will receive reports and assurance from the committees in 19.6 above and will provide assurance to the Trust Board.

## 20. Audit

20.1 Full compliance with this policy will be achieved and evidenced through use of the audit standards in Appendix 4.

20.2 The LAS commits to monitor full compliance with this procedure and the routine achievement of the above to ensure that the audit cycle is completed with learning identified and actioned when an SUI is declared. An audit will be completed by the Investigating Manager in conjunction with the Governance & Compliance team and presented to the Learning from Experience group as evidence of action taken, lessons learnt and improvements made.

## 21. Management of multiple or major incidents

When SUIs occur that may potentially affect large numbers of people or where serial incidents may occur e.g. pandemic issues, terrorist attacks etc, all media enquiries will be managed by the Communications Department in accordance with the Trust's Major Incident Plan.

## 22. Never Events

22.1 Never Events are serious, largely preventable patient safety incidents that should not occur if the available preventative measures have been implemented. Primary Care Trusts (*PCTs*) are required to monitor such occurrences and report these on an annual basis. At present, it is unlikely that the Trust would experience such an incident, given existing definitions. The Trust will, however, continue to monitor the position and give consideration to developing its own criteria so that it may be compliant with National Patient Safety Agency practice guidance. For more information, see:
http://www.nrls.npsa.nhs.uk/resources/collections/never-events/

*Should add in here about a missed performance target (Cat A/B) that directly results in a patient death being considered as a Never Event.*

## 23. Supporting staff

It is recognised that being involved in an incident, complaint or claim which is under investigation may be an incredibly stressful experience.

23.1 It is the duty of the manager of any staff member involved in an investigation to support that staff member and to ensure that they are aware of other sources of support which they may access. The ADO or Senior Manager is responsible for ensuring that this information has been communicated in the case of more serious incidents or complaints. Occupational Health will be able to see staff that wish to self-refer for health advice. The Human Resources Department should be contacted in the first instance in order for members of staff to have full information regarding such support.

23.2 Managers who have concerns about a staff member's fitness to work may wish to formally refer the individual to Occupational Health for advice and possible recommendations. Staff counselling, Occupational Health and HR Department are able to assist with support following a significant traumatic event.

23.3 Independent support may be obtained through the Atos Healthcare Counselling Service and staff can access this service without a referral from their line manager. Additionally, staff may wish to seek the advice of any professional organisation of which they are a member.

23.4 Support to patients and or their relatives/carers should be provided in accordance with the *Being Open* Policy.

## 24. Training

24.1 Training on investigation forms part of the 'Incident Reporting for Managers' course. Requirements for attendance at this course are identified in the Training Needs Analysis (TNA).

24.2 In addition to this the Trust provides ad-hoc RCA training sessions, which are facilitated by an external training provider. There is no formal requirement for all managers to be trained in RCA methodology. Where an investigation needs to use RCA a suitably trained person will be appointed as the Investigating manager.

## 25. Policy Review

25.1 The Policy will be reviewed by the Learning from Experience Group and then ratified by the Quality Committee. The Clinical Quality, Safety & Effectiveness and Risk Compliance and Assurance Groups will also sign off the policy and incorporate it within their terms of reference.

| IMPLEMENTATION PLAN | |
|---|---|
| **Intended Audience** | All LAS Staff |
| **Dissemination** | Available to all staff on the Pulse and to the public on the LAS website. |
| **Communications** | Revised Policy and Procedure to be announced in the RIB and a link provided to the document. |
| **Training** | |
| **Monitoring** | The LAS commits to monitor full compliance with this procedure and the routine achievement of the above to ensure that the audit cycle is completed with learning identified and actioned when an SUI is declared.<br><br>An audit will be completed by the Investigating Manager in conjunction with the Governance & Compliance team and presented to the Learning from Experience group as evidence of action taken, lessons learnt and improvements made.<br><br>The Learning from Experience Group will be responsible for monitoring compliance with this Policy. The effectiveness of this Policy will be monitored through the following:<br><br>Undertaking a periodic review of a random selection of incidents, complaints and claims to verify that the level of investigation is suitable;<br><br>Following up the action points identified in a random selection of incidents, complaints and claims to verify that they have been effectively implemented and that there is demonstrable change;<br><br>Confirming that risk management committees have reviewed relevant incidents and the investigation outcomes;<br><br>Undertaking a thorough review of the process for investigating SUIs when one occurs and identifying any policy improvements that need to be made. |

**Appendix 1**

## Examples of incidents to be reported as SUIs

| **Sub-type** | **Definition** | **STEIS categorisation** |
|---|---|---|
| Child/Vulnerable Child | Any incident reported to the Local Safeguarding Board for follow up.<br><br>Examples include death or injuries where abuse or neglect is suspected or where a child has suffered further harm as a result of a health care worker failing to follow procedures or where a serious Part 8 Joint Services Case Review is to be undertaken.<br><br>Significant cases involving children | Child serious injury<br>Child death<br>Child abuse (family, inst., multiple)<br>Child abuse – family<br>Child abuse – institutional<br>Child abuse – multiple<br>Child serious injury<br>Admission of under 16s to adult mental health ward |
| Cluster | A number of low level incidents which aggregate to suggest a potentially more serious problem<br><br>A cluster of unexpected/unexplained deaths or serious adverse outcomes | Unless specifically listed in other STEIS codes then Serious incident indicating what type of incident<br><br>Unexpected death general inpatient or outpatient |
| Infection/HCAI | Known, or suspected, cases of health care associated infection, which fall within the definitions of this minimum data set or which are deemed a significant outbreak or involve failure of systems, such as decontamination or hospital acquired legionellosis<br><br>Death in which MRSA bacteraemia or C difficile are recorded on part one of the death certificate (parts 1a, 1b or 1c)<br><br>Two or more cases of C difficile in the same ward within the same week and/or third case within the same ward and month. | Communicable disease & infection issue<br><br>MRSA bacteraemia<br><br>C.Diff & HCAI |
| Look back | Infected healthcare workers/patient incidents that necessitate consideration of a look back exercise<br><br>Failures of screening or infection control systems that necessitate consideration of a look back exercise | Hep B infected HC professional<br><br>HIV infected HC professional<br>Infected HC worker<br><br>Communicable disease & infection issue<br><br>Screening issues |

| Vulnerable adult | Any case referred to an Adult Safeguarding board.<br><br>Fraud against a vulnerable adult<br><br>Serious harm to a vulnerable adult including sexual and physical assault | The description of the incident on the case form should always indicate if the patient is a vulnerable adult |
|---|---|---|
| Serious | Significant cases of a specified nature | Accident whilst in hospital<br>Ambulance accidental injury<br>Ambulance (general)<br>Dentistry<br>Drug incident (general)<br>Maternity service<br>Health and Safety |
| Prisons | Death in custody<br>Administration/Handling of medication | Prisoner in receipt of care<br>Drug incident |
| Maternal | Maternal Death<br><br>Post Partum Haemorrhage greater than 2 .5 litres<br><br>Unplanned Hysterectomy<br><br>Unexpected **maternal** admission to ICU<br><br>Retained Swabs / instruments<br><br>Any time a decision is made to suspend maternity services (regardless of outcome)<br><br>Intrauterine Deaths at 24 weeks and above where service or clinical factors might have contributed<br><br>Unexpected Intrapartum deaths (i.e. during labour) regardless of gestational age where service or clinical factors might have contributed<br><br>Unexpected admissions to the Neonatal Intensive Care unit for longer than 24 hours.<br><br>Unexpected Neonatal deaths (death of a baby aged 0- 28 days) | Maternity Service<br><br>Unexpected death<br><br>Ward/unit closure |
| Unexpected | The unexpected death of, or serious/life threatening injury to, a patient under the direct care of a health professional, member of the public or member of staff. | Unexpected death<br><br>Attempted homicide/ suicide<br><br>Homicide / suicide |

|  |  |  |
|---|---|---|
|  | Foul play may or may not be suspected | Death on GP premises<br><br>Prisoner in receipt of care |
| Complaint | A serious complaint or allegation about a member of staff, or suspicion of serious error(s) or repeated serious concern about poor clinical or management judgment, which would give rise to public concern | Allegation against HC professional<br><br>Allegation against HC professional (assault) or (fraud)<br><br>Surgical error |
| Staff | Suspicion of serious error or repeated serious complaints about an individual member of staff | Allegation against HC professional<br><br>Allegation against HC professional (assault) or (fraud)<br><br>Surgical error |
| Confidentiality | Serious breach of confidentiality | Confidential information leak |
| Criminal | Incidents, which might give rise to serious criminal charges<br><br>Any incident that might lead to criminal charges including violent attacks on either staff or patients, or hostage situations | A number are provided for e.g. fire, assault, and allegations against health care professional.<br><br>If none are applicable then the Serious incident field can be used. |
| Major | Major incidents, fires, floods or other events, which cause death or injury or seriously endanger the life of patients or staff, or which threaten the business continuity of a Trust | Serious incident, Fire<br><br>Ward/unit closure<br><br>Security threat<br><br>Bogus Health Worker<br><br>Chemical Incident |
| Suicide | Suicide of any person on NHS premises | Attempted suicide<br><br>Suicide<br><br>Serious self-inflicted injury |
| Surgical Error | Retained instruments, or other material, after surgery and requiring re-operation<br><br>Procedures involving wrong patient or wrong site | Surgical error |
| Never Events | Wrong site surgery<br><br>Retained instrument post-operation | Surgical error<br><br>Suicide |

| | | |
|---|---|---|
| | Wrong route administration of chemotherapy<br><br>Misplaced naso or orogastric tube not detected prior to use Inpatient suicide using non-collapsible rails<br><br>Absconding of transferred prisoners from medium or high secure mental health Services<br><br>In-hospital maternal death from post-partum haemorrhage after elective Caesarean Section<br><br>IV administration of concentrated potassium chloride | Abscond<br><br>Unexpected death<br><br>Drug Incident (general) |
| Equipment | Where a death occurred, an injury took place, or where someone was seriously put at risk as a result of a lack of, or faulty procedures, instructions or faulty equipment or drugs<br><br>Failure or misuse of equipment or plant which either caused or could have constituted a risk of injury, harm or danger to the life of a patient, member of the public/member of staff<br><br>Misuse or diversion of significant quantities of controlled drugs or systematic loss of small quantities of controlled drugs | Transfusion incident<br><br>Unexpected death<br><br>Hospital equipment failure<br><br>Drug incident<br><br>Delayed diagnosis<br><br>Home oxygen<br><br>Critical Care Transfer<br><br>Hospital Transfer Issue<br><br>Medical Equipment failure |
| Procedures | The failure of clinical or non-clinical procedures or their application so serious as to endanger life of a patient, member of the public or member of staff, or to pose a serious security risk or situations when a patient requires additional intervention(s) as a result of failures in the diagnosis/treatment process | If not specifically provided for by the other codes then the Serious incident code can be used. |
| HSE | Any Health & Safety Improvement<br><br>Notices or potential prosecution of an NHS Trust | Chemical incident<br><br>Serious incident<br><br>Health & safety |

| | | |
|---|---|---|
| Ambulance Services | Significant delay in call management or dispatch of a resource or accessing the patient which may have contributed to death or serious harm to a of a patient or where a ‘near miss’ occurred<br><br>Vehicle failure via serious cause, e.g. fire/explosion<br><br>Drug administration errors<br><br>Significant failure in 999 call management or clinical care<br><br>Major or sensitive data/information loss | |

*including guidance as to the type of incident code in STEIS*

***Supplementary notes***

Incidents that involve serious hazards of transfusion (SHOT) or RIDDOR investigations are not normally required to be reported as SUIs unless they result in an unexpected death or serious injury

In addition, with respect to mental health services;

| **Sub-type** | **Definition** | **STEIS categorisation** |
|---|---|---|
| Secure | All deaths within secure settings | Homicide by inpatient (in receipt)<br><br>Suicide by inpatient (in receipt)<br><br>Unexpected death of inpatient (in receipt) |
| Service user | All deaths of people subject to the Mental Health Act, or equivalent legal restriction, who has, or is, receiving care and treatment from mental health services | Mental Health Act – Class A incident |
| Community setting | Serious, unexplained or unexpected deaths in nonsecure settings | Homicide by outpatient (in receipt)<br><br>Suicide by outpatient (in receipt)<br><br>Unexpected death of outpatient (in receipt) |
| Absconsion | Only those absconsions where the patient is deemed to pose an immediate risk to themselves or the public | Abscond<br><br>Mental Health Act – Class C incident |

| | | |
|---|---|---|
| | | Escape |
| Homicide | A homicide, or suspected homicide, by a patient who has received mental health services | Homicide by inpatient (in receipt)<br>Homicide by outpatient (in receipt) |
| Admission | Any admission of an under 16 year old to an adult mental health ward | Admission of under 16s to adult mental<br>health ward |

***Supplementary notes***

The three codes "Mental Health Act–Class A, B or C incident" relate only to those individuals who have been detained under the Mental Health Act.

"patient (in receipt)" refers to those patients who are in receipt of mental health services

"patient (not in receipt)" refers to those patients who are not in receipt of mental health services

**Appendix 2**

## Table 1 Impact Score

Guide:

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.

| | **Impact score (severity levels) and examples of descriptors** | | | | |
|---|---|---|---|---|---|
| | **1** | **2** | **3** | **4** | **5** |
| **Domains** | **Negligible** | **Minor** | **Moderate** | **Major** | **Catastrophic** |
| **Impact on the safety of patients, staff or public (physical/psychological harm)** | Minimal injury requiring no/minimal intervention or treatment.<br><br>No time off work | Minor injury or illness, requiring minor intervention<br><br>Requiring time off work for >3 days<br><br>Increase in length of hospital stay by 1-3 days | Moderate injury requiring professional intervention<br><br>Requiring time off work for 4-14 days<br><br>Increase in length of hospital stay by 4-15 days<br><br>RIDDOR/agency reportable incident<br><br>An event which impacts on a small number of patients | Major injury leading to long-term incapacity/disability<br><br>Requiring time off work for >14 days<br><br>Increase in length of hospital stay by >15 days<br><br>Mismanagement of patient care with long-term effects | Incident leading to death<br><br>Multiple permanent injuries or irreversible health effects<br><br>An event which impacts on a large number of patients |
| **Quality/complaints/audit** | Peripheral element of treatment or service suboptimal<br><br>Informal complaint/inquiry | Overall treatment or service suboptimal<br><br>Formal complaint (stage 1)<br><br>Local resolution<br><br>Single failure to meet internal standards<br><br>Minor implications for patient safety if unresolved<br><br>Reduced performance rating if unresolved | Treatment or service has significantly reduced effectiveness<br><br>Formal complaint (stage 2) complaint<br><br>Local resolution (with potential to go to independent review)<br><br>Repeated failure to meet internal standards<br><br>Major patient safety implications if findings are not acted on | Non-compliance with national standards with significant risk to patients if unresolved<br><br>Multiple complaints/ independent review<br><br>Low performance rating<br><br>Critical report | Totally unacceptable level or quality of treatment/service<br><br>Gross failure of patient safety if findings not acted on<br><br>Inquest/ombudsman inquiry<br><br>Gross failure to meet national standards |

| | Impact score (severity levels) and examples of descriptors | | | | |
|---|---|---|---|---|---|
| | **1** | **2** | **3** | **4** | **5** |
| **Domains** | **Negligible** | **Minor** | **Moderate** | **Major** | **Catastrophic** |
| **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<br><br>Unsafe staffing level or competence (>1 day)<br><br>Low staff morale<br><br>Poor staff attendance for mandatory/key training | Uncertain delivery of key objective/service due to lack of staff<br><br>Unsafe staffing level or competence (>5 days)<br><br>Loss of key staff<br><br>Very low staff morale<br><br>No staff attending mandatory/ key training | Non-delivery of key objective/service due to lack of staff<br><br>Ongoing unsafe staffing levels or competence<br><br>Loss of several key staff<br><br>No staff attending mandatory training /key training on an ongoing basis |
| **Statutory duty/ inspections** | No or minimal impact or breach of guidance/ statutory duty | Breach of statutory legislation<br><br>Reduced performance rating if unresolved | Single breach in statutory duty<br><br>Challenging external recommendations/ improvement notice | Enforcement action<br><br>Multiple breaches in statutory duty<br><br>Improvement notices<br><br>Low performance rating<br><br>Critical report | Multiple breaches in statutory duty<br><br>Prosecution<br><br>Complete systems change required<br><br>Zero performance rating<br><br>Severely critical report |
| **Adverse publicity/ reputation** | Rumours<br><br>Potential for public concern | Local media coverage – short-term reduction in public confidence<br><br>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)<br><br>Total loss of public confidence |
| **Business objectives/ projects** | Insignificant cost increase/ schedule slippage | <5 per cent over project budget<br><br>Schedule slippage | 5–10 per cent over project budget<br><br>Schedule slippage | Non-compliance with national 10–25 per cent over project budget<br><br>Schedule slippage<br><br>Key objectives not met | Incident leading >25 per cent over project budget<br><br>Schedule slippage<br><br>Key objectives not met |

| | Impact score (severity levels) and examples of descriptors | | | | |
|---|---|---|---|---|---|
| | **1** | **2** | **3** | **4** | **5** |
| **Domains** | **Negligible** | **Minor** | **Moderate** | **Major** | **Catastrophic** |
| **Finance including claims** | Small loss Risk of claim remote | Loss of 0.1–0.25 per cent of budget<br><br>Claim less than £10,000 | Loss of 0.25–0.5 per cent of budget<br><br>Claim(s) between £10,000 and £100,000 | Uncertain delivery of key objective/Loss of 0.5–1.0 per cent of budget<br><br>Claim(s) between £100,000 and £1 million<br><br>Purchasers failing to pay on time | Non-delivery of key objective/ Loss of >1 per cent of budget<br><br>Failure to meet specification/ slippage<br><br>Loss of contract / payment by results<br><br>Claim(s) >£1 million |
| **Service/business interruption Environmental impact** | Loss/interruption of >1 hour<br><br>Minimal or no impact on the environment | Loss/interruption of >8 hours<br><br>Minor impact on environment | Loss/interruption of >1 day<br><br>Moderate impact on environment | Loss/interruption of >1 week<br><br>Major impact on environment | Permanent loss of service or facility<br><br>Catastrophic impact on environment |

## Table 2 Likelihood Score (L)

What is the likelihood of the consequence occurring? The frequency-based score is appropriate in most circumstances and is easier to identify. It should be used whenever it is possible to identify a frequency.

| **Likelihood Score** | **1** | **2** | **3** | **4** | **5** |
|---|---|---|---|---|---|
| **Descriptor** | **Rare** | **Unlikely** | **Possible** | **Likely** | **Almost certain** |
| **Frequency** | Not expected to occur annually. | Expected to occur at least annually. | Expected to occur at least every 6 months. | Expected to occur at least monthly. | Expected to occur at least weekly. |
| **Probability** | < 1% | 1-5% | 6-25% | 25-60% | >60% |
| | Will only occur in exceptional circumstances. | Unlikely to occur. | Reasonable chance of occurring. | Likely to occur. | More likely to occur than not. |

## Table 3 Risk Score = Impact x Likelihood (I x L)

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

For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

| | | |
|---|---|---|
| | 1-3 | Low risk |
| | 4-6 | Moderate risk |
| | 8-12 | Significant risk |
| | 15-25 | High risk |

**Instructions**

1. Define the risk(s) explicitly in terms of the adverse consequence(s) that might arise from the risk.
2. Use Table 1 to determine the impact score (I) for the potential adverse outcome(s) relevant to the risk being evaluated.
3. Use Table 2 to determine the likelihood score (L) for those adverse outcomes. If possible, score the likelihood by assigning a predicted frequency of occurrence of the adverse outcome. If this is not possible, assign a probability to the adverse outcome occurring within a given time frame, such as the lifetime of a project or a patient care episode. If it is not possible to determine a numerical probability then use the probability descriptions to determine the most appropriate score.
4. Use Table 3 to calculate: I (Impact) x L (Likelihood) = R (risk score)
5. Identify the level at which the risk will be managed, assign priorities for remedial action and determine whether risks are to be accepted on the basis of the colour bandings and risk ratings.

NB: Using the Trust's risk management schema, consideration should be given to inclusion of an identified risk in the Trust's Risk Register at the appropriate level.

**Appendix 3**

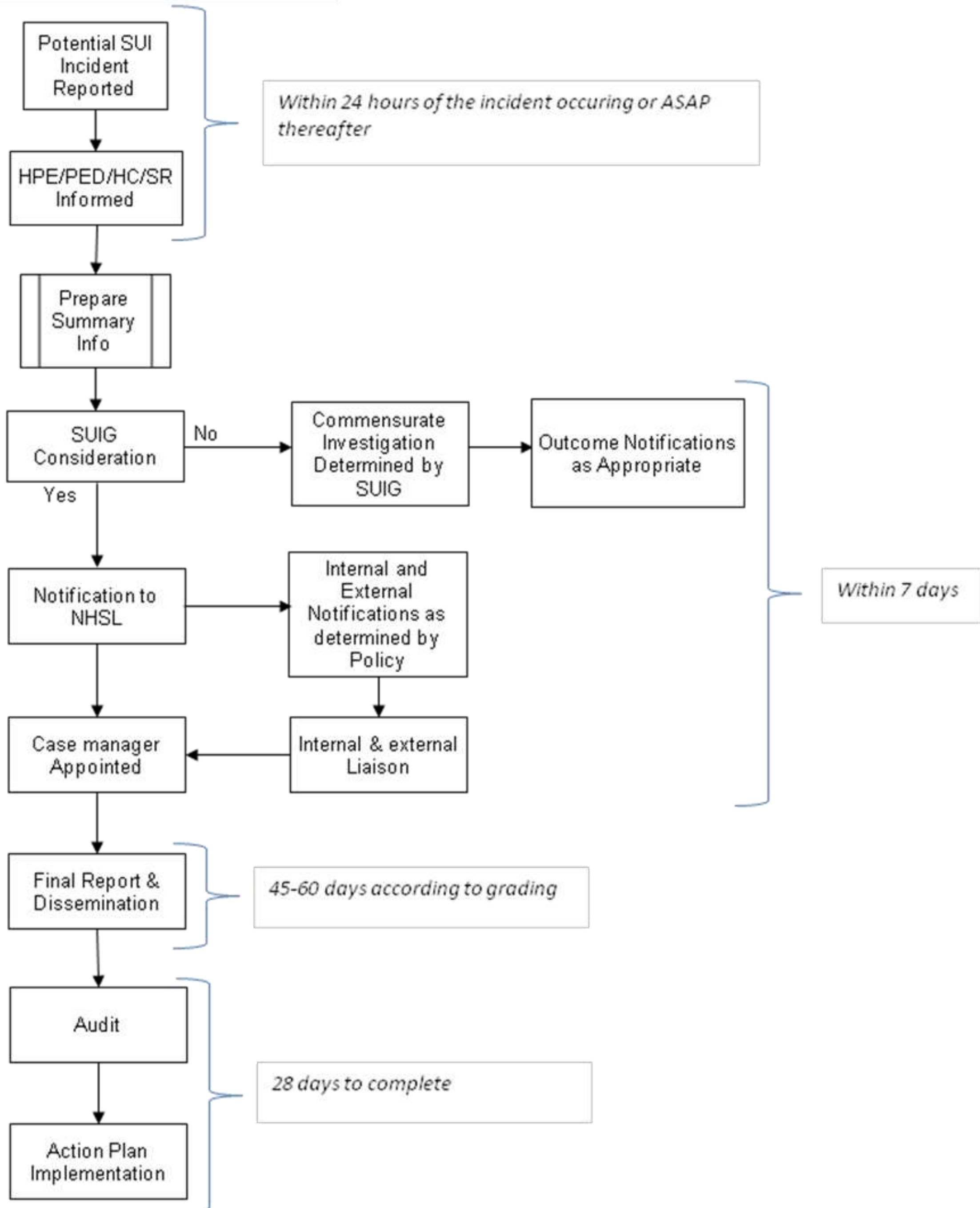
## NPSA Grading Tool

### Table 1: Grading of serious incidents

| Grade | Action required | Monitoring required | Examples of cases |
|---|---|---|---|
| Grade 0 | **Action required**<br>Notification only - it is unclear if a serious incident has occurred.<br>The provider organisation must update the PCT/SHA with further information within three working days of a grade 0 incident being notified.<br>If within three working days it is found not to be a serious incident, it can be downgraded with the agreement of the accountable SHA/PCT.<br>If a serious incident has occurred it will be regraded as a grade 1 or 2 | | |
| Grade 1 | **Action required**<br>Commissioning PCTs will monitor the case and report findings, recommendations and associated action plans to the SHA.<br>SHA will monitor progress on a quarterly basis with PCT unless earlier discussion is required or the serious incident is regraded.<br>**Comprehensive Investigation Root Cause Analysis (RCA) required (level 2 Investigation)**<br>**See Appendix C** | **Monitoring required**<br>**Local monitoring**<br>• The PCT and/or SHA will close the incident when it is satisfied the investigation, recommendations and action plan are satisfactory, and local monitoring arrangements are in place and working efficiently.<br>• Publish incident details within Annual Reports<br>**Timescales:** Up to **45 working days/9 weeks** from the date the incident is notified to the PCT/SHA. | **Examples of cases**<br>• Mental Health – deaths in the community*<br>• HCAI outbreaks<br>• Avoidable/unexplained death<br>• Mental health – attempted suicides as inpatients*<br>• Ambulance services missing target for arrival resulting in death/severe harm to patient<br>• Data loss and information security (DH Criteria level 2, see Information Resource)<br>• Grade 3 pressure ulcer develops<br>• Poor discharge planning causes harm to patient<br>**See Information Resource Tool** |
| Grade 2 | **Action required**<br>Case will be monitored by the SHA/PCT/LA in conjunction with the provider organisation.<br>The SHA will review findings, recommendations and associated action plans.<br>For Never Events, the commissioning PCT will be obliged to monitor overall numbers and actions and report these in its annual reporting arrangements<br>**Comprehensive Investigation (RCA level 2 investigation)** (as above) or **Independent Investigation (RCA level 3 Investigation)***<br>**See Appendix C** | **Monitoring required**<br>**SHA/PCT monitoring**<br>• Incidents leading to an independent investigation or inquiry or those considered high risk will continue to be monitored by the SHA/PCT or Local Authority until evidence is provided that each action point has been implemented. Incidents involving adult or child abuse are referred to local safeguarding arrangements<br>• Publish quarterly reports<br>**Timescales:** For Independent Investigations allow up to **26 weeks/6 months** for completion of investigation. Extensions can be granted on an individual case-by-case basis by the SHA/PCT. | **Examples of cases**<br>• Maternal deaths<br>• Inpatient suicides (including following absconsion)*<br>• Child protection<br>• Data loss and information security (DH Criteria level 3-5)<br>• Never Events<br>• Accusation of physical misconduct or harm is made<br>• Homicides following recent contact with mental health services*<br>**See Information Resource Tool**<br>* Mental Health incidents should refer to DH guidance: *Independent investigation of adverse events in mental health services*[14] |

| Incident Grading | Investigation type | Timescales for completion of investigation |
| --- | --- | --- |
| **Grade 1** | **Comprehensive Investigation (RCA level 2 Investigation)**<br>• Conducted with a high level of detail, including all elements of a thorough and credible investigation.<br>• Conducted by a multidisciplinary team, or involves experts/expert opinion/independent advice or specialist investigator(s).<br>• Conducted by staff not involved in the incident, locality or directorate in which it occurred.<br>• Overseen by a director level chair or facilitator.<br>• Led by person(s) experienced and/or trained in RCA, human error and effective solutions development.<br>• Includes patient/relative/carer involvement and should include an offer to patient/relative/carer of links to independent representation or advocacy services.<br>• May require management of the media via the organisation's communications department.<br>• Includes robust recommendations for shared learning, locally and/or nationally as appropriate.<br>• Results in full report with an executive summary and appendices. | Up to **45 working days/9 weeks** from the date the incident is notified to the PCT/SHA.<br>Comprehensive investigations can be completed more quickly if the provider organisation wishes and extensions beyond the 45 days can be agreed between the provider organisation and PCT/SHA. |
| **Grade 2** | **Comprehensive Investigation (RCA level 2 Investigation** (As above) **or Independent Investigation (RCA level 3 Investigation)**<br>• Must be commissioned and co-ordinated by the Commissioning PCT or Strategic Health Authority and independent to the provider organisation service/s and organisation/s involved in the incident, **for independent investigations only**<br>• Commonly considered for incidents of high public interest or attracting media attention.<br>• An **independent investigation** must be conducted for mental health homicides (where there has been recent contact with mental health services) that meet Department of Health guidance.<br>• Should be conducted where Article 2 of the European Convention on Human Rights is, or is likely to be, engaged. | Up to **60 working days/12 weeks** from the date the incident is notified to the PCT/SHA.<br>Comprehensive investigations can be completed more quickly if the provider organisation wishes and extensions beyond the 60 days can be agreed between the provider organisation and PCT/SHA.<br>For independent investigations allow up to **26 weeks/6 months** for completion of the investigation. |

**Appendix 4**



**Appendix 5**

## Summary of Declaration Process

### 1. Potential SUIs

1.1 A potential SUI may become apparent from a wide variety of sources throughout the Trust, although recent experience indicates that most often this will arise from any of the service-user and stakeholder feedback mechanisms (Complaints and PALs) managed by the Patient Experiences Department (PED).

1.2 They may also arise through concerns raised at a coroner's inquest, through Legal Services or through incidents brought to the attention of senior managers, the on call senior manager arrangements or through local complex management teams.

1.3 Any incident that is the cause of serious concern or that appears to conform to any of the examples listed in the Trust's SUI policy should be reported accordingly. The most important element is that of timeliness – it is crucial that concerns are reported without delay. In most instances they should be reported as soon as we become aware of them.

### 2. Reporting Arrangements

PotentialSUINotification@lond-amb.nhs.uk

2.1 In instances where a local manager has been made aware of an incident, this should be reported to the relevant Assistant Director of Operations (ADO) or line/senior manager and by using the email facility PotentialSUINotification@lond-amb.nhs.uk. An LA52 should be completed, the risk graded, and the form sent to Safety & Risk.

2.2 In the case of the Emergency Operations Centre or Urgent Operations Centre, if an incident becomes apparent as it occurs, all relevant details of the incident must be recorded on the Call Receipt Form (AS1), using the electronic call logs. The incident must be reported through the Bronze, Silver and Gold structure on duty/on call structure and Gold will ensure that the incident is reported via the dedicated email facility cited. An LA52 should be completed, the risk graded, and the form sent to Safety & Risk.

2.3 In the case of Patient Transport Service, the local manager will document events and similarly ensure that the incident is reported using the email facility cited. An LA52 should be completed, the risk graded, and the form sent to Safety & Risk.

2.4 In the case of safeguarding children incidents, the Head of Patient Experiences will liaise with the London Safeguarding Children Board and other relevant agencies in accordance with NHS London requirements.

2.5 For incidents involving vulnerable adults, the Head of Patient Experiences will liaise with any relevant agencies.

2.6 In all other cases, the senior manager of the area concerned (eg Finance, IM&T) will document events and report via the email facility and using an LA52 which is then sent to Safety & Risk.

2.7 In all cases, notification via the email facility should be made within 24 hours or the next normal business day, with an LA52 completed, graded and sent to Safety & Risk within 5 working days

**3. Responsibility for Summarising the Incident**

3.1 The Head of Patient Experiences then has responsibility for compiling supporting documentation and preparing a brief summary of events. This information will be placed on the Trust's designated intranet folder which is a secure facility, Please note this is only available to Senior Management Group, Gold level Operational Managers, Head of Patient Experiences, Head of Communications, Head of Legal Services and appointed Investigating Managers.

**4. Declaration Process**

4.1 The decision to declare a SUI will be taken by at least 3 Directors and the Head of Patient Experiences from those who constitute membership of the Trust's SUI Group (SUI Group). These include:

- Deputy CEO
- Director of Corporate Services
- Director of Operations
- Medical Director
- Head of Patient Experiences.

4.2 The Head of Patient Experiences will be responsible for calling a conference call as soon as possible to discuss the incident and the summary documentation within the SUI folder. A dedicated weekly slot has been created for the purpose but other calls will be arranged as required.

4.3 If an SUI is declared a dedicated Investigating Manager will be appointed by the SUI Group and the Head of Patient Experiences will advise and support this manager as appropriate.

**5. Responsibilities for onward notification.**

The Head of Patient Experiences will also be responsible for notifying the following organisations/departments:

- NHS London using the dedicated STEIS case management system,
- Other external agencies as appropriate
- Communications Department
- Legal Services

Gary Bassett,
Head of Patient Experiences

**Appendix 6**

## Audit Standards

This audit should be routinely undertaken at the conclusion of an SUI investigation and reviewed by the LAS Complaints Panel.

1. Was the incident reported in accordance with the stages identified in practice guidance?

2. Was the matter considered within a reasonable timeframe by SUI Group, and the decision effectively communicated to all relevant parties, including the staff involved?

3. Where a SUI was not declared, was a commensurate level investigation undertaken, the outcomes reported and any actions implemented?

4. Where a SUI was declared, was an appropriate methodology employed?

5. What learning was identified?

6. Was an action plan devised?

7. Were any recommendations or action points implemented within reasonable timeframes?

**Appendix 7**

## Data loss risk matrix

A score of 3 – 5 indicates that a SUI should be reported

| 0 | 1 | 2 | 3 | 4 | 5 |
|---|---|---|---|---|---|
| No significant reflection on any individual body.<br><br>Media interest very unlikely | Damage to an individual's reputation.<br><br>Possible media interest. | Damage to a team's reputation.<br><br>Some local media interest that may not go public | Damage to services reputation.<br><br>Low key media coverage | Damage to an organisation's reputation.<br><br>Local media coverage | Damage to NHS reputation.<br><br>National media coverage |
| Minor breach of confidentiality<br><br>Only a single individual affected. | Potentially serious breach.<br><br>Less than 5 people affected or risk assessed as low. e.g. files were encrypted | Serious potential breach & risk assessed High.<br><br>Up to 20 people affected. e.g. Unencrypted clinical records lost. | Serious breach of confidentiality.<br><br>Up to 100 people affected | Serious breach with either particular sensitivity, e.g. sexual health details or<br>Up to 1000 people affected | Serious breach with potential for ID theft or<br><br>Over 1000 people affected |

**Appendix 8**

## Investigation Process

### Charting the Event with Current Knowledge

1. The first stage of the investigation process is to establish the basic facts. This will help to identify, at an early stage, whether or not specialist advice or guidance may be required from either internal or external sources. The following should be identified:

    - who was affected by/involved in the incident;
    - a summary of what happened;
    - a list of the names of all present at the time of the incident (including contact details) so that statements can be obtained (at the earliest opportunity);
    - a list of all equipment that was potentially involved in the incident (equipment should be taken out of use if safe and appropriate to do so);
    - if possible, and where appropriate, take photographs or make sketches of the incident scene (as this will provide a permanent record of the scene).

2. Where an SUI is being investigated this information will be required for inclusion in the report to NHS London.

### Gathering Evidence

1. **Factual** information should be gathered as soon as possible after an event, whilst people can still accurately recollect what happened and when.

    **From People**

    - Witness statements (see Appendix 2 for guidance) should be obtained from all those who were involved in the incident, complaint or claim.

    - It may be appropriate to interview people involved in an incident, complaint or claim (see Appendix 3 for guidance on conducting an interview). All staff must be advised of the availability of support (e.g. from a Union Representative) during the interview process.

    - Statements should be obtained from anyone present, whether they saw the incident/circumstance about which a complaint is being made or not, if appropriate.

    - Statements should be obtained from other relevant persons who may have information that influences the investigation (e.g. maintenance staff, external contractors).

**From the Environment**

- Records should be made about the physical environment at the time of the incident, where appropriate (e.g. lighting, temperature, available space, positioning of relevant equipment).

**Documentary Evidence**

- Examples of documentary evidence that should be collected are policies and procedures, pre- and post-risk assessments, patient records, training records, relevant incident forms, maintenance records, safe systems of work, correspondence.

**Mapping the events**

1. The information gathered should be used to establish the chronology of events (i.e. when specific events occurred and in what order).
2. The preferred Trust tool for documenting the chronology is a timeline, as it will also allow for the identification of information gaps and any critical problems that arose.

**Identifying and analysing contributory factors to the incident/complaint/claim**

1. Having gathered all of the relevant sources of evidence, the nest stage of the investigation is to identify the contributory factors, including ‘root causes’.

2. The aim of this stage of the investigation is to identify the fundamental causes of the incident, complaint or claim and not just the obvious causes (that can simply be attributed to human error).

   - List the organisational, management and institutional factors that may have contributed to the incident/complaint/claim (e.g. lack of documents to guide practice, lack of risk assessments, lack of equipment, lack of training);

   - List any error producing conditions (e.g. staff shortages, poor working conditions, poor communication);

   - List any violation producing conditions (e.g. poor management culture (violations occurring without being addressed), lack of supervision of untrained staff);

   - List any unsafe acts completed that conflicted with Policy, procedures, training or best practice;

3 The purpose of the subsequent analysis is to identify what happened, why it happened, how did it happen and how can it be prevented from happening again. The aim of the analysis is to determine what lessons can be learned and what changes can be made to improve practice and reduce future risks. The person investigating the incident, complaint or claim should aim to ask the question ‘why

(did something happen)' until the answer is no longer meaningful. Each stage of the analysis should be recorded.

4 Full analysis of the gathered evidence will enable the obvious causes (for an action or event) and the contributory underlying (or root) causes to be identified. The root causes will typically be management factors.

5. *It must be recognised that the cause of an incident, complaint or claim cannot usually be attributed to one particular cause or event.*

**Action planning**

1. The investigation process will have identified a series of recommendations which could be implemented to reduce the level of risk identified.

2. Recommendations that are supported need to be identified within an action plan, with a responsible person identified and a target completion date assigned.

3. In the case of an SUI the Head of Patient Experiences, Head of Safety & Risk /Head of Legal services (on a daily basis) and the Clinical Quality Safety & Risk Committee/Risk Compliance and Assurance group will be responsible for monitoring the implementation of the action plan. Where the incident is not deemed to be an SUI then it will be the responsibility of the ADO or relevant senior manager to monitor implementation of the action plan and to report progress and outcomes to the relevant Committee.

**Completing a report**

1. The investigation report should be a document that identifies all of the factors involved in an incident. The document should encompass all the information that has been collated during the investigation including, for example, photographs, training records, maintenance records.

2 The final document could be used as evidence at a later date and may be requested by enforcing authorities, such as the Health and Safety Executive or the Health Service Ombudsman.

3. The investigation report must include the following:

- Purpose of the report;
- Author of the report;
- A list of staff, patients and visitors;
- Full factual account of the incident, including a detailed chronology of events;
- Background information about the affected person (e.g. patient's clinical details, staff history);
- Findings of the root cause analysis (both positive and negative);
- Recommendations/action plan;

The timescales for completion of investigation reports are identified in the Incident Reporting Policy, Complaints Policy and Claims Policy.

**Appendix 9**

## NPSA RCA Executive Summary Template

### Root Cause Analysis Investigation Report
### Executive Summary for Learning

| Brief incident description |
| --- |
| • Incident date: |
| • Incident type: |
| • Healthcare specialty: |
| • Actual effect on patient and/or service: |
| • Actual severity of the incident: |
| Level of investigation conducted |
| Involvement and support of the patient and/or relatives |
| Detection of incident |
| Care and service delivery problems |
| Contributory factors |
| Root causes |
| Lessons learned |
| Recommendations |

**Appendix 10**

## Recommended Content of SUI report (based on NPSA template)

Incident description and consequences including:

Incident date:

Incident type:

Specialty:

Effect on patient:

Severity level:

Pre-investigation risk assessment (potential x severity = likelihood)

Background and context

Terms of reference

The investigation team

Scope and level of investigation

Investigation type, process and methods used

Involvement and support of patient and relatives

Involvement and support provided for staff involved

Information and evidence gathered

Chronology of events

Detection of incident

Notable practice

Care and service delivery problems

Contributory factors

Root causes

Lessons learned

Recommendations

Arrangements for shared learning

Action Plan

Distribution list

Appendices

Author, Job title, Date

Appendix 11

# Guidance for Special Investigation Teams

## Choosing the Investigation Team

Dependent on the nature of the incident, the inquiry panel could be internal, external or a mixture of both. In all these cases the team will function more effectively if the guidelines set out are followed:

## Chairperson

Should be skilled and independent of the issues being investigated. The Chairperson needs to be able to co-ordinate impartially the various investigative activities, run meetings, lead a decision making progress, report writing and presentation to the client groups.

## Team Members

They need the skill and specific knowledge to contribute to the investigation, so that their role in the enquiry team can be clearly defined. They need also to be capable of playing a team role when it comes to analysing, agreeing decisions and making recommendations. They need to be able to, and be prepared to, give the necessary time.

## Involving Others

The Chairperson will need to recognise the need to co-opt and call upon other skills, either initially or as the investigation ensues.

## Training/Briefing Session

It should not be assumed that an enquiry team is instantly capable of carrying out its role. Ideally, its first meeting should, at least in part, be a training session. As a minimum, an hours briefing by the Chairperson should happen before starting the investigation itself. The briefing should cover:-

- gaining understanding of the aims
- agreeing the style and process of the investigation
- sharing expectations of each role and each other
- agreeing key milestones and how the various investigative strands will be brought together

**Establishing Terms of Reference**

Terms of Reference should be produced in writing and shared with all those involved. They should also include:

- *Aims*
  These should be expressed in neutral language to encourage problem solving rather than blame allocation. The remit should be broad enough to cover both the circumstances around the incident and any other relevant factors raised by the incident. A historical perspective should be encouraged to seek patterns or trends.

- *Enquiry Team*
  Chairperson name and role in co-ordinating the investigation
  Team Members names and roles/specific contributions as appropriate

- *Time Commitment*
  It is likely that dedicated and intensive periods of time will be necessary to achieve the enquiry efficiently and expeditiously and this should be clearly identified.

- *Secretarial Support*
  What clerical support will be available; where will it be located?

- *Authority*
  What authority is vested in the team and who is the person designated to receive the report?

- *Timescales*
  Following the initial 72 hour investigation, it should be possible to estimate the time required to carry out the enquiry. One month would provide sufficient time for most incident enquiries, whilst providing an appropriate sense of urgency. The key milestones should be indicated in the Terms of Reference.

- *Enquiry Process*
  This part should include the investigation process to be undertaken, the meetings schedule, how findings will be brought together, recommendations agreed, how the report will be presented and whether it should be/has to be made public. These aspects should not be left to chance. It should also indicate the decision making progress by which any alterations to Terms of Reference, timescales etc., will be made in light of the progress.

## ENQUIRY REPORT

- *Structure*
  The structure of reports should be broadly consistent. The following headings should suffice for most reports:-
  - Introduction
  - Terms of Reference – including membership of panel
  - Enquiry Process
  - Background – history of events
  - Description of Incident and its Handling
  - Comments on Incident Handling (Enquiry Team)
  - Conclusions
  - Recommendations
  - Implementation Process
  - Tracking

- *Recommendations*
  These could usefully be presented under three headings:-
  Policy and Procedure
  Resources and Assets
  Staff Performance and Capability

  They should be prioritised in terms of **MUST** and **COULD** do. Wherever costs are entailed, these should be itemised along with the benefits anticipated from accruing such costs.

- *Implementation Process*
  This should be in the form of an action chart, showing who, how and When by including key review points. The plan should include communications activity and show how support for those involved in the implementation process would be provided wherever this is likely to be personally stressful.

- *Tracking*
  Ownership for tracking agreed recommendations must be decided. A pro-forma for progress reports is attached. These should be presented at key review points, and at least monthly, so that actions can be signed off and any additional action can be identified.

**Appendix 12**

## Investigating Process

### Process

- Request investigation
- Appoint investigation team
- Nominate support for the staff involved
- Keep the patient / relatives / staff informed
- Gather relevant data – health records / policies / duty rosters
- Map information / generate chronology of events
- Identify problems / barriers / areas for exploration
- Request statements from and interview relevant staff
- Analyse problems
- Agree root causes and safety improvements with the team
- Generate conclusions and recommendations
- Compile draft report
- Share relevant extracts (where appropriate) with individual staff for comment
- Finalise report
- Submit report to appropriate directorate / committee
- Generate action plan for implementation of recommendations, with specific timescales and responsibility
- Share findings and learning with patient / relatives / staff / other relevant stakeholders

### Good Investigation:

| Focuses On: | Avoids: |
|---|---|
| ▪ Structured analysis<br>▪ Openness and fairness<br>▪ Professional accountability<br>▪ Learning and sharing<br>▪ A recognition that things go wrong<br>▪ Good practice identified<br>▪ Minimising future risk<br>▪ Appropriate staff support | ▪ Pre-judging the outcome<br>▪ Personal bias<br>▪ Naming and shaming<br>▪ Looking for a quick fix<br>▪ Recommending solutions that create new risks<br>▪ A negative culture of fear<br>▪ Inappropriate use of the disciplinary process |

### Key Questions to Ask

- What happened?
- How did it happen?
- Why did it happen?
- What was the impact?
- What can we learn?

What action is needed to reduce recurrence?