Incident Management Policy

Document Data			
Document Type:	Policy		
Document Reference:	3900		
Document Status:	Approved		
Document Owner:	Head of Quality and Patient Safety, Head of Health and Safety		
Executive Lead:	Medical Director		
Approval Authority:	Clinical Quality Group		
Review Cycle:	36		
Date Version Effective From:	1st April 2020/ Updated May 2022	**Date Version Effective To:**	30th June 2023

What is in this policy?

This policy covers all processes relating to the management of incidents; from identification to implementation of risk reduction measures. It should be read in conjunction with University Hospitals Bristol and Weston NHS Foundation Trust's (referred to as UHBW or the Trust) Standard Operating Procedure: Incident reporting, investigation and management which underpins this policy; and the Serious Incident Policy which informs the process once an incident has been designated a serious incident. The Trust's Risk Management Policy and Risk Assessment Standard Operating Procedure support the risk assessment of incidents which occur.

The Trust aims to have a culture which includes an open and transparent approach to incident reporting and investigation and to seek to learn lessons and implement risk reduction measures when things have gone wrong. This policy should also be read in conjunction with the Trust's Staff Support and Being Open Policy which explicitly describes the Trust's requirements with regard to Duty of Candour, support for staff involved in an incident and the 'Just Culture' principles.

There are several associated documents referred to within the policy (listed in section 10) to guide staff through what can be a number of processes for complex incident investigations.

Document Change Control				
Date of Version	**Version Number**	**Lead for Revisions**	**Type of Revision**	**Description of Revision**
2003	1	[redacted]	Major	First combined policy
March 2005	2	[redacted]	Minor	Planned review
March 2007	3	[redacted]	Minor	Approved extension of current version. Content unaltered
March 2009	4	[redacted]	Minor	Planned review to reflect NHSLA and National Patient Safety Agency standards
January 2011	5	[redacted]	Major	Acknowledgement of on-line incident process. Reviewed for NHSLA Level 2. Inclusion of serious incidents.
March 2012	6	[redacted]	Minor	Acknowledgement of changes required under NHSLA and general review
October 2012	7	[redacted]	Minor	Acknowledgement of changes required under NHSLA level 3 and general review
December 2012	8	[redacted] Head of Quality (Patient Safety)	Major	Further clarity on governance of RCA's and action plans in response to incidents.
June 2013	9	[redacted] Head of Quality (Patient Safety) [redacted] Head of Health and Safety Services	Major	Update on the roles and responsibilities of key staff particularly Ward/Department. Managers, Divisional and Trust Patient Safety Managers, Divisional Directors, Clinical Chairs, Patient Safety Group, Associate Director for Patient Safety. Updated to be consistent with revised Serious Incident Policy Monitoring table simplified and policy summary added.
August 2016	10	[redacted] [redacted] Patient Safety Manager (Incidents) [redacted] Associate Director of Occupational Health, Safety & Well Being	Minor	Updates to recognise introduction of Datix on line system Minor changes to process Update to ensure consistency with revised Serious Incident Policy

April 2019	11	[redacted] Head of Quality (Patient Safety)	Major	Update to recognise introduction of incident triage process and to reflect changes to external processes including HSIB investigations for maternity incidents. Health and Safety update Rationalisation and removal of duplicated content. New content on management of cross provider incidents Clarification and changes to roles and responsibilities, timeframes and policy content. Process flow charts removed and put into a separate SOP
March 2020	12	[redacted] Head of Quality (Patient Safety), [redacted] Patient Safety Manager (Incidents)		Minor changes to assist with clarification of process.
August 2020	12.1	[redacted] Head of Quality (Patient Safety),	Minor	Clarification to Appendix F regarding sign off of divisional RCAs.
May 2022	12.2.	[redacted] Deputy Head of Patient Safety, UHBW		Interim Update until launch of PSIRF due to change in process for SI identification and change of name to Patient Safety Incident investigation (RCA removed)

Sign off Process and Dates	
Groups consulted	**Date agreed**
Divisional Patient Safety Teams	Click here to enter a date.
Patient Safety Group	Click here to enter a date.
Policy Assurance Group	Click here to enter a date.
Clinical Quality Group	Click here to enter a date.

- **Stakeholder Group** can include any group that has been consulted over the content or requirement for this policy.

- **Steering Group** can include any meeting of professionals who has been involved in agreeing specific content relating to this policy.
- **Other Groups** include any meetings consulted over this policy.
- **Policy Assurance Group** must agree this document before it is sent to the **Approval Authority** for final sign off before upload to the DMS.

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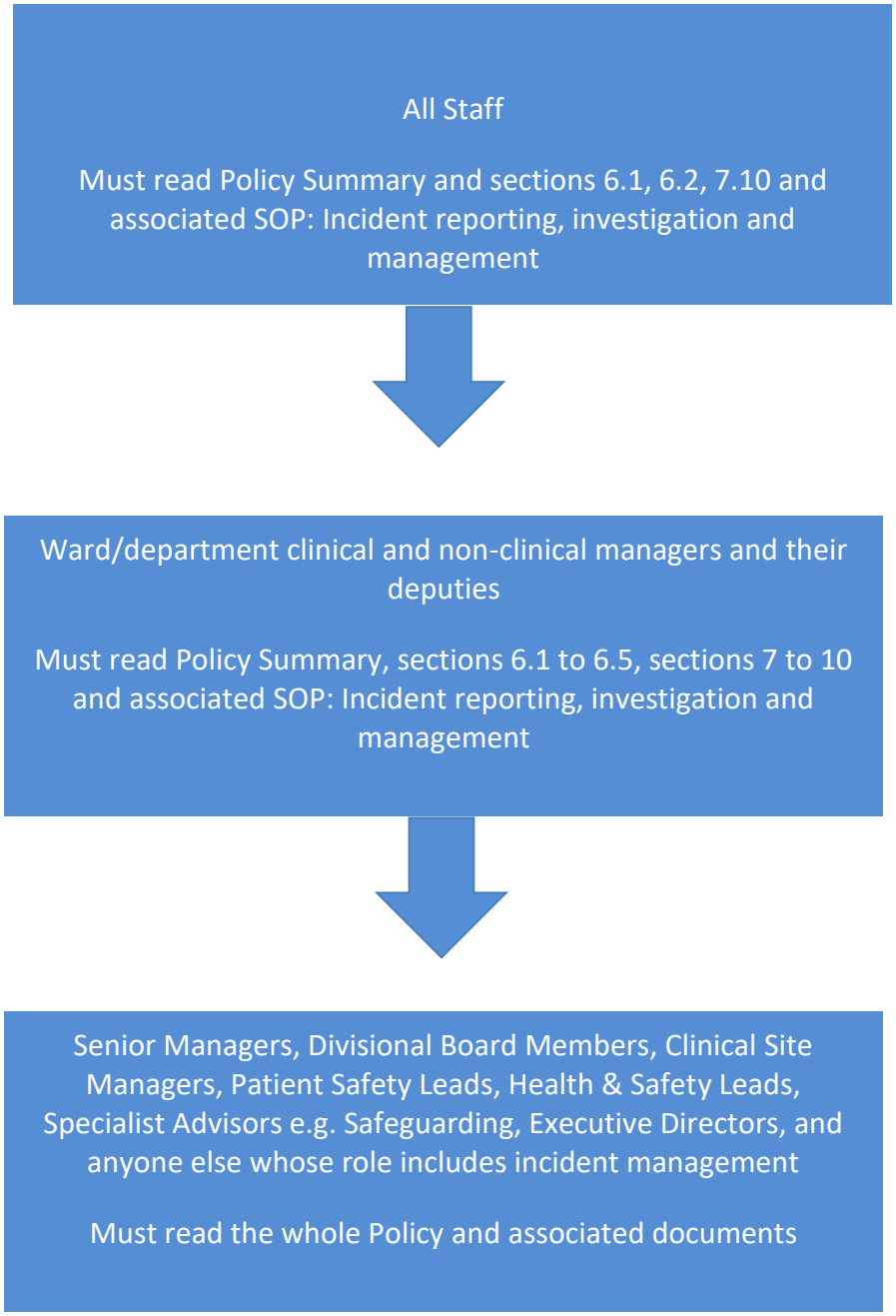
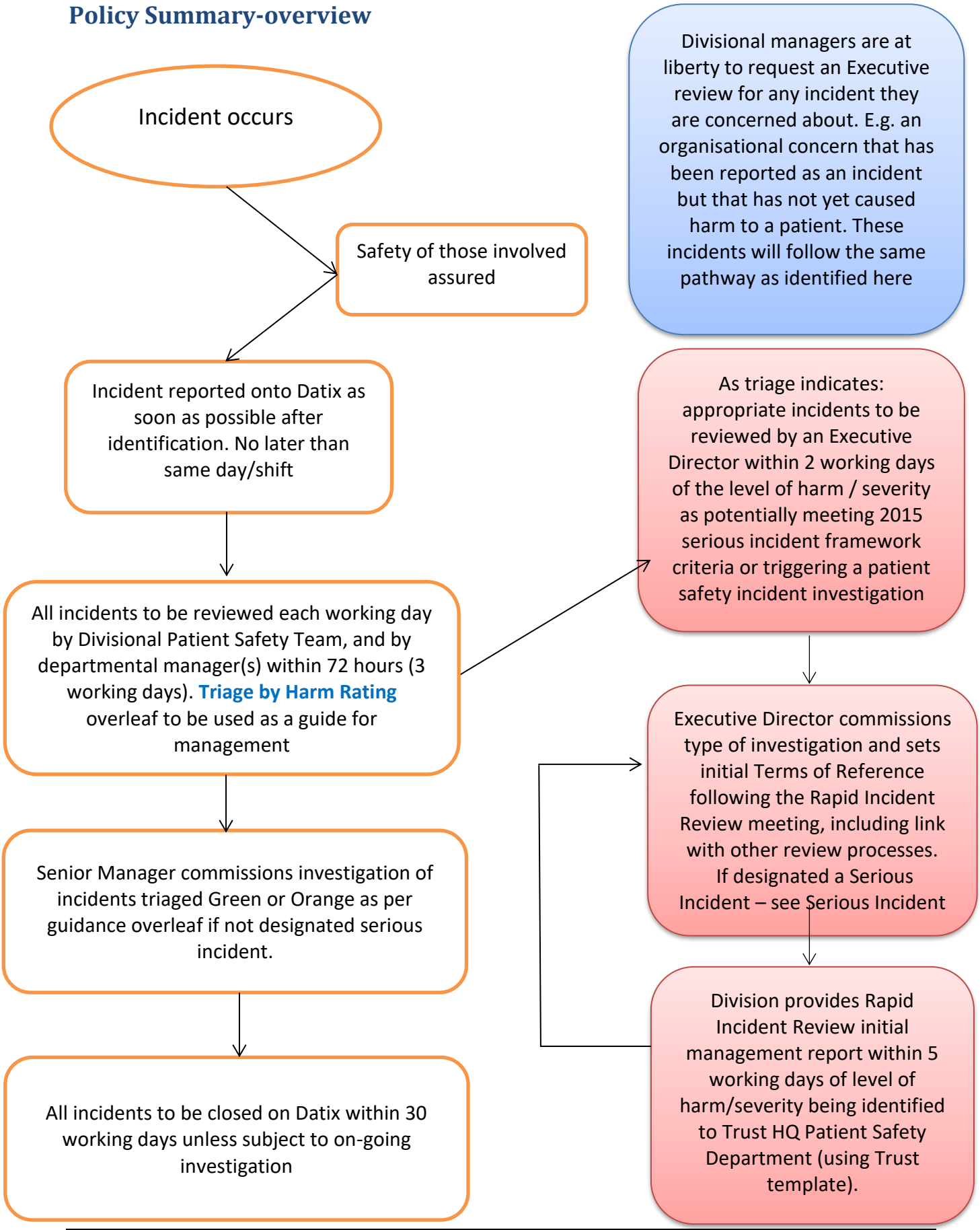
1. Do I need to read this Policy?



Policy Summary-overview



Policy Summary-Decision making criteria for the management of incidents

To provide guidance on the management of incidents via a triage system to ensure a consistently appropriate Divisional and Trust response. If in doubt escalate to the corporate Patient Safety Team.

NO / MINOR HARM INCIDENTS:

- Incidents where patients have not required rapid treatment to resolve a clinical issue.
- Where there has been a system or process malfunction that has **not** impacted on care being provided to patients.
- Unavoidable deaths e.g. resuscitation events / incidents that involve recognised complications in treatment where it is clearly understood that there were **no** issues with the standard of care provided.

ACTIONS

- To be managed within the department and included in divisional governance reports / statistics
- The Division has the option of undertaking a local investigation if there is potential learning
- Follow Staff Support and Being Open Policy

MODERATE HARM INCIDENTS PLUS:

- Incidents involving temporary impact on patient's condition that has required rapid, possibly lifesaving, treatment.
- Any system or process malfunction that has temporarily impacted on care being provided to patients and threatening their well-being.
- A significant unexpected complication or complication not consented for that requires investigation
- Any such incident may be upgraded to Red and receive an Executive review. Discussion with corporate Patient Safety Team advised.

ACTIONS

- For discussion with patient safety team and senior manager in division as a potential serious incident
- Reported through Divisional Governance arrangements
- Duty of Candour to be completed if moderate harm confirmed. Follow Staff Support and Being Open Policy.
- For review by THQ Patient Safety team for advice on management
- If not meeting serious incident criteria (see SI policy) Division to decide level of investigation in accordance with this policy

ALL MAJOR HARM INCIDENTS / UNEXPECTED DEATHS PLUS:

- Moderate harm incidents that could meet serious incident criteria and requires executive director review e.g. Category 3 pressure ulcers
- Any system or process malfunction that has a major impact on the Trust's ability to deliver care: e.g. Fire / IT

ACTIONS

As for moderate harm plus:

- For Rapid incident review with an Executive director (or designated deputy) via THQ Patient Safety team
- Executive Director to commission level of investigation following the "Rapid Incident Review meeting."
- Corporate Patient Safety Team to provide advice and ensure link between executive director, Division, other review processes and commissioners

NEAR MISSES

Any Near Miss can be added to any of these three groups depending upon the level of concern identified by the Division and / or THQ Patient Safety team. Discussion between teams advised.

2. Introduction

University Hospitals Bristol and Weston NHS Foundation Trust (UHBW), in common with all acute hospital environments, operates within a wide range of risks inherent in healthcare provision. The Trust's lowest risk appetite is for risks to safety of patients, their families, staff members and visitors; and for breaching legal obligations. This means that reducing these risks so far as is reasonably practicable will take priority over meeting our other business and strategic objectives.

Incident reporting is a fundamental tool of risk management, the aim of which is to collect information about incidents, including near misses, ill health and hazards, which will help to facilitate wider organisational learning. If incidents are not properly identified and acted on they may result in unknown or unmitigated risks to the safety of patients, families, staff and visitors and lead to a loss of public confidence in the organisation and a loss of assets.

The Trust requires timely reporting of all incidents and 'near misses' to improve patient and staff safety and quality of care.

It is the Trust's intention to have a "Just Culture" throughout the organisation. This includes the Trust's requirements for the statutory Duty of Candour to inform patients when incidents which affect them have occurred and to ensure that staff are supported at difficult times in accordance with the Trust's Staff Support and Being Open Policy.

This policy is based on NHS England's Serious Incident Framework 2015 and NHS Patient Safety strategy July 2019.

This policy describes the overarching management of incidents within the Trust and references additional external specific incident reporting and management processes for some types of incidents.

3. Purpose

The purpose of this policy is to ensure there is a systematic Trust wide approach to the reporting and investigation of incidents and to ensure that analysis of incidents takes place to capture learning which is used to reduce the risk of a recurrence and to inform quality and service improvements.

The Trust promotes an open and transparent approach to incident reporting and investigation and to seek to learn lessons and implement risk reduction measures when things have gone wrong. The incident reporting process must therefore be viewed as non-threatening to ensure the staff feel safe to report incidents.

Staff to whom an incident or near miss is witnessed or reported (whether by a patient, visitor or colleague) are under obligation to respond in accordance with this policy.

4. Scope

This policy applies to all staff working in UHBW services and premises including: temporary (locum, bank and agency) staff, contractors, staff on honorary contracts, students and trainees.

This policy covers:

(a) All incidents involving patient care, whether resulting in actual injury or harm, or having the potential to cause injury or harm;

(b) All health and safety incidents involving patients, staff and visitors whilst on Trust property and staff off site whilst fulfilling the requirements of their employment contract;

(c) All information governance incidents (Please see the Trust's Information Governance Policy);

(d) All incidents relating to the delivery of our services, including those where there are additional specialist reporting and management requirements.

5. Definitions

5.1 Near miss

A situation when an incident or serious incident very nearly happens that could have resulted in injury, damage or loss but did not do so due to chance, corrective action and/or timely intervention.

5.2 None / Negligible Harm Incident

An incident that reached its full conclusion but caused no harm/negligible harm to one or more individuals (Negligible harm = Minimal injury requiring no/minimal intervention or treatment: Full description of levels of harm – see A simple guide to Risk Assessment & Management)

5.3 Patient Safety Incident

A patient safety incident is any unintended or unexpected event which could have or did lead to harm for one or more patients receiving NHS care and is associated with the care provided to that/those patients. This includes all direct care provided to patients and also the operational, management and equipment issues relating to provision of care. The incident may occur due to something that happened which shouldn't have (commission) or something that didn't happen that should have (omission) and may or may not cause harm.

5.4 Health and Safety Incident

Any unexplained, untoward event resulting in injury, ill health, loss or damage which in the case of patients is not due to treatment or care. This includes incidents which impact on staff and visitor safety.

5.5 Operational Incident

An incident whereby the ability of Trust to continue to deliver one or more aspects of its services is compromised.

5.6 Information Security / Governance incident

An incident involving the accidental or unlawful destruction, loss, alteration, disclosure or access to information. Please see the Trust's Information Governance Policy for further information.

5.7 Allegations of Abuse

A violation of an individual's human and civil rights by any other person or persons. Abuse may consist of single or repeated acts. It may be physical, verbal or psychological; it may be an act of neglect or an omission to act, or it may occur when a vulnerable person is persuaded to enter into a financial or sexual transaction to which he or she has not consented, or not able to consent. Abuse can occur in any relationship and may result in significant harm, or exploitation, of the person subjected to it. These incidents should be reported as Safeguarding incidents and correctly designated within health and safety or patient safety categories depending upon Trust involvement. Please see the Trust's Safeguarding Policies for adults and children for further information.

5.8 Screening Programme Incidents

A reportable incident that occurred in relation to English NHS Screening Programmes.

5.9 Hazard

A hazard is anything with the potential to cause harm. Incidents are frequently, but not exclusively, associated with a hazard.

5.10 Risk rating of incidents

Risk rating is the combination of the likelihood of recurrence and the level of consequence of an event. This is set out in the risk matrix in the Trust's Risk Management Policy and Risk Assessment Standard Operating Procedure. This is completed by managers on Datix with the initial assessment being completed when initially reviewed and final assessment completed prior to the closure of the incident.

5.11 Degree of Harm

The degree of actual harm suffered either by those involved or by the organisation as a result of the incident. This may not be confirmed until the incident investigation has been completed. If the investigation determines the degree of harm caused is different from what was originally reported, the degree of harm rating in Datix should be updated. Incident investigations may identify contributory factors, but may not be able to conclude that the harm was a direct consequence of the incident occurring. Patients presenting with pressure ulcers and moisture lesions present on admission should have the level of harm suffered by the patient recorded even if there was no health or social care services involvement prior to admission.

5.12 Serious Incident

The designation of a serious incident is decided by an Executive Director in line with the definitions set out in the Trust's Serious Incident Policy. All unexpected deaths and incidents with a

catastrophic or major harm outcome are considered for designation as serious incidents, although other incidents may also be considered depending on the circumstances.

5.13 Never Events

"Never events" are, by definition, patient safety incidents that should never happen if all preventive measures have been implemented. Never events are automatically designated as serious incidents (please see the Never Events list 2018 (updated February 2021).

5.14 Datix System

The Datix system is the Trust's on-line incident reporting and risk management system accessible via front page of Connect On-Line incident reporting page.

5.15 Unexpected Death

A death that occurs contrary to the expectations of clinical staff bearing in mind their understanding of the patient's clinical condition and the care they were providing to treat them. Such an occurrence should be reported as an incident and reviewed at a Rapid Incident Review meeting to identify whether this triggers a systems patient safety incident investigation to identify learning an improvement actions. The degree of harm rating of the incident must be updated to reflect the findings of a review or investigation in accordance with either paragraphs 5.16 or 5.17. Other review processes exist for patient deaths, please refer to the SOP "Link between incidents, complaints and other investigatory processes".

5.16 Catastrophic incident

An incident leading to the death or severe permanent harm (e.g. permanent paralysis) of an individual(s) that the organisation was in some way responsible for or failed to prevent.

5.17 Unavoidable death

For the purposes of incident reporting, an unavoidable death is the unexpected death of an individual(s) where there is a less than 50:50 chance the death was attributable to problems in healthcare[1].

5.18 Safeguarding

Safeguarding means protecting peoples' health, wellbeing and human rights, and enabling them to live free from harm, abuse and neglect. It is a key part of providing high-quality health and social care.

5.19 Patient Safety Incident Investigation (PSII)

Patient Safety Incident investigations (PSIIs) are conducted solely for the purpose of systems-based learning and safety improvement. This is achieved by identifying the circumstances

[1] Hogal et al: Avoidability of hospital deaths and association with hospital-wide mortality ratios: retrospective case record review and regression analysis, BMJ 2015;351:h3239

surrounding incidents and the systems-focused, interconnected causal factors that may appear to be precursors to patient safety incidents. These factors must then be targeted using strong (effective) system improvements to prevent or continuously and measurably reduce repeat patient safety risks and incidents.

The PSII is not designed to investigate individual fault. The Just Culture Guide and further information in the Trust's Staff Support and Being Open Policy describes how potential individual culpability should be managed.

6. Duties, Roles and Responsibilities

6.1 All staff

(a) All staff are required to report incidents and near miss events via the Trust's on-line incident reporting system (Datix) which is accessible via the Trust's intranet.

(b) If staff are uncertain whether something that has happened is an incident or not they should report it on Datix in any case for onward assessment by divisional/corporate patient safety teams. "If in doubt report".

(c) For the purposes of learning and improvement all staff are expected to share their account of the context, situation and sequence of events relating to any incident under investigation that they witnessed or have information about.

(d) All staff are required to protect themselves, colleagues, patients, visitors and the organisation by complying with safe systems of work.

6.2 Staff member(s) involved in incident

The primary responsibilities of staff are to:

(a) Secure and maintain the safety of all individuals involved (without putting themselves at risk of harm).

(b) Quarantine all equipment that been involved in the incident.

(c) Report the incident or 'near miss' on Datix.

6.3 Person in charge of the department

(a) Secure and maintain the safety of all individuals involved.

(b) Provide support to staff via team and individual debrief.

(c) Ensure incident has been reported on Datix.

(d) Ensure a potential serious incident has been reported appropriately to staff at a senior level and the divisional patient safety team.

6.4 Non UHBW Trust Employees Responsibilities

(a) Non-UHBW employees (e.g. university students, agency staff) must comply with this policy and, if an incident is thought to have occurred, should seek guidance from Trust employees or Trust Headquarters (THQ) Patient Safety Department (x23777).

6.5 Line Manager (or those nominated to manage incidents for their service/clinical area)

(a) On receipt of an incident report, the line manager, senior clinician or nominated deputy is responsible for reviewing all incidents relating to their specialty, or ward/department within 72 working hours of being reported using the Datix system. As part of this review, managers should:

(i) Identify the initial risk rating of the incident using the Trust's risk assessment matrix.

(ii) Confirm the classification of degree of harm based on the information available at the time, or amend if necessary.

(iii) Remove any service user or staff identifiable information from the incident description.

(iv) Ensure that the patient or persons details are validated on the system.

(b) Conduct a local review (or investigation if necessary) of all incidents and take any local action to reduce the risk of a recurrence.

(c) Discuss any amber or red patient safety incidents (as described in Decision making criteria for the management of patient safety incidents rating) or any incident of concern with the divisional patient safety advisor/manager and agree whether a local review/investigation is appropriate or a formal investigation is required. If you are unsure seek advice from your divisional or Trust HQ patient safety team.

(d) Notify any other wards or departments or specialist practitioners relevant to the incidents for their specialist advice on the management of the incident. A record of this must be entered onto Datix.

(e) For Health and Safety RIDDOR (Reporting of Injuries, Diseases and Dangerous Occurrences) reportable incidents: Inform Health and Safety Department and other relevant departments within the Trust as follows:

(i) Needle Stick or sharps injury-Needle Stick Hotline.

(ii) Radiation related incident-Radiation Protection Supervisor.

(iii) Security related incident (including assault)-Security Service.

(iv) Specified injury as in Appendix G, death or dangerous occurrence - immediately inform a Senior Manager and the Safety Department.

(f) Provide initial meaningful feedback to the person who reported the incident on management action being taken as this person may not be included in the automatic notifications of this incident from Datix.

(g) Close the incident within 30 days unless a full investigation involving an patient safety incident investigation is on-going.

(h) The incident should be closed after the investigation has been completed, but not necessarily before all actions have been completed if there is an action plan with a longer timescale.

(i) For patient safety incidents which have resulted in moderate or severe harm (moderate, major or catastrophic) to patients the manager should take action to comply with Duty of Candour requirements in accordance with the Trust's Staff Support and Being Open Policy.

(j) On completion of the local review or incident investigation:

(i) Complete the final risk rating of the incident.

(ii) Confirm the degree of harm caused by the incident.

(iii) Add any other updated information to the incident.

(iv) Close the incident and enter the date closed (actions may remain open until completion at a later date).

(v) Complete the final requirements of the Staff Support and Being Open Policy.

(vi) Complete all Duty of Candour fields on the incident report on Datix.

(vii) For some incidents, managers will be able to complete both (a) and (j) above at the same time. For incidents where a formal investigation is underway the manager will need to return to the incident once the investigation is completed to carry out their responsibilities in (j).

(k) Managers are responsible for sharing local learning from incidents and actions taken to prevent a recurrence with the wider team at safety briefings and team/divisional meetings.

6.6 Divisional Directors

(a) Divisional Directors are responsible for ensuring that systems for managing and investigating incidents are resourced and implemented within their divisions and that all staff are aware of their responsibilities.

(b) Ensuring local managers are performing their duties in relation to incident reporting, management, investigation and implementation of risk reduction measures.

(c) Ensuring there is a divisional governance system in place to report, manage, investigate, analyse, and learn from incidents and to communicate learning within the division. This includes producing actions plans in response to an incident investigation and monitoring completion of such action plans.

(d) Ensuring the Divisional Board receives a quarterly report on incident activity containing quantitative and qualitative analysis and which identifies any key risks arising from incidents.

(e) Ensuring risks arising from incident activity are assessed and managed in accordance with the Trust's Risk Management Policy and entered on the

divisional risk register if appropriate, and the divisional risk register is reviewed by the divisional board at least quarterly.

(f) Commissioning incident investigations for all incidents which are not Serious incidents but which result in major or catastrophic harm and all other incidents for which the Divisional Director deems it to be necessary (Advice and support in the decision making process will be available from Divisional and Trust governance leads and Executive Directors).

(g) Reviewing and signing off cross divisional incident investigations in accordance with Appendix F (N.B. This responsibility cannot be delegated to the divisional patient safety lead/manager/advisor).

(h) In addition, Divisional Directors must ensure all Health and Safety related incidents are investigated and acted upon by their appropriate staff. RIDDOR investigations are instigated by the Safety Department for completion within three weeks.

(i) Identification of a Case Manager where there multiple investigatory processes underway as per the Standard Operating Procedure (SOP) "Link between incidents, complaints and other investigatory processes".

(j) To sign off a divisional patient safety incident investigation that is to be shared with a patient/family/carer or an external body, the Division may request an Executive review prior to sending document) (See appendix F).

6.7 Divisional Patient Safety Leads/Managers/Advisors

Divisional Patient Safety Leads/Managers/Advisors are responsible for:

(a) Taking on delegated responsibilities from Divisional Directors as outlined in section 6.6.

(b) Reviewing incidents in their division resulting in a major harm/catastrophic outcome within one working day, and advising managers on the risk and harm assessments to ensure they are accurately reflected in accordance with this policy prior to escalation for consideration as serious incidents.

(c) Liaising with the central patient safety team regarding the management of incidents resulting in major harm/catastrophic outcome or any potential serious incidents and providing additional information if needed.

(d) Ensuring a rapid action review of incidents which are potential serious incidents within 48 hours of the incident being identified and any immediate risk reduction measures are put in place in accordance with the Trust's Serious Incident Policy.

(e) Ensuring a complete, objective Rapid Incident Review report is provided within the required timescale and is presented to a subsequent Rapid incident Review meeting with a Trust Executive Director (or deputy) for all incidents where moderate, major, catastrophic or unexpected death harm has occurred must be convened at the earliest opportunity. The division may undertake a Rapid Incident Review for any other incident to identify the facts as known at that time

and to identify if a further investigation is required and learning can be gained. The Trust Rapid Incident Review template must be used for this report.

(f) Providing expert advice and liaison with divisional and departmental managers regarding the management of incidents.

(g) Providing expert advice and support for managers conducting Patient Safety Incident Investigations including those relating to serious incidents.

(h) Maintaining a divisional log of incidents under investigation using the Trust template which demonstrates their status and progress through the Divisional and Trust governance incident management systems.

(i) Ensuring all actions arising from incidents are added to Datix immediately after the investigation has been signed off and overseeing and escalating through reports into their divisional quality and safety governance structure actions which have not been completed within the planned timescale.

(j) Monitoring the status of incidents within the Datix system and ensuring incidents under investigation are promptly closed on completion of actions and bringing to the attention of the Head of Nursing areas where there are persistent areas of non-compliance.

(k) Reviewing incident investigation reports to ensure they are fit for sharing with patients/families and/or with external organisations. This includes ensuring the document meets its Terms of Reference and answers all questions asked by the family/carer.

(l) Ensuring organisational learning and actions from divisional incidents are shared via their review at the Patient Safety Group and the mechanisms for sharing incidents described in section 7.18 are used within the division.

(m) Commissioning of relevant audits should they be identified from specific incidents or overall trends in incident activity in order to establish whether changes in process or practice have been embedded. Relevant clinical audits should be fed into the annual clinical audit plan.

(n) Discussing and providing feedback relating to all incidents at relevant divisional management groups and provide an assurance report to the Divisional Board on a quarterly basis.

(o) Ensuring the Divisional Board is made aware of risks arising from incidents and to make recommendation to the divisional board for implementation of division-wide risk reduction measures.

(p) Flagging any recommendations with Trust wide implications to the Patient Safety Group for consideration as a Trust wide clinical risk for the Trust Services Division risk register.

(q) Providing guidance for managers and staff using Datix on-line system.

(r) Conducting spot check audits of compliance with Duty of Candour for moderate and higher level of harm reported with the division.

6.8 Risk Management Team

(a) Provide support to Divisional Patient Safety Leads to ensure accurate and effective use of the Datix system by divisional staff.

(b) Responsible for sending Patient Safety incidents to the National Reporting and Learning System (NRLS) meeting criteria set out by NHS Improvement within 30 days following their initial reporting date.

(c) Responsible for ensuring all incidents are resent to NRLS once the incidents have been closed.

6.9 Divisional Health and Safety Leads

(a) Divisional Health and Safety Leads are responsible for taking on any delegated responsibilities from Divisional Directors as outlined in section 6.6.

6.10 Clinical Chair and Divisional Director

(a) The Clinical Chair and Divisional Director are responsible for ensuring the divisional board take risk based business and investment decisions in response to risk reduction actions arising from incidents.

(b) Reviewing and signing off Serious Incident investigations in accordance with Appendix F.

6.11 Trust Board

(a) The Trust Board has overall responsibility for ensuring that patient and staff safety is maintained and risk is controlled. It takes responsibility for authorising solutions for hazards presented to it or accepting the level of risk identified if the cost of reducing the risk outweighs the benefit.

(b) The Board is collectively responsible to ensure systems are in place to review and challenge the management of incidents where necessary.

6.12 Chief Executive

(a) The Chief Executive is the accounting officer with overall responsibility for safety and for ensuring there are effective incident reporting and investigating arrangements within the Trust, delegating discrete responsibility to the appropriate Executive Director according to their portfolio.

(b) The Chief Executive is ultimately responsible for ensuring that the necessary resources and systems are in place to provide for the timely response to incidents and to ensure that controls are implemented as quickly as possible.

6.13 Medical Director/Chief Nurse

(a) The Chief Nurse or Medical Director (or in their absence their deputies) are responsible for deciding when an incident meets the criteria for reporting as a Serious Incident. This may be carried out following a discussion with the relevant

Divisional Director or Clinical Chair. This may be delegated to another appropriate Executive Director colleague for certain types of Serious Incident.

(b) Where an incident is designated as meeting the criteria for reporting as a Serious Incident, the Chief Nurse or Medical Director or a designated deputy should identify specific terms of reference for the incident investigation including objectivity of the investigating team and how the investigation links with other required review processes e.g. Learning from Deaths process, and these should be recorded in the outcome section 2 of the Rapid Incident Review report.

(c) Should the need arise; the Medical Director will facilitate the timely cross-divisional investigation or implementation of actions arising from a patient safety incident with the Clinical Chairs of the relevant divisions.

(d) If an PSII is required to be sent to a family/carer in draft for prior to sign off at the Trust Clinical Quality Group, the Medical Director or Chief Nurse will review the PSII first and agree preliminary sign off.

(e) Any PSII will have Executive sign off before it goes to the coroner but the legal team will see it and may be involved in it prior to sign off (see appendix F).

6.14 Associate Medical Director for Patient Safety

(a) The Deputy Medical Director for Patient Safety supports the Medical Director in discharging their patient safety responsibilities and chairs the Trust-wide Patient Safety Group.

6.15 Head of Quality and Patient Safety

(a) The Head of Quality and Patient Safety takes the lead in ensuring Trust wide systems are in place to ensure incidents are identified, reported and investigated appropriately and where organisation wide learning results and risk reduction measures are put in place.

(b) Provides expert patient safety advice to managers and executive directors particularly in respect of serious incidents.

(c) Ensures the Patient Safety Group discharges its responsibilities for the management of incidents.

(d) The Head of Quality and Patient Safety will, working with divisional patient safety teams, support the management of incidents involving patient pathways and systems across other external providers to ensure investigations are joined up, timely and signed off with UHBW in accordance with this policy.

(e) Provides the link with commissioners and other healthcare providers for managing cross organisational incidents and serious incidents to ensure investigations are joined up, timely and signed off with UHBW in accordance with this policy.

6.16 Trust Patient Safety Manager

The corporate Patient Safety Managers are responsible for:

(a) Providing support, guidance and assistance in all aspects of incident reporting and management, investigation and analysis to Trust staff at all levels.

(b) Maintaining communication links between Executive Directors, Divisional Patient Safety Managers regarding potential serious incidents

(c) Ensuring that PSII investigation reports from all serious incidents and those from which Trust wide learning results are presented to the Trust Patient Safety Group and assist divisions to provide assurance of implementation of action plans by agreed dates.

(d) Providing quarterly reports of patient safety incident activity for Patient Safety Group, Clinical Quality Group and Senior Leadership Team, which includes analysis of incident activity and trends, themes, learning and risk reduction measures arising from patient safety incidents and exceptions to reporting, investigating and action time scales.

(e) Maintaining the Trust's framework for learning from incidents on the Trust's intranet site.

(f) Maintaining a secure system whereby incidents identified by UHBW but occurring in relation to another provider's services are communicated and followed up, and incidents which occurred within UHBW but were subsequently identified by an external source are reported and managed in line with this policy.

(g) Referring incidents involving other health care providers to the relevant NHS Trust or independent provider and obtaining feedback on completion of their investigation.

(h) Reviewing draft Patient Safety Incident investigation reports from divisions for sand providing feedback for incorporation into subsequent versions.

6.17 Information Governance Team

(a) Assess the severity of Information Governance/Security Incidents within 72 hours of the time the incident was reported.

(b) Advise Trust staff on mitigating actions following an Information Governance/Security Incident.

(c) Report serious Information Governance/Security Incidents, scored as reportable, via the data security and protection toolkit which will notify NHS Digital, the Information Commissioner's Office (ICO) and the Department of Health and Social care as appropriate dependent on the severity within 72 hours of the time the incident was reported as per Information Governance Standard Operating Procedure

(d) Communicate potential information governance serious incidents to the Trust HQ Patient Safety Team on the same day as identified as per Standard Operating Procedure for incident reporting, investigation and management and Information Governance serious incidents Standard Operating Procedure.

6.18 Head of Health and Safety Services

(a) Responsible for providing expert advice on the reporting and investigation of health and safety serious incidents and, when applicable, leading the investigation of cross divisional and trust wide incidents.

(b) Will inform the Health and Safety Executive of reportable incidents via the online system and provide a summary report on request.

(c) Will attend the quarterly Trust Health and Safety Committee, providing feedback reports to the Board and Divisional Health and Safety Leads and Advisors (site/ service) and other forums as appropriate.

(d) Will attend the quarterly Risk Management Group meetings and submit a quarterly report including detail of all incidents reported under RIDDOR.

(e) Ensures effective Trust systems for reporting, investigating and monitoring health and safety incidents including compliance with statutory reporting requirements.

(f) Takes the lead on investigating all serious health and safety incidents including 'near misses'.

(g) Monitors the quality of investigations and provide Divisions with support.

(h) Monitors and supports the Divisions in the process of investigation action plan completion and review.

(i) Maintains web based information re incident data at Trust and Divisional level and learning from incidents so that this is shared across the organisation looking at themes in causation.

(j) Ensures the internal process within the Safety Department meets compliance with RIDDOR on behalf of the Trust. For example all incidents of staff absence for over 7 days or unable to carry out their full range of duties due to work related injury must be reported within 15 days to the Health and Safety Executive.

6.19 Health and Safety Department

(a) The Health and Safety Department are responsible for checking health and safety incidents daily.

(b) The Health and Safety Department are responsible for initiating an investigation for RIDDOR reportable incidents.

(c) For all reportable incidents the Health and Safety Department complete the on line F2508 form and submit to the Health and Safety Executive.

6.20 Medical Device Safety Officer (MDSO).

(a) The role of the MDSO is to improve communication and feedback on reported safety issues and enable safer practice to be discussed and shared through monthly webinars and conferences.

(b) A member of the National Medical Device Safety Network, providing support for reporting and learning and assist with taking local action to improve medical devices safety.

(c) Also involved with influencing policy, planning and commissioning as part of clinical governance.

(d) Regularly review information from National Reporting and Learning System and Medicines and Healthcare Products Regulatory Agency to support improvements in reporting and learning.

(e) To take local action to improve local medical devices safety.

(f) Provides support and guidance to staff managing incidents involving medical devices.

6.21 Medication Safety Officer (MSO)

(a) A member of the National Medication Safety network, providing support for reporting and learning and assist with taking local action to improve medication safety.

(b) Also involved with influencing policy, planning and commissioning as part of clinical governance.

(c) Regularly review information from NRLS and MHRA to support improvements in reporting and learning.

(d) To take local action to improve local medication safety.

6.22 Trust Legal Team

(a) The Trust Legal Team provide support and guidance for any department dealing with any circumstance or event that has or may have legal ramifications.

(b) The Trust Legal Team on request will review patient safety incident investigation relating to inquests and claims or similarly sensitive matters.

(c) Obtain Executive agreement prior to releasing an patient safety incident investigation to HM Coroner prior to Clinical Quality Group (CQG) sign off.

6.23 Patient Safety Group

The Trust Patient Safety Group will:

(a) Receive a monthly report of all incidents which have been reported within the previous month where there has been an unexpected death, a catastrophic or major harm outcome and all incidents that have been considered at a Rapid Incident Review meeting with during the previous month. Any lower harm incident that presents a very high risk to patients, visitors, staff or the organisation may also be included in the report.

(b) Receive completed Patient Safety incident investigation reports for all serious incidents and cross divisional investigations for review of accuracy and to identify and discuss learning.

(c) Review actions plans arising out of incidents in (b) and seek assurance that they have been implemented.

(d) Ensure all actions meet SMART criteria.

(e) The Group, through its membership, will also facilitate cross divisional learning from investigations of incidents.

(f) Identify any Trust wide risks arising from incidents and ensure they are risk assessed in accordance with the Trust Risk Management Policy for consideration as a clinical risk for onward identification to the Risk Management Group.

(g) Receive detailed quarterly reports on incident activity across the Trust and identify any themes requiring further action not already identified and being addressed through individual incident investigations or other sources.

(h) There may be occasions when the Patient Safety Group commissions a short life working party comprising key members of staff to ensure the timely implementation of Trust wide actions arising from patient safety incidents.

(i) Receive quarterly reports from divisions of incident activity.

6.24 Divisional Governance Groups

(a) Divisional Governance Groups are responsible for reviewing the draft reports of incident investigations identified in Appendix I for technical accuracy and for approving the recommendations that should be implemented. (Actions identified from PSII's will be discussed and agreed upon by either the Divisional Governance Group or specialised groups that report to the Divisional Governance Group, depending upon the divisional structure and/or the nature of the PSII /actions required.

(b) They are responsible for reviewing PSII reports and monitoring the completion of actions arising from incident investigations.

(c) They are also responsible for reviewing risk assessments arising out of incidents and making recommendation to Divisional Board for inclusion on the division's risk register.

6.25 Divisional Boards

(a) Divisional Boards are responsible for reviewing trends and themes from incidents within their division and making risk based business decisions regarding further risk reduction measures in response.

(b) Agreeing risks arising from incidents for entry on the divisions risk register.

6.26 Health and Safety Committee

(a) The Health and Safety and Committee will, through review of regular incident reports, seek assurance that action plans for health and safety incidents have been implemented and actions are reviewed.

6.27 Risk Management Group

(a) The Risk Management Group has overall responsibility for the oversight of all risks including clinical risks arising from incidents, including serious incidents.

6.28 Other Committees/Groups with Responsibilities for Incident Management

(a) To review and monitor themes arising from incident reports in their specialist area as follows:

(i) Special Interest Groups which report to the Trust Patient Safety Group e.g. Falls Group, Medicines Governance Group, Thrombosis and Anticoagulant Group, Tissue Viability Group, Hospital Transfusion Group. A full list can be found in Appendix D.

(ii) Sub groups of the overarching Health and Safety Committee include Manual Handling and Display Screen Equipment Group, Control of Substances Hazardous to Health Working Party, and Clinical Sharps Group, Managing Violence and Aggression (including Lone Working and Security of premises and personal possessions) Group.

(iii) Information Risk Management Group for Information Security/Governance incidents.

(b) The Clinical Quality Group maintains an overview of the activities of the Patient Safety group including final reviews of Root Cause Analysis reports from Serious incidents.

7. Policy Statement and Provisions

7.1 Overarching principle

(a) Any manager or staff member can refer any incident to a Divisional or Trust Patient Safety Manager for advice or request review of the incident by an executive director for consideration as a serious incident if of sufficient concern.

(b) If an incident relates to an unexpected death, or is correctly recognised as very high risk or the outcome is catastrophic or major harm and potentially avoidable, the Divisional Director/Head of Nursing and the Divisional Patient Safety Manager are informed as soon as the safety of those involved is assured.

(c) Guidance on the identification of the level of harm relating to an incident and its subsequent management by association is provided in Decision making criteria for the management of incidents of patient safety incidents rating section of this policy.

7.2 Incidents which are subject to other parallel investigatory processes

(a) It is recognised that sometimes the same issue will be addressed through multiple processes, for example as a complaint, an incident, or a Child Death Review. Where this occurs, the Trust will ensure that these processes work

together in a way which patients and their families can understand and which provides a single coordinated point of contact with the Trust

(a) The Standard Operating Procedure Link between incidents, complaints and other investigatory processes describes the Trust's approach to co-ordinating multiple investigatory processes.

7.3 Response, Communication and Notification

(a) In all instances, the first priority is to ensure the needs of individuals affected by the incident are attended to, including any urgent clinical care which may reduce the harmful impact.

(b) A safe environment should be re-established, all equipment or medication retained and isolated, and relevant documentation copied as required and secured to preserve evidence and to facilitate the investigation and learning.

(c) If there is a suggestion that a criminal offence has been committed, the police should be contacted by a senior manager of advice from the legal team.

(d) Early consideration must be given to the provision of information and support to patients, relatives and carers involved in the incident in line with Duty of Candour and the Staff Support and Being Open Policy.

(e) The support needs of staff involved in the incident should also be considered in line with the Staff Support and Being Open Policy.

(f) The incident should be reported as soon as practical after it has occurred/been identified, on the same day or same shift.

7.4 Business continuity for incident reporting

(a) In the event of a failure of access by staff to the Datix On-line Incident reporting system, staff will report the incident to their line managers. The system will be repaired by Datix in line with the associated Service Level Agreement. A concern with the server will be managed by the UHBW Information Management and Technology IM &T) Department. If a major incident occurs, the relevant departmental manager will inform THQ Patient Safety Department who will add the information to a high risk checklist.

7.5 Incident Risk Rating

(a) Incident Risk rating is carried out by the manager handling the incident at the initial management review and finally at the time of incident closure.

(b) Guidance is provided A simple guide to risk assessment and management

7.6 Rapid incident review and incident triage

(a) A rapid incident review should take place for all unexpected deaths, moderate major harm or catastrophic incidents and any potential serious incidents. Its purpose is to:

(i) Initiate immediate actions necessary to ensure patient and staff safety.

(ii) Establish initial facts of the case as known at the time.

(iii) Ensure requirements of Duty of Candour are complied with or make arrangements to do so.

(iv) Ensure key contacts for the patient/family/carer are identified in respect of keeping them informed of the progress of the investigation and supporting them in the aftermath of the incident. This may be the same person or two different people.

(v) Ensure that if a Case Manager has been identified, support is provided to promote communication between that individual and patient and family members/carers.

(vi) Agree the level of harm of the incident is accurate and ensure the incident has been completed accurately on Datix.

(vii) Undertake the Decision making criteria for the management of incidents patient safety incidents rating.

(viii) Agree any immediate mitigating actions.

(ix) Identify and notify other key personnel and relevant external bodies.

(x) Ensure support is in place for the staff involved.

7.7 Cross divisional incidents/actions

(a) Where an incident crosses divisions, a lead incident investigator will be identified either within one of the divisions or externally to the division involved who will lead and co-ordinate the investigation.

(b) Should there be an instance where there is difficulty in managing a cross divisional incident in timely manner, the lead incident investigator will escalate this to the Medical Director who will communicate with the Clinical Chair(s) for the relevant division(s) to resolve the situation.

(c) Should there be an instance when an action plan owner is having difficulty in securing timely implementation of Trust wide or specific actions arising from an incident investigation within another division, the above escalation process will apply.

(d) There may be occasions when the Patient Safety Group commissions a short life working party comprising key members of staff to ensure the timely implementation of Trust wide actions arising from patient safety incidents.

7.8 Accountability

(a) The purpose of incident investigation is solely for learning and improvement. All staff are expected to share their account of the context, situation and sequence of events relating to any incident under investigation that they witnessed or have information about.

(b) Staff remain accountable for their actions and behaviours in the course of their work via other mechanisms such a professional bodies, employment contracts and Human Resources policies.

(c) Follow the Trust's Staff Support and Being Open Policy which makes it clear that an event will be properly analysed before the organisation identifies any system weaknesses that may have contributed to its occurrence.

(d) The Just Culture Tool (See Staff Support and Being Open Policy) will assist this process and provide a standardised approach for all staff involved.

7.9 Patient/Relative/Visitor/Contractor Communication and Support

(a) For patient related incidents the patient must be informed of the incident, advised and supported and any advice documented. Relatives may also be informed depending on the circumstances of the incident as in the Trust's Staff Support and Being Open Policy which incorporates Duty of Candour.

(b) The principles encompassed in this guidance are equally applicable to any visitor or contractor on UHBW premises. Guide for the patients and families about Patient Safety Incidents.

7.10 Process by Which to Raise Concerns

(a) Where an incident has not taken place but staff wish to raise a concern the Trust's expectations and guidance for communication of concerns about practice with an adverse impact on safety is available in the Trust's Freedom to Speak Up Policy.

(b) The Trust Freedom to Speak Up Guardian provides an alternative route for staff to raise a patient safety concern

(c) Specific guidance for healthcare professionals on raising and acting on concerns about patient safety:

General Medical Council: Raising and acting on concerns about patient safety.

Nursing and Midwifery Council: Raising concerns.

Health and Care Professions Council: Raising Concerns.

7.11 Support and Feedback for Staff

(a) Further advice regarding the provision of support to staff following incidents is available in the Staff Support and Being Open Policy and related Health and Safety policies and Wellbeing resources.

(b) Divisions are responsible for feedback to staff following completed incident investigations within their division. Any queries from staff concerning incidents should be directed to their line managers in the first instance and to the Divisional Patient Safety Leads if necessary. Health and Safety enquiries should be directed to Line Managers or the Divisional Health and Safety leads.

7.12 External Stakeholder Notification

(a) All patient safety incidents which occurred in relation to the delivery of the Trust's services and meet criteria set by NHS Improvement (NHSI), reportable to the National Reporting and Learning System (NRLS) are reported (in an anonymised form) in accordance with NRLS guidance.

(b) All patient safety incidents which meet NRLS criteria are to be reported to the NRLS at least monthly and those resulting in severe harm or death that is directly caused by the incident are to be reported within two working days of confirmation of this level of harm (Serious Incident Policy).

(c) Incidents are also reported externally to the Care Quality Commission through the NRLS.

(d) Incidents which meet the criteria for a serious incident are reported to commissioners and the Care Quality Commission via STEIS as described in the Trust's Serious Incident Policy.

(e) RIDDOR reportable incidents are reported to the Health and Safety Executive (please see Appendix G – Health and Safety guidance for managing injury or ill health).

(f) Incidents involving other health care providers must be referred to the relevant NHS Trust or independent provider as described in paragraph 7.11.

(g) (g) Information Governance/Security Incidents that are assessed as being reportable, according to NHS Digital Guidance, must be reported to NHS Digital and the Information Commissioner's Office using the SIRI Reporting Tool on the Data Security and Protection Toolkit as per the Trust's Information Governance Policy.

(h) For a full list of incidents that are required to be reported to External Agencies associated with their speciality is shown in Appendix I. The Trust lead for the specialist area of the incident should be informed and will advise accordingly.

(i) All pressure ulcer and moisture lesion incidents (including those present on admission) are reported to the NRLS as of April 2019.

(j) The Healthcare Safety Investigation Branch (HSIB) will investigate certain maternity and neonatal incidents. Recommendations from the Ockenden Report (published 31st March 2022) require all maternity investigations that meet HSIB criteria since April 2021 are designated as a serious incident. This includes:

(i) Intrapartum Stillbirths.

(ii) Early Neonatal Death (0-6 days of life).

(iii) Severe Brain Injury diagnosed within first 7 days of life.

(iv) Maternal Deaths (within 42 days of the end of the pregnancy).

(v) Full information is available at HSIB maternity.

7.13 Media Involvement

(a) The Communications Department, in collaboration with the Deputy Chief Executive (executive lead for communications) or a nominated director, is responsible for managing the handling of media enquiries surrounding serious incidents. This will be delegated to the on call communications team member and on call director out of hours.

(b) Guidance on the provision of information to media representatives is available in the Trust's Standard Operating Procedure for Communicating and Engaging with the Media.

7.14 Notifying other organisations of incidents identified

(a) All patient safety incidents reported within UHBW relating to another provider's services are sent on to the relevant external organisations. This includes NHS and private organisations. If the incident involves major or catastrophic harm to a patient or patients, the relevant organisation is contacted within 48 working hours by the central patient safety team with all available details. All other incidents are to be sent to their relevant organisations within 30 days of reporting onto Datix. This action is acknowledged for each incident on Datix and closed.

(b) Any updates provided by the external organisation will be added to the Datix entry by the THQ Patient Safety team and sent to the manager of the area where the incident was reported.

(c) The receiving organisation is responsible for investigating and acting upon the incident accordingly, unless there are specific concerns for which UHBW requires assurance, in which case those concerns will be discussed with the external organisation.

7.15 Managing incidents relating to UHBW services but identified by another organisation

(a) Where another provider or commissioner identifies and notifies UHBW of an incident relating it its services, this is reported internally using the Datix systems and managed in line with this policy.

(b) When the incident is closed on Datix, the information gathered during the course of the investigation is to be sent to the organisation that initially reported the incident, this includes all actions carried out to prevent recurrence.

7.16 Managing cross provider incidents

(a) The Head of Quality and Patient Safety will, working with divisional patient safety teams, support the management of incidents involving patient pathways and

systems across other external providers to ensure investigations are joined up, timely and signed off with UHBW in accordance with this policy.

7.17 Risks identified from incident investigations

(a) Where an incident report or investigation identifies a risk for consideration for inclusion on one of the Trust's risk registers, a risk assessment is completed in line with the Trust's Risk Assessment Standard Operating Procedure.

(b) Such risks are managed at the appropriate level as set out in the Trust's Risk Management Policy.

7.18 Process for Analysis, Learning and Improvement from Incidents

The Datix incident reporting system allows linkage between incidents, risks, complaints and litigation to be made enabling risk reduction and service improvement measures to be identified across these areas.

(a) Analysis

(i) Incident analysis takes place largely within and between the Trust and Divisional Health and Safety and Patient Safety Teams. Analysis of incident activity occurs on three main levels:

(A) Special Interest Groups e.g. Falls Group, Health and Well Being Group, Information Governance Steering Group, receive reports analysing relevant incident activity to enable them to identify themes and focus divisional activity on preventive measures.

(B) Divisions review their analysis of local incident activity in their governance/quality/risk management groups.

(C) Extensive Trust wide analysis and scrutiny of incident activity takes place in the Patient Safety Group and Health and Safety Committee for their respective incident types.

(b) Learning and Improvement takes place on several levels:

(i) The Trust issues safety bulletins and rapid response bulletins to share key safety messages arising from incidents and serious incidents across the organisation.

(ii) Specialty safety summits are held in response to themes arising from patient safety incidents.

(iii) Local and specialty learning newsletters/posters are shared e.g. LASER posters (Learning After a Significant Event and Recommendations).

(iv) Key learning points from incidents and serious incidents are fed into patient safety training and update sessions and managers training for accident investigation.

(v) Learning and service improvement from patient safety incidents takes place at Divisional level through governance/quality/risk management meetings and Mortality and Morbidity meetings and through scrutiny of PSIIs.

(vi) The Trust receives data from the NRLS six monthly which includes benchmarking against our "Acute Non Specialist" peer group. A local analysis is presented to the Patient Safety Group.

(vii) Health and Safety learning takes place at Divisional Health and Safety Forum and Specialist Advisor meetings such as Manual Handling and Display Screen Equipment meetings.

(viii) Organisational learning from Health and Safety incidents takes place at the Trust's Health and Safety and Committee.

(ix) Both aspects of incident analysis come together through their reporting to the Risk Management Group and the development of themed reporting across all incidents, complaints and claims.

(x) Responsibility for taking forward local improvements lies with each division, but incident activity also feeds Trust wide improvement to be taken forward by the Trust wide groups such as the Service Delivery Group and Information Risk Management Group.

(xi) Wider improvement work is fed into the Trust's Transformation Programme and Trust Patient Safety Improvement Programme.

(xii) Learning across the wider health community takes place through patient safety improvement initiatives such as the West of England Patient Safety Collaborative themed work stream, NHS Improvement regional learning events and through the IOSH Health and Social care South West Group bi-monthly meetings.

(c) Audit

(i) As part of the incident investigation process, staff should consider whether there is any need to plan and undertake a clinical audit to assess the effectiveness of actions arising from incidents. If audit requirements are identified, these should be listed in the PSII action plan template. Once agreed, projects should be registered with the Clinical Audit & Effectiveness Team who will help advise on and facilitate the process.

(d) Training

(i) Training on incident reporting is provided to all staff as part of corporate induction.

(ii) Patient Safety training is provided to all clinical staff on induction with updates in accordance with the Trust's Trust Essential Training Policy. This includes completion of the NHS England National Patient Safety E-learning (since March 2021).

(iii) Health and Safety and Information Governance Training are provided to all staff in induction with updates in accordance with the Trust's Trust Essential Training Policy.

(iv) Training on Patient Safety investigation is provided to identified staff via the corporate Patient Safety Managers.

(v) Training for managers on use of the Datix system is provided by the Trust Risk Management Team.

8. Standards and Key Performance Indicators

8.1 Measurement and Key Performance Indicators

(a) Incidents should be reviewed by the appropriate manager within three working days of the incident being added to the Datix system.

(b) On request, Rapid Incident Review (RIR) reports should be provided by divisions within 5 working days.

(c) Incidents should be managed within 30 days and closed on Datix by the appropriate manager with the exception of those incidents requiring a formal investigation.

(d) Incidents subject to a formal investigation and action plan should be closed on Datix as soon as all the actions have been completed.

(e) Formal incident investigations (PSII's or local investigation) should be completed within 45 working days.

(f) PSII's that are complex, cross Trust / Division may require further time to be completed. This should be discussed with THQ Patient Safety Department and an extension agreed by the Head of Quality and Patient Safety. Investigations timescale extensions and breaches should be reported to Divisional Governance Groups.

(g) Formal investigation reports should be attached to Datix within a week of being signed off.

(h) Actions arising from formal incident investigations should be entered on Datix within a week of the investigation report being signed off.

(i) Completion of actions to reduce the risk of recurrence should occur within timescale specified in the investigation action plan. Exceptions and breaches should be reported via Divisional Governance Groups and upward to the Trust Patient Safety Group via scheduled quarterly report on incident activity.

(j) All patient safety incidents which meet NRLS criteria are to be reported to the NRLS at least monthly and those resulting in severe harm or death directly caused by the incident are to be reported within two working days following confirmation of level of harm.

(k) RIDDOR investigation completed within three weeks of the incident being notified.

(l) Severe Information Governance Incidents must be reported using the SIRI Reporting Tool on the Data Security and Protection Toolkit within 72 hours of the time the incident was reported.

(m) Requirement to notify the Health and Safety Executive of reportable incidents within a legislative timeframe (10 or 15 days depending on incident) although it is acknowledged there may be occasions where the outcome of the incident may be delayed e.g. where medical diagnosis of the extent of an injury is required.

9. References

(a) Health and Safety Executive (HSE) The Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR), www.hse.gov.uk/riddor

(b) Checklist for Reporting, Managing and Investigating Information Governance Serious incidents NHS Digital

(c) Working Together to Safeguard Children: A guide to inter-agency working. DCSF 2006). Department of Health 2015 Working together to safeguard children DoH 2015

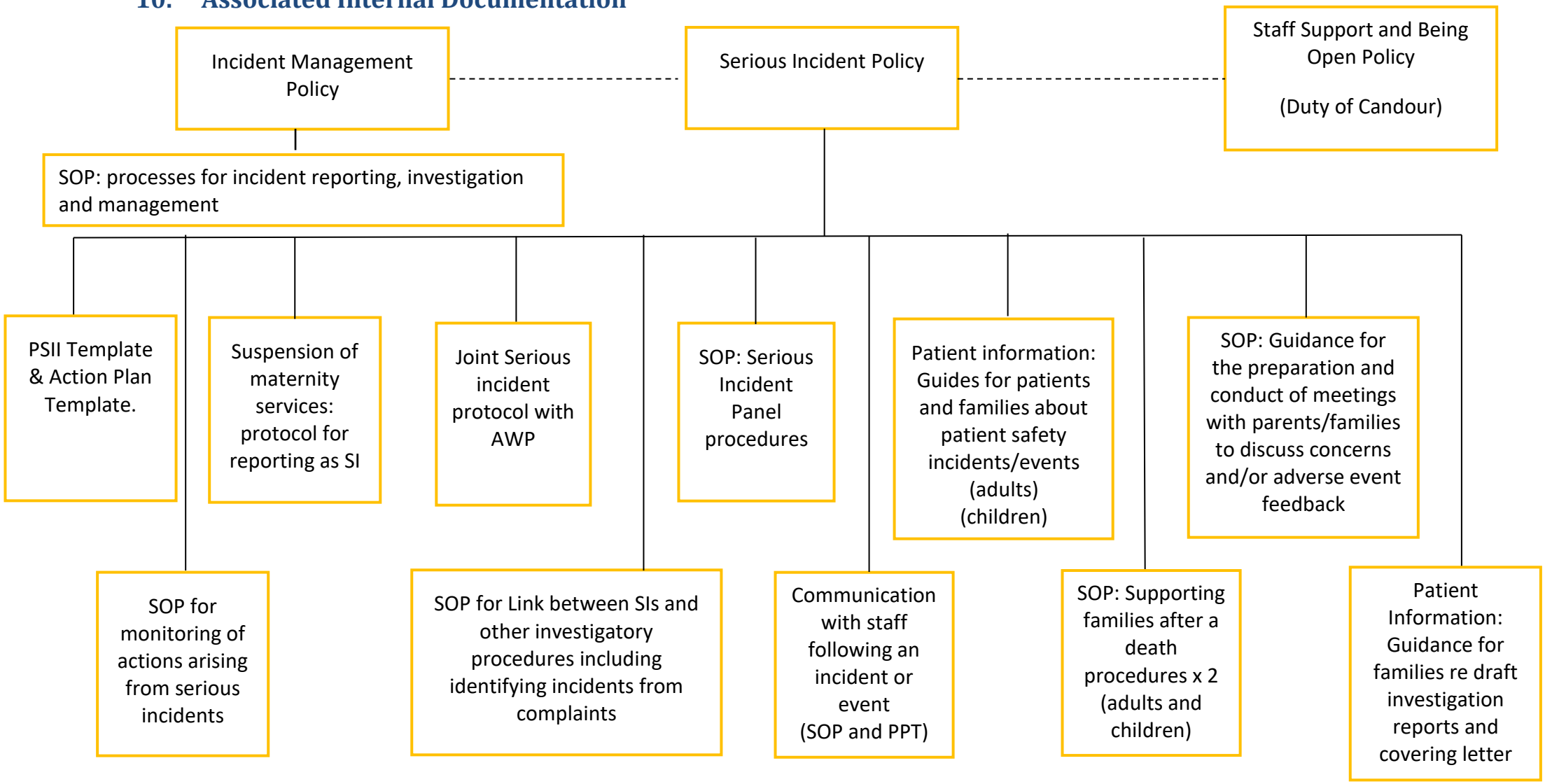
(d) Serious Incident Framework, NHS Improvement, 2015

(e) Never Events Policy and Framework, NHS Improvement, January 2018 (updated February 2021)

(f) NHS Improvement's National Reporting and Learning System web pages

(g) The NHS Patient Safety Strategy, Safer Culture, Safer Systems, Safer Patients, NHS England and NHS Improvement July 2019

10. Associated Internal Documentation



Also:

(a) Freedom to Speak Up Policy

(b) A Simple Guide to Risk Assessment

(c) Trust Risk Management Policy

(d) Trust Risk Management Strategy

(e) Information Governance Policy

(f) Trust Health and Safety Policy

(g) Major Incident Response Plan

(h) Disciplinary Policy

11. Appendix A – Monitoring Table for this Policy

The following table sets out the monitoring provisions associated with this policy. Please ensure any possible means of monitoring this policy to ensure all parts are fulfilled are included in this table.

Objective	Evidence	Method	Frequency	Responsible	Committee
Timely review of reported incidents	Managerial review of all incidents within 72 hours	Datix extract Quarterly Patient Safety Report	Quarterly	Divisional Patient Safety Managers	Divisional Governance Group Patient Safety Group
Timely action and feedback to reporter of incidents not subject to a formal investigation	Open incidents within 30 days of being reported	Datix extract Quarterly Patient Safety Report	Quarterly	Divisional Patient Safety Managers	Divisional Governance Group Patient Safety Group
Openness and transparency	See Staff Support and Being Open (Duty of Candour) Policy				
Timely completion of formal investigations	Formal investigation reports completed within 45 days	Divisional monitoring for non-SIs. THQ monitoring for SIs	Quarterly Patient Safety Report Monthly Serious Incident Report	Divisional Patient Safety Managers THQ Patient Safety Team	Divisional Governance Group Patient Safety Group
Taking action in response to learning from incidents	Number of overdue actions from incidents	Divisional monitoring for non-SIs. THQ monitoring for SIs	Quarterly Patient Safety Report Monthly Serious Incident Report	Divisional Patient Safety Managers THQ Patient Safety Team	Divisional Governance Group Patient Safety Group
Quality of formal incident investigations	Compliance with incident checklist	Divisional monitoring for non-SIs.	Quarterly Divisional Reports	Divisional Patient Safety Managers	Divisional Governance Group

12. Appendix B – Dissemination, Implementation and Training Plan

The following table sets out the dissemination, implementation and training provisions associated with this Policy.

Plan Elements	Plan Details
The Dissemination Lead is:	Head of Quality and Patient Safety
Is this document: A – replacing the same titled, expired policy, B – replacing an alternative policy, C – a new policy:	B
If answer above is B: Alternative documentation this policy will replace (if applicable):	Policy for the Management of Incidents
This document is to be disseminated to:	E mail with DMS link
Method of dissemination:	E mail with DMS link
Is Training required:	No
The Training Lead is:	

Additional Comments

13. Appendix C – Equality Impact Assessment (EIA) Screening Tool

Further information and guidance about Equality Impact Assessments is available here:
http://nww.avon.nhs.uk/dms/download.aspx?did=17833

Query	Response
What is the main purpose of the document?	Prompt identification, management, investigation and learning from incidents and implementation of risk reduction actions.
Who is the target audience of the document? Who is it likely to impact on? (Please tick all that apply.)	Add ☑ or ☒ **Staff ☑ Patients ☑ Visitors ☑ Carers ☑ Others**

Could the document have a significant **negative** impact on equality in relation to each of these characteristics?	YES	NO	Please explain why, and what evidence supports this assessment in relation to your response.
Age (including younger and older people)		☑	

Disability (including physical and sensory impairments, learning disabilities, mental health)		☑	
Gender reassignment		☑	
Pregnancy and maternity		☑	
Race (includes ethnicity as well as gypsy travelers)		☑	
Religion and belief (includes non-belief)		☑	
Sex (male and female)		☑	
Sexual Orientation (lesbian, gay, bisexual, other)		☑	
Groups at risk of stigma or social exclusion (e.g. offenders, homeless people)		☑	
Human Rights (particularly rights to privacy, dignity, liberty and non-degrading treatment)		☑	

Will the document create any problems or barriers to any community or group? NO

Will any group be excluded because of this document? NO

Will the document result in discrimination against any group? NO

If the answer to any of these questions is YES, you must complete a full Equality Impact Assessment.

Could the document have a significant positive impact on inclusion by reducing inequalities?	**YES**	**NO**	**If yes, please explain why, and what evidence supports this assessment.**
Will it promote equal opportunities for people from all groups?	☑		This policy will investigate all incidents and ensure equal opportunities are considered throughout the process
Will it help to get rid of discrimination?	☑		The policy will investigate all incidents and highlight any discrimination encountered
Will it help to get rid of harassment?	☑		The policy will ensure any harassment is highlighted, discussed and removed.
Will it promote good relations between people from all groups?	☑		All groups are considered when investigating serious incidents and given equal information
Will it promote and protect human rights?		☑	

On the basis of the information/evidence so far, do you believe that the document will have a positive or negative impact on equality? (Please rate by circling the level of impact, below.)

Positive impact				**Negative Impact**		
Significant	Some ☑	Very Little	NONE ☑	Very Little	Some	Significant

Is a full equality impact assessment required? NO

Date assessment completed: 1st May 2019 update May 2022

Person completing the assessment: [redacted] Head of Quality and Patient Safety

14. Appendix D – List of Patient Safety Special Interest Groups

(a) Blood Transfusion – Hospital Transfusion Group

(b) Decontamination – Decontamination Group

(c) Clinical documentation – Clinical Record Keeping Group

(d) Infection Control – Infection Control Group

(e) Medical Device/Equipment – Medical Equipment Group

(f) Medical Gases- Medical Gas Group

(g) Medication – Medicines Safety Group

(h) Nutrition – Nutrition & Hydration Steering Group

(i) Obstetrics – Women's Divisional Governance Group

(j) Patient Falls – Falls Group

(k) Pressure Ulcers – Tissue Viability Group

(l) Radiation – Radiation Protection Group

(m) Resuscitation – Resuscitation Group

(n) Venous Thrombo-embolism – Thrombosis and Anti-Coagulation Group

15. Appendix E – Governance process and authority for sign off of health and safety investigation reports and completion of actions.

Level of Incident	Incident Risk Rating / Harm	Level of Investigation	Timescale	Investigation sign off by	Investigation outcome presented to	Action plan monitoring	Action plan sign off	Outcome reported to
Ward/ Department	Low/Minor harm incidents not meeting legislative reporting criteria with low potential for serious harm	Local	Not requiring written incident investigation report other than documentation of manager's review and local action taken in Datix. May prompt review of risk assessments/systems of work					
Ward/ Department	Incidents/near misses not meeting legislative reporting criteria with high potential for serious harm	'Treat As RIDDOR'	3 weeks from receipt of investigation request	Health and Safety incidents Head of Health and Safety Services	Safety Department	Safety Department	Safety Department	Divisional Health and Safety forums
Ward/ Department	RIDDOR reportable as Specified injuries	Local with assistance from Divisional Health and Safety Leads/Advisors, Matrons or Specialist Advisors, where required	3 weeks from receipt of investigation request	Health and Safety incidents - Head of Health and Safety Services	Safety Department	Safety Department	Safety Department	Summary of findings and action taken presented to Risk Management Group and Divisional Health and Safety Leads via Trust Health and Safety Committee and Divisional Health and Safety forums

Level of Incident	Incident Risk Rating / Harm	Level of Investigation	Timescale	Investigation sign off by	Investigation outcome presented to	Action plan monitoring	Action plan sign off	Outcome reported to
Ward/ Department	Reportable Occupational diseases	Local with assistance from Occupational Health or other departments as required	3 weeks from receipt of investigation request	Head of Health and Safety Services	Safety Department	Safety Department	Safety Department	Summary of findings and action taken presented to Risk Management Group and Divisional Health and Safety Leads via Trust Health and Safety Committee and Divisional Health and Safety forums
Ward/ Department	Dangerous Occurrences	Local with assistance from specialist Advisors or other Departments as required	3 weeks from receipt of investigation request	Head of Health and Safety Services	Safety Department	Safety Department	Safety Department	Summary of findings and action taken presented to Risk Management Group and Divisional Health and Safety Leads via Trust Health and Safety Committee and Divisional Health and Safety forums
Cross Divisional	Dangerous Occurrences	Divisional Health and Safety Leads/Advisors/		Head of Health and Safety Services	Safety Department	Safety Department	Safety Department	Summary of findings and action taken

Level of Incident	Incident Risk Rating / Harm	Level of Investigation	Timescale	Investigation sign off by	Investigation outcome presented to	Action plan monitoring	Action plan sign off	Outcome reported to
		Specialist Advisors and other Departments/ External contractors as required.						presented to Risk Management Group and Divisional Health and Safety Leads via Trust Health and Safety Committee and Divisional Health and Safety forums
Corporate	Fatality – As a result of work-related accident	Immediate notification to Health and Safety Executive / Head of Health and Safety Services. Investigation by Safety Department with input by other Departments as required. Potential for external investigation by enforcing authority	Shortest timescale possible	Director of People / Head of Health and Safety Services	Trust Health and Safety Committee / Risk Management Group	Safety Department / Risk Management Group	Safety Department	Summary of findings and action taken presented to Risk Management Group and Divisional Health and Safety Leads via Trust Health and Safety Committee and Divisional Health and Safety forums
Enforcing authority enquiries post incident	RIDDOR reportable as Dangerous Occurrences Specified injuries	Corporate Safety Department	1 week unless extension requested	Director of People / Head of Health and Safety Services	Enforcing Authority	Safety Department / Risk Management Group	Director of People	Summary of findings and action taken presented to Risk Management

Level of Incident	Incident Risk Rating / Harm	Level of Investigation	Timescale	Investigation sign off by	Investigation outcome presented to	Action plan monitoring	Action plan sign off	Outcome reported to
	Reportable Occupational diseases Fatality – As a result of work-related accident							Group and Divisional Health and Safety Leads via Trust Health and Safety Committee and Divisional Health and Safety forums

16. Appendix F – Governance process and authority for sign off of patient safety incident investigation reports and completion of actions.

Level of investigation	Action plan approval	Investigation/ PSII managerial* sign off	Action plan monitoring by	Investigation report Governance approval	Action plan sign-off (completion agreed)	Report supplied for assurance purposes
Local investigation	Divisional Patient Safety Department / Departmental managers	Not requiring written incident investigation report other than completion of managers review of incident on Datix. Documentation on Datix of action(s) taken.				
Divisional PSII(not Serious Incident PSII)	Divisional Governance Group	Divisional Patient Safety Lead/Clinical Governance Lead. (The person signing off must not have been part of the investigating team). A divisional PSII must be signed off by Clinical Chair/Divisional Director/Head of Nursing/Midwifery prior to sharing with patient/family/ carer. A divisional PSII must be signed off by an executive director before sharing externally e.g. the Coroner, the CQC.	Divisional Governance Group	Divisional Governance Group	Divisional Governance Group	Divisional Governance Group
Healthcare Safety Investigation Branch	Divisional Governance Group and Clinical Quality Group	Factual accuracy check with division and contributors. Also Head of Quality and Patient	Divisional Governance Group and	HSIB	Divisional Governance Group and Trust	Divisional Governance Group and Trust Patient Safety Group

Level of investigation	Action plan approval	Investigation/ PSII managerial* sign off	Action plan monitoring by	Investigation report Governance approval	Action plan sign-off (completion agreed)	Report supplied for assurance purposes
maternity incidents - concurrently declared as serious incidents Ockenden Report recommendation		Safety for investigations crossing divisions.	Trust Patient Safety Group		Patient Safety Group	
Cross divisional investigation PSII (not serious incident)	Divisional Governance Groups of relevant divisions Trust Patient Safety Group	Divisional Director, Clinical Chair or Head of Nursing of relevant divisions	Trust Patient Safety Group	Trust Patient Safety Group	Trust Patient Safety Group	Trust Patient Safety Group
Cross provider PSII (not serious incident or serious incident)	If UHBW incident and leading investigation Trust Patient Safety Group and Clinical Quality Group. For serious incidents see Serious Incident Policy. If UHBW not leading but contributing to investigation Divisional Director, Clinical Chair, or Head of Nursing for UHBW actions. For serious incidents see Serious Incident Policy.	Executive Director Head of Quality Patient Safety	Trust Patient Safety Group Divisional Governance Group	Trust Patient Safety Group. Divisional Governance Group	Trust Patient Safety Group Divisional Governance Group	Trust Patient Safety Group Divisional Governance Group

Level of investigation	Action plan approval	Investigation/ PSII managerial* sign off	Action plan monitoring by	Investigation report Governance approval	Action plan sign-off (completion agreed)	Report supplied for assurance purposes
Independent investigation including HSIB	Trust Patient Safety Group, Clinical Quality Group	N/A	Trust patient Safety Clinical Quality Group	N/A	Clinical Quality Group	Quality and Outcomes Committee

17. Appendix G – Documentation for RIDDOR Incidents

Health and Safety Incident reporting and RIDDOR link

REPORTABLE INCIDENTS (Health and Safety)

Certain incidents are reportable to the Health and Safety Executive (HSE) under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations 2013 (RIDDOR).

The following types of incident are reportable:

(1) Where any person at work, as a result of a work-related accident, suffers—

(a) any bone fracture diagnosed by a registered medical practitioner, other than to a finger, thumb or toe;

(b) amputation of an arm, hand, finger, thumb, leg, foot or toe;

(c) any injury diagnosed by a registered medical practitioner as being likely to cause permanent blinding or reduction in sight in one or both eyes;

(d) any crush injury to the head or torso causing damage to the brain or internal organs in the chest or abdomen;

(e) any burn injury (including scalding) which—

(i) covers more than 10% of the whole body's total surface area; or

(ii) causes significant damage to the eyes, respiratory system or other vital organs;

(f) any degree of scalping requiring hospital treatment

(g) loss of consciousness caused by head injury or asphyxia; or

(h) any other injury arising from working in an enclosed space which—

(i) leads to hypothermia or heat-induced illness; or

(ii) requires resuscitation or admittance to hospital for more than 24 hours

(2) Where any person at work is incapacitated for routine work for more than seven consecutive days (excluding the day of the accident) because of an injury resulting from an accident arising out of or in connection with that work, the responsible person must send a report to the relevant enforcing authority in an approved manner as soon as practicable and in any event within 15 days of the accident.

The above includes: incidents involving patients and other persons not at work on healthcare premises or violence to staff resulting in any of the above

Dangerous Occurrences:-

Dangerous occurrences apply to all workplaces and include incidents involving, lifting equipment, pressure systems, overhead electric lines, electrical incidents causing explosion or fire, explosions, biological agents, radiation generators and radiography, breathing apparatus, diving operations, collapse of scaffolding, train collisions, wells and pipelines or pipeline works.

Occupational Diseases:- Particular diseases where the person affected is or has worked in a specified activity

18. Appendix H –External bodies to whom incidents should be reported

Incident Topic	External Agency	UHBW reporter and contact for advice
All patient safety incidents	Care Quality Commission via Datix uploads to the National Reporting and Learning System (NRLS)	Trust Headquarters Patient Safety Team
All serious incidents	Commissioners via South West Commissioning Support Unit	Head of Quality and Patient Safety Trust Headquarters Safety Team
All serious incidents involving welsh patients receiving specialist treatment	Welsh Health Specialised Services Committee	Via BNSSG commissioners as above
All serious incidents	Care Quality Commission via NRLS and STEIS but also proactively in some circumstances e.g. Never Events	Chief Nurse/Medical Director Head of Quality and Patient Safety
Maternity incidents as described in section 7.11	Healthcare Safety Investigation Branch	Head of Midwifery Patient Safety Manager for maternity services
Maternity/ Neonatal Incidents meeting criteria for Early Notification Scheme	NHS Resolution	Legal Team
Maternal and neonatal deaths	Mother and Babies Reducing Risk through Confidential Enquiries	Women's and Children's Division Quality and Patient Safety Manager, St Michaels Hospital
Information Governance Serious Incidents	Information Commissioner's Office, Department of	Head of Information Governance Information Governance Officer

Incident Topic	External Agency	UHBW reporter and contact for advice
	Health via NHS Digital	
Serious Health and Safety incidents (RIDDOR)	Health and Safety Executive	Head of Health and Safety Services
Incidents which involve medical devices Incidents which involve medicines	Medicines and Healthcare Products Regulatory Agency (MHRA)	Medical Devices: Medical Device Safety Officer Medicines: Medicines Safety Officer
Blood Transfusion incidents	MHRA and Serious Hazards of Transfusion	Transfusion Practitioner or Haematology Department Guidance for what is reportable: Serious Hazards of Transfusion web portal (SHOT) and SABRE – Serious Adverse Blood Reactions and Events
Incidents involving possible criminal activity	Police	Head of Legal Services Local Security Management Specialist Director of Finance & Local Counter Fraud Specialist where fraud is suspected to be involved
Emergency Plan/Major incident invoked	NHS Improvement BNSSG regional team[2]	Resilience Manager
Safeguarding Children & Adults	Local Safeguarding Children Board Commissioners	Chief Nurse Nurse Consultant for Safeguarding
Deaths of patients aged under 18	Child Death Review process	Designated doctor for Child Deaths
Incidents where press enquiries are anticipated	Print, Radio and Television Media	Head of Communications
Incidents where Professional	General Medical Council, Nursing	Medical Director or Chief Nurse Divisional Clinical Chair

[2] Bristol North Somerset South Gloucestershire

Incident Topic	External Agency	UHBW reporter and contact for advice
Regulatory or Defence Organisations are likely to be involved	and Midwifery Council or Health Professionals Council, General Pharmaceuticals Council Professional Defence Organisations	Head of Nursing Supervisor of Midwives Lead Allied Health Professional Director of Pharmacy
Major communicable disease outbreaks and MRSA bacteraemia incidents	Health Protection Agency	Infection Control Team
Serious infection related incidents	Health Protection Agency	Infection Control Team
Other unexpected deaths	Referral to HM Coroner	Legal Services
Incidents likely to form the basis of a negligence claim	NHS Resolution	Legal Services
Radiation incidents involving staff Radiation incidents involving patients	Health and Safety Executive Environment Agency IRMER Inspectorate of the Care Quality Commission	Local Radiation Protection Supervisor and Trust Radiation Protection Advisor
Fraud	NHS Protect	Local Counter Fraud Specialist Local Security Management Specialist
Workforce incidents	Home Office	Director of People
Screening Programmes	Relevant Screening Programme Centre	Public Health England Screening Quality Assurance Service (South) Managing safety incidents in NHS screening programmes (Public Health England 30 October 2015)

Incident Topic	External Agency	UHBW reporter and contact for advice
Serious adverse event or reaction resulting from the procurement, testing, transport or infusion of stem cells	Human Tissue Authority within 24 hours	Stem Cell Transplant Quality and Service Manager
Post mortem serious incidents	Human Tissue Authority	Human Tissue Authority Designated Individual (Consultant Senior lecturer Oral and Maxillofacial Pathology) https://www.hta.gov.uk/reporting-incident-or-concern