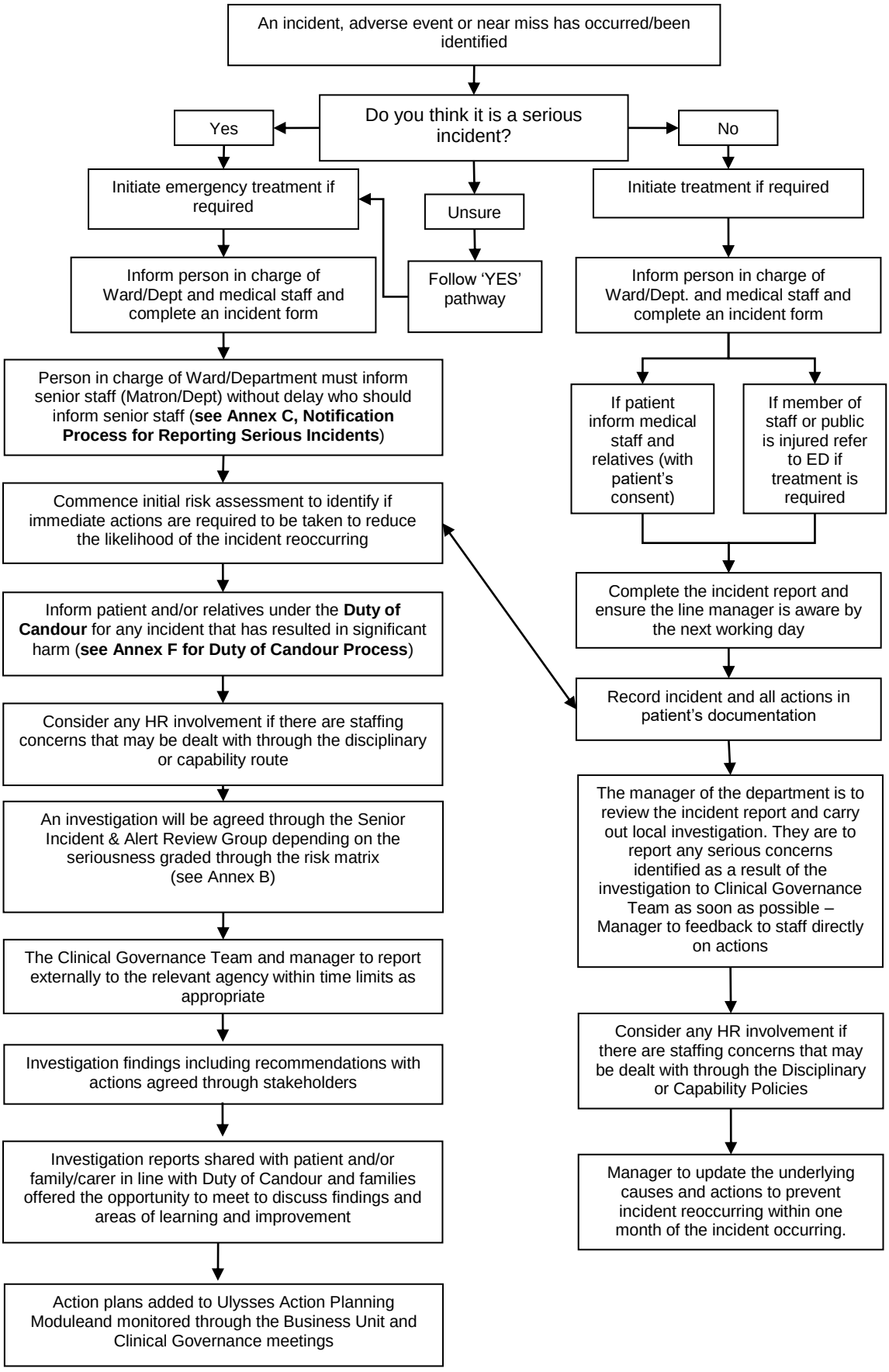
# Incident Reporting and Investigation Management Policy

| | | | |
|---|---|---|---|
| **Version Number** | 4.12 | Version Date | May 2021 |
| **Policy Owner** | Chief Nurse, Director of People and Deputy Chief Executive | | |
| **Author** | Head of Risk & Assurance | | |
| **First approval or date last reviewed** | October 2009, 14 June 2011, 11 Feb 2014, Sept 2014, Aug 2015, October 2017, July 2018 | | |
| **Staff/Groups Consulted** | Deputy Director Quality Governance and Patient Safety<br>Chief Medical Officer<br>Senior Incident & Alert Review Group<br>Health and Safety & Security Committee<br>Patient Safety Committee | | |
| **Discussed by IIL** Incident, Investigation and Learning **Group** | September 2009; Reviewed at CGDC 11th Feb 2014, 09 January 2018, 12 September 2018; 04 March 2021 | | |
| **Approved by PSSG** | 09 October 2009 – Ver 3<br>Chair of Policy Group review 1 July 2011 – Ver 3.1<br>Approved at CGDC 11th Feb 2014 – Ver 4.1<br>Approved PSSG November 14 – Ver 4.2<br>December 14 Minor change reference to external reporting – Ver 4.3<br>March 15 (Ver 4.4) minor changes due to Actual Harm scoring updated through NRLS plus comments from Auditors.<br>Approved PSSG 17 January 2018 (version 4.7)<br>Approved PSSG 19 September 2018<br>Approved PSSG 18 March 2021<br>Approved PSSG 20 May 2021 | | |
| **Next Review Due** | August 2023 | | |
| **Equality Impact Assessment Completed** | | May 2021 | |

# Contents

## ANNEX A – PATIENT SAFETY INCIDENT REPORTING FLOWCHART



## 1. RATIONALE

1.1 The effective reporting and management of incidents is a key component of Yeovil District Hospital NHS Foundation Trust's (the Trust) governance arrangements; and a fundamental mechanism for managing risk and delivering high quality, safe patient care and supporting the health, safety and welling of staff, contractors and visitors to the Trust.

1.2 This policy works in conjunction with the NHS England's Serious Incident Framework 2015 and the Somerset CCG's Process for Reporting and Learning from Serious Incidents Policy.

## 2. AIM

2.1 The Trust operates an open, fair and 'blame-free' culture in relation to reporting incidents and near misses. The Trust encourages the reporting of all incidents, including near misses, as an opportunity to learn for the benefit of patients, staff and visitors.

2.2 The aim of the Incident Reporting and Investigation Management Policy is to:

- Set out the arrangements and responsibilities for reporting incidents and carrying out investigations;
- Enable the Trust to analyse incident trends, root causes and develop appropriate action plans to eliminate or minimise the risk harm to patients, staff and visitors;
- Set out the arrangements for reporting externally, including the 'Duty of Candour'

## 3. APPLICABILITY

3.1 This policy applies to all members of staff in the Trust, including employees of subsidiary companies, volunteers and contractors.

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

- NHS England Serious Incident Framework
- Somerset CCG Process for Reporting & Learning from Serious Incidents Policy
- Being Open and Duty of Candour Policy
- Risk Management Strategy
- Complaints Policy
- Safeguarding Adults Policy
- Child Protection Policy
- HR Manual (particularly in relation to Raising Concerns (Whistle Blowing) Policy, Capability Policy and Disciplinary Policy)
- Health and Safety Policy
- Medical Devices Management Policy

3.3 Staff should be aware that there may be clearly defined occasions where further action will need to be taken, namely where there has been evidence of a breach of the law, professional misconduct or repetitious incidents caused by negligence. Failure to follow this policy by staff may result in action under either the disciplinary or capability policies, or other relevant trust policies.

## 4. DEFINITIONS

- **Accident**; an unplanned and uncontrolled event that has led to or could have caused injury, ill health, harm to persons, damage to equipment or loss. Accidents can relate to:
    - **Staff accident**; e.g. where staff have sustained injuries from an incident in the workplace (slip, needle stick injury etc)
    - **Accidents to patients and visitors**; where patients and/or visitors have sustained injuries from an incident as a result of actions, omissions or whilst under the care of employees, or one health premises (slips, trips and falls)
- **Adverse event**; an incidents that lead to harm or failure to function
- **Candour**; any patient harmed by the provision of healthcare service is informed of the fact and an appropriate remedy offered, regardless of whether a complaint has been made or a question asked about it
- **Clinical incident**; an occurrence, procedure or intervention, which has given rise to actual injury, or to an unexpected or unwanted effect. Examples of clinical incidents include:
    - **Medication error**; e.g. incorrect drug, incorrect dosage through unfamiliar drug label, a drug after its expiry date and an adverse reaction to a drug
    - **Delay in treatment**; e.g. withholding of treatment without good reason or undue delay in receiving treatment. Where the action or delay in providing care and treatment by the clinical staff contributes to the deterioration of the patient's medical condition
    - **Inappropriate discharge**; e.g. to or from primary care
- **Equipment failures and deficits**; where operational equipment is missing or it fails during testing or use (e.g. wheelchair not fit for purpose, defibrillator, not charging, and failure of oxygen supply)
- **Fire incident**; any incident involving a fire, or any incident where the fire alarm sounds
- **Harm**; injury (physical or psychological), disease, suffering, disability or death. Where a patient is concerned harm can be considered unexpected if it is not related to the original cause of the patient's illness or underlying condition or treatment
- **Loss**; financial loss, or loss of data/information
- **Near miss**; those incidents that **did not** lead to harm or loss
- **Openness**; enabling concerns and complaints to be raised freely without fear and questions asked to be answered
- **Patient safety incident**; any unintended or unexpected incident that could have led, or did lead, to harm for one or more patients

- **RIDDOR**; Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013

- **Serious incident**; see section 7.1

- **Security incident**; any incident where a breach or lapse of security is the primary factor (e.g. missing drugs)

- **STEIS;** Strategic Executive Information System, NHS England's web-based serious incident management system

- **Violence and abuse**; where any person is subjected to the threat of, or actual, violence and/or verbal abuse

- **Work related ill health**; illness directly work related (e.g. latex allergy)

## 5. RESPONSIBILITIES

5.1 The **Chief Executive and Board of Directors** have overall responsibility for the implementation of this policy and provisions. They are responsible for ensuring that an open culture of reporting is promoted across the Trust and that there are systems in place for shared learning and delivering service improvement.

5.2 The Chief Nurse, Director of People and Deputy Chief Executive is responsible for ensuring governance arrangements are in place to provide the leadership and support necessary to manage the provisions of this policy. Management of the incident reporting process is delegated to the Deputy Director Quality Governance and Patient Safety.

5.3 The Deputy Director Quality Governance and Patient Safety will ensure incident reporting systems are maintained and processes are supported and monitored including:

- Advise on the level of investigation required and commissioning investigations
- Ensure effective external reporting mechanisms are in place and that they are reported in accordance with national guidance
- Provide access to training for incident reporting and investigation
- Quality assure training programmes and work with the CCG and others to standardise as required
- Quality assure final drafts of serious investigation reports
- Ensure systems and processes are in place for monitoring actions
- Support the Trust with incident reporting data, including the identification of trends for risk reduction measures
- Quality assure all incident reporting data, patient safety and quality reports prior to presentation at Board and Board Sub-Committee level meetings
- Oversee the Trust's Safety Improvement Programme
- Work with the Chief Medical Officer and Chief Nurse to oversee and manage patient safety improvement plans
- Identify requirements for escalation internally and externally for serious incident reporting and management
- Ensure that 'Being Open' and 'Duty of Candour' processes are followed when a patient safety incident occurs

- Ensure that any concerns about professional performance or competency are reported to Human Resources in the event that individual staff are identified as at fault following a serious incident investigation
- Attend and chair meetings of the Incident Investigation and Learning Group

5.4 The **Strategic Business Unit (SBU) Senior Team**, **Associate Medical Directors, Matrons**, **General Managers** and **Clinical Directors** are responsible for:

- Promoting openness within their teams around reporting incidents and providing feedback to patients
- Reviewing incident data to identify trends and agree risk reduction measures within the SBU/CBU
- Ensuring that nominated investigators are appropriately trained, and that investigations are carried out within the required time frames
- Monitoring progress with action plans resulting from incident investigations, and ensuring adequate resource for their implementation where required
- Ensuring disciplinary processes are followed in the event of an individual(s) being identified as at fault following a serious incident investigations, in line with HR procedures

5.5 **Managers** who directly manage services (including Ward Sisters and Departmental leads) are responsible for:

- Ensuring that they have received the relevant training, and have the appropriate access set up so that they can manage incidents for their area
- Reviewing all incidents for their service area/department and validating the actual impact/severity
- Completing the 'managers action' section of the incident form to include any actions taken or planned
- Providing support to staff who report incidents and timely feedback once they have been investigated and signed off
- Nominating a deputy to respond to incidents when away
- Ensuring that Being Open and Duty of Candour processes are followed at ward or department level
- Leading/overseeing investigations relating to their area of responsibility

5.6 The **Patient Experience Manager** is responsible for:

- Acting as a liaison between the Trust and the patient/family throughout the investigation process, including arranging a conciliation meeting where required
- Ensuring meetings with patients/families/carers are carried out and supported appropriately
- Ensuring staff and any patients or their relative/carer affected are invited to contribute to the investigation process and are notified of the outcome and actions taken to prevent re-occurrence. (Refer to Being Open and Duty of Candour Policy)
- To attend meetings of the IIL Group

5.7 The Head of Risk & Assurance is responsible for:

- Ensuring effective external reporting mechanisms are in place and that they are reported in accordance with national guidance
- Lead and manage the operational management of the incident reporting system

- Operational management of the Serious Incident & Compliance Lead and Incident Reporting Lead – ensuring all regulatory requirements are met as appropriate to these roles and responsibilities
- Quality assuring all serious incident investigation reports prior to final drafts reviewed by the Deputy Director Quality Governance and Patient Safety
- Develop, delivery and evaluate access to training for incident reporting and investigation
- Supporting the Trust with incident reporting data, including the identification of trends for risk reduction measures
- Lead and manage the 'Being Open' and 'Duty of Candour' processes and ensure that they are followed when a patient safety incident occurs
- Reviewing monthly published National Reporting and Learning System (NRLS) data to monitor trends in national reporting, benchmarking YDH against similar sized acute trusts and monitor data to ensure YDH are not under reporting incidents

5.8 The nominated **Investigating Officer** is responsible for:

- Undertaking the appropriate level of local investigation and root cause analysis as commissioned by the Deputy Director Quality Governance and Patient Safety
- Communicating with internal and external stakeholders as appropriate to assist in the investigation process and to ensure lessons are learnt
- In consultation with the managers (ward sisters, matrons, heads of department) of relevant areas, make recommendations for actions to prevent reoccurrence, to include the preparation of an action plan and/or improvement strategy
- Provide a copy of the draft investigation report to the Clinical Governance Department for quality assurance processes
- Ensuring they are appropriately trained to undertake on root cause analysis

5.9 The **Incident Reporting Lead** is accountable to the Head of Risk & Assurance and acts as the incident liaison officer. They are responsible for:

- Maintaining the operational management of the incident reporting system
- Checking incident reports as soon as reasonably practical, including the grading of risk and actual impact, and to identify if further investigation or actions are required
- Ensuring that incident reports are fully anonymised before being uploaded to the NRLS
- Undertaking the monthly upload of incident data to the NRLS
- Uploading RIDDOR reportable incidents to Health and Safety Executive (HSE) as required and within the relevant timeframes
- Ensuring the web notifications within the incident reporting system reflect the organisational structures of the Trust
- Maintaining the Trust's register of serious incidents
- Scanning all records and notes into the appropriate investigation folders
- Provide training and ongoing support on the use of the Ulysses Incident Reporting System

5.10 The **Serious Incident & Compliance Lead** will work with the nominated investigating officer and is responsible for:

- Writing formally to the patient/family providing an apology and information on the investigation process triggered by Duty of Candour

- Monitoring levels of incident reporting, identifying themes and trends
- Assisting in the formulation of action plans and ensuring that they are included in the relevant work plan
- Ensuring that overdue action plans are brought to the attention of the SBU and reported through the appropriate governance meetings
- Working with the Incident Reporting Lead to maintain the Trust's serious incident register
- Quality assuring investigation reports prior to them being circulated for comments and quality assured
- Providing support to nominated investigating officers as required
- Logging all externally reportable incidents to STEIS
- Providing the administration support to the IIL Review Group
- Ensuring that the nominated investigating officer is provided with the current templates and information required to commence an investigation

5.11 The **IIL Group** reports to the Patient Safety Committee and is responsible for:

- Providing an oversight of the process for investigating serious incidents, ensuring that investigations are completed within the relevant timescale
- Ensuring that the Duty of Candour is applied as appropriate
- Providing assurance to demonstrate that the Trust is meeting its obligations in relation to learning as set out in Learning, Candour and Accountability December 2016 and NHS England SI Framework 2015
- Review incident and complaint data and patient/user feedback to establish any themes or wards or departments in need of particular attention, and to note complaint and incident action plans, ensuring a standardised approach to capturing learning and developing training and education

5.12 The **Patient Safety Committee** reports to the Governance and Quality Assurance Committee, which is a sub-committee of the Board of Directors, and is responsible for:

- Ensuring that key themes and lessons learned from serious incidents are identified and shared across the Trust for continuous quality improvement
- Monitoring the incident reporting process to ensure that these are functioning in accordance with regulatory requirements and that staff are appropriately engaged with the process
- Monitor action plans against the requirements for NHS Improvement and the Care Quality Commission whilst ensuring compliance with Patient Safety standards

5.13 All **Staff** are responsible for:

- Ensuring that they have received appropriate training on how to access and report incidents using the Trust's web-based reporting system Ulysses
- Reporting incidents as soon as they are identified
- Ensuring incidents that cause harm are notified to their manager, or higher, at the earliest opportunity
- Seeking support from their manager and/or Occupational Health if they are affected by an incident
- Raising concerns if they witness or feel that patient care is being adversely affected

## 6. WHEN AN INCIDENT OCCURS

### Immediate Action

6.1 Annex A provides a flow chart of the incident reporting process.

6.2 The person identifying the incident should take immediate action to ensure the safety of patient(s), other service users and staff and then report the incident to the person in charge of that area. For areas with no local manager (e.g. in corridors or car parks) the appropriate facilities, or housekeeping and domestic team, should be informed if action needs to be taken.

6.3 When the incident involves a patient, details of the incident should also be recorded in the medical and/or nursing notes with appropriate follow up as necessary.

### Reporting an Incident

### Incident Reporting System

6.4 All incidents, including near misses, must be reported on the Trust's web-based incident reporting system, Ulysses accessed via the intranet (link on the yCloud homepage). They should be reported at the earliest opportunity, following an incident occurring, or the incident being identified.

6.5 If an incident is identified after the event, the incident report should be completed by the person who identified it. All applicable fields of the incident report form should be completed including details of any witnesses so that they can be interviewed if an investigation is required.

### Impact of the Incident

6.6 The incident report includes questions to help identify the **actual impact** (level of 'harm' or 'loss') of the incident, in line with the risk matrix shown at Annex B. When reporting a patient safety incident the actual impact indicates the seriousness of the incident and will help inform the level of investigation required.

### Manager Action

6.7 Ulysses automatically notifies relevant managers and other key Trust staff. Managers must log in to the system and ensure the following:

- Confirm the details of the incident and ensure that the risk assessment, and the actual impact, scoring is appropriate
- Advise senior managers if the incident is deemed serious
- Feedback to the individual who submitted the report of any actions taken as a result and provide support accordingly
- Complete and update the incident report as soon as possible, within a maximum of 30 days of the incident being reported, to include:
    - The underlying reasons for the incident occurring; and
    - Actions taken to prevent recurrence

### National Reporting and Learning System (NRLS)

6.8 All patient safety incidents (including serious patient safety incidents as described in section 4) are uploaded to the NRLS each week by the Incident Reporting Lead. The system enables patient safety incident reports to be submitted to a national database, this data is then analysed centrally to identify hazards, risks and opportunities to improve patient safety nationally.

## 7. IDENTIFYING AND REPORTING SERIOUS INCIDENTS

### Identifying a Serious Incident

7.1 As defined by NHS England's Serious Incident Framework, serious incidents in the NHS include:

- Acts and/or omissions occurring as part of NHS-funded healthcare (including in the community) that result in:
    - Unexpected or avoidable death of one or more people. This includes
        - suicide/self-inflicted death; and
        - homicide by a person in receipt of mental health care within the recent past
    - Unexpected or avoidable injury to one or more people that has resulted in serious harm;
    - Unexpected or avoidable injury to one or more people that requires further treatment by a healthcare professional in order to prevent:
        - the death of the service user; or
        - serious harm;
    - Actual or alleged abuse; sexual abuse, physical or psychological ill-treatment, or acts of omission which constitute neglect, exploitation, financial or material abuse, discriminative and organisational abuse, self-neglect, domestic abuse, human trafficking and modern day slavery where:
        - healthcare did not take appropriate action/intervention to safeguard against such abuse occurring; or
        - where abuse occurred during the provision of NHS-funded care
        - this includes abuse that resulted in (or was identified through) a Serious Case Review (SCR), Safeguarding Adult Review (SAR), Safeguarding Adult Enquiry or other externally-led investigation, where delivery of NHS funded care caused/contributed towards the incident (see Part One; sections 1.3 and 1.5 for further information)
- A Never Event – all Never Events are defined as serious incidents although not all Never Events necessarily result in serious harm or death
- An incident (or series of incidents) that prevents, or threatens to prevent, an organisation's ability to continue to deliver an acceptable quality of healthcare services, including (but not limited to) the following:
    - Failures in the security, integrity, accuracy or availability of information often described as data loss and/or information governance related issues;
        - Property damage;
        - Security breach/concern;

  - Incidents in population-wide healthcare activities like screening and immunisation programmes where the potential for harm may extend to a large population;
  - Inappropriate enforcement/care under the Mental Health Act (1983) and the Mental Capacity Act (2005) including Mental Capacity Act, Deprivation of Liberty Safeguards (MCA DOLS);
  - Systematic failure to provide an acceptable standard of safe care (this may include incidents, or series of incidents, which necessitate ward/ unit closure or suspension of services); or
  - Activation of Major Incident Plan (by provider, commissioner or relevant agency)

- Major loss of confidence in the service, including prolonged adverse media coverage or public concern about the quality of healthcare or an organisation

- Incidents which activate the NHS Trust or Commissioner Major Incident Plan

- Incidents which will be of significant public concern

- Incidents which will give rise to significant media interest or will be of significance to other agencies such as the police or other external agencies

**Reporting a Serious Incident**

**Internal Reporting Arrangements**

7.2 All incidents, including serious incidents, must be reported on the Trust's web-based reporting system, Ulysses.

7.3 When a serious incident has occurred, then the notification process outlined in Annex C must be followed (this includes arrangements out-of-hours).

**External Reporting Arrangements**

7.4 The Trust must report serious incidents to the Somerset CCG no later than two working days after a serious incident is identified. Serious patient safety incidents must also be reported on the NHS Strategic Executive Information System (STEIS) within two working days of the incident being identified. The Clinical Governance Team are responsible for ensuring that all incidents fitting the criteria are reported as necessary within the timescale.

7.5 Other regulatory, statutory, advisory and professional bodies should be informed about serious incidents depending on the nature and circumstances of the incident. This should be discussed and agreed with the Clinical Governance Team (Deputy Director Quality Governance and Patient Safety). Serious incident reports must clearly state that relevant bodies have been informed.

7.6 Relevant bodies may include and are not limited to:

- Care Quality Commission (CQC)
- Somerset Clinical Commissioning Group
- Dorset Clinical Commissioning Group
- Coroner
- Department of Health

- Health and Safety Executive
- Police
- Nursing and Midwifery Council
- General Medical Council
- NHS Counter Fraud Authority
- Public Health England
- Health Education England
- Local Authorities
- NHS Digital (reported through the Information Governance Toolkit)
- Medicines and Healthcare Products Regulatory Agency (MHRA)

**Immediate Action Following a Serious Incident**

7.7 A senior manager or clinician should be identified by the Deputy Director Quality Governance and Patient Safety, or Deputy, to undertake the following:

- Arrange for any immediate actions required to ensure the safety of the patient(s), other service users and staff
- Obtain all relevant physical, scientific and documentary evidence, and make sure it is secure and preserved. Initial actions of local managers in the collection and retention of information are important for the overall integrity of the investigation process
- Identify witnesses, including staff, and other service users, to ensure they receive effective support
- Identify an appropriate specialist/clinician to conduct an 72-hour review to confirm whether a serious incident has occurred and if applicable, the level of investigation required and to outline immediate action taken (including where other organisations/partners have been informed)
- Ensure commissioners and other relevant parties (for example, Police, Safeguarding Professionals, the Information Commissioner's Office) are informed at the earliest opportunity and within two working days of a serious incident being identified
- Agree who will make the initial contact with those involved, or their family/carer(s). Where an individual(s) has been harmed by the actions of a patient, particular thought should be given to who is best placed to contact the victim and/or their family. Where necessary the Trust must contact the police and agree with them who will make the initial contact with the victim(s), their family/carer(s) and/or the perpetrator's family. Those involved should have a single point of contact within the Trust, the Patient Experience Manager
- Arrange appropriate meeting(s) with key stakeholders, including patients/victims and their families/carers as required

**Reporting Cases of Restraint**

7.8 An incident form should be submitted in any case where restraint is used for any reason. If the restraint results in harm, including low harm, a separate incident form should be submitted which includes the following information:

- The type or types of restraint used
- The duration of each type of restraint
- The events leading up to the restraint being used
- Details about the harm to the patient

- Detail about what physical observations were undertaken and recorded during the restraint

**Reporting Pressure Damage**

7.9 Please refer to Annex G and H for the process for reporting and investigating pressure damage.

**Safeguarding Incidents**

7.10 Safeguarding is effectively protecting children and vulnerable adults from abuse or neglect. All NHS services have a key role to play in safeguarding and promoting the welfare of children and vulnerable adults, as safeguarding is everybody's business. Safeguarding children is a statutory duty under section 11 of the Children Act 2004 and in accordance with government guidance in 'Working Together to Safeguard Children' 2013. Safeguarding adults is a statutory requirement under the Care Act 2014.

7.11 Please refer to Annex I for the process for investigating safeguarding incidents.

**Information Governance Incidents**

7.12 The General Data Protection Regulations (GDPR) 2016 and the Data Protection Act (DPA) 2018 introduces a duty on data controllers and data processors to report certain types of personal data breaches which meet the criteria of the Data Security and Protection Toolkit (DSPT) IG Incident Matrix to the relevant supervisory authority. There is a requirement this must be completed by the Trust as a data controller within 72 hours of becoming aware of the breach.

7.13 If the breach is likely to result in a high risk of adversely affecting individuals' rights and freedoms, the Trust must also inform those individuals without undue delay.

7.14 All staff have a duty to report any breaches to their Manager, Data Protection Officer and Information Governance Manager. This will be reported through the Trust Incident Reporting System and if a theme or risk is identified, recorded on the Risk Register.

7.15 Where a breach has occurred, disciplinary action may be taken and working practices and procedure will be reviewed.

7.16 Serious breaches, or serious untoward incidents, will be addressed by the Trust Data Protection Officer, by raising a Serious Untoward Incident Form on the DSPT and by informing the ICO.

7.17 Under the GDPR 2016 and DPA 2018 the Trust are required to keep a record of any personal data breaches, regardless of whether the breach has reached the threshold to notify the relevant supervisory authority. This information should be held on the individual incident report within the Trust's Incident Reporting System ensuring that root causes, mitigating controls and appropriate mitigating actions are identified and recorded within the incident report.

7.18 Failing to notify a breach when required to do so can result in a significant fine for the Trust by the ICO. The fine can be combined with the ICO's other corrective powers under Article 58 GDPR.

7.19 As the National SI Framework 2015 has not yet been updated to incorporate the Data Security Protection Toolkit, which replaced the Information Governance Toolkit, the SIARG will determine whether any serious IG incidents meet the current SI Framework and are reported on the Strategic Executive Information System (STEIS).

**Infections and Outbreaks**

7.20 Please refer to the relevant Trust Infection Prevention and Control Policies and Procedures which outline the processes undertaken for infections and outbreaks.

**Managing Safety Incidents in National Screening Programmes**

7.21 Guidance has been developed in collaboration by the NHS screening programmes and NHS England. The full guidance can be accessed at https://www.gov.uk/government/publications/managing-safety-incidents-in-nhs-screening-programmes This guidance is to be used to support the reporting, investigation and management of incidents in screening programmes. It incorporates a process for assessing whether a quality concern is a screening safety incident or a serious incident.

**52 Week Harm Reviews**

7.22 Patients who exceed 52 weeks on a Referral to Treatment (RTT) pathway will have their pathway reviewed at a weekly Trust wide RTT meeting and escalated for a formal Clinical Harm Review (CHR) depending on both the reasoning for their breach of the national RTT guidance and the outcome of their clinical pathway. All CHRs will be incident reported as outlined within this policy. All incidents where a harm level of 3 (moderate harm) or above as a result of the delay has been potentially identified, will be discussed at the weekly Senior Incident and Alert Review Group and a decision will be made regarding the level of investigation required in line with this policy. The CHR will take into account that a patient may choose to wait longer or clinically be unable to be seen or treated within these time frames. Please refer to the Trust's Standard Operating Procedure for Non-Cancer Clinical Harm Reviews which outlines the procedure to be followed in the event of a patient exceeding 52 weeks on a RTT pathway.

## 8 INVESTIGATING SERIOUS INCIDENTS

8.1 Appendix 1 provides NHS England's overview of the incident management process.

**Levels of Investigation**

8.2 The nature, severity and complexity of serious incidents vary on a case-by-case basis and therefore the level of response should be depend on and proportion to the circumstances of each specific incident. There are three levels of investigation as shown in the table below:

| Level | Application | Product/ outcome | Owner | Timescale for completion |
|---|---|---|---|---|
| Level 1 **Concise internal investigation** | Suited to less complex incidents which can be managed by individuals or a small group at a | Concise / compact investigation report which includes the essentials of a | Provider organisation (Trust Chief Executive / relevant deputy) in which the incident occurred, providing principles for objectivity are upheld | Internal investigations, whether concise or comprehensive much be completed within 60 working |

| | | | | |
|---|---|---|---|---|
| | local level | credible investigation | | days of the incident being reported to the relevant commissioner<br>All internal investigations should be supported by a clear investigation management plan |
| Level 2 **Comprehensive internal investigation** (this includes those with an independent element or full independent investigations commission by the provider) | Suited to complex issues which should be managed by a multi-disciplinary team involving experts and / or specialist investigators where applicable | Comprehensive investigation report including all elements of credible investigation | Provider organisation (Trust Chief Executive / relevant deputy) in which the incident occurred, providing principles for objectivity are upheld. Providers may wish to commission an independent investigation or involve independent members as part of the investigation team to add a level of external scrutiny/objectivity | |
| Level 3 **Independent investigation** | Required where the integrity of the investigation is likely to be challenged or where it will be difficult for an organisation to conduct an objective investigation internally due to the size of the organisation or the capacity / capability of the available individuals and / or number of organisations involved | Comprehensive investigation report including all elements of a credible investigation | The investigator and **all** members of the investigation team must be independent of the provider. To fulfil independency the investigation must be commissioned and undertaken entirely independently of the organisation whose actions and processes are being investigated | 6 months from the date the investigation is commissioned |

**72 Hour Report**

8.3 A 72 hour review should be undertaken for those incidents that meet the criteria listed in 7.1, and uploaded onto STEIS. This should be completed within three working days of the incident being identified. The aim of the initial review is to:

- Identify and provide assurance that any necessary immediate action to ensure the safety of staff, patients and the public is in place;
- Assess the incident in more detail (and to confirm if the incident does still meet the criteria for a serious incident and does therefore require a full investigation); and
- Propose the appropriate level of investigation

8.4 The information submitted as part of the initial review should be reviewed by all appropriate stakeholders and the Deputy Director Quality Governance and Patient Safety or deputy in order to inform the level of investigation required.

**Investigation Process**

8.5 When a serious incident has been identified, the Deputy Director Quality Governance and Patient Safety will nominate two investigating officers. It is the responsibility of the investigating officers to keep the Trust fully briefed about the incident and actions being taken. The investigating officers are also responsible for identifying

valuable/safety-critical learning to be shared at any stage of the investigation process. They should not wait until completion of the investigation to highlight system weaknesses/share valuable learning which may prevent future harm.

8.6 The nominated investigating officers should have:

- Knowledge of what constitutes an effective systems investigation process, and the skills/competencies to lead and deliver this
- Skills/competencies in effective report writing and document formulation
- Expertise in facilitating patient/family involvement
- Understanding of the specialty involved – this often requires representation from more than one professional group to ensure investigation balance and credible
- Responsibility for administration and documentation (or for there to be adequate administrative and IT support)
- Access to appropriate legal and/or information governance support where appropriate
- Access to competent proof-reading services where required; and
- Appropriate links/mechanisms to share lesson locally and nationally during the investigation as required

**Investigation Report and Action Plan**

8.7 Serious incident investigation reports must be shared with key interested stakeholders including patients, victims and their families (see section 9 regarding the Duty of Candour). It is recommended that reports are drafted on the basis that they may become public, so issues concerning anonymity and consent for disclosure of personal information are important and should be considered at an early stage in the investigation process. Those investigating serious incidents can seek advice from the Trust's Caldicott Guardian and/or Data Protection Officer if guidance is needed about the disclosure of patient identifiable information.

**Final Report**

8.8 Report templates will be provided by the Clinical Governance Department once an investigating officer has been identified.

8.9 The report should:

- Be simple and easy to read
- Disclose only relevant confidential personal information relevant to the investigation
- Include evidence and details of the methodology used for an investigation (for example timelines/cause and effect charts, brainstorming/brain writing, nominal group technique, use of a contributory factor framework and fishbone diagrams, five whys and barrier analysis)
- Identify root causes and recommendations
- Ensure that conclusions are evidenced and reasoned, and that recommendations are implementable
- Include a description of how patients/victims and families have been engaged in the process
- Include a description of the support provided to patients/victims/families and staff following the incident

8.10 The investigation concludes with an investigation report and action plan. This needs to be written as soon as possible and in a way that is accessible and understandable to all readers.

**Action Plan**

8.11 A SMART approach to action planning is essential. That is, the actions should be: Specific, Measurable, Achievable, Realistic and Timely. To ensure that the most effective actions/solutions are taken forward, it is recommended that an option appraisal of the potential actions/solutions is undertaken before the final action plan is developed and agreed:

- Action plans must be formulated by those who have responsibility for implementation, delivery and financial aspects of any actions
- Every recommendation must have a clearly articulated action that follows logically from the findings of the investigation
- Actions should be designed and targeted to significantly reduce the risk of recurrence of the incident. It must target the weaknesses in the system (i.e. the 'root causes'/most significant influencing factors) which resulted in the lapses/acts/omissions in care and treatment identified as causing or contributing towards the incident
- A responsible person must be identified for implementation of each action point;
- There are clear deadlines for completion of actions
- There must be a description of the form of evidence that will be available to confirm completion and also to demonstrate the impact implementation has had on reducing the risk of recurrence
- All actions identified should be included on the most appropriate work plan for monitoring
- Actions that are overdue must be discussed by the relevant SBU/CBU and added to the work plans which are held within the action planning module on Ulysses

**Quality Assurance Process**

8.12 All investigation reports must be reviewed and agreed by those involved to ensure they are complete and accurate before they are submitted for internal review.

8.13 Completed investigation reports will be reviewed by the Serious Incident & Compliance Lead. They will ensure that all reports are fit for purpose, appropriately anonymised and that actions have been agreed with the staff responsible for taking them forward.

8.14 Completed reports will be circulated to the Deputy Director Quality Governance and Patient Safety, Clinical Director of Patient Safety and the Head of Risk & Assurance and if relevant, Legal Services Manager for final review.

8.15 Details of the learning from the completed investigations must be discussed at IIL Group and Patient Safety Committee.

8.16 The investigating officer(s) and Clinical Governance Team are responsible for the security of documents and information and must have due regard to Caldicott principles on patient confidentially and requirements under the GDPR 2016 and DPA 2018.

## 9 DUTY OF CANDOUR & SUPPORTING THOSE INVOLVED

9.1 Duty of Candour (Regulation 20 of the Health and Social Care Act 2008) should be applied in all serious incidents where harm is caused (moderate harm, severe harm, death and prolonged psychological harm). This statutory requirement has been introduced to ensure health care providers operate in a more open and transparent way when certain incidents occur in relation to the care and treatment provided to people using the service.

9.2 Annex E outlines the process for Duty of Candour, for further information please refer to the Being Open and Duty of Candour Policy.

**Involving Patients, Victims and Their Families/Carers**

9.3 Please refer to the Being Open and Duty of Candour Policy.

**Supporting Staff**

9.4 It is important to recognise that serious incidents can have a significant impact on the staff involved or who may have witnessed an incident. Like victims and families they will want to know what happened and why and what can be done to prevent the incident happening again.

9.5 Staff involved in to the investigation process should have the opportunity to access professional advice from their relevant professional body or union, staff counselling services and occupational health services. They should also be provided with information about the stages of the investigation and how they will be expected to contribute to the process.

9.6 It must be made clear to staff involved that investigation process is separate to any other legal and/or disciplinary process. The Trust advocates justifiable accountability but there is zero tolerance for inappropriate blame, those involved must not be unfairly exposed to punitive disciplinary action, increased medico-legal risk or any threat to their registration by virtue of involvement in the investigation process.

## 10 DISCIPLINARY AND CAPABILITY PROCESS

10.1 The incident decision tree (Appendix 2) should be used to promote fair and consistent treatment of staff. In the very rare circumstances where a member of staff has committed a criminal or malicious act, the member(s) of staff should be advised at an early stage to enable them to obtain separate legal advice and/or representation.

10.2 In cases where individuals have been identified as making serious mistakes, or where their competence may be in question, a decision must be made about whether they are able to remain in their current role for the safety of patients and others. In such cases it may be appropriate to instigate the Disciplinary or Capability Policy contained within the HR Manual. The senior SBU team must make a decision, with guidance from the Deputy Director Quality Governance and Patient Safety and Human Resources.

10.3 The decision to report individuals to their governing bodies, such as the General Medical Council (GMC) or Nursing and Midwifery Council (NMC), will be taken through the Chief Medical Officer or the Chief Nurse, Director of People and Deputy Chief Executive.

10.4 Any decisions must be communicated to the individual and their line manager, in line with the Disciplinary or Capability Policy contained within the HR Manual, and documented on the staff member's personnel file.

## 11 STAFF RAISING CONCERNS

11.1 A member of staff who wishes to report concerns in person, or outside the incident reporting system, should follow the guidance provided in the Trust's Raising Concerns (Whistle Blowing) Policy contained within the HR Manual; advice is also available on the Trust's intranet site yCloud.

## 12 DEBRIEF ARRANGEMENTS

12.1 A Standard Operating Procedure is being developed which will cover the debrief arrangements within the Trust. For further details please contact the Clinical Governance Department on extension 3117,

## 13 ANALYSIS REVIEW & DISSEMINATION OF LEARNING

13.1 The Clinical Governance Department will produce quantitative reports on a quarterly basis as part of the Trusts Quality Report. The report will detail the number of incidents reported on a range of patient safety aspects including all incidents by risk category. Data from the NRLS reports will be used to support this information on levels of reporting against other acute trusts.

13.2 The number of internally and externally reported investigations will also be reported.

13.3 Incidents are reviewed at the Patient Safety Committee, Governance and Quality Assurance Committee and SBU/CBU meetings as part of the governance agenda. Specific incident categories will be reviewed at relevant patient safety meetings (such as falls and pressure ulcers and Medicines Committee) or task and finish groups as appropriate.

13.4 Areas of focus will support the Trusts activities to reduce risk, areas of improvement and progress will be monitored through the Trusts Safety Improvement Programme.

13.5 All incident investigations completed, with lessons learned and actions taken may be considered for presentation at the bi-monthly Trustwide Rolling Governance meetings to allow cross-organisation learning; this may include externally reported incidents that have been shared across healthcare organisations.

## 14 TRAINING REQUIREMENTS

14.1 Incident reporting and investigation training will be carried out in line with the Training Needs Analysis (TNA). The training available includes:

- Induction training for all new staff
- Managers training, 'How to Manage Risk'
- Ad hoc online Ulysses attend training on the Ulysses incident reporting system
- Root Cause Analysis (RCA) training for nominated staff
- NHS England provide tools for completing incident investigations (http://www.england.nhs.uk/ourwork/patientsafety/root-cause/)

14.2 Details of all training on investigation processes and root cause analysis to assist in implementing this policy can be accessed via the Clinical Governance Department.

## 15 IMPLEMENTATION, MONITORING AND EVALUATION

15.1 Responsibility for implementation, monitoring and evaluation is identified in the Trust's Policy on Procedural Documents. An equality impact assessment has been carried out to ensure the policy is fair and does not discriminate any staff groups. A completed Equality Impact Assessment can be found at Annex J.

15.2 Internal key performance indicators:

- 72 hour report to be completed within 3 working days for all STEIS reportable incidents
- Level 1 investigation reports to be completed within 20 days
- Level 2 investigation reports to be submitted to the Clinical Governance Department within 30 working days, in order to achieve the national requirement of submission within working 60 days

15.3 Trust's external key performance indicators (monitored by Somerset CCG as Commissioner):

- Incident reported on STEIS within 2 working days of being identified as a Serious Incident
- 72 hour review received by Somerset CCG within 3 working days of incident being identified
- Final RCA report to be received by Somerset CCG no later than 60 working days
- SMART Action plan to be received by Somerset CCG no later than 60 working days of STEIS notification
- Action plan completed and evidence provided within CCG agreed deadline

15.4 Somerset CCG's external key performance indicators (monitored by Trust) as per the Somerset Serious Incidents Requiring investigation Policy:

- Commissioner review of 72 hour undertaken within 5 working days
- Commissioner RASCI matrix completed for all STEIS
- Commissioner review of final report communicated to provider in 20 calendar days
- Commissioner review of action plan communicated to provider in 20 calendar days
- Action plans monitored and quality assured via CCG SIRI panel
- Learning from serious incidents to be shared via Commissioner's local 'safety net' bulletin

## 16 SUBSIDIARY COMPANIES OF YEOVIL DISTRICT HOSPITAL (YDH)

16.1 Any employees of subsidiary companies of YDH will adhere to this policy and will receive consistent training in relation to policy implementation.

## 17 RELEVANT PUBLICATIONS

Statutory Duty of Candour
https://www.cqc.org.uk/guidance-providers/regulations-enforcement/regulation-20-duty-candour
CQC Learning, Candour and Accountability December 2016
https://www.cqc.org.uk/sites/default/files/20161213-learning-candour-accountability-full-report.pdf
NHS England Serious Incident Framework
http://www.england.nhs.uk/wp-content/uploads/2015/04/serious-incidnt-framwrk-upd.pdf
NHS England Never Events Policy and Framework
https://improvement.nhs.uk/resources/never-events-policy-and-framework/
Data Security and Protection Toolkit – IG Incident Reporting Tool User Guide
https://www.dsptoolkit.nhs.uk/
National Safety Standards for Invasive Procedures
https://improvement.nhs.uk/resources/national-safety-standards-invasive-procedures/

## ANNEX B – INCIDENT REPORTING POLICY RISK MATRIX

### Risk Consequence Score

| Descriptor | Insignificant | Minor | Moderate | Major | Catastrophic |
|---|---|---|---|---|---|
| **Injury** | Minor injury not requiring first aid | Minor injury or illness, first aid treatment needed | Over seven days off "sick" = **RIDDOR** reportable. | Major injuries, or long term incapacity / disability (loss of limb) | Death or major permanent incapacity |
| **Patient Experience** | Unsatisfactory patient experience not directly related to patient care | Unsatisfactory patient experience - readily resolvable | Mismanagement of patient care – short term effects | Mismanagement of patient care – long term effects | Totally unsatisfactory patient outcome or experience |
| **Complaint / Claim Potential** | Locally resolved complaint | Justified complaint peripheral to clinical care | Below excess claim. Justified complaint involving lack of appropriate care | Claim above excess level. Multiple justified complaints | Multiple claims or single major claim |
| **Objectives / Projects** | Insignificant cost increase / schedule slippage. Barely noticeable reduction in scope or quality | < 5% over budget / schedule slippage. Minor reduction in quality / scope | 5 -10% over budget / schedule slippage. Reduction in scope or quality requiring client approval | 10 - 25% over budget / schedule slippage. Doesn't meet secondary objectives | > 25% over budget / schedule slippage. Doesn't meet primary objectives |
| **Service / Business Interruption** | Loss / interruption > 1 hour | Loss / interruption > 8 hours | Loss / interruption > 1 day | Loss / interruption > 1 week | Permanent loss of service or facility |
| **Human Resources / Organisational Development** | Short term low staffing level temporarily reduces service quality (< 1 day) | Ongoing low staffing level reduces service quality | Late delivery of key objective / service due to lack of staff (recruitment, retention or sickness). Minor error due to insufficient training. Ongoing unsafe staffing level | Uncertain delivery of key objective / service due to lack of staff. Serious error due to insufficient training | Non delivery of key objective / service due to lack of staff. Loss of key staff. Very high turnover. Critical error due to insufficient training |
| **Financial** | Small loss(> £100) | Loss > £1,000 | Loss > £10,000 | Loss > £100,000 | Loss > £1,000,000 |
| **Inspection / Audit** | Minor recommendations. Minor non-compliance with standards | Recommendations given. Non-compliance with standards | Reduced rating. Challenging recommendations. Non-compliance with core standards | Enforcement Action. Low rating. Critical report. Multiple challenging recommendations. Major non-compliance with core standards | Prosecution. Zero Rating. Severely critical report |
| **Adverse Publicity / Reputation** | Rumours | Local Media - short term | Local Media - long term | National Media < 3 Days | National Media > 3 Days. MP Concern (Questions in House |

### Risk Likelihood Score

| | | |
|---|---|---|
| **1** | Rare | Only occurs in exceptional circumstances, <1%, 1 – 5 year strategic risk |
| **2** | Unlikely | Could occur at some time, 1- 5%, at least annually |
| **3** | Possible | Should occur at some time, 6 – 20%, at least monthly |
| **4** | Likely | Will probably occur, 21 – 50%, at least weekly |
| **5** | Almost Certain | Expected to occur, > 50%, at least daily |

**Risk Rating**

Insert frequency and severity scores on the risk assessment form and consult matrix below:

- If a risk falls in one of the boxes numbered **16 - 25**, immediate action required, so far as is reasonably practicable
- If a risk falls in one of the boxes numbered **12 - 15**, prompt action required, so far as is reasonably practicable
- If a risk falls in one of the boxes numbered **8 - 10**, risk reduction required, so far as is reasonably practicable
- If a risk falls in one of the boxes numbered **1 - 6**, further risk reduction may not be feasible or cost effective.

**Risk Matrix**

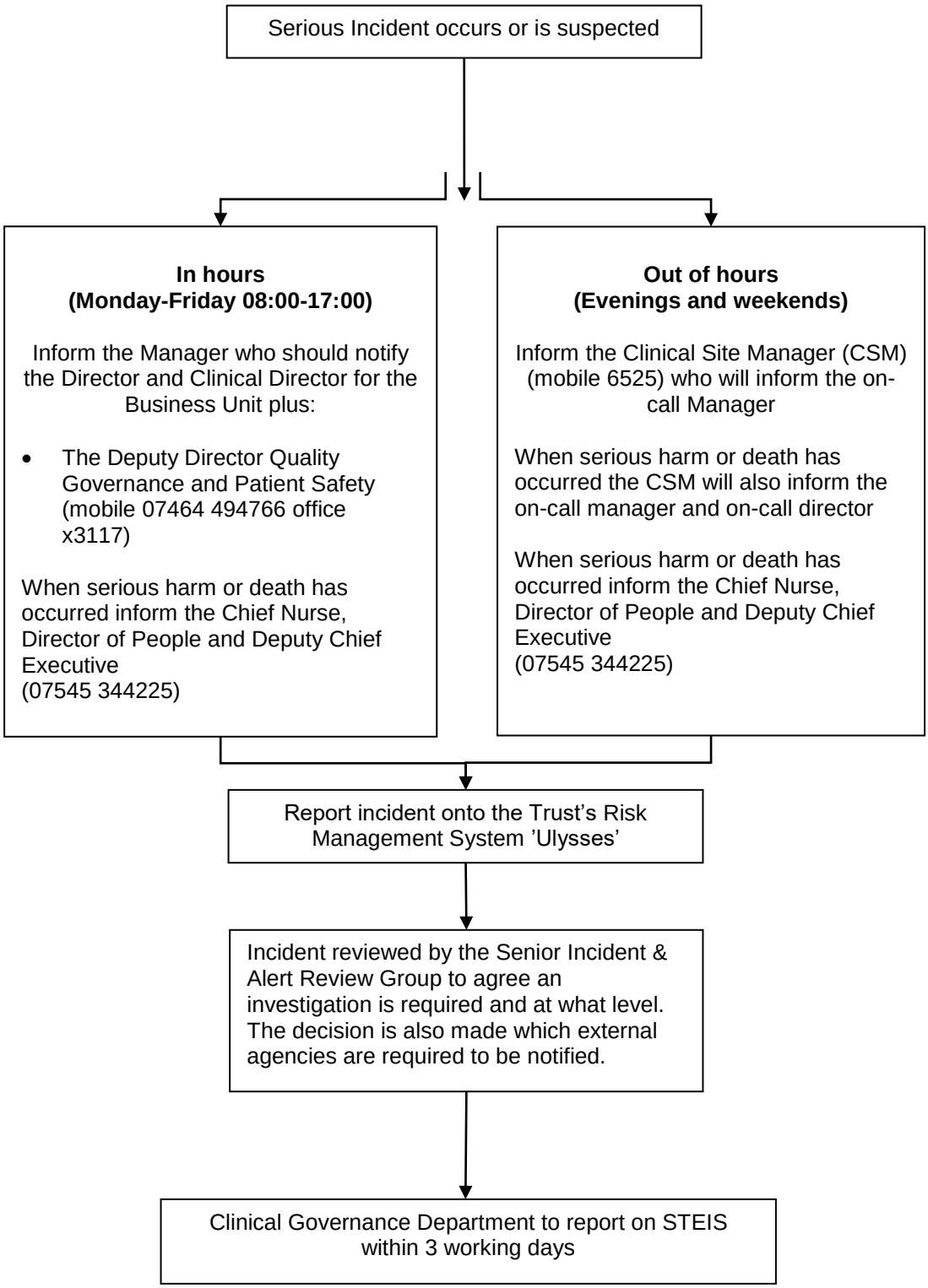
For grading risk, the scores obtained from the risk matrix are assigned grades as follows:

| Consequence | Likelihood | | | | |
|---|---|---|---|---|---|
| | Rare 1 | Unlikely 2 | Possible 3 | Likely 4 | Certain 5 |
| **Negligible - 1** | 1 | 2 | 3 | 4 | 5 |
| **Minor - 2** | 2 | 4 | 6 | 8 | 10 |
| **Moderate - 3** | 3 | 6 | 9 | 12 | 15 |
| **Major - 4** | 4 | 8 | 12 | 16 | 20 |
| **Catastrophic - 5** | 5 | 10 | 15 | 20 | 25 |

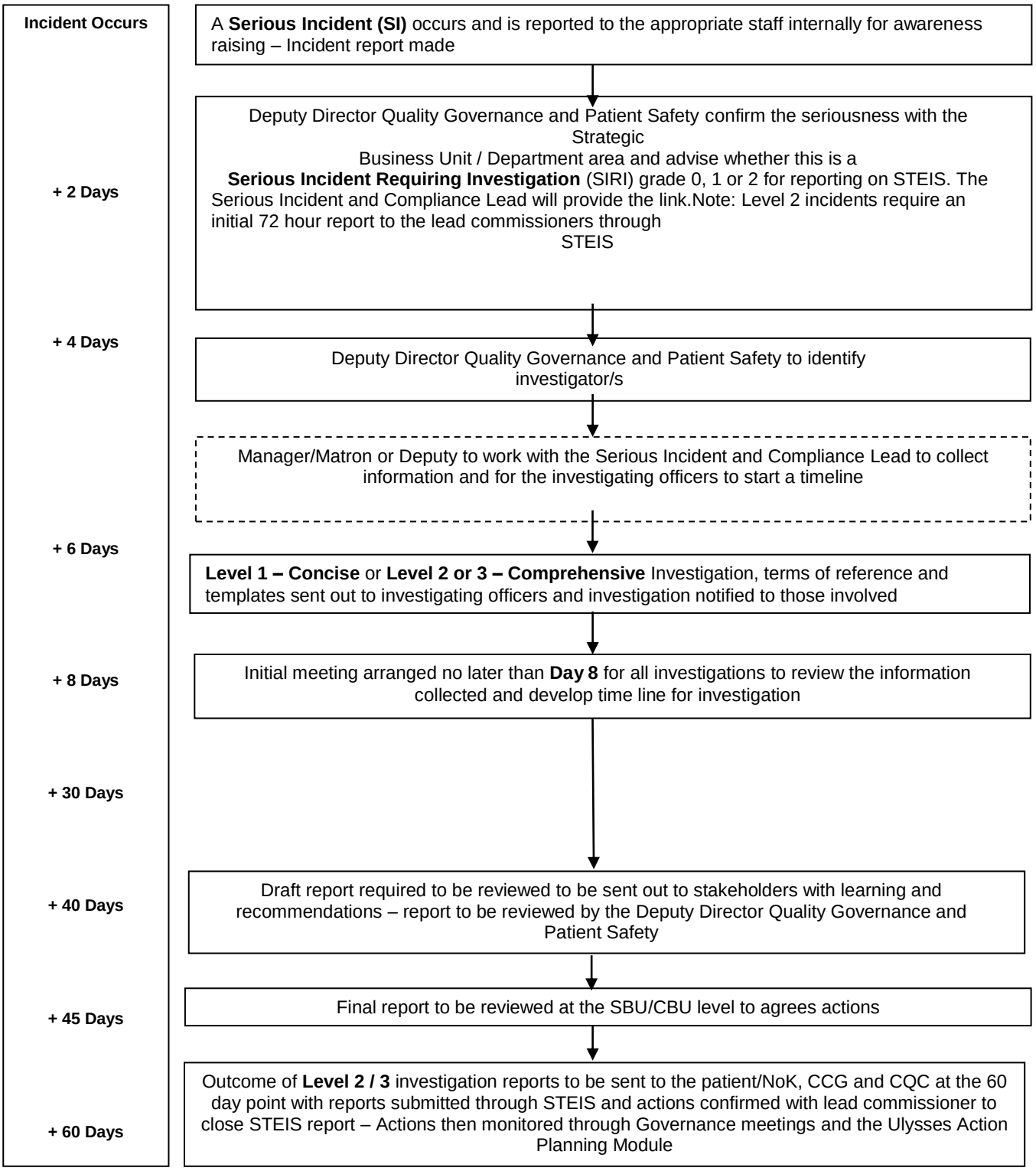
**KEY:** Low risk | Moderate risk | Significant risk | High risk

| |
|---|
| 1-6 = Low Risk |
| 8-10 = Moderate Risk |
| 12-15 = Significant Risk |
| 16-25 = High Risk |

## ANNEX C – NOTIFICATION PROCESS FOR REPORTING SERIOUS INCIDENTS



## ANNEX D – TIMELINE FOR REPORTING AND INVESTIGATING INCIDENTS



## ANNEX E – REGULATION 20: DUTY OF CANDOUR

### Must act in an open and transparent way with relevant persons* in relation to care and treatment provided

**1. As soon as reasonably practicable after becoming aware that a notifiable safety incident has occurred the Trust must:**

a. notify the relevant person that the incident has occurred; and

b. provide reasonable support to the relevant person in relation to the incident, including when giving such notification.

↓

**2. The notification must:**

a. be given in person by one or more representatives of the Trust;

b. provide an account, which to the best of the Trust's knowledge is true, of all the facts the Trust knows about the incident as at the date of the notification;

c. advise the relevant person what further enquiries into the incident the health service body believes are appropriate;

d. include an apology; and

e. be recorded in a written record securely kept by the Trust.

↓

**3. The notification must be followed by a written notification given or sent to the relevant person containing:**

a. the information provided under 2b;

b. details of any enquiries to be undertaken in accordance with 2c;

c. the results of any further enquiries into the incident; and

d. an apology.

↓

**4. But if the relevant person cannot be contacted in person, or declines to speak to the Trust representative:**

a. above boxes 1 to 3 are not to apply; and

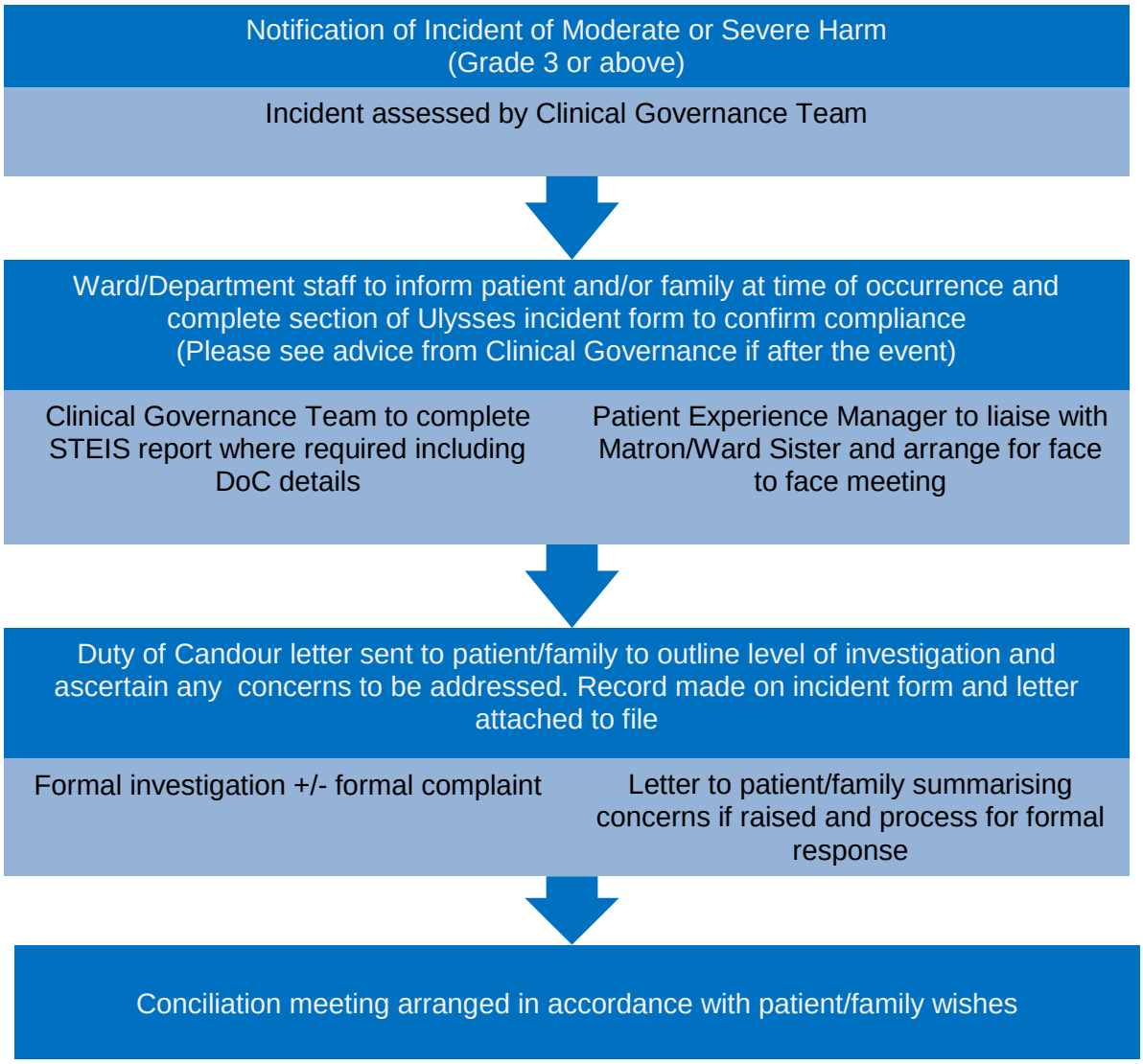
b. a written record is to be kept of attempts to contact or to speak to the relevant person

↓

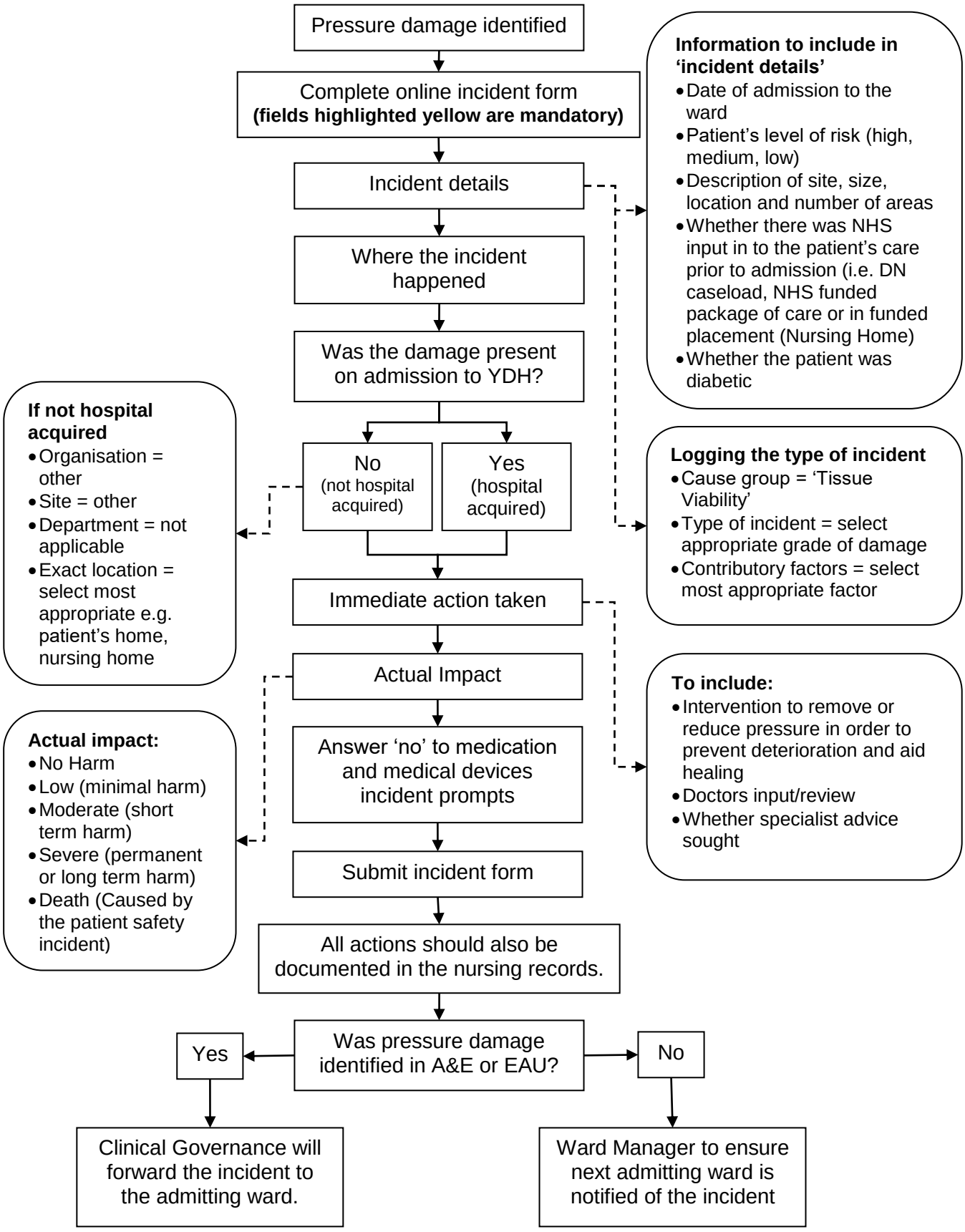
**5. The Trust must keep a copy of all correspondence with the relevant person under box 3**

*The relevant person is the person using the service and, in certain situations, extends to people acting lawfully on their behalf (for example a person under 16 who is not competent to make decisions about their care and treatment, or a person aged 16 or over who lacks the capacity to make decisions about their care and treatment). For those patients that are over the age of 16, and have capacity, staff should only speak to family members if the patient has given their permission for this.

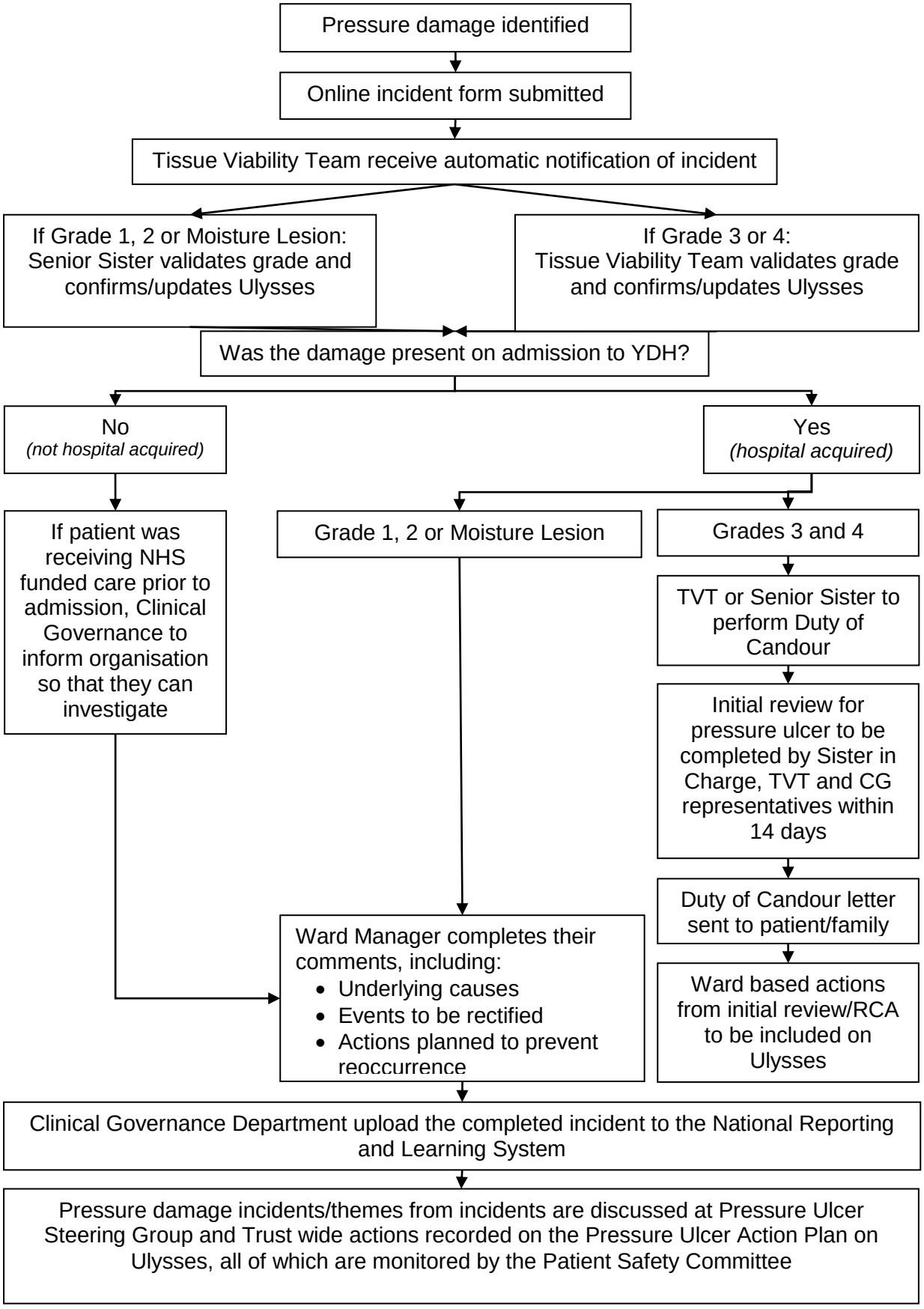
## ANNEX F – DUTY OF CANDOUR PROCESS



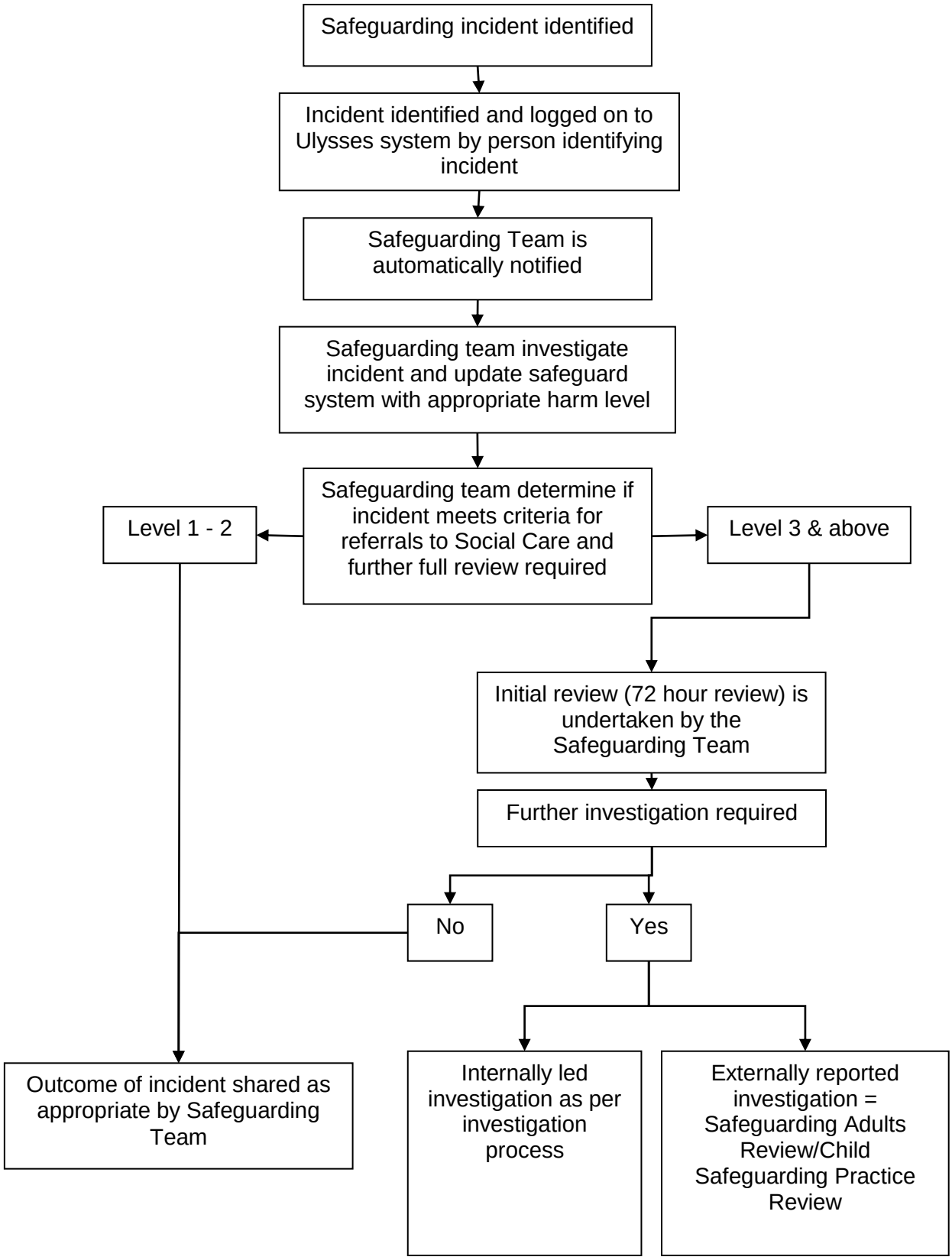
## ANNEX G – PROCESS FOR INCIDENT REPORTING PRESSURE DAMAGE



## ANNEX H – PROCESS FOR INVESTIGATING PRESSURE DAMAGE



## ANNEX I – PROCESS FOR INVESTIGATING SAFEGUARDING INCIDENTS



## ANNEX J – DEBRIEF FLOWCHART

A Standard Operating Procedure is being developed which will cover the debrief arrangements within the Trust which will include the flowchart. For further details please contact the Clinical Governance Department on extension 3117.

# Somerset Equality Impact Assessment

| | | | |
|---|---|---|---|
| Before completing this EIA please ensure you have read the EIA guidance notes – available from your Equality Officer | | | |
| **Organisation prepared for** | **Yeovil District Hospital NHS Foundation Trust** | | |
| **Version** | **1** | **Date Completed** | **1 March 2021** |
| **Description of what is being impact assessed** | | | |
| **Policy for the Development and Management of Procedural Documents** | | | |
| **Evidence** | | | |
| **What data/information have you used to assess how this policy/service might impact on protected groups?** Sources such as the Office of National Statistics, Somerset Intelligence Partnership, Somerset's Joint Strategic Needs Analysis (JSNA), Staff and/ or area profiles,, should be detailed here | | | |
| No impacts on protected groups | | | |
| **Who have you consulted with to assess possible impact on protected groups?** If you have not consulted other people, please explain why? | | | |
| Equality & Diversity Lead | | | |

| Analysis of impact on protected groups | | | | |
|---|---|---|---|---|
| The Public Sector Equality Duty requires us to eliminate discrimination, advance equality of opportunity and foster good relations with protected groups. Consider how this policy/service will achieve these aims. In the table below, using the evidence outlined above and your own understanding, detail what considerations and potential impacts against each of the three aims of the Public Sector Equality Duty. Based on this information, make an assessment of the likely outcome, before you have implemented any mitigation. | | | | |
| **Protected group** | **Summary of impact** | **Negative outcome** | **Neutral outcome** | **Positive outcome** |
| **Age** | • n/a | ☐ | ✓ | ☐ |
| **Disability** | • n/a | ☐ | ✓ | ☐ |
| **Gender reassignment** | • n/a | ☐ | ✓ | ☐ |
| **Marriage and civil partnership** | • n/a | ☐ | ✓ | ☐ |
| **Pregnancy and maternity** | • n/a | ☐ | ✓ | ☐ |
| **Race and ethnicity** | • n/a | ☐ | ✓ | ☐ |
| **Religion or belief** | • n/a | ☐ | ✓ | ☐ |
| **Sex** | • n/a | ☐ | ✓ | ☐ |
| **Sexual orientation** | • n/a | ☐ | ✓ | ☐ |

| | | | | |
|---|---|---|---|---|
| **Other, e.g. carers, veterans, homeless, low income, rurality/isolation, etc.** | • n/a | ☐ | ✓ | ☐ |

**Negative outcomes action plan**
Where you have ascertained that there will potentially be negative outcomes, you are required to mitigate the impact of these. Please detail below the actions that you intend to take.

| Action taken/to be taken | Date | Person responsible | How will it be monitored? | Action complete |
|---|---|---|---|---|
| n/a | Select date | | | ☐ |
| | Select date | | | ☐ |

**If negative impacts remain, please provide an explanation below.**

n/a

| | |
|---|---|
| **Completed by:** | **Samantha Hann** |
| **Date** | **11/05/2021** |
| **Signed off by:** | **Bernice Cooke** |
| **Date** | **11/05/2021** |
| **Equality Lead/Manager sign off date:** | **Not required as no significant service change as a result of this policy** |
| **To be reviewed by:** (officer name) | **Not required as no significant service change as a result of this policy** |
| **Review date:** | **n/a** |

**APPENDIX 1 – NHS ENGLAND'S OVERVIEW OF THE SERIOUS INCIDENT MANAGEMENT PROCESS**

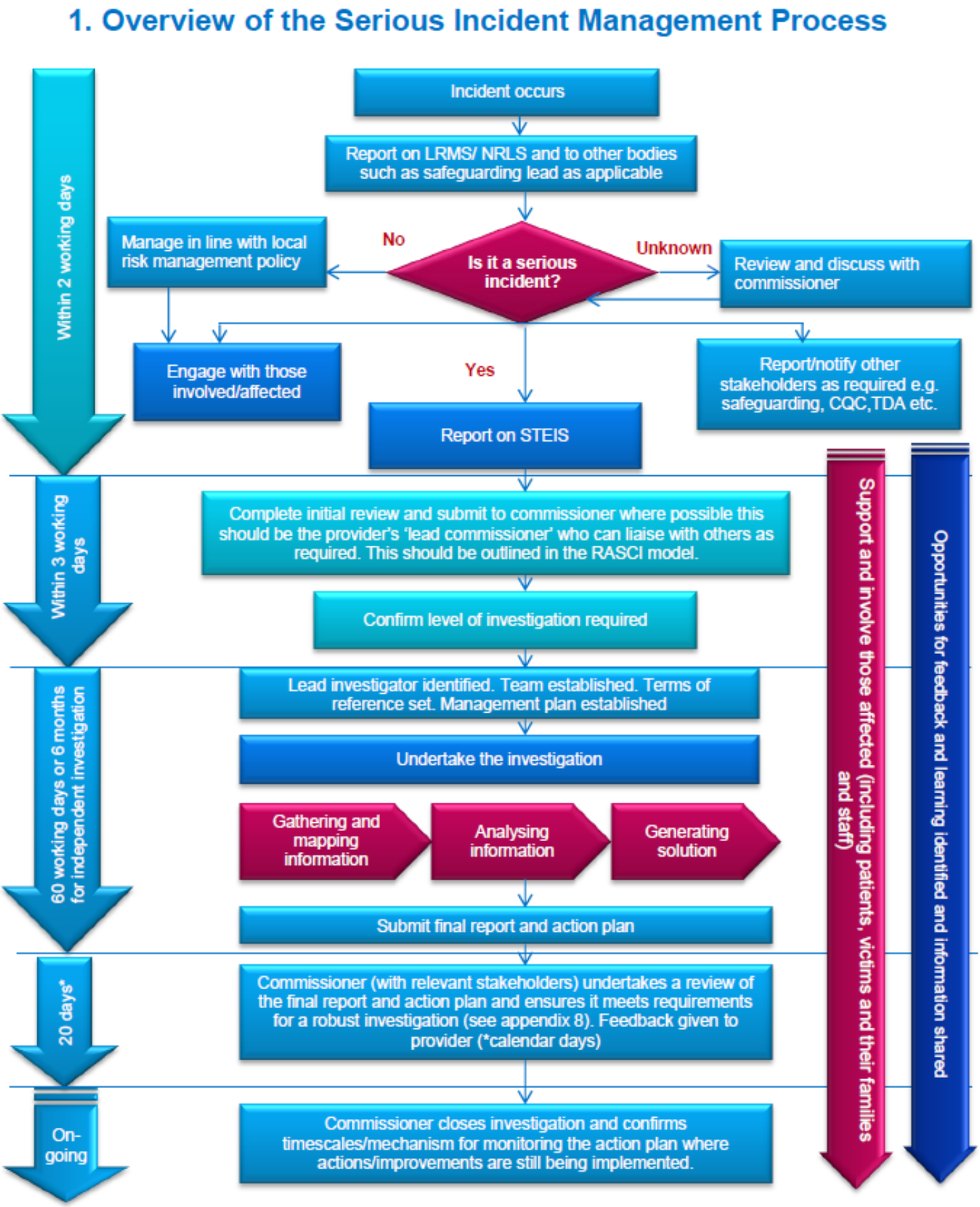



**Figure 1:** NHS England, Serious Incident Framework March 2015

## APPENDIX 2 – NPSA INCIDENT DECISION TREE

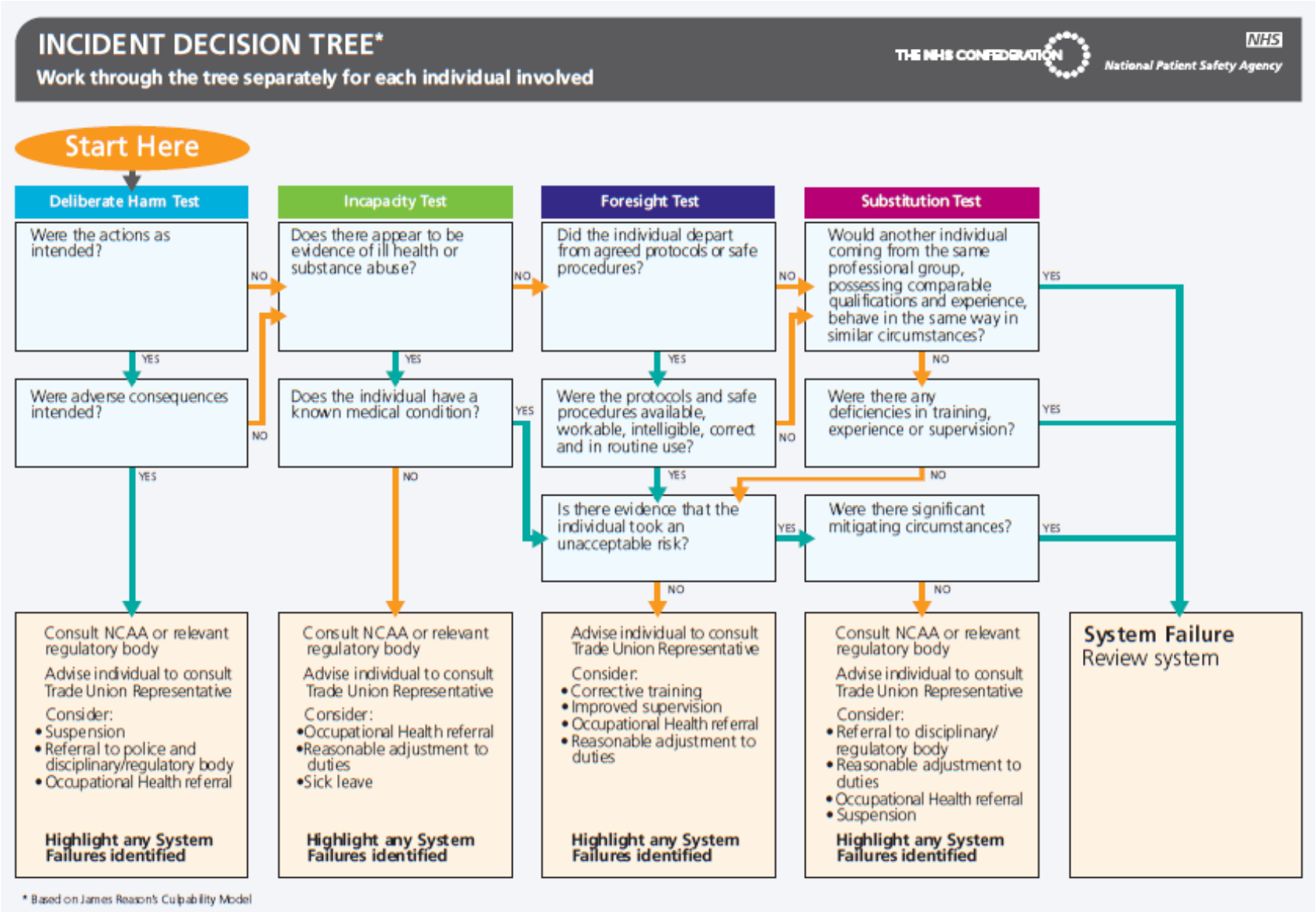





Figure 2: National Patient Safety Agency 2003, The Incident Decision Tree Information and advice on use