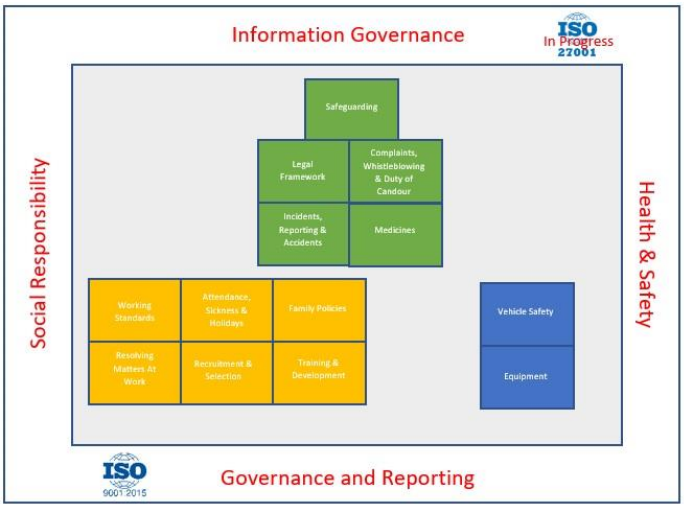
Secure Care UK

Policy Framework

Policy Title: Incidents, Reporting and Accidents (inc PSIRF) V1.7

SECURECARE UK



Approved: Lyndsay Bedford-Briggs Head of Quality & Governance	Last Reviewed Date: 07.12.23
Approved: Matt Jackson Managing Director	Last Reviewed Date:

The Secure Care Policy Framework.

Secure Care UK has a clear policy structure which is managed using our ISO 9001 quality framework. We are keen to ensure that we have a clear and easily understood basis to our policies and where individual topics require documentation and policy consideration, we will attempt to add these sections into our current framework to avoid increasing our number of policies. The benefit of this approach is that we can ensure that the risk of contradictions and confusion is reduced, and we are able to insist that policies are understood by our team. All policies are freely available to all team members on our "Basecamp" internal communication IT platform.

Our policies fall into 4 broad categories as shown in the diagram below.

Overarching Policies

We have four overarching policies which we see as the crucial "bedrock" of what we do, these are the Information Governance Policy which includes compliance with NHS Data Protection and Anti-Fraud requirements, Our Health and Safety Policy (H&S), our Governance and Quality (ISO 9001) Framework and our Social Responsibility Policy which includes Environmental considerations. These four overarching policies are shown in the large triangle as they surround and control all other policies.

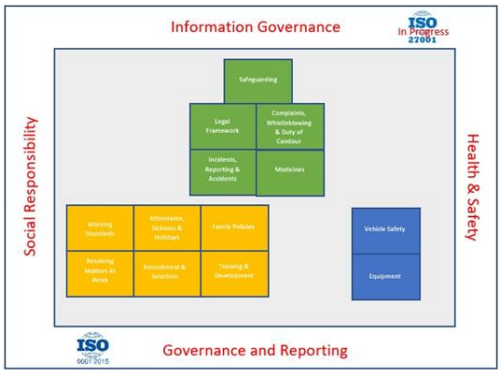
People, Resources and Clinical Policies

We have three groups of important detailed policies covering the three topic areas above. These three policy categories are strongly influenced by our Overarching Policies above (IG, H&S, GRF, SR) which are all considered in detail in the writing and ongoing development of all People, Resource and Clinical Policies. Our Clinical Policies layout how we embrace the rules and guidelines required by our regulating bodies. Our People Policies are consolidated into our Employee Handbook.

Standard Operating Procedure Policies

Our final two policies describe how we practically deliver our service to our patients and clients these are our Operations Management and Patient Safety and Care Policies. These describe the practical application of our care on a day-to-day basis. These policies incorporate our ISO 9001 Process which are our 14 Standard Operating Procedures

This **Incidents, Reporting, PSIRF and Accidents** Policy is one of our clinical policies which are designed to ensure our values and legal requirements are embedded in our processes.



Document Control

Date	Version	Comments
01.09.2020	V1.1	Annual Policy Review
22.12.2020	V1.2	Policy Framework updated
17.11.2021	V1.3	Policy review
28/06/22	V1.4	Removal of complaints, addition of incident reporting
07.12.22	V1.5	Policy review
15/09/2023	V1.6	Policy amendment in line with new incident process and PSIRF
15/11/2023	V1.6	Policy review in line with calendar, no amendments, as last update was 2 months ago previous version number maintained
07.12.23	V1.7	Policy rewrite for PSIRF

Review Control

Reviewer	Section	Comments	Date
Lyndsay Bedford-Briggs	3	Quality Manager replaces Managing Director	01.09.20
Lyndsay Bedford-Briggs	8.8 and 8.10	Details of IRC	01.09.20
Lyndsay Bedford-Briggs	8 & 9	Updated language to reflect organisational changes	17.11.21
James Harry & Martin McCann	7-8	Addition of Incidents and incident reporting process	06.06.22
James Harry	7,8,9,12, appendix 1, appendix 2	Update of policy in line with new incident management process and PSIRF (removal of SI)	15/09/2023
Lyndsay Bedford	All	Policy rewrite for PSIRF	07.12.23

Contents

Purpose

The purpose of the policy is to establish the standards for the management of investigations into Incidents and Accidents and to distribute responsibility for their achievement to all managers, supervisors, and other employees through the normal line management processes. Secure Care is committed to continually learning and improving its policies, training and standard operating processes based on the accurate recording of fact and the effective analysis of issues.

This policy supports the requirements of the Patient Safety Incident Response Framework (PSIRF) (NHS England's Patient Safety Incident Response Framework (PSIRF).) and sets out Secure Care UK's approach to developing and maintaining effective systems and processes for responding to patient safety incidents and issues for the purpose of learning and improving patient safety.

The PSIRF advocates a co-ordinated and data-driven response to patient safety incidents. It embeds patient safety incident response within a wider system of improvement and prompts a significant cultural shift towards systematic patient safety management.

This policy supports development and maintenance of an effective patient safety incident response system that integrates the four key aims of the PSIRF:

- compassionate engagement and involvement of those affected by patient safety incidents
- application of a range of system-based approaches to learning from patient safety incidents
- considered and proportionate responses to patient safety incidents and safety issues
- supportive oversight focused on strengthening response system functioning and improvement.

Scope

The scope of this policy will cover all the business activities undertaken by Secure Care UK including the management of supplier and sub-contracting relationships. This policy applies to all employees within the organisation and identifies where particular responsibilities are assigned to members of the management structure.

Responses under this policy follow a systems-based approach. This recognises that patient safety is an emergent property of the healthcare system: that is, safety is provided by interactions between components and not from a single component. Responses do not take a 'person-focused' approach where the actions or inactions of people, or 'human error', are stated as the cause of an incident.

There is no remit to apportion blame or determine liability, preventability, or cause of death in a response conducted for the purpose of learning and improvement. Other processes, such as claims handling, human resources investigations into employment concerns, professional standards investigations, coronial inquests, and criminal investigations, exist for that purpose. The principle aims of each of these responses differ from those of a patient safety response and are outside the scope of this policy.

Information from a patient safety response process can be shared with those leading other types of responses, but other processes should not influence the remit of a patient safety incident response.

Safeguarding will remain it's own separate process which can be found in Secure Care UK Safeguarding Policy.

Definitions

- PSIRF – Patient Safety Incident Response Framework
- PSIRP – Patient Safety Incident Response Plan
- ROC – Review of Care
- SCAAR – Secure Care After Action Review
- PSII – Patient Safety Incident Investigation
- SCSM – Secure Care Scoping Meeting
- SOP's – Standard Operating Procedures
- PCR – Patient Care Record
- PCE – Patient Care Episode
- SCIPS – Secure Care Integrated Patient System
- DOC – Duty of Candour
- RCOM – Regional Care Operations Manager
- COM- Care Operations Manager
- DCOM – Deputy Care Operations Manager
- CLM – Client Liaison Manager
- MD – Managing Director
- SDM- Service Development Manager
- SOM – Shift Operations Manager
- TL – Team Leader
- ICB – Integrated Care Board
- LFPSE – Learning From Patient Safety Events
- LeDeR – Learning Disabilities Mortality Review

Related Documents

This policy should be read in conjunction with the following documents:

- Secure Care UK Employee Handbook
- Secure Care UK Code of Conduct
- NHS England's Patient Safety Incident Response Framework (PSIRF).
- NHS England Engaging and involving patients, families and staff following a patient safety incident
- NHS England: Guide to Responding Proportionately to Patient Safety Incidents
- NHS England: Oversight and Responsibility
- NHS England: Patient Safety Incident Response Standards
- NHS England Never Events policy and framework
- NHS England Never Events list 2018 (updated 2021)
- Secure Care UK – Patient Safety Incident Response Plan
- Secure Care UK Safeguarding Policy
- Secure Care UK Working Standards Policy

Oversight Roles and Responsibilities

It is the responsibility of the Head of Quality & Governance to review this document and to recommend its approval to the board.

It is the responsibility of all employees with any management responsibilities to ensure that the requirements of this policy are communicated, trained and, where necessary, enforced.

It is the responsibility of all employees at Secure Care to follow this policy.

Oversight of Patient Safety Responses will take a range of formats. Initially the policy standards will be under the oversight of the Board of Secure Care UK, this will be delivered through a quarterly report to the Board:

• The arrangements to align patient safety response to quality improvement. This component will be delivered through the functions of the Patient Safety Panel and Safeguarding Panel and will be clearly visible in the development of ISO Quality Objectives.

• The progress made towards just and learning culture ensuring that appropriate and proportionate responses are maintained for those staff involved in patient safety incidents.

• Effective information sharing for joint working in relation to patient safety learning.

• The governance and reporting structures, along with the process to ensure all staff, patients and public are supported to engage and are treated with dignity and respect supporting openness and transparency

The oversight of the patient safety incident response plan and delivery of patient safety incident responses will be led, internally by the Quality Team. This oversight will primarily be delivered through the Governance Structure. This will include:

• Collaborative stakeholder engagement via the Patient Safety Panel, Safeguarding Panel, and external client reporting.

• Clarity on leadership for each response, including the skill set of the leads.

• Clarity on the Engagement Lead support provided to those effected by the patient safety incidents.

• The alignment of the learning from responses and the ISO quality objectives and themes within Secure Care UK. Oversight of individual patient safety responses will be completed through the Governance Team to seek assurance that adequate investigation, learning and action planning has taken place to allow quality improvement. In addition to the Patient Safety Panel, all PSIIs will be reviewed and approved as complete via Secure Care UK Governance Team.

Our Patient Safety Culture

Secure Care UK have in place a series of values and competencies that all staff are expected to always adhere to, these are navigated towards a patient centred, open and transparent culture. Appendix 1 shows our Vision, Values and CARE Competencies.

Secure Care UK strive to operate a 'Just and Learning culture' that facilitates continuous learning, creates psychological safety; supports staff to raise and address concerns, and focuses upon good practice that is shared and replicated within and beyond organisational boundaries.

Patient safety culture is at the heart of PSIRF and SCUK organisational values. With regards to culture and delivery of the PSIRF, evidence of a patient safety culture will be provided through a low threshold for reporting incidents and escalating concerns allowing the greatest range of learning opportunities. This process will sit alongside our Whistleblowing and Freedom To Speak Up Guardian. This culture requires a fundamental level of psychological safety that is driven through the just and learning culture priority. Alongside the opportunities to learn from incidents, SCUK are committed to learning from excellence and doing this through the reporting of excellence and reflecting on opportunities to make care currently considered as excellence, the future standard care within Secure Care UK.

Training and Induction

The importance and expectations for incident reporting are set out from the induction training all operational staff receive. This is a comprehensive package and addressed both the legal requirements as well as the positive impact on patient centred care.

Incident Reporting

We have structured our incident reporting system to be learning focussed. The key aspect is the identification of learning is sought at every opportunity throughout the reporting and review process.

The Cloud Apps incident management system allows for after action reviews, review of care and other associated documents and actions to be held and managed centrally.

Feedback is identified as being a key component in encouraging staff to routinely report all incidents.

To provide assurance in the incident reporting, weekly dip samples of PCE's are conducted and audited to ensure the fullness of their completion and missed reportable incidents from the patient care notes.

Operational leadership conduct regular spot checks on staff. These are not designed to catch anyone out or to be a punitive measure but allow us to understand the work as done, and to provide real time support and guidance to the patient facing colleagues.

The care operation managers who predominantly complete the review of care where required are led by the PSIRF approach and systems thinking to ensure that staff involved see first-hand the blameless way in which we respond. This 1st hand experience of the process is another important method as peer-to-peer learning is impactful.

To ensure that our learning approach reaches all parties both internally and externally, we will also be producing a quarterly learning newsletter to highlight how we have responded and learnt from incidents being reported.

BILD and Restraint Reduction

We are accredited through BILD under the restraint reduction network for our training programme. As an organisation we are committed to the standards set out with the RRN, these standards acknowledge the impact that restraint has on the individuals care journey.

A final component in the patient safety culture across Secure Care UK is that of compassion, understanding and engagement of those effected by patient safety incidents. This includes patients, their families, and our staff. This also includes staff working with external partners as most of the care

we undertake is in collaboration with Trusts, ICB's, care providers. The engagement lead role is vital in driving the improvements for patient and families; however, this approach will also be adopted by all staff.

Patient Safety Partners

As a smaller provider for a relatively niche service provision, we assessed our historical data to gauge how many potential patient safety incidents would have been triggered. With this being a low level and the principles of PSIRF being proportionality we did not engage patient safety partners at the initial point of drafting our policy or PSIRP. With the nature of our services meaning that we do not have ongoing access to patients, we rely on our contractors (NHS Trusts and ICB's) to support with patient engagement where required. Incidents and patient feedback that have been received during historical investigations informed our planned response under the new framework.

We have engaged with various trusts for whom we provide services to ensure partnership working throughout the various aspects of the PSIRF framework and will continue to engage the trusts and ICB's where links to patient safety partners, patients and their families is required.

Addressing Health Inequalities

Secure Care UK have a national footprint and, as such, care for patients from numerous demographics and ethnicity. Our Equality, Diversity and Inclusivity Policy, located within our Working Standards Policy provides more context on this. In addition, we have a 'bitesize' training session for Equality, Diversity and Inclusion and a Code of Conduct. We monitor our workforce against the NHS Workforce Race Equality Standard and, by employing a diverse workforce, we can address the needs of individuals from all backgrounds.

We are committed to delivering high-quality and equitable patient care, with a strong focus on reducing health inequalities. This section outlines the organisation's dedication to addressing disparities and ensuring the safety and well-being of all patients within the context of secure mental health transport. We recognise that individuals sectioned under the Mental Health Act may have unique needs and characteristics that require tailored attention to promote health equality.

Data-Informed Approach

We understand the importance of applying a flexible approach to patient safety incident response. Our commitment to health equality is reflected in the intelligent use of data to identify and address any disproportionate risk to patients with specific characteristics. We continually analyse patient safety incident data to recognise patterns and trends that may affect different patient groups. This information informs our patient safety incident response strategies, ensuring that we address disparities effectively.

Development and Maintenance of Policy

Secure Care UK takes a proactive stance in exploring and responding to issues related to health inequalities. Our patient safety incident response policy and plans are developed and maintained with a dedicated focus on reducing disparities. We continually assess and update these policies to align with best practices in health equality and patient safety.

Tools and Safety Actions

Our tools for responding to patient safety incidents are designed to prompt consideration of inequalities. We recognise the importance of tailored safety actions that address the unique needs of our patients. This includes interventions to support health equality and reduce disparities among individuals in our care.

System-Based Approach

We uphold a system-based approach rather than a 'person-focused' approach in our patient safety incident response. This approach emphasises the importance of understanding the broader system in which incidents occur and seeks to reduce the focus on individual blame. To support this approach, our staff undergo relevant training and skill development, which equips them to participate in the development of a just culture. This training not only reduces the ethnicity disparity in rates of disciplinary actions across our workforce but also fosters a more inclusive and equitable working environment. We ensure that our response to incidents is sensitive to the individual and cultural differences that may exist.

Engaging and involving patients, families and staff following a patient safety incident

The PSIRF recognises that learning and improvement following a patient safety incident can only be achieved if supportive systems and processes are in place. It supports the development of an effective patient safety incident response system that prioritises compassionate engagement and involvement of those affected by patient safety incidents (including patients, families, and staff). This involves working with those affected by patient safety incidents to understand and answer any questions they have in relation to the incident and signpost them to support as required.

Secure Care UK is committed to engaging and involving patients, their families, and staff following a patient safety incident while considering their diverse needs. We actively seek input from patients and their families to better understand their experiences and perspectives. As we are only involved with patients for a very short period, usually whilst they are in crisis and transition between settings, this is predominantly done by seeking advice and support from the professional in charge of the patients care to ensure they are well enough to engage with. We strive to have the voice of the patient heard throughout our review process.

Duty of Candour

One of SCUK's core values is transparency, within which sits Duty of Candour. We aim to discharge duty of candour at every opportunity. Detail of this can be found in the Whistleblowing and Duty of Candour Policy.

Patient Safety Incident Response Planning

PSIRF supports organisations to respond to incidents and safety issues in a way that maximises learning and improvement, rather than basing responses on arbitrary and subjective definitions of harm.

Owing to the specific nature of the non-clinical care we provide; our patient safety incidents are predominantly owing to a patient's risk behaviours. Our care is undertaken collaboratively with clinical staff working for NHS trusts and other care organisations and as such our response will be closely linked to their approaches and views. Figure 1 depicts our process for recording, triaging, and

responding to incidents. Appendix 2 shows the Terms of Reference for this same process in more detail. Appendix 3 shows our Risk Assessment Framework on which we determine next steps following an incident.

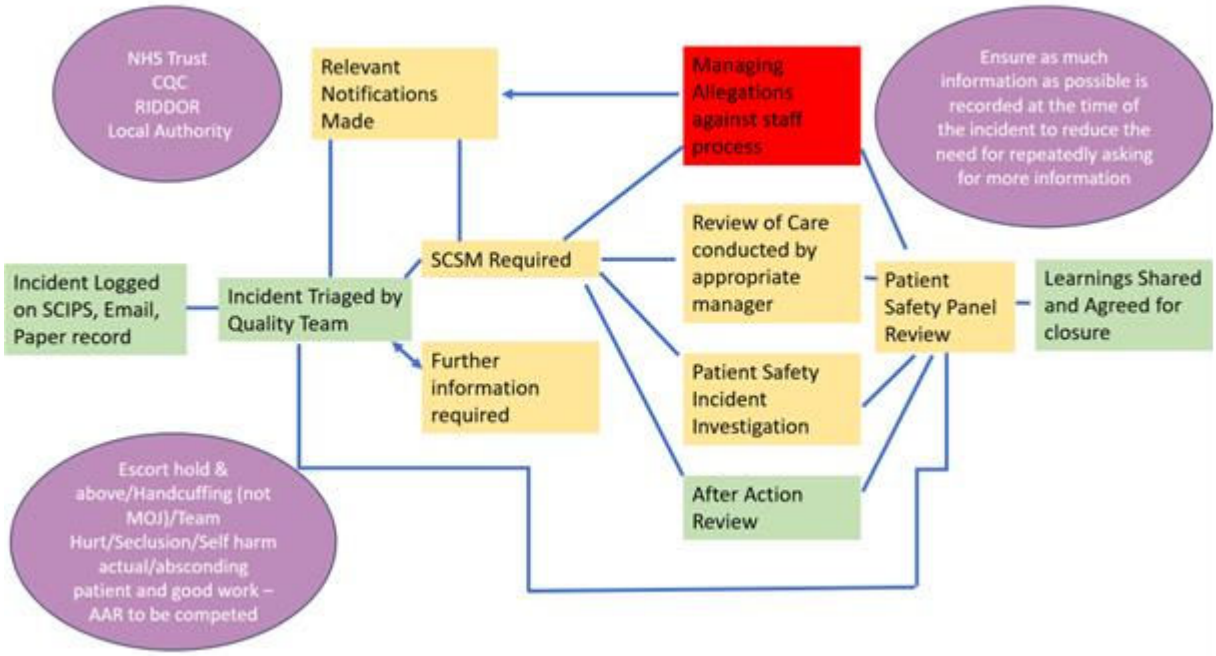


Figure 1 Secure Care UK Incident Process

Resources to Support Patient Safety Incident Support

To allow effective learning from Patient Safety Incidents and ensure actions leading to sustainable improvements it is important to ensure those involved in the responses have adequate capacity and competency.

Secure Care UK's Patient Safety Incident Responses will contain the following and all will be undertaken in line with the latest NHS England guidance:

Secure Care Scoping Meeting – SCSM

The concept of the scoping meeting is that when an incident occurs that is likely to require a level of review, partner agency involvement or has been identified as a patient safety incident response priority within the PSIRP, a panel will meet to discuss the incident and agree further steps. The meeting may be triggered by any DCOM, COM or member of the leadership team when they believe they have identified an incident that meets the criteria. The SCSM ensures that incident responses remain proportionate and remove a single point of failure for identifying actions.

After Action Review – AAR

An After-Action Review is a method of evaluation that is used when outcomes of an activity or event, have been particularly successful or unsuccessful. It aims to capture learning from these tasks to avoid

failure and promote success for the future. Reflection and a learning culture are core to improvement, the minimum expectations for AAR completion are set out in Appendix 3.

Review of Care - ROC

The review of care (previously known as investigation) is designed to apply a systems approach to learning from incidents. Unlike the PSII this may be undertaken for any incidents that occur. The purpose is to be clear about what went wrong with the care of the patient, avoiding blame, to minimise the likelihood or reoccurrence and recommend improvements that can be made.

Patient Safety Incident Investigation – PSII

A patient safety incident investigation is undertaken when an incident or near-miss indicates significant patient safety risks and potential for new learning. Investigations explore decisions or actions as they relate to the situation. The method is based on the premise that actions or decisions are consequences, not causes, and is guided by the principle that people are well intentioned and strive to do the best they can. The goal is to understand why an action and/or decision was deemed appropriate by those involved at the time.

Systems Based Approach Using SEIPS

This principle is core to all the responses and seeks to understand that we work in systems all the time. Health and social care organisations are complex adaptive systems:

- Systems in the sense that there is coordinated action towards some purpose.
- Complex in the sense that there are many and varied relationships among parts of the systems, making detailed behaviour hard to predict.
- Adaptive in the sense that people who make up the systems can change and evolve in response to new conditions in the environment. SEIPS is a framework for understanding outcomes within complex socio-technical systems.

Our Patient Safety Incident Response Plan

Our full PSIRP outlines our methodology for determine our Patient Safety Incident Response Priorities and how we intend to respond to incidents.

From the three years of incident data, accidents, and complaints, figure 2 shows our five key priorities and the rationale. Due to the unpredictability of the patients, we care for, we will have to determine the appropriate response based on the learning potential and outcomes of each incident, using the matrix in Appendix 3. This means that the response may be an AAR, SCSM, ROC or full PSII. In addition, we will seek to work with partner organisations where joint learning opportunities are presented.

Key Theme	Key Risks from Activity
Use of non-standard restraint	Although there have not been any significant incidents involving the use of non-standard restraint, we acknowledge that this is a high-risk area for our patients. The use of non-standard restraint holds risk to the patient in that the methods used may result in serious injury or harm. Whilst we recognise that our staff have the right to protect their own life and limb, and that in the most extreme circumstances the use of a non-standard restraint may be the only available option, all uses of these restraints require a robust review in line with PSIRF.
Team Hurt	Team hurt, although not directly affecting patient safety holds vicarious impact on patient safety. Our staffing is provided to ensure the safe care of a patient and when a staff member is injured the affects the ability to intervene with risk behaviours.
The use of Positive Handling	Whilst the use of positive handling, including the use of mechanical restraint, is recognised, can be necessary within the environment that our staff operate, and the use of restrictive intervention holds an inherit risk. The use of this intervention is predominantly to prevent risk behaviours (such as violence or self-harming behaviour) by the patient which could lead to a more substantial patient safety incident.
Self-Harm	Owing to the specialist service that SCUK provide e encounter patients who exhibit self-harming behaviours on a regular basis. As in theme 4 staff are trained in the use of PMVA and can use this to attempt to prevent such behaviours. However, the nature of harm can mean that acts are performed before physical intervention can be taken, and in line with our requirements under the RRN the use of physical intervention must be 'last resort'. We recorded 2 incident types around this, 'self-harm' attempt' and 'self-harm actual'. When the patient has achieved harm, we must seek to understand the factors that led to this incident.
Absconding Patient	The patients we provide service to are predominantly detained for a legal perspective, as such they have restrictions as to where they may go. On the occasions where a patient manages to abscond from our team there is a risk to that person's safety and potential risk to others. SCUK staff as mentioned above are trained in the use of physical intervention to prevent the absconding and in the cases that this is not successful, we seek to understand why, the potential risk and the actual risk, to ensure appropriate learning.

Figure 2 SCUK Patient Safety Incident Priorities

All incidents will be recorded and managed as per Appendix 2, meaning that incidents which fall outside of these priorities will still be reviewed and given due diligence. In accordance with our BILD/RRN accreditation, we monitor all episodes of restraint and produce data around the usage.

Colleagues record incidents, initially, on SCIPS, Figure 3 shows the incident categories available. There are four incident types which we have identified may require immediate response, and as such, when a team member presses the incident on SCIPS, a text alert is sent to the leadership team. These categories are:

Team Hurt

Self-Harm Actual

Absconding Patient

Safeguarding.

Clinical Support - Crew	Clinical Support - Patient check	Patient Secluded - Clinically led
Attempted Absconsion	Immobilisation - Above Escort Hold	Environment
Hinged Cuffs Used - Unplanned	IT Systems Failure	Other (describe in background)
Soft Cuffs Used – Unplanned	Vehicle accident	Safeguarding
Absconding Patient	Unplanned use of vehicle cell	GDPR
Healthcare Prof Issue	Patient Hurt	Missing/Incorrect Documentation
Infection Control	Self-Harm Actual	
Team Hurt	Self-Harm Attempt	

Figure 3 SCUK Incident Categories

Reviewing our patient safety incident response plan

Our patient safety incident response plan is a 'living document' that will be appropriately amended and updated as we use it to respond to patient safety incidents. We will review the plan every 18 to 24 months to ensure our focus remains up to date; with ongoing improvement work our patient safety incident profile is likely to change. This will also provide an opportunity to re-engage with stakeholders to discuss and agree any changes made in the previous 18 to 24 months. The rationale for our timescale being slightly longer than NHS services is due to the number of patient safety incidents we have had over the preceding three years being low. As we continue to monitor patient safety through our governance processes, any increases or changes will be highlighted, and the priorities reviewed as appropriate.

Responding to patient safety incidents

Patient safety incident response arrangements

Secure Care UK has a rigorous framework in place for the recording, reporting, triaging an response to incidents. These include our own bespoke patient care record application where team members make regular notes regarding patient care, including incidents and episodes of restraints. In addition, we have a 24/7 monitored Incident Review Committee mailbox where staff can email incidents. All patient data is kept secure and when communicating with the mailbox, the SCUK reference number is used instead of patient identifiable information.

All incidents are reviewed daily by the COM and uploaded to our incident management system, where they are then triaged by the Quality Team.

Learning responses will be led by either our SOMs who are at the forefront of central operations within our National Care Operations Centre and, as such, available remotely to support any immediate actions. Our Quality Team will also be the Learnings Response Leads. In addition, both the Quality Team and the SOMs, will be trained to be Engagement Leads.

Patient Safety incident response decision making

All incidents logged via SCIPS will be triaged by the Quality Team and the response determined as per the matrix in Appendix 3.

Responding to cross-system incidents/issues

Due to the nature of our service, we are always providing care in conjunction with a clinician from another service (NHS or Private sector) and we hold several contracts with ICB's across the UK. Where there are incidents that hold significant joint learnings, a collaborative approach will be taken. SCUK also produce quarterly reports to the ICB's where data, incident information, safeguarding information and learnings are reported and discussed at a quarterly review meeting.

Timeframes for learning responses

All incidents will be triaged within 48 hours of being recorded and an appropriate response assigned. As an organisation, we are championing after actions reviews being undertaken following any incident or positive learning experience as a way of embedding reflective practice and facilitating our ambition to become a learning organisation. As such, we will support Team Leaders, DCOM's and our MHTA's to become comfortable and proficient in completing these regularly. It will be the responsibility of the COM's, with support from the Quality Team, to identify any themes or escalate/share any examples of good practice and learnings.

Review of care's will be aimed to be completed within thirty days of reporting, whereas larger scale PSII's will naturally be given a longer timescale as will likely involve more participants. These timelines are guidance and as such, cannot accommodate for unforeseen events. This will be considered on a case-by-case basis.

Safety action development and monitoring improvement

Through the investigation process areas for improvement will be defined. Following the areas for improvement, safety actions will be developed to address each of these. When developing the safety actions a quality improvement methodology will be utilised to ensure the actions are; clearly defined, describe responsibilities and timescales, aligned to reportable outcome measures, and include a detailed assurance / monitoring process. We will utilise the software, Asana to undertake these projects.

Complaints and appeals.

Please see Secure Care UK Complaints and Whistleblowing Policy for details of our complaints process. All complaints will follow the guidelines set out within.

Links to other processes

This policy describes how Secure Care UK will manage and respond to patient safety incidents, including how it plans its response activities for the purpose of improving patient safety and how it engages with those affected. This policy and the response activities it supports explicitly exclude activities that apportion blame or determine culpability, determine preventability, or identify cause of death. Some patient safety incidents may also require a separate response that is not focused on learning for patient safety improvement. For example, some incidents where a patient dies may be subject to investigation by a coroner to determine how, when and where they died, or LeDeR. Others may involve the police where there is a reason to think criminal activity may have taken place. Some

incidents will lead to concerns about an individual's fitness to practise or ability to do their job, and so may be considered through HR processes or a professional regulator/external body. Where a response is required that is not focused on learning for patient safety improvement, relevant referrals will be made to ensure it is conducted entirely separately. Care must be taken not to conflate and combine patient safety incident response activity with other remits.

Never Events

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.

NHS England have produced an evidence-based list of Never Events that must be reported. At the present time, none of these Never Events are applicable to SCUK due to the nature of the service we provide. This will be reviewed for changes and amendments to the policy as applicable.

Accidents

- Secure Care's approach to Accidents is directed by our Health and Safety Policy.
- Secure Care believes that the effective analysis and investigation of accidents enables learning and improves processes and procedures thereby making our business safer.
- All accidents need to be reported via the Online Accident Book and updated by a member of management (TL role upwards)
- The system allows for specific and related updates, statements and photographic evidence to support the incident or accident.
- Colleague welfare calls can be logged to assist in the wellbeing and return of injured colleagues and are the initial responsibility of the colleague's line manager.
- The following timeline will be applied to all accidents.
- All accidents will be logged onto the Online Accident Book within 24 hours of occurrence. The Quality Manager and any relevant managers with review all accidents to determine if a RIDDOR report is required as per our Health and Safety Policy
- Following a full investigation, the conclusion(s) from any accident will be reported to the next Governance Board
- The adherence to these timeline commitments will be measured and reported to the Board via the Governance Board

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Appendix 1 – Secure Care UK Vision, Values and CARE Competencies

Vision

Improve the lives of vulnerable patients by providing safe and responsive mental health care

Our Values

P	**Patient First:** Make it happen, positively promote, professional, effective
R	**Respectful:** Diversity, build relationships, integrity, fairness & dignity
O	**Openness:** Positive communication, support, honest & willing
U	**United:** Team work, consistency, selfless, trust, credibility, collaboration
D	**Determined:** to develop self & others, continual improvement, adapting to change, availability

Appendix 2 – SCUK Terms of Reference for Incident Management

Introduction

At Secure Care UK we are dedicated to providing the highest quality of patient care. As such responding to incidents is a pivotal factor in supporting the safe and conscientious care of those who use our service. The introduction of the Patient Safety Incident Response Framework introduces different approaches to incidents with the intent of making the process more inclusive and centered around improvement and learning. The process for incident management will reflect the PSIRF approach and will consider organisational changes, including the introduction of the CloudApps incident management software. The response we provide to reported incidents also recognises the Health & Social Care Act 2008 (Regulated Activities) Regulations 2014.

Process

1. Incidents will be logged by staff using either SCIPS or via the IRC email address where necessary. Following an incident, the DCOM/TL on shift should facilitate the AAR

2. The COM/CLM/DCOM who has responsibility for the hub area will complete a daily review of incidents reported in the last 24 hours (or since the last review to account for weekends/rest days). They will upload all incidents CloudApps system (all incidents occurring on a PCE will be uploaded to 1 entry)

3. The Quality Team will perform a daily (Monday – Friday) triage of all incidents uploaded to CloudApps. At this point an incident that have not been recorded in the correct category will be recategorized.

4. The Quality Team will define required actions for the submissions, this will include:

- Requests for further information
- Request for an SCAAR (if not already completed)
- Request for DOC to be completed

- Request for a Review of Care
- Request for a PSII
- Request for a SCSM (this may include an invite to partner agencies such as the ICB)
- Agreed for closure of the incident

The actions will be assigned using the CloudApps system.

5. The RCOM will be responsible for a weekly review of the outstanding actions to their COM/CLM/DCOM to ensure responsiveness. This may be supported by a quality dashboard for increased oversight.

6. A monthly Patient Safety Panel will be held using Microsoft Teams, this will be held on the Friday before the Governance Meeting (the Governance Meeting is held on the second Tuesday of each month). This meeting will be attended by

- Quality Team
- RCOM
- COM/CLM
- RCOM (for areas where there is no COM/CLM and the RCOM provides this function)
- SDM
- SOM
- HR
- The MD will have an open invite to attend these meetings but is not required attendee

This meeting is for the oversight of all learnings identified, updates on any Review of Care that are being undertaken and any interagency communications (such as those for clinical support incidents). The COM/CLM/DCOM will be responsible for presenting and overview of their incidents, themes/trends and all identified learnings. The meeting will also ensure that use of restraint is monitored in line with our RRN (BILD) requirements.

7. Following the Patient Safety Panel, the Quality Team will upload any agreed incidents to the LFPSE system, this will also be in line with our PSIRF requirements

8. Reporting from the Patient Safety Panel will go to the Governance Meeting, Board Meeting and be included in Quarterly Contract Reports as locally agreed

Roles and Responsibilities

All Staff

- Reporting of Incidents
- Responding to requests relating to incidents in the required timeframe given

TL/DCOM/COM/CLM

- Ensuring the completion of AAR's
- Gathering requested information from staff in the required timeframe
- Responding to requests relating to the incident process in the required timeframe

DCOM (where no COM/CLM)/COM/CLM

- Review and upload all incidents to CloudApps (daily Monday - Friday)
- Identify Learning (recorded on CloudApps)
- Completion of Review of Care where requested
- Present incident information to the monthly patient safety panel
- Response in the allocated timeframe to any requests in relation to incident management
- Support in sharing learning
- Support in any changes as a result of learning

RCOM

- Perform a weekly review of all outstanding actions and requests for their hubs
- Attend the monthly patient safety panel
- Provide support to their COM/CLM/DCOM responsible for their hubs where required
- Support in identifying learning
- Support in sharing learning
- Support in any changes as a result of learning

Quality Team

- Triage all incidents submitted on CloudApps (daily)
- Allocate any required actions
- Chair the monthly patient safety panel
- Provide reports to the Governance, Board and quarterly reports as locally agreed
- Support in identifying learning
- Support in sharing learning
- Support in any change as a result of learning

SDM/SOM/HR

- Attend the monthly patient safety panel
- Support in identifying learning
- Support in sharing learning

- Support in any changes as a result of learning
- RRN (BILD) restraint monitoring requirements

Board

- Oversight of high level activities
- Engage in any organisational change as a result of learning

Review

The incident process will be subject to audit and review in line with our calendar of required activities set out within our ISO 9001:2015 framework.

Appendix 3 – Secure Care UK Incident Triage and Grading

Likelihood of occurrence

Level	Descriptor	Description
5	Almost Certain	Likely to occur on many occasions, a persistent issue
4	Likely	Will Probably occur but is not a persistent issue
3	Possible	May occur occasionally
2	Unlikely	Do not expect it to happen but it is possible
1	Rare	Can't believe this will ever happen

Severity of Outcome

Level	Descriptor	Actual or Potential Impact on person	Actual or Potential Impact on Organisation
5	Catastrophic	Death	National adverse publicity. Investigation. Litigation expected/certain
4	Major	Permanent Injury (e.g. RIDDOR reportable injury / illness)	RIDDOR reportable Long-term sickness. Litigation expected/certain.
3	Moderate	Semi-Permanent injury / damage (e.g. injuries that take up to 1 year t0 resolve or requires rehabilitation)	Litigation possible but not certain. High potential for complaint
2	Minor	Short-Term injury / damage (e.g. injury that has been resolved within 1 month or short term sickness)	Minimal risk to organisation. Litigation unlikely. Complaint possible
1	Insignificant	No injury or adverse outcome	No risk at all to organisation. Unlikely to cause complaint. Litigation risk remote.

Matrix for Scoring

Likelihood	Severity				
	1 Insignificant	2 Minor	3 Moderate	4 Major	5 Catastrophic
1. Rare	1	2	3	4	5
2. Unlikely	2	4	6	8	10
3. Possible	3	6	9	12	15
4. Likely	4	8	12	16	20
5. Almost Certain	5	10	15	20	25

Organisational Action

No Immediate Action	Action within 12 Months	Urgent Action

Likely Triage Response

Severity	Likelihood	Likely Response
1	1	AAR
2	1	AAR
3	1	ROC / PSII
4	1	PSII
5	1	PSII
1	2	AAR
2	2	AAR
3	2	ROC / PSII
4	2	PSII
5	2	PSII
1	3	AAR
2	3	AAR
3	3	ROC / PSII
4	3	PSII
5	3	PSII
1	4	Closed
2	4	AAR
3	4	ROC / PSII
4	4	PSII
5	4	PSII
1	5	Closed
2	5	AAR
3	5	ROC / PSII
4	5	PSII
5	5	PSII

Incident Categories **Requiring** SCAAR

- Examples of good work
- Restraint EH or Above
- Handcuffs (unplanned)
- Team Hurt
- Seclusion
- Self-Harm Actual
- Absconding Patient