Understanding Serious Incidents-
Information for Trainees and Trainers

Speciality: Paediatrics

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This booklet has been created to help trainees understand serious incidents (SI) and the investigation processes involved. It also provides information about support and teaching available for trainees in the aftermath of an SI.

It is relevant for any incident that could have or did lead to patient harm, including near misses.

The original document has been adapted to include additional information for individual roles and responsibilities of trainers involved in supporting trainees through an SI.
SERIOUS INCIDENTS

A serious incident (SI), (previously known as a Serious Untoward Incident) requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care resulting in one of the following:

- **Unexpected** or **avoidable** death of one or more patients, staff, visitors or members of the public;
- **Serious harm** to one or more patients, staff, visitors or members of the public or an outcome which requires life-saving or major surgical/medical intervention;
- **Permanent harm, a reduction in life expectancy, prolonged pain or psychological harm**;
- A scenario that prevents or threatens to prevent a provider organisation’s ability to continue to deliver healthcare services, e.g. 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 or the wider NHS;
- One of the core set of ‘Never Events’. This is defined as a very serious, largely preventable patient safety incident that should not occur if the relevant preventative measures have been put in place. This list is published by the Department of Health and updated on an annual basis. The current list includes:
  - Wrong site surgery
  - One or more retained foreign objects post-operatively e.g. swab or instrument
  - Wrong route administration of medication
  - Misplaced nasogastric or orogastric tubes not detected prior to use
Background Information

When a serious incident occurs it can have a devastating and far-reaching effect. It may have an impact on those directly involved, patients, relatives, staff or visitors, and also on the reputation of the healthcare organisation, the service or the profession within which the incident occurred, and the wider NHS.

As a trainee it is a distinct possibility that you may be involved directly or indirectly in a Serious Incident. Being involved in a SI can be a very stressful process. It is natural to feel upset or feel responsible when involved in a SI. The key is to seek help either locally or via the London School of Paediatrics for support and to talk through the process. You should never be alone when involved in a SI. The purpose of this document is to clearly layout what support is available to you and how you can expect to be helped through a potentially difficult experience.
SI reporting

Reporting any adverse event should be encouraged and the SI investigation aims to identify ways to prevent errors recurring and not to apportion blame. Clinical incident reporting within each trust utilises an electronic +/- paper-based reporting system that is centrally collated within that trust. Any incident that is thought to be serious and could be an SI is flagged and has a further more comprehensive investigation undertaken by the Risk Management team. Incidents are reviewed nationally by the National Reporting and Learning System (NRLS) who produce reports regularly on incidents and patient safety alerts in order to share learning and good practice across the NHS.

What is the SI investigation Process and how long will it take?

Each trust has its own SI investigation pathway that can be found on trust intranet sites or via the risk management team and should be made available to you at Induction to the Trust.

The processes will vary but generally once an SI is declared, within a 48 hour period, a lead investigator will be appointed who will interview staff (with transcription of the interviews), gather statements, review the notes and other evidence and develop a report. Interviews are especially important if inconsistencies are found within the information gathered from statements. If you are interviewed you should be given the transcript to check and amend as you see fit so that you agree with everything recorded in the final transcript.

A panel will later review the investigator’s report and recommendations and this panel will usually include a Trust executive as chair, a consultant(s), a nurse/midwife and may include external panel members who are experts in their field.

A root cause analysis of events is undertaken (National Patient Safety Agency guidance).
Very occasionally, at the same time as an SI is declared or during investigation, legal proceedings are started. In this very unlikely event, legal advice will be sought for the investigation so as not to prejudice the proceedings. Legal proceedings may not be commenced for some years after an incident.

The panel will then write a report (NPSA format) of the incident that is presented to the Clinical director and up to the Chief Executive. It is then passed on to the NHS England London Regional Office (All SIs), the National Reporting and Learning System (NRLS) and the Commissioners (CCGs and NHS Commissioning Board) to identify opportunities for learning outside the organisation. The time frame for this is 45 working days/9 weeks from start to finish for a Grade 1 Incident (e.g. Avoidable or unexplained death) and 26 weeks/6 months for grade 2 incidents (e.g. child protection incidents and never events). The following NRLS document clarifies the grading between incidents. (http://www.nrls.npsa.nhs.uk/EasySiteWeb/getresource.axd?AssetID=68464&type=full&servicetype=Attachment)

What am I going to Learn from the SI?

Learning from an SI relies on several factors and should be carried out in an open and transparent environment. Importantly being involved in an SI gives you experience of risk management first hand. Risk management is an essential part of modern practice, particularly in the NHS after the Francis Report and complements reflective practice and a commitment to lifelong learning, which are themselves key parts of revalidation.

The learning points and recommendations of an SI will be disseminated through the department, or on a wider basis, providing important access to suggestions of improvement. Improvement may be needed generally within the whole department to tackle system errors. Most importantly the SI process gives you, the trainee, the chance to reflect on the events and come to conclusions of your own. When you are a Consultant, you will be asked to act as investigator so it is paramount that as a trainee you have a full appreciation and understanding of the SI process.
What to do if a serious incident occurs

Whether your Trust needs it or not, it is good practice to write a statement as soon as possible after the event whilst recollection of the event is fresh. This should be separate to the clinical records. **NEVER ALTER THE WRITTEN CLINICAL RECORD; IF ABSOLUTELY NECESSARY MAKE A SEPARATE ENTRY, DATE AND TIME IT AND MAKE IT CLEAR THAT THIS HAS BEEN WRITTEN AFTER THE EVENT.**

Whilst the Serious Incident is being investigated what happens to me?

Serious Incidents can lead to anxiety and stress for all involved. It is important to realise that there is support available to trainees involved in SI cases. At a local level the trainee’s Educational Supervisor will provide sound objective advice and counsel. The College Tutor is another person nearby who can provide support when needed. The Clinical lead is available for further support and may refer to the Head of School for further mentoring or counselling. The Director of Medical Education (DME) in the trust has a duty to ensure any trainee involved in SI cases is provided with the appropriate support.

The SI investigation is a confidential process that will not concern many others at work; however, immediate lessons learnt can be ‘actioned’ as soon as possible after the incident. This may lead to the incident being discussed in the public arena before the investigation has started or finished. This discussion however should be anonymised and not be in the context of blame. The only foreseeable circumstance where departmental concerns may arise is if doubt has arisen about a trainee’s competence.

Patient safety is paramount; in extremely rare circumstances there may be such clinical concern about a trainee that it is necessary to limit their practice, change the required level of supervision or exclude them. This might also occur if there are concerns about the trainee’s well being, or if it is thought their continued presence
might interfere with the investigation. It is important to note that this is an extremely rare event, and very strict rules govern such action.

In particular the Deanery/Lead Provider will be closely involved in any incidents that highlight training concerns at an institution, raise concerns about a trainee’s conduct, performance or health, or might lead to media attention.

In addition to reporting an SI for investigation, any SI that involves a trainee is reported to the London Deanery Shared Services unit. This unit is responsible for recruitment, quality assurance of training as well as Trainee Revalidation and support for trainees in difficulty. This information is used to help support trainees and identify training needs where relevant. It may also be used to identify recurring events.

**How you may react**

When you are involved in an SI it is likely that you will have many strong and conflicting emotions. This is normal! Following the incident itself you may have feelings of anxiety, denial, shame, fear, or guilt. Some doctors who are involved in incidents may even find their self-confidence suffers, they may feel like an “imposter” or even consider giving up their chosen career. Feelings like this are usually temporary, and discussion with others involved / supervisors/ colleagues and working through the SI investigation should be helpful and restore your equilibrium. Participation in the SI process is vital and helps avoid feelings of isolation which if not dealt with can lead to depression. It is vital that you seek support locally and /or centrally.

**Steps to recovery**

- **Understand the process** of investigation – if you do not know what is happening – seek clarity – your clinical lead or the DME can contact the risk management department
- An adequate and thorough **debrief** is essential – this may be as part of the investigation or may occur outside the formal investigation. Being able to
express your thought processes in a secure and confidential environment and being able to ask the “what if” questions can be very helpful. You do need to make sense of what has happened and re-establish your sense of self and professional capability

- **Identify any learning needs** you have – don’t be afraid to ask for more training, or focused discussions/training. Many incidents occur because of a combination of factors and are related to team working as well as system failures. If you feel the team needs some time together and help to be more effective – then say so. Taking control of how you can improve is immensely helpful to your personal wellbeing and healing.

- Don’t be afraid to revisit the problem in your educational meetings or departmental meetings. **Sharing your experience** will help others whether it is through your description of the medical decisions you made or how the incident investigation worked.

- **Seek help** from professionals – Appendix B has a list of people outside the Trust who can help you. This is important – your health and well-being must not suffer and you have a life long career to continue. You may already have a mentor who you can talk to. Speaking about events is an important part of the process to recovery and learning.

**Will being involved in an SI hinder my training?**

One of the important features of the root cause analysis of any SI is to create learning points that all healthcare professionals can learn from – not just those directly involved in an incident. SIs provide each trainee with the opportunity to learn and modify their practice if necessary. Unless the SI has led to a suspension from clinical work or other local HR action there is no reason why you would be prevented from rotating to your next post. This is as long as you satisfy the standard criteria set for the yearly ARCP.

The vast majority of incidents are treated as learning experiences and discussed at ARCP panel meetings and the Deanery clearly states that simply being involved in
an SI is not a reason for an unsatisfactory outcome at an ARCP. However if locally devised remedial teaching has been put in place the Deanery will support this and in this scenario an unsatisfactory ARCP may be of benefit to allow the trainee to undergo the pre-arranged further training in order to reach the appropriate competence.

**Revalidation and your ARCP Enhanced Form R**

Revalidation is the GMCs way of regulating licensed doctors. The aim is to support doctors in their professional development, helping to improve quality, patient safety and public confidence in the profession. As part of the revalidation process, you will now be asked to complete an enhanced Form R, which will require you to submit additional supporting evidence to enable your ARCP panel to make a recommendation to your Responsible Officer.

Reporting SIs, and co-operating with their investigation is an essential part of revalidation (Domains 1.1 and 2.1), and should be included in your annual appraisal. As a trainee this will be part of your signoff discussion prior to the ARCP, and the issues may be discussed at your ARCP.

For the purposes of the Enhanced Form R, you need to record any complaints and significant events that were **formally investigated** by your employing organisation/Deanery/professional body, or that are currently unresolved since your last ARCP. The ARCP panel is interested in what you have learnt as well and you should reflect on any significant events, complaints and investigations in your e-portfolio (see below).

The GMC state that a significant event is any unintended or unexpected event, which could or did lead to harm of one or more patients. This includes incidents that did not cause harm but could have done, or where the event should have been prevented, which is significant enough to be investigated by your employing organisation.
Within each trust, the postgraduate medical education department will also report any significant event that involves a trainee (all grades including Foundation) via a specific electronic secure portal.

You may be asked to write a statement by your clinical lead or educational supervisor if you were:

1. Present at the time, but not directly involved in the SI
2. Present at the time, not directly involved in the SI, but personally affected by the SI
3. Involved, but in a minor way, e.g. as part of the team
4. Directly implicated as contributing to the SI
5. Directly implicated in the response to, and management of, the SI
6. Or a combination of the above

Advice on statement writing can be found in Appendix B.

Your Trust Risk Management department will decide on the level of investigation required and the severity of the incident. Following this, your clinical lead and educational supervisor will determine whether it requires reporting to the Deanery.

**What is a Responsible Officer?**

This is a senior clinician in a Designated Body who ensures that the doctors for whom they act in this nominated capacity, continue to practice safely and are properly supported and managed in maintaining their professional standards. The Postgraduate Dean is the Responsible Officer (RO) for trainees, and the GMC requires all employers to inform the Deanery/LETB when a doctor in postgraduate training has been involved in an SI.

The three London ROs are:

Health Education North West London - Dr Julia Whiteman
Health Education North Central and East London - Dr Tim Swanwick
Health Education South London - Dr Andrew Frankel
Reflective Practice

Reflection is an important part of postgraduate education and helps to improve clinical practice as well as patient safety. In the aftermath of any significant event it is important to reflect on the event itself, your own practice and any learning outcomes that have been implemented.

In addition to reporting significant events or complaints on your enhanced form R, each incident should be accompanied by a note of personal reflective practice (this is also required at consultant level for the annual appraisal and revalidation; it is not limited to trainees).

Other possible outcomes

Inquests
Any SI which results in the death of a patient should be reported to the Coroner. The Coroner will decide if an Inquest should be held, which will inevitably be some months after the incident, and will almost always await the findings of the Trust’s SI investigation. An Inquest is a fact-finding exercise and not concerned with findings of negligence or blame. Reports to the Coroner must be completed promptly, and you should always seek senior advice and/or discuss with your Indemnity Organisation.

Complaints
SIs may also result in complaints from patients or their family. Each Trust will have a Complaints Policy, with a strict timetable for responses. A senior clinician will write the response, co-ordinated by the Complaints Department. You should respond to any request for information in a timely manner; this is both a reasonable expectation by your employer and required by the GMC. If you have been named in a complaint this should be included in your portfolio and Enhanced Form R with a reflective practice report and these will be discussed as part of revalidation at your ARCP.
Civil litigation

Any civil claim arising from an SI will be against the Trust and will be managed by the Legal Department in conjunction with the NHS Litigation Authority. Although it is good practice to apologise after any incident, you should avoid admitting liability and seek advice from a Consultant and/or the legal department as soon as you become aware of any claim. Civil claims may take several years to conclude.

General Medical Council

The GMC has a responsibility to inquire into any occasion where a doctor’s actions may have put a patient in danger, or there are issues about a doctor’s honesty. Patients and their families may make a complaint, as may other doctors (indeed in some circumstances they are required to). Only in extremely rare circumstances would a Trust respond to an SI by involving the GMC rather than initiating local action in conjunction with the LEP, LETB and Deanery. The GMC would similarly make enquiries with these bodies, except in exceptional circumstances, to prevent patient harm or to protect the reputation of the profession.

If you are contacted by the GMC, you should inform your employer, Educational supervisor and your Medical Indemnity Organisation as soon as possible, and must cooperate promptly and fully with its enquiry.

What you can expect from your Lead Provider?

Support

Support is available locally from the Educational Supervisor, College Tutor and Director of Medical Education. Any decision about a trainee’s working patterns or supervision must be made in conjunction with the clinical lead.
**Education**

Many SIs will lead to the identification of learning needs, which may be delivered in a number of ways, and are most commonly managed locally. An SI you have been involved with may form the basis of, for example, case discussion or simulation training. Any such training should be on the basis of anonymisation, and you should never be identified. You would of course be able to share your own learning and reflection if you choose to, but this would not be expected of you in such a public environment.

**Legal Advice**

Since August 2015, it is a statutory requirement for doctors to have insurance or indemnity. In addition to NHS indemnity covered by the Clinical Negligence Scheme, any doctor undertaking clinical practice is required to be a member of, and make use of, one of the Medical Indemnity Organisations (Medical Protection Society, Medical Defence Union or Medical and Dental Defence Union of Scotland). These organisations can provide trainees with a wide range of assistance. This may include telephone advice, help writing a statement and in some cases an offer to attend an interview with you and assisting with making comments in response to an investigation. They extend their help further when dealing with disciplinary action or exceptionally rarely criminal proceedings. Possibly just as important they offer confidential counselling services if the in house support is not providing adequate guidance.

You should also be able to contact the Legal department within your Local Education Provider to obtain advice.
Appendix A

The ‘Never Event List’

The ‘Never Event List; 2015/16 Update’ published by the Department of Health:


The following never events list is the list that all organisations providing NHS care should use. It is applicable for all incidents that occur on or after 1 April 2015.

1. Wrong site surgery
2. Wrong implant/prosthesis
3. Retained foreign object post-procedure
4. Mis-selection of a strong potassium-containing solution
5. Wrong route administration of medication
6. Overdose of Insulin due to abbreviations or incorrect device
7. Overdose of methotrexate for non-cancer treatment
8. Overdose of midazolam during conscious sedation
9. Failure to install functional collapsible shower or curtain rails
10. Falls from poorly restricted windows
11. Chest or neck entrapment in bedrails
12. Transfusions or transplantation of ABO-incompatible blood components or organs
13. Misplaced naso- or oro-gastric tubes
14. Scalding of patients
Appendix B

Statement and Interview Advice/Support

Statement Writing Advice

Your statement should be an accurate logical recollection of events with explanation of any decisions that you made. By writing the statement as close to the event as possible you will be able to recall factors and events that a patient's medical notes may not reflect.

You should aim not to copy out a patient's notes verbatim nor use any abbreviations/clinical terminology remembering that your statement may be read by a layperson. **Your statement is a document of fact NOT opinion.**

In response to the Freedom of Information Act 2000 and the Data Protection Act 1998, the information in your statement is disclosable.

Simple guidance includes:

1. Your full name, qualifications and position
2. Type your statement and lay it out clearly with a title and page numbers
3. Stick to the facts but do add any other recollection of the incident that may not be in the notes that may be relevant (common examples here include being called to other work and sometimes itemising this is very helpful). Clearly say what your involvement in the case was and why you made any decision
4. Include dates and times wherever possible. If you are uncertain of these, say so.
5. When referring to other members of staff use their full name and position
6. It is very important that when writing a statement you do not blame or criticise others. Keep any such observations purely factual
7. Be as clear and concise as possible
8. Sign and date the statement

9. Keep a copy for your records

Further advice can be obtained from the risk management team in your unit or Consultants. In addition the MPS/MDU are happy to read statements and give advice on the content. An extra-added benefit is that they will keep a confidential copy for you if you ever needed to refer back to it in the future.

**Interview Advice**

If you are invited for interview it is important you attend and the sooner the interview occurs after the event the better your memory will be. Most people are happy to attend alone but you are entitled to be accompanied by someone and as learning outcomes are possible you may choose to ask your educational supervisor to attend with you. After the interview you should be given the transcript to check and amend as you see fit so that you agree with everything recorded in the final version.

**Other avenues of support: The Professional Support Unit (PSU)**

The PSU provide an expert shared service of resources to support the professional development of clinicians working in the capital. Further information and advice on how to access the service can be found at: [http://www.londondeanery.ac.uk/professional-development/professional-support-unit](http://www.londondeanery.ac.uk/professional-development/professional-support-unit)

**What do the PSU offer?**

- Careers support including psychometrics and occupational psychology
- Coaching and Mentoring
- Complex case advice and management including GMC referrals
- Fresh Start Courses (currently available to GPs)
  1. Consulting, keeping records and communicating
2. Consultation skills
3. Management in clinical practice

- Language and Communication Resource Unit (LaCRU)
- PHP HEE (London)- Expert assessment and support for psychological aspects of doctor’s health. Any postgraduate trainee doctor or dentist with a current London training number is eligible to self-refer to this service (Via phone: 02030494505 or via email: England.phpadmin@nhs.net)
- Arranging and managing clinical placements and workplace supervision including retraining through:
  1. GP Induction and Refresher Scheme
  2. Medical Pre-CCT Return to Practice Scheme
  3. Refugee Doctor Foundation Clinical Apprenticeship Scheme
- Access to occupational health advice services.

RCPCH Courses (See http://www.rcpch.ac.uk/courses for further information available to all trainees):

Examples of useful courses:

- **Safeguarding: Statement and report writing (Level 3):** ‘A one day course exploring what is required from statements and reports’.
- **Child protection: Examination to court (Level 3):** ‘A two day course run in conjunction with medical and legal experts who are highly trained and bring vast experience from within the safeguarding sector. The course is to increase knowledge of legal proceedings, develop competencies in engaging with proceedings and build confidence amongst paediatricians to tackle this area of work’.
Appendix C

Paediatrics

Background Information and advice

Paediatrics, as with any frontline clinical specialty, has its fair share of situations which may or may not lead to Serious Incidents (SIs) or at least result in trainees finding themselves in situations where patient harm has occurred or came very close to occurring (a near miss).

The commonest clinical arena for clinical risk as a Paediatrician is probably on the Labour Ward. It is very common for Paediatric trainees to be part of a Serious Incident, albeit peripherally, and therefore be asked to write a statement as part of a wider Obstetric investigation. More generally, as Paediatricians we are always striving to improve the care of our patients. So you will probably find that in most hospitals there is a very pro-active approach to identifying near misses and then learning the lessons from them. Please take part in this process as they invariably present valuable learning opportunities. Do not be frightened or anxious about this as we now work in a culture of candour (i.e. transparency and openness, with a freedom to share and discuss information). Talk to your Educational Supervisor if you want to discuss a risk-related issue in more detail.

If you are asked to take part in an investigation into a SI or a near miss, please write a reflective piece and upload it into your Personal Library on ePortfolio. You should then discuss it with your Educational Supervisor at one of your meetings.

Once a year we will ask you whether you have been involved in an SI or Complaint, as part of the “Form R” which you submit with your ARCP paperwork. If you have been involved, you simply need to acknowledge it and then mention that you have reflected and uploaded your reflection onto ePortfolio. This will almost certainly not prevent you progressing in the normal way at ARCP. However, failing to
acknowledge involvement in a SI or not reflecting on it is likely to lead to concerns being raised at ARCP.

**Support**

**Local**
The Trust you are working in is responsible for investigating any SIs and your Educational Supervisor / College Tutor and Lead Clinician (for the particular case) should all be available to help and support you. Similarly the Director of Medical Education and Clinical Governance/ Risk Management team can help to support and guide you. In addition never underestimate the help your peers and nursing colleagues can give: they are all part of the team and mutual support in difficult circumstances is invaluable and part of all of our roles

**Training Programme Directors**
The Training Programme directors (TPDs) have a key role in managing the specialist-training programme. Their fundamental role is that of co-ordinator and communicator between Paediatric trainees, the Postgraduate Dean, the Specialty Training Committee, and the appropriate Royal College or Faculty. They are also present to offer counselling to individual trainees, particularly where local tutors are unable or inappropriate to fulfil this function. If you want to chat to one of the TPDs, please get in touch with the Chair of your Specialty Training Committee:

If you are in ST1-5: **Bob Klaber (North West Thames)**

E-mail address: Robert.klaber@imperial.nhs.uk

**Sue Laurent (North Central and East Thames)**

E-mail address: sue.laurent@nhs.net

**Simon Broughton (South Thames)**

Email address: s.broughton@nhs.net

If you are in ST6-8: **Camilla Kingdon**

E-mail address: camilla.kingdon@gstt.nhs.uk
Lead Provider

The Lead Provider is also available to offer additional support in a confidential and individualised manner if needed. Examples of situations where this might be helpful to you include if:

- You feel bullied or isolated
- You feel you are being made a scapegoat
- Inferences are being made before an investigation is complete
- There is conflict

Deanery / Shared Services

Camilla Kingdon is the head of the Specialty School of Paediatrics and she is very happy to be contacted. You can email her at Camilla.kingdon@gstt.nhs.uk. In addition, the Paediatric Operations Team is an invaluable source of help and information. They can be contacted at paediatrics@southlondon.hee.nhs.uk.

Further support from the deanery is available at the professional support unit (PSU) and they can be contacted at PSU@southlondon.hee.nhs.uk. In addition to any specific case that you feel you need help with the PSU also run services to help in career support including psychometrics and occupational psychology.

The London Deanery also offers a mentoring service to trainees. The Coaching and Mentoring Service was first launched as The Mentoring Service in May 2008.

‘It provides support and guidance to enable the mentee to drive change in order to fulfil their potential as a future leader in the NHS. The service provides insight for those facing decisions or going through a change. This helps to prevent ‘burn out’ and release their career potential in the health care system’.

Since the inception of its coaching and mentoring scheme in 2008 the PSU has dealt with over 1500 applications from London deanery doctors. Further information is available at http://mentoring.londondeanery.ac.uk/our-scheme
Education setup in your area

Individual

Local Department

Local Education Provider

Specialty Leads

Lead Provider

Department Of Health

TRAINEE

Educational Supervisor

Clinical Supervisor

Director of Medical Education

Specialty Programme Director

Lead Provider (LETB)

Health Education NW/HFEL/South London

Shared Serviced / Deanery

Health Education England

College Tutor

Royal College

Director of Medical Education

Specialty Programme Director

Lead Provider (LETB)

Health Education NW/HFEL/South London

Shared Serviced / Deanery

Health Education England

College Tutor

Royal College

Director of Medical Education

Specialty Programme Director

Lead Provider (LETB)

Health Education NW/HFEL/South London

Shared Serviced / Deanery

Health Education England

College Tutor

Royal College

Director of Medical Education

Specialty Programme Director

Lead Provider (LETB)

Health Education NW/HFEL/South London

Shared Serviced / Deanery

Health Education England
Appendix D

Information for Trainers Supporting a Trainee through an SI

Each trust should have a policy for recognising and investigating serious incidents.

**Individual roles and responsibilities:**

**Clinical Supervisor:**
- To ensure the trainee remains supported in their day to day clinical work, providing extra support where necessary

**Educational Supervisor:**
- Ensures the trainee has extra support during the process and has reflected on the incident and is aware of their own role and responsibility
- Supports the trainee during on-going investigations and ensured they are aware of other agencies e.g. Occupational Health, Counselling, MPS/MDU etc.
- Will need to comment on the SI in the form of a formal report/within the paperwork submitted for the trainee’s ARCP
- Should ensure they seek advice and keep all appropriate parties informed

**Specialty/College Tutor:**
- Responsible for ensuring that the trainee has appropriate clinical supervision and an Educational Supervisor with the knowledge and skills to provide good support
- Ensures that the trainee has an opportunity to go through the SI report with a consultant. This may be the college tutor themselves, the Educational or Clinical Supervisor.

**Director of Medical Education:**
- Supports primarily trainers during on-going investigations and ensures they are aware of other agencies e.g. Occupational Health, Counselling, MPS/MDU etc.
- Ensures key learning from SI is rolled out more widely in the organisation and liaises with the Medical Director, Clinical Director, Head of School, Dean and other external agencies as required
- Reports outcomes to Dean/School.
- Ensures the final report reaches the trainee
Medical Education Manager:

- Key role in facilitating communication between all parties and providing ad hoc pastoral care
- Maintains confidential records

Medical Director:

- Ensures that the Director of Medical Education is informed of all incidents involving trainees at an early stage
- Ensures that the final SI report is sent to the DME

Postgraduate Dean:

- Ensures that DMEs inform LETB/Deanery/School of trainees involved in SIs.
- Ensures that mechanisms are in place to support trainees
- Ensures that patterns of incidents are identified and that learning is shared across schools and specialties

Educational Governance Groups:

- Many Trusts and Deaneries have now set up Educational Governance Groups to monitor issues around Doctors with difficulties using a multi-disciplinary approach. Membership at Trust level might consist of:
  - Director of Medical Education
  - Medical Director
  - Occupational Health Physician
  - HR Representative
  - Foundation Programme Director
  - Medical Education Manager
  - Foundation Programme Administrator

The information supplied has been provided from: (http://www.gmc-uk.org/Final_Appendix_7___Serious_Incident_Analysis.pdf_53816879.pdf). Please refer to this document for further information to support trainees through a serious incident.