University Hospitals of Morecambe Bay
NHS Foundation Trust

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Which Principles of the NHS Constitution Apply? **Please list from principles 1-7 which apply** 3,4,5 Principles	**Which Staff Pledges of the NHS Constitution Apply?** **Please list from staff pledges 1-7 which apply** 1-7 Staff Pledges

Does this document meet the requirements of the Equality Act 2010 in relation to Race, Religion and Belief, Age, Disability, Gender, Sexual Orientation, Gender Identity, Pregnancy & Maternity, Marriage and Civil Partnership, Carers, Human Rights and Social Economic Deprivation discrimination? **Yes**

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BEHAVIOURAL STANDARDS FRAMEWORK

To help create a great place to work and a great place to be cared for, it is essential that our Trust policies, procedures and processes support our values and behaviours. This document, when used effectively, can help promote a workplace culture that values the contribution of everyone, shows support for staff as well as patients, recognises and celebrates the diversity of our staff, shows respect for everyone and ensures all our actions contribute to safe care and a safe working environment - all of which are principles of our Behavioural Standards Framework.

Behavioural Standards Framework – Expectations 'at a glance'

RIDDOR on a Page: For Managers and Staff

Why we need this guidance

The H&S Team reports around 24 incidents to the Health and Safety Executive every year.

We are required to do this by law under the **R**eporting of **I**njuries, **D**iseases and **D**angerous **O**ccurrences **R**egulations which specifies **timescales** within which must report certain types of incidents.

Some reports of staff incidents are reported late because managers do not state that the member of staff is absent or on restricted duties as a result.
Some reports of patient incidents are reported late because the possibility of being RIDDOR reportable is not always considered by the investigating manager.

What do we need to report and how quickly

There is a requirement to report certain incidents related to both staff and patients:

- The death of any person **(staff, patient or visitor)** arising out of or in connection with work – **report immediately**
- Accidents which result in an **employee or contractor** dying, suffering a **specified injury** or being **absent from work for more than 7 days** or **unable to do their normal duties for more than 7 days – report within 24 hours of the incident OR as soon as you know they will reach 8 days.**
- Accidents which result in a **patient, service user or visitor** suffering an injury and being taken directly to a hospital for treatment, or if the accident happens at a hospital, if they suffer a **specified injury- report immediately**
- An **employee or contractor** has one of the specified occupational diseases or is exposed to carcinogens, mutagens and biological agents – **report within 24 hours**
- Specified dangerous occurrences, which may not result in a reportable injury, but have the potential to do significant harm – e.g. high-risk needle-stick injuries – **report within 24 hours but act immediately**
- For patient incidents we look for “the failure of a patient safety management system” to help us decide if it is reportable.

Late reporting puts the Trust in breach of the Regulations.

Specified Injuries

Fracture other than fingers, thumbs or toes
Amputation of arm, hand, finger, thumb, leg, foot or toe
Crush injuries leading to internal organ damage
Loss or reduction of sight
Serious burns covering more than 10% of the body or damaging the eyes or respiratory system or other vital organs
Any other injury leading to hypothermia, heat induced illness, scalping (separation of skin from the head) which

- require hospital treatment or lead to unconsciousness (caused by asphyxia or head injury)
- requiring resuscitation or requiring admittance to hospital for more than 24 hours

Dangerous Occurrences

Our most common ones to be aware of are:

- accidental release of any biological agent likely to cause severe human illness (this includes Hep B, Hep C, Hep D and HIV) e.g. through high-risk needle-stick injury
- accidental release of any substance which may damage health – a COSHH incident.
- collapse, overturning or failure of patient hoists and slings whilst in use.

Contact

If you are unsure whether an incident is reportable to HSE its better to check than miss one! Contact the Health and Safety Team on **Ext 45260**

Please read the Reporting and Management of Incidents including Serious Incidents Policy

V4 – March 2018, Review: 01/07/2019
ID No. Corp/Proc/022

1. SUMMARY

This document sets out the arrangements for the reporting and management of all incidents including Serious Incidents. This policy applies to all staff working across the Trust including locum, agency, students and trainees.

The Trust has a duty to all patients, staff, contractors, volunteers and visitors to fully investigate all incidents, which have caused harm or have the potential to cause harm.

Having an extensive incident reporting system acts as an on-going method for identifying risks and thereby aids both reactive and proactive risk management. Whilst not individually of a serious nature, several similar reports may indicate a growing trend or allow a possible serious incident to be identified.

It is likely that many incidents will occur outside the routine weekday period and it is important that on-call managers are able to oversee these systems.

Individual incidents will vary in the scope of the investigation due to the nature, severity, likelihood of reoccurrence and the degree of public interest. The Trust recommends that the complexity of the investigation should be determined through risk assessment of the incident, therefore this policy provides guidance and is not a 'one size fits all'. Timescales should be proportionate to each incident.

2. PURPOSE

This policy sets out the processes for reporting and managing all incidents Implementation of the policy will lead to:

- An 'open and fair' blame culture where staff feel comfortable reporting
- Safer and healthier environment for patients, staff and others
- Decrease in the severity of incidents
- A significant contribution to the Trust's Five Year Strategic Plan and Quality Improvement Plan

3. SCOPE

This policy has been devised to provide guidance on the roles, responsibilities and actions of individuals in the event of any incident. It covers the immediate response, investigation and follow-up of all clinical and non-clinical incidents including serious incidents.

The guidance covers incidents from a limited, isolated incident involving one individual, through to a critical threat to the continuity of the service provided by the whole Trust.

This policy does not cover serious incidents relating to fraud/suspected fraud or any financial anomalies including theft, these must be immediately reported to the Local Counter Fraud Specialist (LCFS or Call the NHS Fraud & Corruption Line 08000284060 in Line with NHS Protect guidance).

Breast Care members of staff must refer to Incident Reporting and Investigation in Breast Care Unit Standard Operating Procedure in addition to this policy. The Standard Operating

procedure provides practical implementation of the policy.

4. PROCEDURE

4.1 Duties

4.1.1 Board of Directors

The Board of Directors has the ultimate responsibility for the management or acceptance of all risk.

- To receive incident reports via Quality Committee including quantitative and qualitative information, lessons learnt, examples of good practice, any changes of practice and risks identified for inclusion on the risk register.
- The Trust has a legal requirement to ensure that reportable incidents, particularly those with health and safety or patient safety implications, are reported to the appropriate bodies.
- Ensure adequate resources are available for the management and investigation of incidents and accidents and implementation of any remedial actions.

4.1.2 Chief Executive

The Chief Executive has overall responsibility for the Risk Management Strategy, associated policies and all issues relating to risk management.

4.1.3 Director of Governance

The Director of Governance holds responsibility for the strategic development and implementation of policies relating to Governance, Health and Safety, Patient Safety and Risk Management including safety incidents, hazards and near miss reporting.

4.1.4 Senior Information Risk Owner (SIRO)

The Senior Information Risk Owner (SIRO) is a member of the Trust Board who has allocated responsibility for the information incident management framework. The SIRO is responsible for ensuring that the organisation has implemented an effective information incident management and response capability that allows learning and sharing of experience from events throughout the organisation and for the prevention of similar events elsewhere.

- ensure that identified information threats and vulnerabilities are followed up for risk mitigation
- perceived or actual information incidents are managed in accordance with NHS IG requirements.
- ensure that there are effective mechanisms in place for reporting and managing incidents relating to information

4.1.5 Divisional Managers, Assistant Chief Nurses and Clinical Directors:

- Ensure the appropriate manager carries out any investigations on accidents/incidents.
- Ensure all investigations are completed in a timely manner by allowing staff to be released and affording all appropriate assistance.
- Ensures that all relevant risks identified from incident reports are included on the divisional risk register.
- Monitor the completion of any action plans arising from incident investigations
- Report as necessary to any professional bodies eg. GMC, NMC,

4.1.6 Governance Leads/Matrons/Head of Departments/Clinical Leads/IG Manager:

- Ensure that all staff are aware of their responsibilities
- Ensure that an appropriate investigation is carried out for each accident or incident, identifying appropriate actions and lessons to be learned

4.1.7 Consultant Clinically responsible for patient:

- Take appropriate action and give advice in regard to on-going care of the patient
- Attend if appropriate to support staff involved and aid an investigation including being part of the investigation team, if appropriate
- Liaise with on call duty manager out of hours and Medical Director in hours if evidence of adverse circumstances e.g. relatives critical of care in the death of a patient, consideration of poor care contributing to death and before communicating with external agencies
- Share reports to external agencies with senior managers
- Ensure Patient/ relatives are informed appropriately.

4.1.8 Consultants with line manager responsibility for junior staff are responsible for the trainee involved:

- Make any relevant report to the Deanery in line with the Deanery reporting procedures and advise the Clinical Director if required
- Provide feedback and offer support in line with the being open policy

4.1.9 Line Managers' Responsibilities:

- Ensure that the patient, relatives and other persons who need to have details of the events receive timely and adequate explanations from appropriate members of staff
- Ensure that all incidents including staff accidents are reported and the incident reporting form completed correctly.
- Conduct an investigation of the incident. This must include, how it happened, where it happened, when and to whom, identifying and initiating any immediate action required and future actions to prevent reoccurrence.
- Ensure that any equipment involved is retained for inspection.
- Ensure Governance Directorate is advised as soon as possible of any incident that needs to be referred to an external body to ensure any statutory timescales are met.
- Review the initial grade of the incident according to significance immediately on notification. Re-grade if appropriate following investigation.
- Provide support for staff involved in incidents.
- Provide feedback to all staff completing incident forms and closure of the incident on completion.
- Record action plans following an incident and evidence that action plans have been completed.

4.1.10 Governance Directorate:

- Ensure that data collection is complete and appropriate maintaining the electronic database of all accidents and incidents.
- Identify serious accidents or incidents, which require immediate follow-up.
- Patient Safety Team – hold daily teleconference to discuss incidents reported the previous day, identify concerns or information requirements and escalate to divisions, Weekly Patient Safety Summit or the Executive Team as appropriate.

- Health and Safety Team – hold weekly teleconference to discuss incidents reported the previous week, identify concerns or information requirements and escalate to divisions, Weekly Patient Safety Summit or the Executive Team as appropriate.
- Make external reports as necessary. E.g. Submit reports to the NPSA, StEIS, CQC, MHRA or HSE
- Report, review and monitor the 'Reporting of Injuries Disease and Dangerous Occurrence Regulations 2013 (RIDDOR)[1] incidents and liaise with the Health and Safety Executive, Local Authorities and Police when required.
- Report all incidents of physical or verbal abuse to staff or theft from staff via the Security Incident Reporting System
- Provide advice on appropriate action to minimise risk.
- Provide training on incident reporting and management
- Provide a quarterly summary incident report to the SIRI Panel

4.1.11 Occupational Health Team

The Occupational Health Team is responsible for notifying the Health and Safety Department of any confirmed reportable diseases, or dangerous occurrences relating to contamination with a Blood Bourne Virus (BBV) and reporting to Health Protection Agency.

Health and Safety Representatives and Champions are authorised to be involved in and support the investigator in any incident investigation relating to a health and safety incident or accident in their area of work.

4.1.12 Employees' Responsibilities:

- Take any remedial action to minimise the harm.
- Every employee has a duty to report any accident or injury they sustain regardless of seriousness or cause. They must also report any breaches in security, vandalism, thefts, losses or anti-social behaviour and any incidents relating to patients.
- Where the injured party is a visitor to site the accident/incident form will be completed by the member of staff attending to the injured party or the member of staff hosting the visitor on site, in conjunction with the injured party.
- Where the injured party is a contractor the accident/incident form will be completed by the member of staff responsible for supervising the contractor or the person in control of the area in which the accident/incident occurred, in conjunction with the injured party.
- Verbally report all incidents/accidents/near Misses to the person in charge of the area at the time, inform Clinical Site Manager if incident has caused moderate harm or above.
- Ensure a Trust's electronic incident form is completed before going off duty, following the guidance (see Appendix 1-3)
- Retain all relevant equipment for examination and inform Medical Devices Department. If appropriate complete the MHRA electronic incident form[2] available on the MHRA website[2] to report faulty medical devices. Assist with any incident investigations, providing timely and accurate statements as required

4.1.13 Associate Director of Corporate Affairs

- The development and implementation of a strategy for the communication of bad news with the appropriate stakeholders
- Liaison with Executive Team to ensure Trust staff both involved and remote from the

investigation, receive appropriate information
- Ensuring that information released to the media will be in accordance with the Trust's policy

4.1.14 Weekly Patient Safety Summit

The Weekly Patient Safety Summit receives weekly information on incidents initially thought to cause moderate or greater harm to patients and takes the following actions:

- Ensures that adequate immediate actions have been taken to protect patients
- Confirms the level of investigation required for the event
- Ensures that Duty of Candour is appropriately carried out.
- Identifies issues for investigation as a thematic review and reporting to the SIRI Panel.

4.1.15 Divisional Governance and Assurance Groups

Divisional Governance and Assurance Groups will receive incident data for review and action, monitor action plan and provide a regular report to the Quality Committee.

4.1.16 Health and Safety Committee

The Health and Safety Committee will receive quarterly reports regarding accidents within the Trust and review any statistics or trends, making recommendations to the Trust Management Board on unsafe and unhealthy conditions and practices.

4.1.17 Quality Committee

The Quality Committee will receive quarterly information on patient safety incidents and incident data as part of the quality account.

4.1.18 Serious Incident Requiring Investigation Panel

This panel is chaired by a Non-Executive Director with representatives from the CCGs. Its purpose is to review all patient related RCA reports and action plans to ensure that issues are addressed.

4.2 Process for reporting all incidents

4.2.1 Internal Reporting

Verbally report the incident to person in charge of the area immediately. If the incident is deemed serious, the Site Manager and the Governance Department must be informed immediately, i.e. where unexpected death or serious injury or serious dangerous occurence has occurred. In the event of a serious incident occurring outside working hours the Senior Manager on-call must be contacted.

An electronic incident report form must be completed by the individuals involved or their nominee, prior to them going off duty and submitted within 1 working day. Details of how to report incidents is included in local induction, training bookable through the Training Management System (TMS) and in user guides on the Governance Division pages of the Intranet. The manager will document action(s) taken on the electronic manager's form.

Decisions about whether a report is to be made under RIDDOR[1] will be made by the Health and Safety Team in conjunction with relevant managers. The report will be sent to the Health and Safety Executive by the Health and Safety Team on behalf of the Trust.

4.2.2 Grading

The initial grading using the Trust Risk Matrix (see the Risk Management Strategy) will be undertaken by the reporter. Information and examples of grading is available in user guides on the Governance Division pages of the Intranet. Grading will be reviewed for a consistent approach by the line manager and final grading assigned.

4.2.3 External Reporting

Relevant incidents are reported to:
National Reporting and Learning System[3]
Care Quality Commission[4]
CCG's StEIS
HSE[5] in accordance with RIDDOR[1]
Security incidents to NHS Protect[6]
SIRS
MHRA using the electronic form[2]
Screening Quality Assurance Service[14]

The Infection Control Team Notify the Public Health England[7] of any reportable incidents.

The Information Systems Manager will report any information security incidents to the Information Commissioner's Office as appropriate.

If there is any doubt the Director of Governance must be contacted for advice.

4.3 Confidentiality

Incident reports are sensitive documents and must be considered confidential. Incidents can become the subject of internal and external scrutiny. All information recorded must be fact. No opinion or any conclusions assigning fault or blame must be included in the details of incident section of the incident form or clinical notes.

4.4 Positive and fair blame culture

This Trust promotes an 'open and fair culture' and will conduct an investigation of incidents to establish the facts, looking at processes and procedures in place and recommend changes if and when appropriate.

If after initial review of the incident and after use of the National Patient Safety Agency (NPSA) decision tree[8] a disciplinary investigation is required; the disciplinary procedure will be followed. The Trust will not consider disciplinary action except in the following instances:

- Acts of misconduct/criminal acts
- Professional malpractice
- Repeated occurrences involving the same individual

4.5 Issues of Concern and "Whistle blowing" Policy

There may be occasions when staff may wish to raise concerns including actual incidents or near misses anonymously.

There are two mechanisms that can be used to raise issues:

a) If staff are struggling to resolve an issue they can email Resolve@MBHT.nhs.uk and the issue will be alerted to the Governance Team for appropriate follow-up.
b) Fill out a comment card and place in the RED BOXES at WGH Staff Entrance, FGH Conference Room or RLI near the Restaurant and the issue will be alerted to the Governance Team for appropriate follow-up.

b)

The Policy for 'Whistle Blowing' is intended to encourage and enable staff to raise serious issues of concern within the Trust, rather than overlook the problem or "blowing the whistle" outside. It is recognised that certain cases will have to proceed on a highly confidential basis and the policy makes it clear that staff can do so without fear of reprisal. The policy covers issues which :-

- The member of staff believes are unlawful
- Are against Trust Policies and Procedures
- Fall below established standards of practice
- Amount to improper conduct

Patients/Parents/Carers/relatives may also have occasion to raise concerns, this can be done through existing systems:

- Discussing the issue with a senior nurse or clinician
- PALS
- Complaints
- Public reporting through the National Reporting and Learning System

4.6 Incident Investigation

No Harm or Low Harm (Actual Impact 1 or 2) – investigated and if necessary an action plan developed within 20 working days (i.e. 1 month). Feedback to the reporter must also be completed within the timescale.

Moderate Harm (Actual Impact 3) – A Rapid Review (a structure template document now available as a Ulysses Safeguard Questionnaire) will be initiated following any incident categorised as Moderate Harm (Actual Impact 3). Investigated and an action plan developed within 20 working days (i.e. 1 month); this will be undertaken through an electronic questionnaire within Ulysses Safeguard. Feedback to the reporter must also be completed within the timescale.

Significant Harm (Actual Impact 4 or 5) – a Root Cause Analysis (RCA – to be completed through the Ulysses Safeguard RCA Module) will be initiated following any incidents categorised as Significant Harm (Actual Impact 4 or 5), led by staff trained in RCA. Completed RCAs are subject to a divisional quality check and review by the RCA Fresh Eyes Scrutiny process.

Incidents reported externally under the NHS Improvement Serious Incident Framework[9] or Never Event Policy and Framework[10] will be investigated within the nationally prescribed timescales. In order to achieve this, the internal timeframe is a s follows:

1. Draft RCA to be completed within 25 working days (i.e. 5 weeks) on Ulysses Safeguard
2. First QA check (nominated person) within 5 working days (i.e. 1 week)
3. Amendments incorporated within 5 working days (i.e. 1 week)

4. Final scrutiny within 5 working days (i.e. 1 week)
5. 5 working days to submit to CCG (i.e. 1 week)

Other incidents reported externally will be investigated within national or statutory timeframes.

This guidance does not preclude any incident from being investigated at a more in-depth level if this is deemed to assist the identification of learning from the incident.

Incidents reported externally under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (2013) (RIDDOR)[1] will require a RCA and may be required within a shorter timescale subject to Health and Safety Executive request for further information.

Principles of Incident Investigation and procedure are outlined in Appendix 7. The purposes of incident investigation are outlined in Appendix 8. Training on incident management and investigation is bookable through the Training Management System (TMS) and in user guides on the Governance Division pages of the Intranet.

Members of staff who have been key witnesses to an incident will be asked to provide a statement as soon as possible. The gathering of statements will be carried out within a ten day period post incident if possible, due to the effect of memory recall which will become steadily less reliable over time. Statements must consist of an explanation of the facts that led up to the incident and must not include conjecture or opinion. Members of staff who need support or assistance in making statements may contact the Governance Team, Health and Safety team, their own solicitor or consult their professional body or trade union representative.

Staff including students and contractors involved in an incident must be made aware of the support available to them, by their manager, and in the first instance they must be referred to the Occupational Health Department who can refer them on to relevant organisations or to their GP. Staff involved in an incident will be provided with details of the incident.

4.7 Involvement of relevant stakeholders

There will be occasions when the Trust will need help to investigate certain incidents, which may be outside our area of expertise. These include Health and Safety Executive (HSE), and / or the police. In these circumstances the Trust may invoke the Memorandum of Understanding[11].

The Trust will ask external agencies whether they wish to nominate a representative to join the investigation team, if the incident involves cross boundary issues, e.g. CCG's, Social Services etc. It is important that they have input into the final recommendations where it is deemed that they will be affected by them. A list of external agencies can be found in Appendix 6.

4.8 External Investigation/Review of Care or of a Service

Should an incident highlight an area of concern regarding a service or an area of care, the Trust may commission an external investigation/review. The process initiating an external

investigation/review is documented in the Trust's Management of External Agency Visits, Inspections and Accreditations.

4.9 Communication with patient and family support

Communications with patients, relatives and /or carers will be in line with the Trust 'Being Open' Policy. All communication with patients or relatives must be recorded, signed and dated in accordance with the Being Open Policy.

It is extremely important that patients/relatives are kept informed if a Serious Incident occurs and that they are communicated with on a consistent and timely basis. The patient's consultant will need to be involved in what information is given and how it will be conveyed.

Communications with patients, families and /or carers must be carried out by an appropriate person with sufficient training and experience. It may not be appropriate for the lead investigator or part of the investigation team to also take lead responsibility for supporting the patient and family.

4.9.1 Process for Recalling the Patient

Where it is identified that patients must be recalled following investigation of a serious untoward incident, the responsible clinician has the responsibility for co-ordinating the recall process.

The responsible Clinician will:

- Identify the lead specialist(s) health professional who will speak to the individual patients to be recalled.
- To identify an agreed script for the lead specialist(s) health professional to follow when speaking to the patients to be recalled.
- To establish a helpline during office hours.
- Duty Manager / Duty Director to be informed of the agreed script and patients to be recalled in case of the need for further support / advice outside office hours.
- To ensure the Communications Department are aware of any media issues that may arise from patients being recalled.
- Inform any relevant parties where a patient is involved in a national screening programme.
- Inform NHS Improvement Lancashire Team.
- Speak to the patient(s) on the telephone.
- Send a follow up letter to support the information provided to the patient(s) on the telephone.
- Diarise clinics as soon as possible for those patients who need to be recalled.
- Run clinics in the evening and weekends as necessary to accommodate the patient(s).
- Invite the patient(s) to attend clinic with a relative or friend if they wish.
- Offer the patient(s) counselling if required.
- Contact the relevant General Practitioner to inform them of the situation.
- Provide the patient(s) with contact details for specialist nurse, therapist or Consultant lead.

4.10 Sharing lessons learnt

The outcomes of any investigation will identify causational factors attributing to the incident (either directly or indirectly). These factors will lead the Trust to identify any changes that have to be made to avoid a recurrence of the incident; this learning is referred to as 'Lessons Learnt'.

The identification of lessons learnt is a key requirement of any investigation and as such they will be shared within the Trust, externally with its stakeholders and also with those affected by an incident.

A debriefing may be given to relevant Trust staff within as short a time as possible including an outline of any action plan; this could be through Trust wide staff briefings, ward / departmental meetings or via line managers to individual members of staff. If appropriate a "RED ALERT" will be issued through the Ulysses Safeguard Alert Module, this is a learning from experience notice that is communicated to clinical staff during handovers for a period of one week in order to draw their attention to issues that require immediate action.

The Trust works with external agencies including CCG, NRLS,CQC, HSE , North West Deanery and networking groups to ensure lessons learned are disseminated across the wider NHS.

4.11 Monitoring action plans

The progress and implementation of any action plan will be monitored by Divisions and included in the divisional report to the Quality Committee as appropriate. As action plans are completed, evidence of completion will be added to the incident record on Safeguard, the incident can then be closed.

The appropriate Clinical Director is responsible for ensuring that following implementation these actions are audited to ensure that lessons from incidents are learned and risk of repetition is reduced or if possible completely eliminated.

4.12 Media relations

Incidents which cause media interest will always require careful handling. The person conducting the investigation must do everything to ensure that the patient and their family are aware of any relevant information prior to the media or general public.

The Chief Executive / Medical Director / Executive Chief Nurse/ Chief Operating Officer will in regard to an incident need to ensure that the control of information to other parties is clear and controlled, i.e.:

- Police – where violence or other major criminal activity could have been involved
- Patient's GP – where death or significant harm has occurred
- Coroner – where death has resulted
- Social Services – where there is a need for them to be notified
- Medicines and Healthcare products Regulatory Agency (MHRA)[2] – where equipment may have failed or was in some way involved in the incident (Health & Safety Manager can advise on this issue)

- Health and Safety Executive[5] – death, specified injuries or dangerous occurences
- Safeguarding Adult/ Children – where there are concerns involving the future welfare of a vulnerable person
- Public Health England[7] – where there may be a significant public interest or a need to effect control measures (Infection Control Department to be contacted for advice)
- Information Commissioner's Officer – serious data loss or breach of the Data Protection Act[12] or Freedom of Information Act[13]

Members of staff who are approached by the media relating to an incident must refer all enquirers to the Communications Team.

4.13 Hotline arrangements

It may be necessary for incidents potentially involving large numbers of patients to establish hotline facilities for patients to contact to obtain further information, guidance and advice. The Chief Executive and either the Medical Director / Executive Chief Nurse will decide whether to set up hotline facilities. Communication rooms will be established in line with the Major Incident Plan and associated policies.

5. ATTACHMENTS	
Number	**Title**
1	Triggers for Incident Reporting
2	Never Events 2015 /16
3	Accidents and Incidents Reportable to the Health and Safety Executive
4	Incident Reporting Flowchart
5	Completing an Incident Form
6	External Stakeholders
7	Principle of Incident Investigation
8	Purposes of Incident Investigation
9	Staff Guidance for Producing a Statement
10	SIRI Process – See NHS Improvement Serious Incident Framework
11	Equality and Diversity Impact Assessment Tool

6. OTHER RELEVANT / ASSOCIATED DOCUMENTS	
Unique Identifier	**Title and web links from the document library**
Corp/Pol/112	Freedom to Speak Up – Raising Concerns http://uhmb/cs/tpdl/Documents/CORP-POL-112.docx
Corp/Pol/023	Being open policy UHMB http://uhmb/cs/tpdl/Documents/CORP-POL-023.docx
Corp/Pol/089	Medical Device Management policy UHMB http://uhmb/cs/tpdl/Documents/CORP-POL-089.docx
Corp/Pol/121	Fire Safety Management UHMB http://uhmb/cs/tpdl/Documents/CORP-POL-121.docx
Corp/Plan/001	Major Incident Plan [FGH] http://uhmb/cs/tpdl/Documents/CORP-PLAN-001.docx
Corp/Plan/002	Major Incident Plan [RLI] http://uhmb/cs/tpdl/Documents/CORP-PLAN-002.docx
Corp/Plan/003	Major Incident Plan [WGH] http://uhmb/cs/tpdl/Documents/CORP-PLAN-003.docx

Corp/Pol/041	Manual Handling of Inanimate and Patient Loads UHMB http://uhmb/cs/tpdl/Documents/CORP-POL-041.docx
HR2	Policy for supporting staff following traumatic and stressful incidents UHMB http://uhmb/cs/tpdl/Documents/HR2.pdf
Corp/Pol/088	Safe use and disposal of sharps policy UHMB http://uhmb/cs/tpdl/Documents/CORP-POL-088.docx
Corp/Pol/064	Control of substances hazardous to health (COSHH) policy UHMB http://uhmb/cs/tpdl/Documents/CORP-POL-064.docx
Corp/Proc/030	Management of external agency visits, inspections and accreditation UHMB http://uhmb/cs/tpdl/Documents/CORP-PROC-030.docx
Rad/SOP/043	Incident Reporting and Investigation in Breast Care Unit http://uhmb/cs/tpdl/Documents/RAD-SOP-043.docx
BCSP/Guid/003	Managing Clinical Incidents within the Cumbria & Morecambe Bay Bowel Cancer Screening Centre http://uhmb/cs/tpdl/Documents/BCSP-GUID-003.docx

7. SUPPORTING REFERENCES / EVIDENCE BASED DOCUMENTS

References in full

Number	References
1	Great Britain (2013) The Reporting of Injuries, Diseases and Dangerous Occurences Regulation 2013 (RIDDOR). Available online at: http://www.legislation.gov.uk/uksi/2013/1471/contents/made (accessed 25.6.15)
2	Medicines and Healthcare products Regulatory Agency (MHRA) Available at: https://www.gov.uk/government/organisations/medicines-and-healthcare- products-regulatory-agency (accessed 25.6.15)
3	National Reporting and Learning System (NRLS) Available at: https://report.nrls.nhs.uk/nrlsreporting/ (accessed 25.6.15)
4	Care Quality Commission (CQC) Available at: http://www.cqc.org.uk/ (accessed 25.6.15)
5	Health and Safety Executive (HSE) Available at: http://www.hse.gov.uk/ (accessed 25.6.15)
6	NHS Protect Available at: http://www.nhsbsa.nhs.uk/Protect.aspx (accessed 25.6.15)
7	Public Health England. Available at: https://www.gov.uk/government/organisations/public-health-england (accessed 25.6.15)
8	National Reporting Learning Service (NRLS). National Patient Safety Agency (NPSA) Incident Decision Tree. Available online at: http://www.nrls.npsa.nhs.uk/resources/?EntryId45=59900 (accessed 25.6.15)
9	NHS England (2015). Serious Incident Framework. Available online at: http://www.england.nhs.uk/ourwork/patientsafety/serious-incident/ (accessed 25.6.15)
10	NHS England (2015). Never Events Policy and Framework 2015/16. Available online at: http://www.england.nhs.uk/ourwork/patientsafety/never- events/ (accessed 25.6.15)
11	NHS England. Memorandum of Understanding. Available online at: http://www.england.nhs.uk/ourwork/part-rel/understanding/ (accessed 25.6.15)
12	Great Britain (1998) Data Protection Act 1998. Available online at: http://www.legislation.gov.uk/ukpga/1998/29/contents (accessed 25.6.15)
13	Great Britain (2000) Freedom of Information Act 2000. Available online at: http://www.legislation.gov.uk/ukpga/2000/36/contents (accessed 25.6.15)

14	Managing Safety Incidents in NHS Screening Programmes. Available online at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/472611/Managing_Safety_Incidents_in_National_Screening_Programmes_gateway_291015.pdf (accessed 01.03.2017)

8. DEFINITIONS / GLOSSARY OF TERMS

Abbreviation or Term	Definition
Serious Incident Requiring Investigation	A serious incident requiring investigation is defined as an incident that occurred in relation to NHS-funded services and care resulting in one of the following: • On the list of Never Events, provided by NHS Improvement • Within the Serious Incident framework or included in the contract with CCGs
Strategic Executive Information System (StEIS)	The electronic databases 'hosted' by the Department of Health and onto which all serious patient safety incidents are submitted by a member of the Governance Team. Information Governance (IG) incidents are submitted via IG Incident Reporting Tool product (hosted on the IG Toolkit Website)
Patient Safety Incident (PSI)	An event or series of events or omission(s) causing or having the potential to cause actual harm to a patient receiving care.
Non-clinical Incident	An event or series of events or omission(s) directly or indirectly causing injury, damage or loss which was unexpected or not planned. (Appendix 3 provides a list of accidents/ incidents reportable to the HSE and NHS Protect), (Appendix 1 provides a list of incidents reportable to the Information Commissioner's Officer (ICO) and DoH).
Types of error	2) Care Delivery Problems (CDPs) • Care deviated beyond safe limits of practice • The deviation had a direct or indirect effect on the eventual adverse outcome for the patient b) Service Delivery Problems (SDPs) • Acts or omissions that are identified during the analysis of the patient safety incident, but are not associated with direct provision of care • These are generally associated with decisions, procedures and systems that are part of the whole process of service delivery
Near Miss	Any event which does not, but has the potential to, result in injury, damage or loss. Sometimes referred to as a Prevented Safety Incident.
Hazzard	This is something that has the potential to cause harm, damage or loss. A hazard can develop over time and can often lie dormant before combining with other factors to cause an incident or Prevented Safety Incident (formerly Near Misses).
Risk Grading	This indicates the consequence of the incident based on likelihood of actual harm occurring and the consequence of that harm, which will determine how it will be managed.
Investigation	An investigation is a review of the incident in order to establish what and why the incident happened, in addition to the chances of it recurring and measures needed to reduce this.

9. CONSULTATION WITH STAFF AND PATIENTS Enter the names and job titles of staff and stakeholders that have contributed to the document	
Name	**Job Title**
Geoff Hind	Head of Patient Safety
Anna Smith	Head of Health and Safety

10. DISTRIBUTION PLAN	
Dissemination lead:	Head of Patient Safety
Previous document already being used?	Yes
If yes, in what format and where?	Heritage
Proposed action to retrieve out-of-date copies of the document:	N/A
To be disseminated to:	
Document Library	Yes
Proposed actions to communicate the document contents to staff:	Include in the UHMB Weekly News – New documents uploaded to the Document Library

11. TRAINING Is training required to be given due to the introduction of this procedural document? Yes		
Action by	**Action required**	**Implementation Date**
Patient Safety Team	A continual educational process is available through TMS for staff to access.	Ongoing

12. AMENDMENT HISTORY				
Version No.	**Date of Issue**	**Page/Selection Changed**	**Description of Change**	**Review Date**
1.5	December 2012	Throughout the document	This is an amalgamation of Patient Safety Incident Reporting Policy, the Patient Safety Incident Management Policy and the Serious Untoward Incident Reporting and Management Policy Reporting and Investigation for Accidents/ Incidents involving Staff, Contractors and Visitors	August 2013
1.5	October 2013		Extension of review date	January 2015
1.6	December 2013	Duties	Reflect changes in titles of groups and individuals. Reflects changes duties of individuals. Inclusion of IG	January 2016

		Appendix 5	incidents. Reflect changes to processes and development of Ulysses safeguard use to support incident management	
2.0	April 2015	Reformat	Incorporate changes to the Risk management Strategy and the NHS Improvement Serious Incident Framework and Never Event Policy and Framework published in March 2015.	April 2018
2.1	January 2016	Page 4	Added RIDDOR on a Page	April 2018
2.2	June 2016	All	References to NHS England changed to NHS Improvement	April 2018
2.3	July 2016	Throughout	Amendments to 4.1.9, 4.1.10, 4.1.14, 4.5, 4.6	April 2018
2.4	26/01/2016	Page 4	Updated version of RIDDOR on a page	April 2018
2.5	01/03/2017	Section 4.2.3 Section 7	Added Screening Quality Assurance Service and reference in section 7	April 2018
2.6	11/08/2017	Section 6	Added link to 'Incident Reporting and Investigation in Breast Care Unit'	April 2018
2.7	Oct 2017	Page 4	BSF Page Added	April 2018
2.8	11/04/2018	Page 1	Review Date extended – form 049/2018	01/09/2018
2.9	12/09/2018	Page 1	Review Date extended – form 125/2018	01/12/2018
2.10	13/05/2019	Page 1	Review Date extended – form 076/2019	01/07/2019

Appendix 1 - Triggers for Incident Reporting

The Trust promotes the reporting of any event which has caused harm to patient, staff or others or has the potential to cause harm to staff, patient or others. These include:

Patient Safety Incident	**Non – Clinical (relating to staff, contractors, volunteers or visitors)**	**Prevented Safety Incident**
medication error including omission patient accidents, including slips, trips and falls pressure ulcers/tissue damage hospital acquired infections inappropriate treatment delay in treatment consent issues medical devices medical consumables patient accident staffing issues documentation	personal accidents, including slips, trips and falls dangerous occurrences incidents of occupational disease security data protection including data loss, breach of confidentiality fire violence and aggression bullying and harassment verbal abuse/ antisocial behaviour COSHH Sharps Injury IT issues including disruption to information system or network Non-medical equipment	any clinical or non-clinical incident that had the potential to cause harm but didn't actually cause harm , damage or loss

These lists are not meant to be exclusive or exhaustive.

Triggers for Information Governance Reporting

Breach Type	Examples / incidents covered within this definition
Lost in Transit	The loss of data (usually in paper format, but may also include CD's, tapes, DVD's or portable media) whilst in transit from one business area to another location. May include data that is; - Lost by a courier; - Lost in the 'general' post (i.e. does not arrive at its intended destination); - Lost whilst on site but in situ between two separate premises / buildings or departments; - Lost whilst being hand delivered, whether that be by a member of the data controller's staff or a third party acting on their behalf Generally speaking, 'lost in transit' would not include data taken home by a member of staff for the purpose of home working or similar (please see 'lost or stolen hardware' and 'lost or stolen paperwork' for more information).
Lost or stolen hardware	The loss of data contained on fixed or portable hardware. May include; - Lost or stolen laptops; - Hard-drives; - Pen-drives; - Servers; - Cameras; - Mobile phones containing personal data; - Desk-tops / other fixed electronic equipment; - Imaging equipment containing personal data; - Tablets; - Any other portable or fixed devices containing personal data; The loss or theft could take place on or off a data controller's premises. For example the theft of a laptop from an employee's home or car, or a loss of a portable device whilst travelling on public transport. Unencrypted devices are at particular risk.
Lost or stolen paperwork	The loss of data held in paper format. Would include any paper work lost or stolen which could be classified as personal data (i.e. is part of a relevant filing system/accessible record). Examples would include; - medical files; - letters; - rotas; - ward handover sheets; - employee records The loss or theft could take place on or off a data controller's premises, so for example the theft of paperwork from an employee's home or car or a loss whilst they were travelling on public transport would be included in this category. Work diaries may also be included (where the information is arranged in such a way that it could be considered to be an accessible record / relevant filing system).

Breach Type	Examples / incidents covered within this definition
Disclosed in Error	This category covers information which has been disclosed to the incorrect party or where it has been sent or otherwise provided to an individual or organisation in error. This would include situations where the information itself hasn't actually been accessed. Examples include: - Letters / correspondence / files sent to the incorrect individual; - Verbal disclosures made in error (however wilful inappropriate disclosures / disclosures made for personal or financial gain will fall within the s55 aspect of reporting); - Failure to redact personal data from documentation supplied to third parties; - Inclusion of information relating to other data subjects in error; - Emails or faxes sent to the incorrect individual or with the incorrect information attached; - Failure to blind carbon copy ('bcc') emails; - Mail merge / batching errors on mass mailing campaigns leading to the incorrect individuals receiving personal data; - Disclosure of data to a third party contractor / data processor who is not entitled to receive it
Uploaded to website in error	This category is distinct from 'disclosure in error' as it relates to information added to a website containing personal data which is not suitable for disclosure. It may include; - Failures to carry out appropriate redactions; - Uploading the incorrect documentation; - The failure to remove hidden cells or pivot tables when uploading a spread-sheet; - Failure to consider / apply FOIA exemptions to personal data
Non-secure Disposal – hardware	The failure to dispose of hardware containing personal data using appropriate technical and organisational means. It may include; - Failure to meet the contracting requirements of principle seven when employing a third party processor to carry out the removal / destruction of data; - Failure to securely wipe data ahead of destruction; - Failure to securely destroy hardware to appropriate industry standards; - Re-sale of equipment with personal data still intact / retrievable; - The provision of hardware for recycling with the data still intact
Non-Secure Disposal – paperwork	The failure to dispose of paperwork containing personal data to an appropriate technical and organisational standard. It may include; - Failure to meet the contracting requirements of principle seven when employing a third party processor to remove / destroy / recycle paper; - Failure to use confidential waste destruction facilities (including on site shredding); - Data sent to landfill / recycling intact – (this would include refuse mix up's in which personal data is placed in the general waste);

Breach Type	Examples / incidents covered within this definition
Technical security failing (including hacking)	This category concentrates on the technical measures a data controller must take to prevent unauthorised processing and loss of data and would include: - Failure to appropriately secure systems from inappropriate / malicious access; - Failure to build website / access portals to appropriate technical standards; - The storage of data (such as CV3 numbers) alongside other personal identifiers in defiance of industry best practice; - Failure to protect internal file sources from accidental / unwarranted access (for example failure to secure shared file spaces); - Failure to implement appropriate controls for remote system access for employees (for example when working from home) In respect of successful hacking attempts, the ICO's interest is in whether there were adequate technical security controls in place to mitigate this risk.
Corruption or inability to recover electronic data	Avoidable or foreseeable corruption of data or an issue which otherwise prevents access which has quantifiable consequences for the affected data subjects e.g. disruption of care / adverse clinical outcomes. , for example; - The corruption of a file which renders the data inaccessible; - The inability to recover a file as its method / format of storage is obsolete; - The loss of a password, encryption key or the poor management of access controls leading to the data becoming inaccessible
Unauthorised access/disclosure	The offence under section 55 of the DPA - wilful unauthorised access to, or disclosure of, personal data without the consent of the data controller. **Example (1)** An employee with admin access to a centralised database of patient details, accesses the records of her daughter's new boyfriend to ascertain whether he suffers from any serious medical conditions. The employee has no legitimate business need to view the documentation and is not authorised to do so. On learning that the data subject suffers from a GUM related medical condition, the employee than challenges him about his sexual history. **Example (2)** An employee with access to details of patients who have sought treatment following an accident, sells the details to a claims company who then use this information to facilitate lead generation within the personal injury claims market. The employee has no legitimate business need to view the documentation and has committed an offence in both accessing the information and in selling it on. A recent successful prosecution for a s55 offence: http://www.ico.org.uk/news/latest_news/2013/medical-receptionist-prosecuted-after-unlawfully-accessing-patients-details-12032013
Other	This category is designed to capture the small number of occasions on which a principle seven breach occurs which does not fall into the aforementioned categories. These may include: - Failure to decommission a former premises of the data controller by removing the personal data present; - The sale or recycling of office equipment (such as filing cabinets) later found to contain personal data; - Inadequate controls around physical employee access to data leading to the insecure storage of files (for example a failure to implement a clear desk policy or a lack of secure cabinets).

Breach Type	Examples / incidents covered within this definition
	This category also covers all aspects of the remaining data protection principles as follows: - Fair processing; - Adequacy, relevance and necessity; - Accuracy; - Retaining of records; - Overseas transfers

Appendix 2 Never Events 2015/16

i. Wrong site surgery
ii. Wrong implant/prosthesis
iii. Retained foreign object post-procedure
iv. Mis-selection of a strong potassium containing solution
v. Wrong route administration of medication
vi. Overdose of insulin due to abbreviations or incorrect device
vii. Overdose of methotrexate for non-cancer treatment
viii. Mis-selection of high strength midazolam during conscious sedation
ix. Failure to install functional collapsible shower or curtain rails (Mental Health setting)
x. Falls from poorly restricted windows
xi. Chest or neck entrapment in bedrails
xii. Transfusion or transplantation of ABO-incompatible blood components or organs
xiii. Misplaced naso- or oro-gastric tubes
xiv. Scalding of patients

This list is changed annually. A complete list is provided by NHS Improvement.

Appendix 3 Accidents and Incidents Reportable to the Health and Safety Executive

1.1 Death – the death of any person, whether or not they are at work must be reported if it results from an accident arising out of or in connection with work

1.2 Specified injuries
- fracture other than fingers, thumbs or toes
- amputation of arm, hand, finger, thumb, leg, foot or toe
- crush injuries leading to internal organ damage
- loss or reduction of sight
- serious burns covering more than 10% of the body or damaging the eyes or respiratory system or other vital organs
- any other injury leading to hypothermia, heat induced illness, scalpings (separation of skin from the head) which require hospital treatment or to unconsciousness (caused by asphyxia or head injury) requiring resuscitation or requiring admittance to hospital for more than 24 hours

1.3 Dangerous occurrence
- collapse, overturning or failure of load-bearing parts of lifts and lifting equipment, including patient hoists and slings;
- explosion, collapse or bursting of any closed vessel or associated pipework;
- plant or equipment coming into contact with overhead power lines;
- electrical short circuit or overload causing fire or explosion;
- any unintentional explosion, misfire, failure of demolition to cause the intended
- collapse, projection of material beyond a site boundary, injury caused by an explosion;
- accidental release of any biological agent likely to cause severe human illness (this includes BBV of hep B, hep C, Hep D and HIV);
- failure of industrial radiography or irradiation equipment to de-energise or return to its safe position after the intended exposure period;
- malfunction of breathing apparatus while in use or during testing immediately before use;
- collapse or partial collapse of a scaffold over five metres high, or erected near water where there could be a risk of drowning after a fall;
- dangerous occurrence at a pipeline;
- unintended collapse of : any building or structure under construction, alteration or demolition where over five tonnes of material falls; a wall or floor in a place of work; any false-work;
- explosion or fire causing suspension of normal work for over 24 hours;
- accidental release of any substance which may damage health;
- accidental spillage of more than 5litre of glutaraldehyde;
- accidental spillage of more than 5litre of formaldehyde (methanal);
- any accidental spillage of mercury;
- any accidental spillage of liquid nitrogen;
- any accidental spillage of a corrosive substance, i.e. acid, alkali, etc.
- discovery of disturbed asbestos

1.4 Disease – if a doctor notifies you that your employee suffers from a reportable work related disease

1.5 Over-seven-day injuries is one which is not “serious injury” but result in the injured person being away from work or unable to do the full range of their normal duties for more than seven days.

Appendix 4

Incident Reporting on e-Form (ASAP or within 24 hours) Ensure immediate action has been taken to protect the safety of patients, staff, visitors or contractors. Verbally report the incident to person in charge of the area immediately. If the incident is deemed serious, the Site Manager and the Governance Department must be informed immediately. In the event of a serious incident occurring outside working hours the Senior Manager on-call must be contacted.

↓

Manager (and others through notification rules) informed via automated email + acknowledgement to reporter

↓

Manager Review (within 5 working days)
Manager must review/validate incident details and confirm the grading.

Significant Harm (Actual Harm 4 or 5)	Moderate Harm (Actual Harm 3)	No Harm or Low Harm (Actual Harm 1 or 2)
Root Cause Analysis This is a structured investigation that aims to identify the cause(s) of a problem and the actions necessary to eliminate or significantly reduce risk. It will be undertaken by a team of staff with the support of someone trained in RCA techniques. • The investigation and action plan must be reviewed through the divisional quality assurance process. • The final report must be submitted to the SIRI Panel for approval of the investigation and action plan. Incidents reported externally will be investigated within national or statutory timescales.	**Rapid Review** A detailed review of the event by a member of staff nominated by the manager or matron: • Immediate action(s) taken • Duty of candour • What problems identified • Was current guidance followed • What lessons were identified • What good practice was identified • What actions are to be undertaken • Is further investigation required The rapid review is undertaken through an electronic questionnaire within Ulysses Safeguard. Incidents are reviewed at the Weekly Patient Safety Summit.	**Individual Review** A review by a member of staff nominated by the manager to include: • Circumstances • Was appropriate action taken • What lessons were identified • What follow-up action is appropriate

Staff named in incidents will receive details of the incident and if they are trainees, information will be provided to training supervisors.
Feedback by the manager to staff and the reporter at the completion of the investigation.
Scrutinised by governance staff each week for investigation and feedback completion with performance management and escalation processes
Trend or theme analysis + organisation wide learning + use of audit to ensure "embedding" of learned lessons

Appendix 5 Completing an incident form

Following an incident and any remedial action taken report it immediately to your line manager or person in charge of the area at the time and complete an incident form before you leave work that day.

Document Fact only include:

- Date, Time, Hospital and exact location of the incident e.g. 01/08/10 16.55 ward 4 RLI, outside the linen room
- Name of the person involved with NHS number if patient, contact details if staff, visitor or contractor
- Type of incident Patient Safety Incident (Clinical), Non Clinical, Prevented Safety Incident (formerly Near Misses)
- Asset number if piece of equipment
- Batch number for consumables
- Assess with your immediate manager the severity of the incident/ Prevented Safety Incident (formerly Near Misses), accident
- Detail of the injury, harm, damage or loss, sprain, sharps injury, medication error, theft, damage incurred or the potential. Indicate the affected body part.
- Detail of numbers of patients/data subjects affected, list of data/information affected
- Explain what happened simple clear sentences covering the facts. This will help you if you are required to provide a statement at a later date.
- Detail any remedial action taken e.g. :
    - IV infusion discontinued for an infiltration/ extravasation
    - Hazard warning signs put in place for a leaking ceiling
    - Removal of any equipment / furniture
    - Attempts to recover data or misdirected emails
- If you have any suggestions to prevent reoccurrence document them
- Give details and contact numbers (if appropriate) of any witnesses
- Provide details on who has been informed, including patient, police etc as appropriate

.

Appendix 6: External Stakeholders

These include:
Other NHS Organisations
Care Quality Commission
Strategic Health Authorities
Local Area Teams
Local Safeguarding Boards
Clinical Commissioning Groups (CCG)
Commissioning Support Services (CSS)
NHS Litigation Authority
The Police
HM Coroner
Social Services
Medicines and Healthcare Products Regulatory Agency (MHRA)
Health and Safety Executive (HSE)
Blood Transfusion Service
Area Child Protection Committee
Health Protection Agencies
Health Protection Agency
Legal Advisors
National Patient Safety Agency
Local Representative Committees
Medical Defence Organisations
GPs
NHS Protect
Universities
Northwest Deanery
MHRA
Information Commissioner
NHS Protect

Appendix 7: Principles of Incident Investigation.

Procedure for Incident Investigation
This guidance may be applied to the investigation of any organisational, clinical or professional issue causing a problem, or potential problem.

- Start the investigation as soon as possible.
- Keep a detailed, contemporaneous record.
- Isolate the area or object until it has been examined, photographed, measured etc if required.
- Examine the general environment, equipment involved etc.
- Identify and secure any documentation which may be required, off duty rota's, policies equipment training / maintenance records
- Identify witnesses, staff who were present either as a witness or participants. They may need to provide a statement or be interviewed. Any statements must be restricted to a factual account and requested within 2 working days and submitted within 5 working days
- Witnesses must be interviewed singly as soon as possible without having the opportunity to discuss events with other potential witnesses They must not be prompted, subject to duress or pressure during the interview. They must be encouraged to distinguish between fact and hearsay.
- It may be useful to ask them their opinion of what had happened, or talk through their recollection of the event / shift etc.
- Establish the facts.
- Establish a sequence of events leading to the incident
- Record all the information gained
- Evaluate facts and reports for accuracy, reliability and relevance and triangulate evidence.
- Investigate contradictory evidence.
- Establish the indirect and direct causes of the incident.
- A clinical incident may require detailed examination of the medical records. If these need to remain in circulation for clinical use then copies must be made for the use of the investigation
- During the above processes specialist independent advice may be needed where specific specialised areas of work are involved to assist the investigation
- Record your findings submit RCA and update line managers comments section on Ulysses (Safeguard)
- Review and update any appropriate Risk Assessments

For tools to assist in undertaking the investigation please see the Governance Directorate pages on the Intranet.

If it becomes apparent that during the investigation there are personal or professional issues relating to individuals these may be dealt with under the appropriate Trust procedures. The Kennedy report stresses the importance of a realisation that failures are more likely to be systems than people and even if people, they are unlikely to be malicious. The Trust aims to maintain a culture of fairness in any allocation of responsibility.

Appendix 8: Purposes of incident investigation

This list is indicative, not exhaustive but includes:

- Accountability
- Agreeing recommendations and action plan
- Assurance to the Board and the public
- Awareness raising
- Building confidence in organisation
- Closure
- Communication
- Encouraging reporting
- Issuing an apology and / or explanation
- Identifying system failures and taking remedial action
- Identifying trends
- Improving practice
- Informing patients/carers/families
- Learning and sharing
- Litigation
- Ongoing review audit/monitoring
- Ownership
- Prevention
- Promoting an open and fair culture
- Quality assurance
- Resolving complaints
- Supporting, valuing staff
- Transparency

Appendix 9: Staff Guidance for producing a statement

1. Purpose
- To tell a third party about events in which the author participated.
- To tell a third party about events which the author witnessed.

If you neither participated in, nor witnessed the events, you cannot make a statement

2. When writing a statement ensure
- Your statement is factual.
- Your statement is accurate.
- You check the facts.
- Ensure it is concise.
- Includes relevant information.
- Explain words or phrases of a technical/clinical nature.
- Ensure it is legible if hand written.
- Check for errors if it has been typed from hand written.
- Give sufficient detail about the incident.
    - Where did it happen
    - When did it happen
    - What happened
    - Who was involved
    - What was your involvement
    - How did you hear about the accident /incident
    - What was happening at the time of the Accident/ incident
    - What where you doing at the time
    - Environmental factors
    - Staffing
    - dependency
- Retain a copy.

3. Do not
- Exaggerate.
- Use abbreviations.
- Minimise events.
- Use ambiguous terms.
- Include hearsay.
- Use jargon
- Sign the statement unless you are 100% satisfied with it.

However you produce your statement (typed/written) it will be reproduced onto Hospital headed paper. You will be given the opportunity to check this prior to signing and dating.

4. Laying out your statement
Centre heading person's full name and DOB and /or Incident Number
(Mrs Jane Smith DOB 03/05/1932) or incident Number

I (your full name Julie Susan Brown) my (UKCC PIN). My qualifications are (relevant qualifications). I have been asked by the (name of requesting person) to provide a statement detailing my involvement in the care of the late (Mrs Smith). I have had access to a copy of the clinical records to assist me.

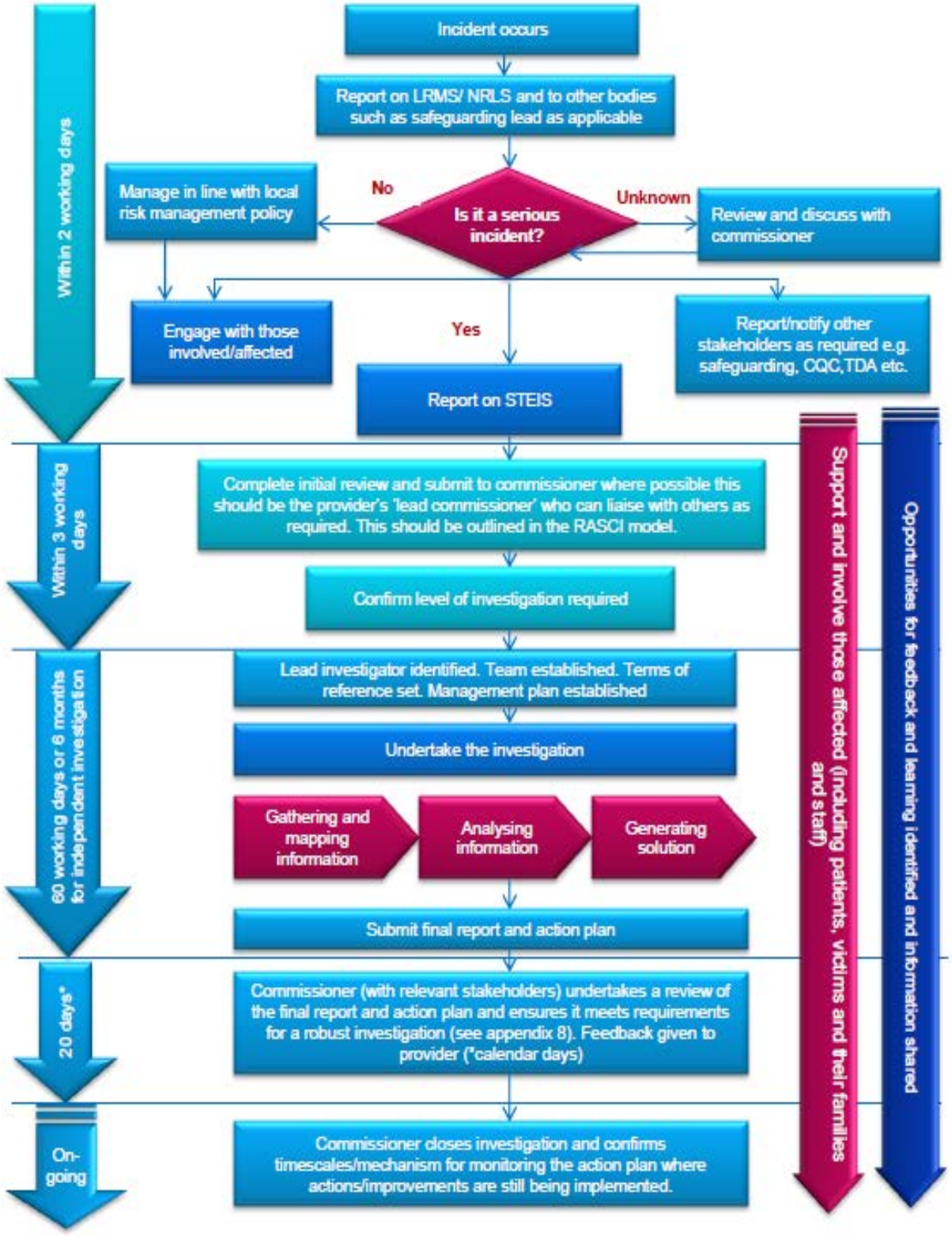
I have been employed at (Detail of Hospital) since (September 1975). I have worked on (ward) as a (position and grade) since (date).

Details of the incident

(Include all your contact with the patient as well as any observations you remember about their overall condition). Statement ends with – and that was the last contact I had with (Mrs Smith).

Signed…… Dated…….

Appendix 10: SIRI PROCESS – See NHS Improvement Serious Incident framework



Appendix 11 : EQUALITY & DIVERSITY IMPACT ASSESSMENT TOOL

		Yes/No	Comments
1.	**Does the policy/guidance affect one group less or more favourably than another on the basis of:**		
	• Race	No	
	• Ethnic origins (including gypsies and travellers)	No	
	• Nationality	No	
	• Gender	No	
	• Culture	No	
	• Religion or belief	No	
	• Sexual orientation including lesbian, gay and bisexual people	No	
	• Age	No	
	• Disability - learning disabilities, physical disability, sensory impairment and mental health problems	No	
2.	**Is there any evidence that some groups are affected differently?**	No	
3.	**If you have identified potential discrimination are there any exceptions - valid, legal and/or justifiable?**	No	
4.	**Is the impact of the policy/guidance likely to be negative?**	No	
4a	**If so can the impact be avoided?**	N/A	
4b	**What alternative are there to achieving the policy/guidance without the impact?**	N/A	
4c	**Can we reduce the impact by taking different action?**	N/A	

If you have identified a potential discriminatory impact of this procedural document, please refer it to the HR Equality & Diversity Specialist, together with any suggestions as to the action required to avoid/reduce this impact.

For advice in respect of answering the above questions, please contact the HR Equality & Diversity Specialist, Extension 6242.