Incidents and Investigations

GMMH is committed to achieving and sustaining service that deliver safe, effective and efficient care, one of the ways that we strive to achieve and drive quality is to support learning through the identification and investigation of incidents.

An incident can be defined as an unplanned or unintended occurrence that results in the potential for or actual harm, this harm or potential harm can be to a service user, their family or carer, a member of staff or the wider public.

Incident Reporting

Incidents can be reported by any staff member using the Incident report software. Once an incident is reported a local manager will review the incident adding the harm that occurred and any investigation that needs to be completed. Incidents are also levelled for severity with levels four and five indicating further investigation initially from as a three day review. However incidents of any level can be reviewed if there is a significant risk raised or if as part of a cluster further review would be useful to capture learning.

The Trust completes a review of all of the 3 Day Review submitted. This is completed in a weekly executive panel Serious Incident Review panel .

The 3 Day Reviews are considered against the criteria set out in the NHS England Serious Incident Framework and can result in:

- No further action required
- Structured Judgement Case Note Review
- RCA1 – this is usually completed by a manager local to where the incident occurred
- RCA 2 local – the lead investigator for this investigation will come from the Directorate in which the incident occurred, supported by appropriate panel members dependent on the incident
- RCA 2 external – the lead investigator for this will come from a Directorate external to the one in which the incident occurred, supported by a local lead in addition to any other panel members dependent on the incident

The NHS England Serious Incident Framework requires that organisations complete investigations into incidents that are relevant and proportionate to the incident, and a good use of time and money. Having a range of levels of investigation allows GMMH to meet this requirement.

The purpose of the incident investigation, regardless of the level of investigation, is not to blame individuals involved but to identify where there has been a breakdown in local or Trust systems and processes that may have contributed to the incident. The primary aims are to highlight where there has been good practice; the identification and service delivery concerns due to lapses in care or missed opportunities that may have had a direct contribution to the incident occurring and where deviations from policies and procedures have occurred; identify the key root causes of why the incident may have occurred and promote learning through improvement in future practice.

All of the managers who complete RCA investigations have received training in Root Cause Analysis techniques and use them to support the investigation and reach conclusions. These techniques include developing a timeline (chronology); the 5 Whys; Fishbone; Change Analysis; Human Factors.

The Trust is committed to investigate and report on all incidents in a thorough and robust manner in line with the requirements of the NHS England Serious Incident Framework and to support this there is an internal assurances process that ensures all investigations and reports are subject to appropriate scrutiny through the Serious Untoward Incident (SUI) Panel and for more serious incidents the Post Incident Review Panel.

Whether an incident has been reported on StEIS, the national incident reporting system will be dependent on the level of harm the patient has come to; whether the 3 Day Review identifies any short falls in care; and whether there is any learning from the incident for the Trust. Incidents can be reported on StEIS at any time, so a decision not to report on StEIS following a 3 Day Review does not mean that it may not be StEIS in the future, e.g. after the completion of the investigation and report or when information is received about a cause of death.

All reports into incidents that have been StEIS reported are submitted to the relevant CCG, the Trust has developed close links with all of its' CCGs to provide assurance external to the Trust that the investigations and reports are of a good quality, and that the conclusions reached are fair and appropriate.

Learning from incidents is supported through the development and completion of action plans, all levels of investigation and report, from a 3 Day Review to an RCA 2 that is presented to the PIR Panel, will result in recommendations and an action plan intended to support and embed the learning from the incident. Reflective practice is used to support the learning from al RCA2 investigation with the investigation lead supporting a Learning Event within two months of the report being finalised.