Incident Reporting and Investigation including Duty of Candour Policy

Mandatory Read

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Document Change Control

Version	Status	Description (of changes)	Reviewed by	Reviewed/ Issued Date
0.1	Draft	• Removed Sudden Unexpected Death section as now separate SOP. • Updated Duty of Candour • Included the NHS shift to The Patient Safety Incident Response Framework (PSIRF) from the 2015 Serious Incident framework. • Included Serious Incident Review Group and Rapid Response Panel process (evolved from RCA Panel) • Removed templates as likely to go out of date	Claire Champion (Interim Director of Nursing and Quality)	15th August 2022
0.2	Draft	• Removed challenging behaviours and replaced with behaviours of concern	Melanie Burrough (Director of Therapies	17th august 2022
		• Included responsibilities for Director of Education, and Health & Safety manager. • Duty of Candour clarified as not a statutory duty applicable to education settings, but principle should be followed.	Launa Randles, (Head of School), Claire Champion (Interim Director of Nursing and Quality)	7th September 2022
1.0	Final			13th September 2022
1.1	Revision	Updated 2.1.6 on 'Near Miss' to align with NHSE framework.	Claire Champion (Interim Director of Nursing and Quality)	2nd November 2022
1.2	Revision	Updated to reflect the implementation of the Clinical Site Manager role, and new role titles post restructuring.	Claire Champion (Interim Director of Nursing and Quality)	29 August 2023

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Appendices

Policy

1 Purpose and Objectives

The objectives of the policy and this procedure are to:

- To provide staff with an agreed method of reporting, investigation and management of incidents and development of action plans, where appropriate.

- To ensure that each department, and The Children's Trust as a whole, has accurate information on incidents so that trends can be identified, learning from events takes place and steps taken to prevent similar incidents from occurring in the future.

- Where appropriate, to support the investigation of complaints and provide evidence in pursuance of litigation claims, both for and against The Children's Trust.

- The purpose of this policy is to provide guidance to ensure all communication is open, honest and occurs as soon as possible following an incident, complaint or claim.

Relevant laws and regulations include but are not limited to:

- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20
- Health & Safety at Work Act (1974)
- Provision and Use of Work Equipment Regulations (1998)
- Management of Health and Safety at Work Regulations (1999)
- CQC The duty of candour: guidance for providers (30 June 2022)

2 Scope

This policy applies to:

- All colleagues across The Children's Trust

The principles of this document apply to all communications with children and their families when errors have been made, this applies to incidents as well as complaints

3 Definitions

Unless otherwise stated, the words or expressions contained in this document shall have the following meaning:

the Charity/ organisation/	means The Children's Trust TCT
SOP	Standard Operating Procedure

4 Policy Statement

The Children's Trust is committed to being an open, learning organisation from floor to Board and ensuring a full understanding of factors which have led to an incident. The Serious Incident framework describes the process and procedures to help ensure serious incidents are identified correctly, investigated thoroughly and, most importantly, learned from to prevent the likelihood of similar incidents happening again.
The purpose of reporting and investigating is to:

- Identify risks
- Learn from incidents that have occurred
- Improve the quality of care for the children we support
- Maintain the safety of the children, families, staff, volunteers and visitors at The Children's Trust.

The detailed procedures for the management and investigation of Serious Untoward Incidents are set out within the Trust's Emergency Procedures File.

5 Stakeholder Consultation

Appendix 1 details the stakeholders who were consulted in the development of this policy and

6 Related Policies and Procedures

The following policies and procedures stated below support the effective application of this policy and SOP:

- Risk Management Policy
- Health & Safety Policy
- Sudden Unexpected Death Policy
- Disciplinary Policy and SOP; 2021
- Safeguarding and Child Protection Policy and SOP

7 External References and Guidance

The following external resources and guidance were consulted in drafting this policy and SOP:

- NHSE Serious Incident framework

- Health and Social Care Act 2008 (Regulated Activities) Regulations 2014: Regulation 20 (Duty of Candour)

Standard Operating Procedures (SOP)

1 Roles and responsibilities

- Board of Trustee / CEO
  - Ensure notification is made to the charity commission if required

- **Medical Director**

The Medical Director is responsible for:

- Ensuring the principles set out in this policy are followed within their directorate.
- Ensuring the medical team have the knowledge and understanding of the principles and can support the immediate management of an event.
- Participating in the Serious Incident Review Group.

- **Director of Nursing and Quality**

The Director of Nursing and Quality is responsible for:

- Ensuring the principles set out in this policy are followed within their directorate
- In collaboration with the Medical Director, Head of Nursing and on call manager appoint or assume the role of the Lead Clinician investigating Serious Incidents
- Manage the progress of Serious Incident Investigations including notifications and updates to the Senior Leadership Team and the Board of Trustees.
- Ensuring the Serious Incident report is appropriately detailed and robust.
- Following up implementation of recommendations from the Serious Incident report
- Ensuring the Head of Clinical Support and Education and the Clinical Site Manager team have the knowledge and understanding of the principles to lead the immediate management of an event out of hours.

- **Director of Therapies**

The Director of Therapies is responsible for:

- Ensuring the principles set out in this policy are followed within their directorate
- Ensuring the Head of Rehabilitation Therapies and School Therapy Team and their teams have the knowledge and understanding of the principles to lead the immediate management of an event in their area of responsibility.
- In collaboration with the Medical Director and Director of Nursing & Quality appoint or assume the role of the Lead Clinician investigating a Serious Incident in Therapy areas of responsibility

- **Director of Education**

The Director of Education is responsible for:
- Ensuring the principles set out in this policy are followed within their directorate

- In collaboration with the Medical Director and Director of Nursing & Quality appoint or assume the role of the Lead Investigator investigating a Serious Incident in Education areas of responsibilit

- **Head of Nursing and Care (Registered Manager)**

The Head of Nursing and Care is responsible for:

- Making statutory notifications of Serious Incidents
- Follow local processes to notify SI incident to the child's social worker
- Ensuring the principles set out in this policy are followed within their teams
- Ensuring the Nursing and Care teams have the knowledge and understanding of the principles

- **Head of Health and Safety**

The Head of Health and Safety is responsible for:

- Making statutory notifications of relevant incidents to the Health and Safety Executive (RIDDOR reports)
- In collaboration with the Director of Nursing & Quality appoint or assume the role of the Lead Investigator investigating a Incidents in non-clinical areas
- Ensuring the principles set out in this policy are followed within their teams
- Ensuring the Clinical on call manager team have the knowledge and understanding of the principles related to Health and Safety
- Ensuring The Children's Trust teams have the knowledge and understanding of the principles related to Health and Safety

- **Clinical Site Manager**

The Clinical Site Manager will manage a Serious Incident out of hours, and is responsible for:

- Ensuring the principles set out in this SOP are followed in respect to internal actions, in particular
- Ensuring an IRAR is submitted
- Collecting relevant contemporaneous evidence and statements
- Notifying the director on call if a potential serious incident has occurred
- Ensuring safety has been restored after the event or risk mitigated as far as reasonably practicable
- Ensuring the notes have been copied if a CYP has gone to hospital as a result of a SI
- Notifying the family/carer and supporting as able
- Supporting staff

- **On Call Director**

The on-call manager is expected to judge the need for on site presence in the event of a Serious Incident out of hours, and is responsible for:

- Ensuring the principles set out in this SOP are followed in respect to internal actions, in particular
- Ensuring safety has been restored after the event or risk mitigated as far as reasonably practicable
- Managing external agencies on site
- Managing any media interest
- Reporting to Chief Executive and other relevant directors at the earliest reasonable opportunity
- Supporting staff

- **OLT Members**

OLT managers are responsible for:

- Ensuring the principles set out in this SOP are followed within their teams
- Ensuring the teams have the knowledge and understanding of the principles

2 Process / Procedure

2.1. Definitions

2.1.1 Duty of Candour

In 2013 the Francis Inquiry recommended that a statutory Duty of Candour (DoC) be introduced for all health and care providers, in addition to the existing professional Duty of Candour.

This statutory Duty of Candour was brought into law in 2014 for NHS Trusts and 2015 for all other providers and is now seen as a crucial, underpinning aspect of a safe, open and transparent culture.

The statutory Duty of Candour is regulated by the CQC, while the professional duty is overseen by the various regulators of professional practice – e.g., the General Medical Council, Nursing and Midwifery Council and Health & Care Professions Council.

The statutory Duty of Candour requires The Children's Trust to ensure that children/families are informed of errors causing moderate, severe harm or death resulting in services regulated by the CQC. This regulation does not include The Children's Trust School or Surrey Teaching Centre, however The Children's Trust expects the principles will be followed in all settings. The child and family must also be provided with support. This includes receiving an apology, as appropriate, and the investigations findings and actions to prevent recurrence are shared.

2.1.2 Being Open

Being open refers to the process for communicating adverse events. It is a process of actions and behaviours that are determined by the Ten Principles of Being Open which can be found in Appendix 1.

Organisations are said to be 'open' when the prevailing culture visibly encourages key behaviours. These include honesty, openness, appropriate sharing of information and a willingness to learn from experience to change how the organisation functions.

2.1.3 Serious Incidents

A Serious Incident requiring investigation is defined as an accident or omission incident that occurred in relation to NHS funded services and care. In broad terms, serious incidents are events in health care where the potential for learning is so great, or the consequences to patients, families and carers, staff or organisations are so significant, that they warrant using additional resources to mount a comprehensive response.

The occurrence of a serious incident demonstrates weaknesses in a system or process that needs to be addressed to prevent future incidents leading to avoidable death or serious harm to children or staff, future incidents of abuse or future reputational damage to the organisation involved.

There is no definitive list of incidents that constitutes a serious incident and lists should not be created locally as this can lead to inconsistent or inappropriate management of incidents. The definitions below set out circumstances when a serious incident must be declared:

- Unexpected or unavoidable death of one or more people. This includes:
  - suicide / self-inflicted death; and
  - homicide by a person in receipt of mental health care within the recent past
- Unexpected or avoidable injury to one or more people that has resulted in serious harm – including those where the injury required treatment to prevent death or serious harm, abuse, Never events, incidents that prevent (or threaten to prevent) and organisations ability to continue to deliver an acceptable quality of healthcare services and incidents that cause widespread public concern resulting in loss of confidence in healthcare services.
- Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent:
  - the death of a service user; or
  - serious harm
- Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative or organisation abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where:
  - healthcare did not take appropriate action / intervention to safeguard against such abuse occurring, or
  - where abuse occurred during the provision of NHS-funded care

The needs of those affected should be the primary concern of those involved in the response to the investigation of serious incidents. Children and their families must be involved and supported throughout the investigation process.

Investigations under this Framework are not conducted to hold any individual or organisation to account, as there are other procedures for this purpose such as; criminal proceedings, disciplinary procedures, employment law and systems of service and professional regulation such as the Care Quality Commission, Nursing and Midwifery Council, Health and Care Professionals Council and General Medical Council. Investigations should link to these other processes where appropriate.

Serious incidents must be declared internally as soon as possible and immediate action must be taken to establish facts, ensure the safety of children, other service users and staff, and to secure all relevant evidence to support further investigation. The child and their family should be informed as soon as possible. The commissioner must be informed in writing or verbally within 2 working days of it being discovered. Regulatory bodies must be informed such as Ofsted within 24 hours and CQC without delay by the Registered Manager or Responsible Individual in their absence. Other partners such as the police or local authority should be informed as required.

The recognised system for conducting investigations is Root Cause Analysis and this should be applied to serious incidents.

Any non-contributory issues identified during the course of an investigation may also require further investigation and recommendations.

Serious incidents should be closed by the relevant commissioner when they are satisfied that the investigation report and action plan meets the required standard. Incidents can be closed before the actions are complete but there must be mechanisms in place for on-going monitoring and implementation. This ensures that lessons can be learnt to prevent similar incidents recurring.

2.1.4 The Patient Safety Incident Response Framework (PSIRF) is being piloted nationally, and will replace the 2015 Serious Incident Framework (SIF), from which it differs in the following key aspects:
• Broader scope: the PSIRF moves away from reactive and hard-to-define thresholds for 'Serious Incident' investigation and towards a proactive approach to learning from incidents. It promotes a range of proportionate safety management responses.
• Investigation approach: safety investigation is now tightly defined. Quality of investigation is the priority with the selection of incidents for safety investigation based on opportunity for learning and need to cover the range of incident outcomes.
• Experience for those affected: expectations are clearly set for informing, engaging and supporting patients, families, carers and staff involved in patient safety incidents and investigations. In accordance with a just culture, so staff involved in incidents are treated with equity and fairness.

The principles of this policy should comply with the latest CQC and NHSE guidance if this changes before the policy is reviewed.

2.1.5 National Never Events
The revised Never Events policy and framework and updated Never Events list was published in January 2018. Never Events are incidents that require investigation under the Serious Incident framework.
Never Events are defined as Serious Incidents that are wholly preventable because 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. Strong systemic protective barriers are defined as barriers that must be successful, reliable and comprehensive safeguards or remedies – for example, a uniquely designed connector that stops a medicine being given by the wrong route. The importance, rationale and good practice use of relevant barriers should be fully understood by and robustly sustained throughout the system, from suppliers, procurers, requisitioners, training units to frontline staff.
(Revised Never Events Policy Framework, NHS England Patient Safety Domain March 2018).

2.1.6 Near miss
"An event not causing harm, but has the potential to cause injury or ill health", [Health & Safety Executive (HSE) October 2016].
It may be appropriate for a 'near miss' to be a classed as a serious incident because the outcome of an incident does not always reflect the potential severity of harm that could be caused should the incident (or a similar incident) occur again. Deciding whether or not a 'near miss' should be classified as a serious incident should therefore be based on an assessment of risk that considers:

- The likelihood of the incident occurring again if current systems/process remain unchanged; and
- The potential for harm to staff, patients, and the organisation should the incident occur again.

This does not mean that every 'near miss' should be reported as a serious incident but, where there is a significant existing risk of system failure and serious harm, the serious incident process should be used to understand and mitigate that risk.
TCT expects that a Near Miss will be reported on IRAR in order that appropriate scrutiny can be made to mitigate future risk.

2.1.7 Accident / Incident

"An event that results in injury or ill health", [HSE October 2016].

2.1.8 Medication incident

The National Reporting and Learning Systems (NRLS) defines a 'patient safety incident' (PSI) as, 'any unintended or unexpected incident, which could have or did lead to harm for one or more patients receiving NHS care'.

Medication errors are any PSIs where there has been an error in the process of prescribing, preparing, dispensing, administering, monitoring or providing advice on medicines. These PSIs can be divided into two categories; errors of commission or errors of omission. The former include, for example, wrong medicine or wrong dose. The latter include, for example, omitted dose.
[NHS England March 2014].

2.1.9 Child Behaviours of Concern

Behaviours of concern are defined as "Culturally abnormal behaviour(s) of such an intensity, frequency or duration that the physical safety of the person or others is likely to be placed in serious jeopardy, or behaviour which is likely to seriously limit use of, or result in the person being denied access to, ordinary community facilities" (Emerson, 2001): Challenging Behaviour: Analysis and intervention in people with learning disabilities.

2.1.10 Incident Severity Grading

Grade of incident	National Patient Safety Definition	Actions
No harm (including prevented safety incident/near miss)	Incident prevented that had potential to cause harm but was prevented and no harm caused. Incident not prevented and occurred but no harm was caused.	Children/parents are not usually contacted or involved in investigations and these types of incidents are outside the scope of Duty of Candour. It is decided locally whether 'no harm' events (including prevented patient safety incidents) are discussed with parents, their families and carers, depending on local circumstances and what is in the best interest of the child.
Low harm	Any safety incident that required extra observation or minor treatment and caused minimal harm. Minor treatment is first aid, additional therapy or additional medication.	Unless there are specific indications or the parent requests it, the communication, investigation and analysis of the event, and the implementation of changes will occur at local level with the participation of those directly involved in the event. Reporting to the Clinical Governance team will occur through standard incident reporting mechanisms and be analysed centrally to detect high frequency events. Review will occur through aggregated trend data and local investigation. Where the trend data indicates a pattern of related events, further investigation and analysis may be needed.

		Communication should take the form of an open discussion between the staff. Low incidents are outside the scope of Duty of Candour but staff should apply the principles of being open.
Moderate harm	Any safety incident that results in a moderate increase in treatment and / or caused significant but not permanent harm Moderate harm may also be caused by negligent acts or omissions. Moderate increase in treatment is transfer to hospital as in an inpatient or outpatient or prolonged episode of additional care	A higher level of response is required in these circumstances. The Head of Nursing & Care should be notified immediately and be available to provide support and advice during the *Being Open* process. Once the level of harm is validated to be moderate or higher, the 'Being Open' process should be applied. **Apply the Duty of Candour process**
Severe, significant harm or death	Any safety incident that directly results in death. Serious harm to one or more children, staff, visitors or members of the public or where the outcome requires life-saving intervention, major surgical/medical intervention, permanent harm or will shorten life expectancy or result in prolonged pain or psychological harm A scenario that prevents or threatens to prevent a provider organisation's ability to continue to deliver healthcare services, for example, actual or potential loss of personal/organisational information, damage to property, reputation or the environment, or IT failure; allegations of abuse; adverse media coverage or public concern about the organisation One of the core set of 'Never Events' outlined by the NPSA	A higher risk of response is required in these circumstances. The Head of Nursing & Care and the Director of Nursing and Quality , Medical Director and Director of Therapies should be notified immediately and be available to provide support and advice during the *Being open* process if required. **Apply the Duty of Candour process**

2.2 Emergency Procedures

In the event of the incidents below, refer to the Children's Trust Emergency Procedures File for appropriate action.

2.2.1 Procedure & Protocols Following a Serious Incident involving a Child / Young adult

- M4 Medical Emergency – Child stops breathing / cardiac arrest / sudden unexpected death

- A2 Accident involving serious illness / major injuries for a child
- C5 Child missing / absconding
- S1 Safeguarding – reporting concerns about children.

2.2.2 Procedures involving staff, volunteers / visitors

- A1 Accidents involving serious / major injuries or fatality
- M2 Emergency Medical Incident: potential occupational blood borne virus exposure
- O1 Off site emergencies involving threatening incidents or mugging.

2.3 Duty of Candour/Being Open Grading of Response

'*Being Open'* begins with the detection of an event. The first step of the process is the recognition of an incident and when the level of harm dictates that it is appropriate to apply the 'duty of candour' approach.
This can be identified by any of the following mechanisms:

- Via staff at the time of the incident
- Via staff retrospectively
- By child/ family/ carer raising a concern, either at the time, or via a complaint or claim in retrospect
- Via the incident reporting system
- Via other sources, such as the incident being highlighted by another child, visitor or non – clinical staff

Where necessary immediate clinical care should be given to prevent further harm.

The response should be guided by the level of severity of the event.

Staff are encouraged to apologise when things go wrong, offering sympathy and demonstrate a caring attitude. An apology is not an admission of liability. The Duty of Candour Policy does not require prevented patient safety incidents to be reported to parents/relatives. The decision of whether to communicate these to parents/children depends on local circumstances and advice can be sought from a line manager if there is concern. Low harm incidents should always be reported to the child and/or parents.

The statutory '*Duty of Candour'* will apply to moderate, severe harm or death incidents.

2.4 The Children's Trust Incident Reporting Arrangements

2.4.1 An electronic Incident Report Form must be accurately completed and submitted for all incidents via the electronic Incident & Risk Assessment Reporting system (IRAR). This should be completed as soon as possible (within 24 hours) following the incident. Where electronic access is not possible, the Rapid Review Report should be completed and entered at the next opportunity onto IRAR.

The incident should be risk rated and the severity of the incident identified and recorded on IRAR in order to determine the level of investigation required.

On successful submission of the electronic form, a unique incident number will be generated.

2.4.2 Rapid Review process: If an incident is graded moderate to severe harm, the Director of Nursing and Quality, or in their absence the Head of Nursing and Care in hours, or the Clinical Manager out of hours should be informed by telephone immediately, as well as the IRAR submission. If the notification is made out of hours, the Director of Nursing and Quality, or in their absence the Head of Nursing and Care should be informed at the earliest opportunity.

The manager receiving the information can either establish the facts immediately and ratify the severity grading, or in more complex situations there should be a Rapid Review panel convened by the Director of Nursing and Quality, or in their absence the Head of Nursing and Care on the next working day. Duty of Candour should be completed as soon after the incident as possible.

2.4.3 Notifications: The Director of Nursing and Quality, or in their absence the Head of Nursing and Care will ensure that all statutory notifications are made to Ofsted, CQC and NHSE via STEIS, and a CYP's statutory social worker if appropriate. They will also ensure the Board of Trustees are appropriately updated.

2.5 Duty of Candour Process

2.5.1 Process for acknowledge, apologising and explaining when things go wrong

See Appendix 1 Duty of Candour Flow Diagram.

The regulation states that you must:

1. Tell the relevant person, face-to-face, that a notifiable safety incident has taken place.
2. Apologise.
3. Provide a true account of what happened, explaining whatever you know at that point.
4. Explain to the relevant person what further enquiries or investigations you believe to be appropriate.
5. Follow up by providing this information, and the apology, in writing, and providing an update on any enquiries.
6. Keep a secure written record of all meetings and communications with the relevant person.

2.5.2 Initial discussion

Following identification of an incident, a preliminary team discussion should be undertaken to establish; as soon as possible to the incident, once the child is safe

- Basic clinical facts
- Assessment of the incident and determine level of immediate response required
- Individual responsible for discussing / liaising with child/ relative/ carer
- Whether child/family support is required
- Immediate support required for staff involved
- A clear communication plan
- Is it a safeguarding incident? If yes, refer to the safeguarding policy before informing parents

2.5.3 Identifying who should be responsible

In determining who will be responsible for communicating with the child/ family carers the individual should:

- Have a good relationship with the child and / or their parents
- Have a good understanding of the relevant facts
- Be senior enough or have sufficient experience and expertise in relation to the type of incident to be credible to the child, parents and colleagues
- Have excellent interpersonal skills, including being able to communicate with children and / or their parents in a way they can understand
- Be willing and able to offer an apology, reassurance and feedback to the child and /or their parents.
- Be able to maintain a relationship with the child and / or their parents and to provide continued support and information
- Be culturally aware and informed about specific needs of the child or their parents

2.5.4 When should the initial discussion be held?

The initial Duty of Candour discussion with the child and / or their carers should occur as soon as possible after recognition of the incident. Delay in disclosure should be avoided whenever possible. If the incident occurs out of hours it may be necessary to wait until a senior member of the team is available to contact the parents. The communication can occur by any appropriate means – face to face is best, but it can be a telephone call or e-mail to those parents who prefer this method of communication.

Initially, it is worth noting that something has gone wrong but that the cause is not yet known. It must be communicated to the child and their family/ carers that we will be taking the event extremely seriously, that the event will be investigated and that the findings of the investigations will be shared with them.

This initial communication must be recorded in the child's records with a heading 'Duty of Candour Meeting'. Date, time and people present or taking part in the phone call. Outline the apology, what was discussed, concerns raised by the family and arrangements for future communications and support.

An offer to meet should be made to the family, this is usually at the end of the investigation so the findings can be shared and discussed, but may also occur before the investigation starts or during the process. The approach is agreed with the family and this may change at any stage during the investigation.

Factors to consider when timing this discussion include:

- Some families may require more than one meeting to ensure that all the information has been communicated to and understood by them.
- Availability of key staff involved in the incident and in the Duty of Candour process.
- Availability of the child's family and / or carers
- Availability of support staff, for example a translator or independent advocate, if required
- Arranging the meeting in a sensitive location.

Written information regarding the content of this meeting must be given to the family.

2.6 Provision of additional support

2.6.1 Support of the child, their family/ carers

Children, their family/ carer should be provided with support as is necessary during the process of Duty of Candour. At any face to face meeting, they should be encouraged to be accompanied by another family member/ friend/ representative. Where appropriate, an independent advocate or interpreter should be offered.

2.6.2 Where the child/young person is assessed not to have capacity

Where the child/young person has a formal assessment of lack of capacity, the principles of 'Being Open' still apply. In circumstances where the child/young person has a registered person with Lasting Power of Attorney (LPA), it may be a legal requirement that they are informed (dependent on the terms of the LPA). If there is no LPA for the child/young person it is best practice that the family and or carers for the child/young person are informed of the incident. The occurrence of this conversation and the grounds for it must be recorded in the child/young person's medical records.

2.6.3 Professional support

It can be very traumatic for staff to be involved in an event. The Children's Trust are committed to ensuring that staff feel supported through the Duty of Candour process. Staff are also encouraged to seek support from their relevant professional body.

Additional, confidential support is available to staff from

- Occupational Health
- People Team
- Workplace Options
- Staff are encouraged, if appropriate to seek advice from their trade union representative.

2.7 Risk management and system improvement

The Children's Trust supports the root cause analysis (RCA) approach to looking at the cause of child safety incidents.

2.8 Multi professional responsibility

The Children's Trust acknowledges that care is delivered through multi professional teams and the investigation into child's safety incident/ complaint or claim is focused on systems and process, rather than individuals. For this reason, senior clinicians and managers must participate in the investigation process.

2.9 Confidentiality

Details surrounding an event are confidential. Full consideration should be given to maintaining the confidentiality of the child, parents and staff involved.

It is good practice to inform the child, their family and carers about who will be involved in the investigation, and give them the opportunity to raise any objections. Communication outside the clinical team should be strictly on a 'need to know basis'. Equally the relatives may need specific questions answered by the investigation process and should be given the opportunity to raise these.

2.10 Continuity of care

Children/families have the right to expect that their care will continue, and that they will receive all their usual treatment with the care, respect and dignity that they are entitled to.

2.11 Requirements for documenting all communication

All discussions and communication with the child, their family or carers should be carefully detailed within the care file.

Where it occurs as the result of a child safety incident, this will be recorded within the investigation report.

2.11.1 Process for encouraging open communication between organisations, teams, staff, patients/carers.

'Being Open – a duty to be candid' forms part of education programmes. These encourage staff to 'be open' with children, their relatives and carers, and make explicit their requirement to do so.
Where the incident, complaint or claim involves outside agencies (e.g. other healthcare providers, the Commissioners or social services) whether raised by The Children's Trust or the other agency, there is an obligation to fully co–operate with them and to communicate collaboratively with them.

2.11.2 Procedure for conducting different levels of investigations

The Children's Trust have an identified group of senior staff who are trained as investigating managers. At least one member of the investigation team must be trained in root cause analysis.

At the onset of the investigation a team must be established. The number of staff on the team will be determined on a case by case basis but, as a minimum should include;

- Investigation manager
- Medical and/or nursing lead
- Social worker, to provide child/family support
- For severe incidents the Director of Nursing and Quality/ Medical Director

The investigating manager will be appointed by the Director of Nursing and Quality or the Head of Nursing & Care, or the Children's Trust School Head Teacher, dependent upon the nature of the incident.
The investigating manager can be from the clinical area where the incident occurred, but they must be independent of the incident and not involved in the team where the care was provided.

All investigation reports for moderate to severe harm incidents will be presented to the Serious Incident Review Group. Once accepted by that group, they will be escalated to the Clinical Governance Committee, then Clinical Governance and Safeguarding Committees in summary or full format as appropriate. Any incidents involving 'severe, significant harm or death' will be taken in full and signed off at the Clinical Governance and Safeguarding Committee. The Chair of Clinical Governance and Safeguarding Committee will decide which reports need to be taken to the full Board of Trustees for information and discussion.

2.12 Process for learning from Investigations

- *No harm or low harm incidents*

Reflection can be undertaken by the manager or supervisor, as appropriate to facilitate the learning process.
The reflection will then be uploaded on the IRAR system. And the learning points cascaded through teams via the team meeting system, clinical governance and health & safety forums.

- *Moderate/Severe incidents*

The action plans from the investigations will be overseen by the Serious Incident Review Group to ensure they are completed within the agreed time frame. The actions will be driven by the Quality Group. A summary of all moderate/severe clinical incidents will be presented to the Clinical Governance Committee and Clinical Governance & Safeguarding Committee for review. Incidents relating to education will be presented to the Education Governance Committee. Health and Safety and any other incidents will be presented to the Finance and General Purposes Committee. The Board receives minutes from Clinical Governance & Safeguarding Committee, Finance & General Purposes

and the Education Governance Committee and Key Performance Indicators detailing numbers of incidents including those which cause moderate to severe harm.

- Non-contributory issues

Any non-contributory issues identified during the course of an investigation may also require further investigation and recommendations.

The learning from these incidents will be cascaded via newsletters, managers' meetings and team meetings. Key learning themes are made anonymous and used within the training. The Clinical Education and Training Team will regularly explore these incidents in scenarios and case studies in mandatory, clinical and developmental training.

Policies, procedures and guidelines are regularly reviewed and updated to include the learning from incidents and complaints.

2.13 Monitoring of Incidents

The Children's Trust Board review all moderate and severe incidents on a 3 monthly basis.

2.13.1 Clinical Governance and Safeguarding Committee (sub-committee of the Board)
Every 3 months reports on incidents involving the children are prepared by the Head of Nursing & Care and reported to the Clinical Governance Committee. These define statistics and trends and are elaborated by a specific report on medication incidents.

2.13.2 Educational Governance Committee (sub-committee of the Board)
The Children's Trust School Head of School/Lead DSL reports on all incidents logged by the school to the Educational Governance Committee (*sub-committee of the Board*)

2.13.3 Independent Visitor
The Trust's Independent Visitor who attends to meet the requirements of Regulation 44 of the Children's Home Regulation 2015, reviews the incident reports within The Children's Trust Houses and includes the findings in the monthly report. A copy of the report is kept on file for the Ofsted inspectors and circulated to the Board of Governors.

2.13.4 Finance and General Purposes Committee
Health and Safety and other incidents of moderate severity and above which are non-clinical, or education related will be presented to the Finance and General Purposes Committee in order to monitor and ensure implementation of any action plans.

2.14 Disciplinary Action

The Children's Trust encourages open and honest reporting. Prior to initiating an investigation the manager will consult the Incident Decision Tree flow chart to determine whether a root cause analysis or disciplinary investigation should commence. Members of staff involved in the incident must be informed as to whether a disciplinary or root cause investigation is being undertaken. In instances where a root cause analysis investigation has commenced and it becomes clear that there may be a disciplinary case to answer, the investigation can continue but the member/s of staff must be informed that the matter will be dealt with in accordance with the Children's Trust Disciplinary policy and procedures.

2.15 Notifications

2.15.1 The following notifications are required by law to be reported to the Care Quality Commission/Ofsted via the Registered Manager,

- Death of a child/young person – that occurred whilst services were being provided. In The Children's Trust School, all deaths must be reported to the minister of education. Refer to the Children's Trust End of Life Policy, CS016, and Sudden Unexpected Child Death Policy.

- Any abuse or allegation of abuse – abuse in relation to the child/young person means sexual abuse, physical or psychological ill treatment; theft, misuse or misappropriation of money or property; or neglect and acts of omission which cause harm or place at risk of harm. Refer to the Children's Trust Safeguarding Policy, CS003.

- Events that stop or may stop the service from running safely and properly – a level of staff absence or vacancy, or damage to the service's premises that mean that people's assessed needs cannot be met; the failure of a utility for more than 24 hours; the failure of fire alarms, call systems or other safety-related equipment for more than 24 hours; and other circumstances or events that mean the service cannot, or may not be able to meet service user assessed needs safely.

- Serious injuries to people who use the service which include: injuries that lead to or are likely to lead to permanent damage or damage that lasts or is likely to last more than 28 days; injuries or events leading to psychological harm.

- Where there is any incident relating to a child which the Registered Manager considers to be serious.

These notifications identify the person they are about, by the use of initials only.

2.15.2 Medicines and Healthcare Products Regulatory Agency (MHRA)

Any incident relating to medical equipment should be notified formally to the MHRA using the relevant form supplied by that office.

Managers in those areas affected can report directly to the MHRA at the following address:

Manager
Medicines and Healthcare Products Regulatory Agency
151 Buckingham Palace Road
Victoria
London
SW1 9SZ.
Tel: 020 3080 6000.
Email: info@mhra.gsi.gov.uk.

Incidents relating to adverse drug reactions are reportable on the yellow forms in the British National Formulary (BNF). Reporting can be done electronically via www.yellowcard.gov.uk.

2.15.3 Reporting of Injuries, Diseases and Dangerous Occurrences (RIDDOR 2013)

Under RIDDOR, we have a duty to make reports to the Incident Centre.

The following work-related incidents are reportable:

- Work-related deaths
- Work-related accidents which cause certain specified serious injuries or which result in a worker being incapacitated for more than 7 consecutive days
- Certain dangerous occurrences (near miss accidents)
- Over 7 day injuries to workers
- Injuries to a person who is not at work, such as a member of the public, which are caused by an accident at work and which result in the person being taken to hospital from the site for treatment.

The timeframes for reporting are:

- Death, dangerous occurrence or specified injury – immediately by the quickest and most practical means with online submission within 10 days
- Reports of over 7 day injuries - online submission within 15 days.

Certain occupational diseases, where these are likely to have been caused or made worse by work must also be reported as soon as these are known to us.

Guidance, including timeframes for reporting, can be found on The Loop under Health & Safety/Emergencies/Reportable Incidents.

The Incident Manager will, on receipt of a reportable Incident Report, identify the manager responsible for the Riddor investigation and follow up actions, then monitor and record the progress and results of the investigation. The RIDDOR Investigation Form on IRAR must be completed.

The Health & Safety Manager is responsible for completing online RIDDOR submissions, and informing the Director of Finance / Senior Accountant.

2.15.4 Police

Apparent criminal incidents will, by their nature, be reported to the police. These may include assaults, actual or threat, theft, vandalism, suspicious activity or unexpected deaths.

Section 47 Safeguarding investigations may also be led by the police as deemed appropriate.

An electronic incident form must be completed for all above incidents.

2.15.5 Local Authority Social Workers

The child's local authority social worker will be informed of incidents under the Duty of Candour policy of moderate and report to the LADO.

2.15.6 Commissioners

The child's commissioner will receive anonymised investigation reports of incidents under the Duty of Candour Policy of moderate and above

2.16 Monitoring and Audit

This policy will be monitored by the following indicators:
All moderate and serious clinical incidents will have Duty of Candour disclosures and offers of Duty of Candour meetings.
Any difficulties will be raised at the monthly Clinical Governance meetings or Health & Safety Committee Meetings.

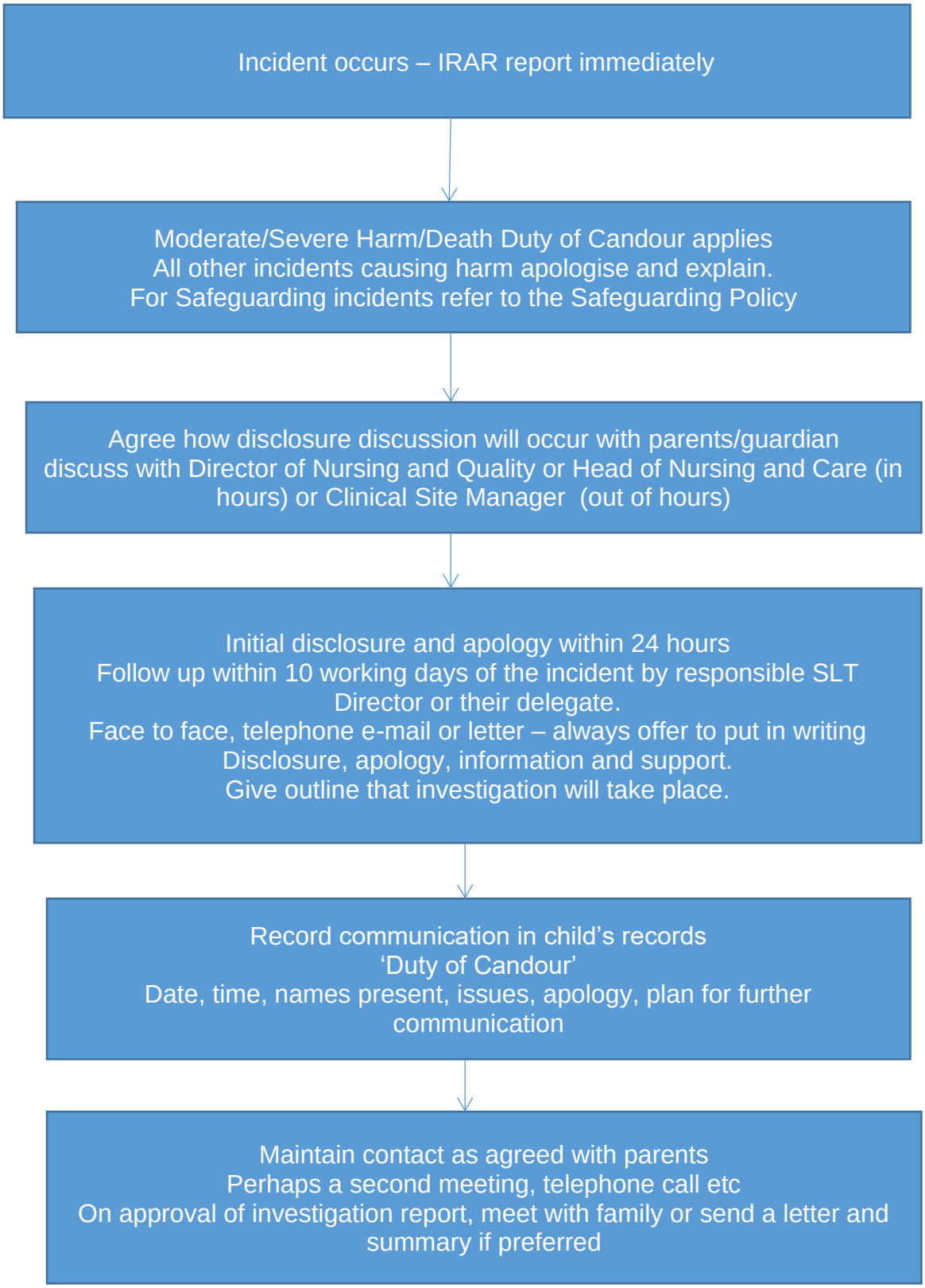
This process will be overseen by the Clinical Governance and Safeguarding Committee reporting to the Board of Trustees.

2.17 Review

This policy will be reviewed at intervals not exceeding 3 years, or more frequently if there is significant statutory policy change.

Appendix 1

Duty of Candour Flow Diagram



Appendix 2

Duty of Candour Time Scales

	Requirement under Duty of Candour	Responsible Person	Timeframe
1.	Child and/or their family must be informed that a suspected or actual incident has occurred (moderate, severe harm or death) Initial notification of incident should be verbal (face to face where possible) unless family decline notification or would prefer e-mail contact. Step by step explanation of the facts (in plain language) must be offered. This may just be an initial view, pending investigation. Sincere expression of apology must be provided verbally. This must be recorded.	Shift Leader, lead therapist or consultant responsible for the episode during which the incident occurred should conduct the initial conversation. Medical Director, Director of Nursing & Quality, Director of Therapies, or Head of Nursing & Care should be informed (in hours) or Clinical Site manager (out of hours) and should conduct the initial DoC conversation once facts established.	Within 24 hours
2.	Follow up should take place verbally (face to face where possible) unless family decline notification or would prefer e-mail/written contact. A written follow up should always be offered and sent unless family decline. Sincere expression of apology must be provided verbally. This must be recorded	Head of House, Nurse Manager, Therapy Lead or Consultant responsible for the episode when the incident occurred. Letter from relevant SLT Director or their delegate.	Maximum 10 working days from incident being reported on IRAR
3.	Maintain full written documentation of any meetings. If meetings are offered but declined this must be recorded	As above	No time frame prescribed but documentation must be contemporaneous
4.	Emerging information (whether during or after investigation) must be offered	As above	As soon as practicable
5.	Investigation process	Appointed investigating officer	Completed within 28 days
6.	Share summary of approved incident investigation report (including action plans). Ensure they are written in plain language.	As above (all investigations are reviewed by the Director of Nursing and Quality or the Medical Director though the Serious Incident review Group)	Within 10 working days of the report being signed off as complete and incident closed

Appendix 3 Rapid Review Report for potential Serious Incident

IRAR Identification Number:	
Date/Time/Location of Incident	
Incident type	Accident/Incident Medication Behavioural Complaint Other
Safeguarding Consideration	
Details of contact with or planned contact patient/family or carers	
Update on patient status	
Immediate actions taken including actions to mitigate any further risk	
Details of other organisations/individuals to be notified or already notified	Date Ofsted informed: Date CQC informed: Date STEIS submitted and STEIS number: Date statutory SW informed:
Details of any police or potential media involvement/interest	
Type of investigation required: *Level 1 (concise), 2 (comprehensive), 3 (independent)*	
Report completed by **Designation** **Date / time report completed**	

Appendix 4 DoC Letter ***(letters should be adapted for the circumstances).***

Dear [name]

I am writing following the conversation you had with *insert name* on *insert date.*

I would like to express my sincere apologies that your son/daughter *insert name* has been involved in an incident – *insert details.*

I would like to assure you that we are taking the incident very seriously and we are undertaking a full investigation in an effort to understand exactly what happened and, once this is completed, we would like the opportunity to discuss our investigation and findings with you.

The initial investigation may take up to 45 working days to complete and there may be a number of actions that come out of the investigation. There may also be additional information that comes to light as the investigation proceeds and we have agree that we will contact you via telephone/e-mail to ensure you are kept informed.

When our investigation is complete we will contact you to arrange a mutually convenient time to discuss our findings. *Insert name of investigator* is leading the investigation and you can contact them on xxxxxxx or by e-mail xxxxxxxx.

If there is anything else you would like to mention to assist us with our investigation please do contact *name of investigator.*

Yours sincerely

Director of Nursing and Quality
T | +44 (0)1737 365 085
@thechildrenstrust.org.uk

Appendix 5 Summary letter

Dear

Further to my letter dated *insert date*, I am writing following the completion of the investigation (known as a Root Cause Analysis) into *(give details of the incident)*. I would also like to thank you for meeting with *insert name* to discuss the findings and recommendations of the investigation.

I and the staff at The Children's Trust are very sorry for any suffering and distress caused as a result of this incident. I wish to assure you that we have conducted a full and thorough investigation and have learnt from the events surrounding *insert child's name.* As a result of the investigation, we have agreed to implement a number of actions, which include:

Insert learning actions

I would like to thank you for bringing this matter to our attention/your assistance with our investigation and once again, apologise for any distress this has caused you and *name of child*.

If you have any further questions please do not hesitate to contact me.

Yours sincerely

Director of Nursing and Quality

T | +44 (0)1737 365 085
@thechildrenstrust.org.uk

Appendix 6 – Stakeholder Engagement Checklist

Review and complete the following checklist to indicate which stakeholders were consulted in the development of this policy.

#	Question	Yes/ No	Stakeholder(s) to be consulted
1	Is there a statutory requirement to have in place this particular policy/ does the policy need to comply with detailed legislation?	Yes	Audit, Risk and Governance team
2	Is implementation of the policy (or any element of it) dependent on the use of new or existing information technology?	No	Head of IT
3	Does implementation of the policy (or any element of it) place any demands on/ or affect the activities of the Estates and Facilities teams (e.g. does it impact the provision or maintenance of premises, equipment, vehicles or other TCT assets)?	No	Head of Estates
4	Does implementation of the policy or any element of it involve/ impact the processing of personal data?	yes	Data Protection Officer
5	Does implementation of the policy require significant unbudgeted operational or capital expenditure?	no	Finance Director
6	Does implementation of the policy (or any element of it) directly or indirectly impact on the delivery of services / activities in other areas of the organisation? E.g. a policy written by a clinical lead in CF&S might impact on the delivery of care for CYP attending the School.	yes	Relevant, impacted OLT members
7	Is there a need to consider Health and Safety or potential environmental impacts in developing and implementing the policy?	No	Health and Safety Manager
8	Have you consulted with a representative of those who will be directly impacted by the policy?	Yes	Critical readers
9	Is there a need to consider Equity, Diversity and Inclusion in developing and implementing the policy?	No	EDI Lead
10	Is there a need to consider sustainability and potential environmental impacts in developing and implementing the policy?	No	Lead for Responsible Organisation
11	Please detail any other stakeholder groups consulted, if applicable.		Critical readers.