### Name of Guidance

Serious Incidents; reporting of trainee involvement, and investigation - the role of Health Education England in Yorkshire and the Humber

### Category

| Quality Management |
| Patient Safety |

### Authorised by

Postgraduate Dean’s Senior Management Team

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### Document Author

David Eadington, Deputy Postgraduate Dean

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### Related Document (hyperlink)

- [National Framework for Reporting and Learning from Serious Incidents requiring investigation](#)
Section 1: Introduction

Proper investigation of clinical incidents is an essential part of maintaining patient safety. A survey of Yorkshire and Humber trainees in 2011 showed that:

- many have been involved in a serious clinical incident during their training
- most have incomplete understanding of the investigation processes following clinical incidents
- very few understand the changing role of the Deanery/HEYH in this area
- attitudes and support behaviours exhibited by colleagues after serious incidents vary
- the overall experience is often negative

This guidance is written to fill some of these gaps and to explain the role of Health Education England working across Yorkshire and the Humber (HEE YH) in managing trainees who are involved in serious clinical incidents. More detailed background material is given in the National Framework for Reporting and Learning from Serious Incidents requiring investigation.

Every Trust has a public policy on how it will manage clinical incidents; these documents are available via Trust’s local internet pages.

Section 2: Who does this guidance apply to

- Trainee medical staff working across Yorkshire and the Humber
- Educational and clinical supervisors employed across Yorkshire and the Humber
- HEE YH Staff

Section 3: Definitions and abbreviations used throughout the document

- ARCP – Annual Review of Competency Progression
- GMC – General Medical Council
- HCAI – Healthcare Associated Infections
- HEE YH – Health Education England working across Yorkshire and the Humber
- MRSA – Methicillin-resistant Staphylococcus Aureus
- SI – Serious Incident

Section 4: Roles and responsibilities of the users

Trainees may be cited in serious incidents (SI's) at any time in their careers. They have a responsibility to inform their supervisors at the time of the event.

Educational and Clinical Supervisors are required to escalate detailed information on trainee involvement in SI’s to their Trust based Director of Medical Education for HEE YH records. HEE YH is responsible for retaining SI information on file.

Section 5: Monitoring and compliance

This guideline will be reviewed every 3 years by the Postgraduate Dean's Senior Management Team.

Trainees are required to submit a Form R for Revalidation purposes that must contain information on any SI’s they have been involved in. LEPs submit an Exception Report per SI (with trainee involvement) to enable HEE YH to triangulate the data received.
Section 6: Appeals Process

Not covered within the remit of this guideline

Section 7: What is a Serious Incident?

There is a large body of evidence on the risk of clinical incidents associated with healthcare activity. Serious incidents are uncommon, but they cause major distress to the patients and families affected, and often also to the staff involved. All clinical incidents require a prompt and effective response in order to address immediate patient safety issues, and to identify causal factors that can be modified as part of individual and/or organisational learning to avoid recurrence.

‘Serious Incident’ (SI) defines the most serious clinical incidents (and within those Never Events cause the most concern). Among various definitions, a simple view is to say that a SI has occurred “whenever a patient(s), member of staff, visitor, or other member of the public has suffered unexpected death or serious harm, or where avoiding a catastrophic outcome requires major corrective intervention”. The practical definition is inclusive and often includes ‘near miss’ events which point towards system failures that could recur, and require organisational change.

The sort of events that would usually be notified as a SI include:

- serious injury from deliberate self-harm while in NHS care
- patients detained under the Mental Health Act who abscond, or who harm staff or other patients
- diagnostic failures leading to serious harm or death
- serious medication incidents
- medical equipment failure (even if a near miss)
- surgery/procedure performed on wrong side of body (a Never Event)
- outbreaks of disease in hospital (including MRSA), and death related to HCAI (especially clusters)
- major system failures (such as a diagnostic service not reporting a critical result in a timely way)
- major environmental incident in the hospital, or service disruption
- major confidentiality breaches (i.e. a lost laptop with patient data on)
- serious recurrent concerns about an individual or department (although there are separate ways to deal with that which would usually be more effective)

This is a selective list, which highlights just how much can and does go wrong in a healthcare setting. Medical Directors and Chief Executives have some discretion over whether a particular incident is declared externally as a SI, but in many organisations a lot of SIs which do not actually involve an extreme outcome are reported, in a spirit of openness. Once classified as a SI, local reporting mechanisms to the Clinical Commissioning Group must be followed, both for immediate actions to be taken, and for epidemiological purposes.

There are wide variations in reporting rates by different Trusts, which are increasingly being reviewed as part of quality control processes. High reporting rates may indicate an important underlying problem or an organisation with a lower threshold for classifying incidents as serious. A low reporting rate may indicate an excellent safety culture or poor recognition systems.
Section 8: What is the involvement of HEE YH?

The Temple Report considered the risks of changing working hours on the quality of training, and commented that "training is the most important investment in patient safety for the next 30 years"; training and service delivery are inextricably linked. Revalidation of doctors by the General Medical Council began in 2013.

Every healthcare organisation now has a Responsible Officer (usually the Medical Director) with responsibility for monitoring and collating the evidence required to revalidate senior doctors. For doctors in training the responsibility for providing revalidation evidence to the GMC lies with the Postgraduate Dean, who is a separate Responsible Officer. Most of the evidence required is provided by assessment of evidence in the trainee portfolio, and by the ARCP process. Employers are required to provide HEE YH with any relevant information about adverse trainee experience in the workplace, including any involvement in serious clinical incidents, complaints, or conduct concerns.

HEE YH has created an Exception Reporting system to ensure early notification of trainee involvement in a serious incident by the Director of Medical Education within a Trust to HEE YH. The first use of this information will be to ensure that trainees are getting suitable support at what can be a difficult time; most doctors feel personally responsible when things go wrong. The second step is the role of HEE YH as a central reporting point, so that evidence required for the portfolio and for the GMC revalidation process is collated reliably. A third step, if needed, is to identify any learning needs and provide suitable remedial training.

Section 9: What happens after a SI has occurred?

Junior doctors are at the frontline of healthcare processes, and will often be involved in the events surrounding a clinical incident. That involvement may be conscious or unconscious, depending on the nature of the event and timescales. It may also be central to the event or peripheral. When a serious incident is reported, a preliminary investigation, within the trust, seeks to establish who may have had a relevant role in the event; those people will contribute to the detailed investigation that will follow.

The first priority of the investigation is to establish the facts and the cause(s); it is not an exercise to apportion blame (if indeed any is actually attributable). **Being involved in a SI investigation makes no presumption about responsibility or fault, and trainees must not feel any prejudgement is being made in advance of the investigation findings.**

SI investigations may take a long time (often months rather than weeks), and are conducted confidentially. Some cases have potential for legal action, and a very small minority have police interest. The involvement of junior doctors in a coroner’s inquest is an overlapping but separate issue which is dealt with in a separate document.

The investigation report is written to indicate what happened, and to analyse what/how relevant causal factors contributed. Most investigations reveal system failures in organisational structures and processes alongside some degree of individual error(s). It is common that a sequence of actions (each of which may not in themselves even be outright errors) combines to produce the serious event; the ‘Swiss cheese’ model. Patient pathways need to be designed in ways which prevent a series of small errors being able to escalate cumulatively into a severe event.
Section 10: Impact on Training Progression

Many trainees experience problems during their training, for many reasons, and this is discussed in the HEE YH ‘Doctors in Difficulty’ guidance. Most problems are transient and are solved by simple remedial action. HEE YH keeps a register of trainees with active serious problems but being involved in a SI investigation does not make a trainee a Doctor in Difficulty. During the investigation process we adopt the term “Doctor at Risk”. Where an investigation reveals an important individual error by a trainee, that will first be viewed as identifying a learning need(s); this requires reflection by the trainee and planning of remedial targets with the Educational Supervisor/Training Programme Director. This process would take account of any other concerns that had been recognised during training. Lack of progress in meeting remedial targets at the next ARCP would influence progression in training, but a decision to delay progression would not necessarily follow directly from the SI itself.

Rarely, an employer may decide that a disciplinary process also needs to be followed. This is handled entirely separately to educational processes involving HEE YH, but again suitable personal support should be provided to the trainee. HEE YH may be asked to give evidence about training progress at a disciplinary hearing.

Very rarely, concerns can be so serious that a question arises about the Fitness to Practice of the trainee, and the General Medical Council would become involved. There are additional support processes within HEE YH for doctors in this position.

Section 11: Summary – best practice process

- You should be informed as early as possible if you have been involved in a SI (you may not already be aware of it). Your Educational Supervisor/Director of Medical Education should also be informed, so that suitable pastoral support for you can be confirmed. Everyone recognises the stress involved, whatever the findings of the investigation. Support can come from any combination of your clinical department, the Trust education department, and the Specialty School.

- In some situations it may be useful to involve the Occupational Health service or seek advice from the counselling services (HEE YH offers Take Time or Workplace Wellbeing, many Trusts also have local resources).

- You should meet with your Clinical or Educational Supervisor as soon as possible to discuss the case and begin the process of reflection. If they were also involved in the incident you might both decide that support would be better coming from an alternative source.

- You will be interviewed as part of the Trust investigation. Give as open and full an account as you can. Writing down your recollections of events and actions as soon as possible will help you contribute accurately to the investigation.

- Once the investigation is complete, if individual learning needs are identified you will be expected to engage in forming a plan to meet these, within a defined timescale (using SMART objectives).

- Whether or not there are any specific learning needs identified for you, you will be expected to mention the event when you complete Form R before your next ARCP panel, and to make a portfolio entry about the SI and your reactions to it, as a piece of reflective practice.
Section 12: Equality & Diversity

This guidance applies to all, irrespective of age, race, colour, religion, disability, nationality, ethnic origin, gender, sexual orientation or marital status, domestic circumstances, social and employment status, HIV status, gender, reassignment, political affiliation or trade union membership. In overseeing Equality and Diversity, Health Education England, working across Yorkshire and the Humber, will treat those concerned in a fair and equitable manner and reasonable adjustments will be made where appropriate.

A full Equality Impact Assessment of this guidance is available upon request.